Item 1

NHS Orkney Board
30 April 2026

Purpose of Orkney NHS Board

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

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

- Open and honest
- Respect
- Kindness

Our **Strategic Objectives** are:

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

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

People Ensure NHS Orkney is a great place to work

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

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

Quorum:

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

Minute Public Board Meeting
Thursday 26 February 2026

Present

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

In attendance

Debs Crohn (Head of Corporate Governance - Minutes), Tammy Sharp (Director of Performance,Transformation), Shona Lawrence (NHS Orkney Corporate Communications Officer), Dave Harris (Director of People and Culture), Dave Harris (Director of People and Culture), Stephen Brown (Chief Officer - Integration Joint Board).

Observers

Barbara Graham, Andrew Smith, Sophie Marriott, Brenda Wilson, Michael Morrison, Alex Francis, Natasha Cornick, Brenda Wilson, Andrew Stewart, Iain Grant, Cameron Stout, Jenny Devlin, Wendy Corstophine

1. Cover page

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2. Welcome and Apologies (Presenter: Chair)

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

No apologies were noted.

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

The Interim Board Chair thanked the Interim Director of Finance for their support over the past 18 months and acknowledged that it is testament to their hard work that the Boards financial improvements have been made.

The Interim CEO thanked the Interim Director of Finance for the support offered to them since they joined the Board in September 2025.

3. Declarations of Interest (Presenter: Chair)

No declaration of Interest to be recorded.

4. Minutes of Previous Meeting 11 December 2025 (Presenter: Chair)

Minutes of the meeting held on 11 December 2025 were accepted and approved as an accurate record of the meeting.

J Taylor to be added as an attendee to the Minute from the meeting 11 December 2026.

5. Matters Arising (Presenter: Chair)

No matters arising were raised.

6. Action Log (Presenter: Chair)

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

7. Board Chair and Chief Executive Report to the Board – February 2026 (Presenters: Interim Board Chair, Interim CEO)

The Interim CEO presented the Board Chair and Chief Executive Report providing an update on key events and activities in January and February 2026.

The Interim CEO recognised the pressures being seen across our health and social care system resulting in an increase in demand. To address the increased demand, additional capacity has been put in place, noting the impact this has on staff.

The Interim CEO advised that there has been a whole system response to the increased demand, and we continue to work with partners to address the additional pressures.

The Board continues to face financial difficulties, although there has been some year-end improvement from increased income. However, major spending cuts have not yet occurred.

Earlier this year, the Board conducted an external peer review of maternity services. The feedback was positive regarding patient satisfaction, organisational culture, and a strong partnership with NHS Grampian. The review identified areas needing improvement, such as clinical governance and the need for a separate hospital entrance to enhance patient confidentiality. It also recommended evaluating our leadership and staffing approach in maternity care. The EDoNMAHP will move forward with implementing an action plan.

The Interim CEO and Chief Officer IJB met with the Minister for Mental Health, who acknowledged that our CAMHS and Psychological Therapies Service consistently met the national targets for timely access.

Performance remains on track to deliver no >52-week waits across all specialties by 31 March 2026.

We continue to work with East of Scotland Health Boards on sub-regional planning and the opportunities this provides for delivery of the My Care app and the Business Systems Programme.

National and local engagement continues particularly in relation to Public Sector Reform.

The Interim Board Chair advised that recruitment for the 2 Non-Executive Board Members will commence 26 February 2026.

I Grieve asked for clarity on the plans for GP walk-in centers for Orkney noting other Health Boards have put this in place. The Interim CEO advised that the Board were unable to meet the criteria proposed at that time due to the lack of community estate. The Chief Officer IJB advised that a submission was made to Scottish Government, conversations will continue and will monitor the roll out of GP Walk-in services across Scotland.

Decision / Conclusion
The Board noted the update provided.

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

The Medical Director presented the Corporate Risk and Assurance report, updating the Board on the highest corporate risks, these being financial sustainability, lack of senior leadership capacity and capability and clinical engagement.

The Interim Board Chair asked for clarity on the risk in relation to social care capacity. The EDoNMAHP apologised that the risk had not being updated due to system pressures and provided assurance to Board that this will be updated ahead of the next meeting.

J Taylor raised a concern in relation to risk 1225 and asked for clarity in relation to the fourth wing at Hamnavoe House. The Chief Officer IJB advised the issue is in relation to

staffing the facility and will be reliant on agency staffing which could de-stabilise the whole system. Agency staffing continue to support the care at home service, conversations have taken place with local colleges and Scottish Government in relation to recruitment challenges noting this is not unique to NHS Orkney.

Dr. K Cole requested details on digital risks and mitigation timelines. The Interim Director of Finance responded that the team is addressing these through internal risk management and will present a consolidated digital risk in the Corporate Risk Register at the next meeting.

Decision / Conclusion
The Board noted the progress made to update and the current mitigation of risks highlighted.

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

The Director of Performance and Transformation reminded members of the areas covered within the Integrated Performance Report (IPR) up till the end of December 2025, advising that we continue not to meet the waiting times target however we remain on target to deliver the nationally mandated target of zero waits over 52 weeks by 31 March 2026. The Interim Board Chair recognised the progress being made against this target.

Patient Safety, Quality and Experience

The Medical Director reminded the Board that the number of inpatient falls, in the IPR are not falls with harm, falls are being reported as a quality measure only.

Compliance against the Pediatric Early Warning Scores (PEWs) remains off track due to recording challenges. The Maternity Early Warning Scores (MEWs) target has seen a dip in performance, a rapid deep dive has been undertaken, and indications are that no patient harms have occurred as a result of the dip in performance.

I Grieve thanked the team for the narrative in the IPR, however raised concerns in relation to how the data is presented and requested that an additional column be added to identify the changing position. The Director of Performance and Transformation advised that the data is presented on the individual Statistic Process Control (SPC) charts and advised that arrows could be added back in to the IPR to show the direction of travel for Key Performance Indicators (KPI's).

J Stevenson asked if the issue in relation to the dip in performance of the MEWs KPI was raised during the maternity peer review. The EDoNMAHP advised that this was not raised in the peer review.

Operational Standards

The EDoNMAHP updated that compliance against the Scottish Ambulance Service (SAS) turnaround time, the 4- and 12-hour Emergency Department (ED) waiting times remain on target.

The Medical Director advised that the reduction in waiting times has a knock-on effect in relation to our Treatment Time Guarantee (TTG). Following significant outpatient improvements, the TTG targets is now off-track.

Improvements are being seen, in relation to our endoscopy and diagnostic services.

R Gold requested confirmation about when progress would be made towards achieving our Delayed Transfers of Care (DTOC) target. The Chief Officer IJB explained that the challenges affecting DTOC are connected to care home beds, guardianship issues, and packages for care at home. Although the numbers remain consistently high, this does not involve the same individuals each time. There is no clear timeline for meeting the target trajectory. However, increasing staffing levels, introducing a frailty pathway, and making decisions earlier in the patient journey should help improve the situation, bearing in mind the need to balance patient risk with their rights.

Dr. K Cole asked the Chief Officer IJB how DTOC affects primary care, especially regarding families and carers, pointing out that the IPR seems to focus more on secondary care impacts. The Chief Officer IJB recognised broader risks affecting carers and noted that while the IJB has raised concerns about the impact on carers, further action is needed, including better metrics for tracking community waiting lists.

The Interim CEO recognised the need to better understand capacity and demand, noting that the increase in DTOC's is not acceptable and there needs to be a step change to reduce the number of DTOC's.

F Mackay asked the Executive team to review the mitigating actions if they are not improving the Key Performance Indicators.

Community

The Chief Officer IJB recognised the work undertaken within the Children's Adolescent Mental Health Service (CAMHs) noting that the 18-week target is being consistently met.

Our podiatry service has achieved a significant improvement in reducing the waiting lists and this needs to be recognised and celebrated.

Dr K Cole asked where the Phio report will be presented. The Chief Officer IJB advised this will be presented to the Joint Clinical Care Governance Committee (JCCGC) to enable feedback to be presented to the Board and the IJB. Over 70 patients have engaged with the Phio app, this has seen a reduction in the overall number of people on the waiting list.

Population Health

The Director of Public Health advised that our immunisation performance continues to be on trajectory.

The smoking cessation team have been working with our pharmacy team and previous referrers have been asked to provide feedback on those attending the service. Digital display screens at The Balfour have also been updated to provide information on the service.

There has been a drop in newborn blood spot screening due to staffing issue. The Board were assured that the staffing issues have now been resolved.

J Stevenson noted a slight decline in MMR vaccination uptake and asked if more communications are needed. The Director of Public Health said national communications are ongoing but agreed local efforts could help.

The Interim Board Chair asked the Director of Public Health how we locally appraise ourselves and celebrate the areas we do well. The Director of Public Health advised that communications population health is promoted locally, recognising that more could be done.

Workforce

The Director of People and Culture advised that challenges continue in relation to sickness absence impacted by operational pressures.

The Director of Public Health asked if we are looking at options to support staff with long-term conditions, for example access to work. The Director of People and Culture recognised the need for managers to support staff with Long Term Conditions.

Appraisal compliance remains a challenge, a review is being undertaken in relation to when appraisals are completed, there will be a focus on this at the upcoming Performance Review Meetings (PRM's).

J Stevenson reflected that appraisal rates remain challenging and asked if the process could be refined to make the process easier for managers. The Director of People and Culture advised that there are many reasons for the appraisal rates and advised that the focus has to be on a mindset shift, all staff have a responsibility to engage in the appraisal process. All managers will be set an objective around staff appraisals.

The Employee Director recognised the need to set expectations and shifting mindset of managers in relation to increasing appraisal compliance.

We continue to see high reliance on temporary staffing; workshop took place last week with consultant to look at recruitment and retention.

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.

10. CHAIR'S ASSURANCE REPORTS

10.1. Audit and Risk Committee Chair's Assurance Report 2 December 2025 - (Presenter: Jason Taylor – Chair Audit and Risk Committee)

The Chair of the Audit and Risk Committee presented the Chair's Assurance Report from the 2 December 2025 meeting. Key matters of concerns raised were as follows:

- Committee noted that the payroll audit has resulted in several recommendations and pieces of work being taken forward.
- Ownership of risks and audit actions – this is being taken forward by the Interim CEO with the Executive Management Team.

Decision / Conclusion
The Board noted the update and took assurance on the report.

10.2. Finance and Performance Committee Chair's Assurance Reports 17 December 2025 and 28 January 2026 (Presenter: Fiona Mackay - Chair of Finance and Performance Committee)

The Chair of the Finance and Performance Committee presented the Chair's Assurance Reports from the 17 December 2025 and 28 January 2026 meetings. Key matters of concerns raised are as follows:

- Robertsons contract – an interim contract manager has been appointed, and improvements are now being made in relation to the contract,
- A consolidated digital risk has been developed and was discussed earlier in the agenda.
- The number of Delayed Transfers of Care (DTOC's) remains unacceptable.
- Financial Performance remains off track, however at month 10 we are reporting an improved position.

Work is underway to focus on the financial aspects of medical staffing; an improvement plan was discussed by Committee. Plans were presented for the 3 'big ticket items'/priorities for 2026/27: these being GP Out of Hours, Isles Model of Care and Digital.

The Board noted that the Finance and Performance Committee are meeting monthly to strengthen the role of the Committee.

I Grieve asked for clarity on the digital risk and asked when an action plan will be brought forward. The Interim Director of Finance advised that the risk will be brought through the Risk Management Group in March and back to Board in April 2026.

Decision / Conclusion
The Board noted the update and took assurance on the report.

10.3. Senior Leadership Team Chair's Assurance Report 12 January 2026 (Presenter: Interim CEO - Chair of Senior Leadership Team)

The Chair of the Senior Leadership Team (SLT) presented the Chair's Assurance Report from the 12 January 2026 meeting summarising the main points as follows:

- Risks in relation to Digital Services
- Financial position
- Partnership Working
- Reduced Working Week

The Interim Board Chair welcomed the changes made at the SLT, the Interim CEO advised that changes have been made in relation to the Executive Management Team and welcomed the feedback re SLT.

Decision / Conclusion
The Board noted the update and took assurance on the report.

10.4. Joint Clinical Care Governance Committee Chair's Assurance Report 4 February 2026 (Presenter: R Gold, Chair Joint Clinical Care Governance Committee)

The Chair of the Joint Clinical Care Governance Committee (JCCGC) presented the Chair's Assurance Report from the 4 February 2026 meeting summarising the main points as follows:

- Cost pressures in relation to Personal Protective Equipment
- Clinical Engagement in Serious Adverse Event Reviews (SAER's)

The Chair asked for clarity on what actions could be taken by the Board in relation to the areas of concern raised.

The EDoNMAHP reported a nationwide change to PPE requirements for Highly Infectious Disease, creating cost pressures for Health Boards. Discussions with the national team continue as they await the final costs and anticipate additional financial challenges.

The Medical Director advised that clinical quality groups have been established to support SAER's recognising the additional ask this puts on our clinical colleagues.

Decision / Conclusion
The Board noted the update and took assurance on the report.

10.5. Staff Governance Committee Chair's Assurance Report 12 February 2026 (Presenter: R Gold, Chair Joint Clinical Care Governance Committee)

The Chair of the Staff Governance Committee presented the Chair's Assurance Report from the 12 February 2026 meeting summarising the main points as follows:

- In sufficient Senior Leadership capacity and capability remain a challenge

- Appraisals rates remain off target.
- Resuscitation and face fit testing compliance remains off target – plan in

The Committee took assurance for the first time on the Quarter 3 Health and Care Staffing Act Report.

J Stevenson requested an update on resuscitation training compliance. The EDoNMAHP responded that an extra trainer has been recruited though releasing staff for sessions remains a challenge. Clinical Nurse Managers are actively addressing this.

R Gold asked that all Committees assess the risk of senior leadership capacity and capability beyond just financial factors. The Interim CEO agreed, emphasising consideration of long-term effects.

Decision / Conclusion
The Board noted the update and took assurance on the report.

10.6. Area Clincial Forum (ACF) 12 December 2025 and 4 February 2026 (Presenter: Dr K Cole, Chair Area Clinical Forum)

The Chair of the Area Clinical Forum presented the Chair's Assurance Reports from the 12 December 2025 and 4 February 2026 meetings summarising the main points as follows:

- Ongoing lack of hospital sub-committee and area dental committee attendance at ACF impacting on the quality of scrutiny being applied
- Maturity of the Area Clinical Forum

The Interim Board Chair requested clarification on the governance gap and current actions. The Medical Director reported discussions with the ACF Chair, noting challenges due to a shortage of candidates for Area Medical Committee Chair. It was decided to establish a formal Area Medical Committee. Attempts to recruit the Hospital Sub Committee Chair were unsuccessful; consultants are meeting with the Medical Director.

The Medical Director advised that administrative support is being provided to all clinical advisory groups.

Decision / Conclusion
The Board noted the update and took assurance on the report.

10.7. Area Partnership Forum 20 January 2026 (Presenter: R McLaughlin, Employee Director)

The Chair of the Area Partnership Forum (APF) presented the Chair's Assurance Report from its meeting 20 January 2026. Points to note:

- Positive performance of NHS Orkney in the national iMatter benchmarking
- Issues in relation to Robertsons contract discussed.

- Workforce report was discussed, a deeper dive analysis has now been taken forward.
- A review of the Health and Social Care data has been undertaken; staff side members are keen to see real-time staffing tool/method being used on an annual basis.

Decision / Conclusion
The Board noted the update provided.

11. STRATEGIC OBJECTIVE - PLACE

11.1. Integration Joint Board (IJB) key items, decisions and finacial update (Presenter: Chief Officer - IJB)

The Chief Officer IJB presented the Integration Joint Board (IJB) key items, decisions and financial update following the IJB December 2025.

The Interim Board Chair welcomed the update.

Decision/Conclusion
The Board noted the Integration Joint Board (IJB) key items, decisions and financial update.

11.2. Community Planning Partnership Update (Presenter: Chief Officer - IJB)

The Chief Officer IJB presented the Community Planning Partnership updates from the meetings previous quarter. The Scottish Government Place Director attended the December meeting, focus on public sector reform.

Board Chair welcome equalties and population health groups.

Decision/Conclusion
The Board noted the Community Planning Partnership Update.

11.3. Public Sector Reform Update (Presenter: Chief Officer - IJB)

The Chief Officer IJB presented an update on Public Sector Reform. Following Orkney's 'Routemap to Reform' document being approved 11 December 2025; this was submitted to Scottish Government 12 December 2025 following approval by the JB and Orkney Island Council.

Some positive verbal feedback has been received from Scottish Government officials but, as yet, no written feedback has been received from Scottish Ministers.

A Leadership Steering Group (comprising the Chief Executives of NHS Orkney and Orkney Islands Council, the Chair of the NHS Orkney Board, the Leader of Orkney Islands Council, the Chair, Vice Chair and Chief Officer of the Integration Joint Board and the Governance Leads from NHS Orkney and Orkney Islands Council) meets on a three-weekly basis.

To further strengthen relationships and begin planning the implementation of the routemap a session with the steering group was helpfully supported by John Sturrock K.C, with a further session planned for early March and a wider engagement session planned for May 2026 following the upcoming election period.

Decision/Conclusion
The Board noted the Public Sector Reform update.

11.4. Sub-national regional planning update (Presenter: Director of Performance and Transformation)

The Director of Performance and Transformation presented an update on sub-national regional planning. This mandated Health Boards across Scotland to work more closely on 5 key priorities, and to agree joint plans to deliver these by 31st March 2026.

SPDCE has also commissioned work on Rural and Island healthcare, and terms of reference for orthopaedics, emergency healthcare, digital front door, and Rural and Islands work have been agreed.

Ministerial Direction is to bring forward plans by 31st March against the five key priorities above, expectation that SPDCE and SPDCW will continue to work after that date to ensure delivery against plans by 31st March 2029.

The Interim Board Chair reflected that concerns in relation to North of Scotland work previously undertaken would be lost, this has certainly been heard.

I Grieve raised concerns about the amount of staff time required to attend the East of Scotland meetings and asked for clarity on when we are likely to see the benefits in Orkney.

The Interim CEO recognised the ask on Executive staff and all Board CEO's have been asked to look at backfilling recognising this is part of Boards discharging their responsibilities for collaboration. Work is underway to look at how patients access urgent care services, orthopaedic plans are currently in draft, this is being worked up but no timelines at present.

Dr K Cole asked if there is a date when the remote and rural workstream leads will be confirmed. The Interim CEO advised that there is strong support for this workstream. Since papers were submitted workstream leads have been confirmed.

Decision/Conclusion
The Board noted the sub-national regional planning update.

12. STRATEGIC OBJECTIVE – PEOPLE

12.1. Agenda for change Reform - Reduced Working Week Implementation Plan (Presenter: Director of People and Culture)

The Director of People and Culture presented the Reduced Working Week Implementation Plan for assurance. Implementation of the Reduction in the Working

Week (RWW) is underway across NHS Orkney, with services having plans to transition from 37 to 36 hours per week.

Work continues to be taken forward in partnership with recognised Trade Unions, ensuring staff-side engagement in the process.

Efforts are now focused on ensuring colleagues are supported to retain part-time hours, and recruiting is progressing for clinical backfill, where approved, to ensure service delivery remains and staff personnel records are updated.

The Interim Board Chair asked for confirmation of the roles being backfilled and asked if there are any risks associated with implementing the RWW. The Director of People and Culture advised that part-time staff can retain part-time hours and acknowledged that there may be questions once implemented.

J Taylor reflected that the organisational response has been to flex resources to deliver the mandated request noting that we still haven't addressed the local issue of appraisal and training compliance. The Director of People and Culture acknowledged the reflection.

Dr K Cole asked how that RWW fits with the wider asks around staffing establishment. The Director of People and Culture advised that this also needs to include financial, health and care staffing act and establishment. The EDoNMAHP advised that protected learning time, health and care staffing act and time to lead was taken into consideration when developing the RWW implementation plan.

J Stevenson asked if staff working part time would be willing to increase hours. EDoNMAHP advised that this has been considered and offered to staff and teams.

J Stevenson asked for clarity on maternity staff reducing the working week and the impact this may have on handover. The EDoNMAHP advised that this has been mapped out by the Lead Midwife, but there will be no impact.

J Kenny thanked those who contributed to the RWW Implementation Plan.

The Interim CEO recognised the need to step back noting the number of national workforce asks which remains challenging for smaller Boards.

The Medical Director advised that in some areas RWW has provided an opportunity for service re-design and this will feed into workforce planning in those areas.

Decision/Conclusion
The Board took assurance on the Reduced Working Week Implementation Plan.

12.2. Update on Equality Outcomes Report 2026-2029 (Presenter: Director of People and Culture)

The Director of People and Culture presented an update on Equality Outcomes Report 2026-2029.

NHS Orkney is legally required to publish Equality Outcomes every four years. As outcomes for 2021–2025 have expired and none were published in 2025, there is a pressing need to agree and progress Equality Outcomes for 2026–2029 to ensure compliance and mitigate reputational and governance risk.

The Executive Team presented the Board with three draft suggested equality outcomes. The draft outcomes aim to balance ambition with realism given limited specialist equality capacity and known data quality challenges with tangible outcomes. Further updates will be presented to Board in due course.

J Kenny acknowledged the report, highlighting the challenging decisions required by the Board, especially those in outcome 3. He expressed concern about lacking capacity to meet statutory requirements. The Director of People and Culture confirmed that no resources are currently allocated to this piece of work.

R Gold thanked the Executive Team for the report and highlighted a discussion in relation to outcome 1 which addresses patient feedback on quality and asked consideration by given to protected characteristics.

R Gold asked if outcome 2 needs to be focused on outcomes and access. The Director of People and Culture noted the comments from R Gold.

F Mackay asked if there is an opportunity for this piece of work to be undertaken collaboratively with Orkney Island Council and the Integration Joint Board. The Chief Officer advised that this could be built into the work being undertaken on Public Sector Reform.

Decision/Conclusion
The Board discussed the Equality Outcomes Report 2026-2029 and noted progress being made.

13. PATIENT SAFETY, QUALITY AND EXPERIENCE

13.1 Financial Case for MRI provision in NHS Orkney (Presenter: Medical Director)

The Medical Director presented the financial case for MRI provision in NHS Orkney to the Board for assurance.

NHS Orkney is seeking Scottish Government agreement to sustain the MRI provision beyond the end of the current time-limited funding period in May 2026. A relocatable MRI scanner has been successfully implemented at The Balfour Hospital and has been validated for a wide range of examinations including prostate MRI.

The service has repatriated the majority of MRI activity that would otherwise have been referred to NHS Grampian, materially improving access, pathway timeliness, and patient experience. We anticipated 800 scans being delivered, however that number is likely to be over 1,000.

A proposal for an additional year and ongoing funding has been submitted to the national imaging group, following positive patient feedback.

Feedback has not yet been received; this is likely to be provided by late March 2026. The Medical Director reminded the Board that the MRI scanner is relocatable, and not a permanent fixed scanner, costs for a fixed scanner are likely to be significantly higher.

J Taylor observed that the report references costs associated with NHS Grampian and inquired whether the costs related to the Service Level Agreement (SLA), specifically regarding cost savings for NHS Grampian and diagnostic capacity across the East of Scotland, have been quantified. The Medical Director responded that patient treatment in Aberdeen would not be cost neutral and highlighted challenges concerning the review of the SLA due to reluctance to proceed with such an undertaking. Scottish Government has requested that all Boards adopt a national strategy towards achieving savings.

The Interim CEO acknowledged that it is complex for Health Boards to review SLAs. Work is currently in progress to establish a baseline for all SLAs, which will also be applied to our MRI service.

The EDoNMAHP thanked the Medical Director and the Radiology Manager for the work to date and asked that consideration be given to a covered walkway being put in place for patients accessing the MRI scanner.

J Kenny asked that sustainability by better reflected in the business case particularly from a travel perspective. The Medical Director acknowledged that air travel has been included in the business case, as well as remote consultations.

I Grieve noted their hesitation to agree with the Scottish Government's stance on the national diagnostics approach and expressed interest in thoroughly examining the cost savings achieved by NHS Grampian. The Medical Director shared that discussions have occurred with NHS Highland and is interested in exploring options for patients in Caithness.

The Medical Director advised that whilst this should be celebrated there is a risk that if the service ceases patients will need to travel to Aberdeen and we will lose the back up for our CT scanner.

Decision/Conclusion
The Board took assurance from the report.

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

The EDoNMAHP presented the Healthcare Associated Infection Reporting Template Report (HIART) advising that local delivery standard targets are currently within projected levels and one outwith, however this target was also set at zero.

Hand Hygiene and Multi Drug Resistance Organism (MDRO) targets have been achieved for this report.

The EDoNMAHP commended the infection control and estates team for achieving the targets.

Decision/Conclusion
The Board took assurance from the report.

13.3 Safety, Quality and Experience Report, Quarter Two – Quality Extract (Presenter: Medical Director)

The Medical Director presented the Safety, Quality and Experience Report, Quarter Two report for assurance.

The Excellence in Care (EiC) approach continues to strengthen assurance, with improved organisational participation and improving data submission rates (15% to 41% over 12 months).

Falls remain a significant challenge to describe those with and without harm. With increasing reporting and active mitigation; NHS Orkney will participate in the national SPSP falls with harm programme.

Key service improvement work is progressing, including the Community Dressings pilot and behavioural standards framework.

Overdue incidents and delayed SAERs remain a concern due to lack of clincial engagement.

Decision/Conclusion
The Board took assurance from the report.

14. STRATEGIC OBJECTIVE - PERFORMANCE

14.1. Month 10 Finance & Improving Together (efficiency programme) progress report (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Month 10 finance and Improving Together (efficiency) Programme progress report.

There has been a significant improvement in the YTD position as at Month 10 which is predominantly due to the release of reserves by the IJB, additional funding and release of accruals. This is a non- recurring benefit for 2025/26 and the position remains challenging for 2026/27.

At the end of Month 10, the reported financial position an overspend of £2.220m, which is £44k higher than the planned deficit of £2.176m but £195k lower than the planned trajectory.

A revised year-end forecast was submitted to SG in Month 8, predicting a deficit of £4.2m at 31 March 2026. Due to the improvements in Month 9, a revised forecast of £3.6m was submitted. With the release of the IJB reserves, the forecast has been further reduced in Month 10 to £2.7m.

Scottish Government have confirmed that the transitional funding of £2m will be provided, however any deficit position over £2m will be shown as an overspend in the annual accounts.

The Interim Board Chair noted the current position brings the Board under the 1% RRL position, which is due to IJB reserves and thanked the teams for the report.

I Grieve thanked the finance team for their work to date and asked the Interim CEO if achieving the financial target set by Scottish Government will de-escalate the Board from level 3. The Interim CEO advised that if we achieve the finacial target, this is year 1 of the plan and confirmed this would be a decision by Scottish Government.

R Gold reflected the significant financial challenges noting that difficult decisions are now required and where budgets need to be aligned to ensure effective service delivery.

Decision/conclusion
The Board discussed and noted Month 10 financial performance.

14.2. Draft 2026/27 Financial Plan for NHS Orkney (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the draft 2026/27 Financial Plan for NHS Orkney submitted 2 February 2026. The final plan will be submitted to Scottish Government by 16 March 2026. The final plan will include a section on the East of Scotland and how the Board will support collaboration and an updated savings plan.

NHS Orkney is entering the 2026/27 planning cycle in a highly constrained financial environment.

The Board faces a revised opening deficit of £3.6m, requiring delivery of £4.173m in savings to achieve the planned position. Scottish Government planning assumptions include a 2% baseline uplift and an expectation of 3% recurring savings, alongside clear guidance that brokerage is no longer available.

1.6m cash releasing savings have been identified through the Improving Together Programme; this has contributed to our current Year End position.

Scottish Government planning assumptions for 2026/27 include a 2% baseline funding uplift (£1.6m) to cover pay and inflationary pressures, full funding for the 2025/26 pay deal and Agenda for Change reform. There is an expectation of 3% recurring savings on baseline budgets. No new recurring commitments should be undertaken without funding being confirmed.

Delivery risk remains high; transformational change and integrated planning are critical to financial sustainability and potential Section 22 qualification if plan is not achieved.

J Taylor asked for an update on the requirement from Scottish Government to reduce our WTE staffing establishment. The Interim Director of Finance advised that the main focus has been on the Board achieving the 1% RLL reduction.

R Gold thanked the Interim Director of Finance and requested clarification on plans for 2026/27 and their feasibility. The Director of Performance and Transformation stated that activity is based on 2025/26, with financial requirements pending, as funding is not yet confirmed.

Decision/conclusion
The Board discussed and welcomed the update.

14.3. Corporate Strategy 2024-2028 Year 2 Quarter 3 Reportt (Presenter: Interim CEO)

The Interim CEO presented the Corporate Strategy 2024-2028 Year 2 Quarter 3 Report, reflecting that the report duplicates reports being presented to our governance committees.

The Board asked the Executive team to review how the Corporate Strategy could be included in other reports to the Board going forward.

Decision/conclusion
The Board discussed and noted the update.

15. STRATEGIC OBJECTIVE – POTENTIAL

No papers were presented.

16. ANY OTHER COMPETENT BUSINESS (AOCB)

No other competent business raised.

17. APPROVED MINUTES FROM GOVERNANCE COMMITTEE MEETINGS

17.1. Audit and Risk Committee – 7 October 2025
Members noted the minutes of the Audit and Risk Governance Committee 7 October 2025.

17.2. Area Clinical Forum – 12 December 2025
Members noted the minutes of the Area Clinical Forum 12 December 2025.

17.3. Area Partnership Forum – 18 November 2025
Members noted the minutes of the Area Partnership Forum 18 November 2025.

17.4. Finance and Performance Committee – 17 December 2025
Members noted the minutes of the Finance and Performance Committee 17 December 2025.

17.5. Joint Clinical Care Governance Comittee – 1 October 2025
Members noted the minutes of the Joint Clinical Care Governance Committee 1 October 2025.

17.6. Staff Governance Committee – 3 December 2025
Members noted the minutes of the Staff Governance Committee 3 December 2025.

18. ITEMS FOR INFORMATION

18.1. Board Meeting Schedule 2026/27(Presenter: Chair)

Members noted the meeting schedule 2025/26.

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

Members noted the meeting schedule 2025/26.

18.3. Questions from the public and the media

B Smith asked for confirmation of the staffing in place for the MRI service. The Medical Director advised that an MRI Lead has been recruited but is not aware of any challenges in accessing the service.

B Wilson asked the Board a question in relation to theatre utilisation which is currently at 43% and asked in an improvement plan is likley to be implemented. The EDoNMAHP advised that a new senior charge nurse in now in place and this is being reviewed as part of our Improving Together Programme.

The Interim Board Chair closed the meeting at 12.28

Item 7

Board Chair and Chief Executive Report to the Board

Meeting	NHS Orkney Board
Meeting date	Thursday, 30 April 2026
Responsible Executive/Non-Executive	• James Goodyear, Interim Chief Executive • Davie Campbell, Board Chair
Report Author(s)	• James Goodyear, Interim Chief Executive • Davie Campbell, Interim Board Chair
Purpose of report	• Assurance
Contribution to Strategic ambition	• Corporate Strategy 2024-2028 – Place, Patient Safety, Quality and Experience, People, Performance and Potential strategic objectives • Operational Improvement Plan • Integrated Joint Board Strategic Plan • Annual Delivery Plan 2024-2025 (ADP) • Financial Sustainability
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred • Sustainability
Key points for consideration	• This report has been provided to update the Board on our performance, operational standards, key external/internal events and activities from March – April 2026, including meetings with external stakeholders and partners.
Route to meeting	• Prepared for NHS Orkney Board – 30 April 2026
Recommendation(s)	• **Assurance - For members assurance only**

Item 7

Board Chair and Chief Executive Report to the Board

James Goodyear, Interim Chief Executive
Davie Campbell, Interim Board Chair
03/04/2026

1. Situation

1.1 This report has been provided to update the Board on our performance, operational standards stakeholders and partners.

2. Assessment

2.1 Healthcare Improvement Scotland – unannounced inspection Maternity and Acute Services

On the 23 and 24 March 2026, Healthcare Improvement Scotland (HIS) undertook an unannounced inspection of our Maternity and Acute Services. Initial feedback from the Healthcare Improvement Scotland team was positive, describing staff as having real pride in the care they provide, that there is a positive culture and senior leaders are visible and supportive. They described positive feedback from women and families in maternity with areas of good practice recognised in medicines management, infection prevention and control and fire safety.

We are particularly proud that HIS found that we deliver person centred compassionate care, where women feel heard and involved in their care decisions.

There are several areas where we have agreed to provide further evidence to support the inspection, overall, very positive feedback and some points of learning for the Board.

We expect the final report due to be received in June 2026 and within 14 weeks of the inspection date.

2.2 A summary of our overall performance

2.2.1 Celebrating our successes 2025/26

As we start the new financial year, our Senior Leadership Team took time to celebrate our successes in 2025/26. Here are a few our achievements over the past 12 months

- Supported the delivery of a successful Island Games
- Only 5 patients now waiting over 52 weeks for planned care down from 145 patients waiting over 52 weeks this time last year.
- Consistently achieved waiting times in our Child and Adolescent Mental Health Services
- Forecast delivery of our financial plan
- Launched recruitment and engagement campaigns including ‘Where compassion meets adventure’ and ‘Real Life Stories’

- Achieved most improved Health Board status in Scottish Hip Fracture Audit (SNAP)
- Secured ongoing funding for our MRI scanner for Quarter 1 2026/27
- Introduced a Reduced Working Week for Agenda For Change staff across all services
- Increased Excellence in Care submissions and compliance
- Rolled out Care Opinion across the Organisation
- Raised Manual Handling Training compliance from 54% to 72%
- Improved National Information Security Audit score from 50% to 56%
- Implemented MORSE Electronic Patient Record in Community Mental Health Team
- Completed migration to SWAN2 network

We wish to acknowledge and commend the outstanding achievements of all teams across the organisation.

2.2.2 What's going well

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

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

Diagnostics

Diagnostic performance varies across modalities. Cardiological diagnostics have improved, with six-week compliance reaching 96.65%, due to better staffing and less locum use. Endoscopy waiting lists are down from 49 to 14 for upper endoscopy and 68 to 28 for colonoscopy compared to 2025. Despite this, six-week compliance remains under target: 67.92% for endoscopy and 81.40% for imaging, mainly due to reliance on visiting staff and ongoing ultrasound and MRI challenges.

Emergency Department (ED)

Compliance with the A&E four-hour standard was recorded at 89.91% in February 2026, falling short of the 95% target. This performance is indicative of increased patient acuity and ongoing system flow challenges, particularly those associated with delayed discharges.

Conversely, adherence to the 12-hour standard remains robust at 99.66%, providing assurance that extended waiting times continue to be effectively minimised.

Cancer Standards

Cancer performance remains strong, with 100% compliance against both the 31-day and 62-day standards in the latest reporting period.

People & Culture

Workforce capacity continues to be identified as a significant risk Sickness absence remains within acceptable SPC parameters, offering a measure of assurance.

Appraisal compliance is still low at 39.51% and is being actively addressed as a corporate risk.

2.2.3 Areas for Improvement

Finance

NHS Orkney's financial situation continues challenging. The Board remains in a deficit position; however, we expect to end the financial year in line with our revised deficit support funding of £2.9m.

Scottish Government have approved our Financial Plan for 2026/27 which forecasts a deficit of £2.4m as at 31 March 2027, including a £3.8m savings target

Patient Safety, Quality & Experience

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

Patient safety performance is strong, with core safety processes meeting standards. No inpatient-acquired pressure ulcers occurred in February 2026. Incident reporting and seven-day review compliance remain at 100%. Inpatient falls rose to 23 in February, mainly due to patient frailty and acuity.

New Outpatients

By the end of February 2026, outpatient appointment waiting lists fell to 1,082 patients from 1,707 in February 2025, due to targeted investments and increased activity in key specialties.

Highlights are as follows

- ENT: Waiting list dropped from 293 to 155; >26 weeks waits reduced from 162 to 3.
- Ophthalmology: Waiting list decreased from 305 to 68; >26 weeks waits cut from 146 to 2.
- Cardiology: Waiting list declined from 38 to 26; >12 weeks waits lowered from 10 to 2.

Treatment Time Guarantee

Compliance with the 12-week outpatient standard remains below target at 52.31%, and TTG performance at 48.99% continues to reflect downstream constraints, including theatre capacity, diagnostic availability and workforce pressures.

Reducing our Waiting Lists

At the year-end, only five patients waited >52-weeks across all specialties. Although we have just missed the target to have 0 patients waiting this represents a very significant overall improvement in our longest waiting times.

Delayed Transfers of Care

Delayed Transfers of Care (DTOC) continue to affect hospital flow and capacity.
As of February 2026

- Only 20% of patients were discharged within two weeks (target: 100%)
- 19 patients experienced delays at the census point (target: 4)
- 528 bed days were lost to delayed discharge during the month

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

2.4.1 Interim Board Chair - Davie Campbell

Discussions are ongoing with the Board Chairs Group regarding how, as strategic leaders, we can further the principles of the Service Renewal Framework and Population Health Framework. Part of this effort involves promoting a greater emphasis on prevention within our organisations, our communities and within the Community Planning Partnership.

In March, we held our second facilitated session with Orkney Islands Council and the Integration Joint Board facilitated by John Sturrock KC to further advance our Routemap to Reform. Another session is scheduled for 8 June 2026 with the Board, OIC elected members, Integration Joint Board (IJB) members and Senior Leaders to discuss next steps and collaborative opportunities for sustainable public services for Orkney.

The Interim CEO and I attended a two-day Board Chair and Chief Executive Away Days focused on Public Sector Reform and East of Scotland sub-regional planning.

Recruitment for a substantive Chief Executive Officer has commenced, interviews and stakeholder panels are scheduled for 19 and 20 May 2026.

Recruitment for 2 Non-Executive Board Members is progressing, with 3 well-attended information sessions completed. Interviews are set for April 2026, and we anticipate successful appointments.

2.4.2 Interim Chief Executive – James Goodyear

National Priorities

I have worked with Chief Executives from East of Scotland health boards to further advance DL(2025)25 sub-national planning co-operation and directions for 2025. A draft plan has been developed which was shared with Scottish Government in late March 2026. More to follow on next steps shortly.

Local engagement

The health and care system in Orkney experienced pressure through the winter period. At The Balfour, this has required additional inpatient capacity to be opened. I wish to express my gratitude to all staff members for their dedication in ensuring patient safety, quality care, and a positive experience during these challenging times. The leadership team, together with the Integration Joint Board (IJB) and Orkney Islands Council, remains committed to improving patient flow. We took measures such as increasing staffing levels across social care and acute services, and this has now alleviated pressures.

Since the last Board Meeting, I have met with colleagues and stakeholders throughout the Organisation.

I had the opportunity to meet with our dental services team and to discuss the vital contributions of our reception and administrative teams in ensuring a positive patient experience, as well as identifying further possibilities to enhance preventive health measures. As we enter the new financial year, we will continue to explore how we can

progress toward becoming a population health-focused organisation.

We've had several important digital updates in March including the move to the new SWAN2 network infrastructure and also the next stage in the roll out of Morse (Community Electronic Patient Record) for our community menta health team.

Damian Reid, interim Director of Finance, joined the Board in March 2026 and is being welcomed through the induction process. Meetings are scheduled for him to connect with Board Members and key stakeholders.

To facilitate an effective transition, Melane Barnes will continue to assist the Finance Team through April 2026, particularly in preparing the Year-end Annual Accounts. I would like to acknowledge Mel's exemplary leadership during her tenure as a member of our executive team. We extend our best wishes to Mel as she resumes her position with the Scottish Ambulance Service.

Tammy Sharp (Director of Performance and Transformation) will be ending her contract with NHS Orkney at the end of June as she has accepted an exciting new role closer to home in the south of England.

I'm sure you will join me in congratulating Tammy and expressing our gratitude for the contribution she has made here in Orkney. I will work with Tammy and the wider executive team to ensure a planned handover of her responsibilities in due course.

NHS Orkney

Item 8

Corporate Risk and Assurance Report

Meeting	**NHS Orkney Board**
Meeting date	Thursday, 30 April 2026
Responsible Executive/ Non-Executive	• Dr Anna Lamont, Medical Director
Report Author(s)	• Diane Smith, Clinical Governance and Risk Facilitator
Purpose of report	• Discussion
Contribution to Strategic ambition	• Annual Operational Plan • Emerging Issue • Local policy
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective
Key points for consideration	• Risk C-2025-05 Project Management and Change Management has reduced in score from high to moderate risk. • Corporate financial sustainability remains the highest-rated risk (current risk level 20; target 10), with delivery of the approved 2026/27 financial plan dependent on full implementation of efficiency and transformational schemes and strengthened financial governance. • There are no risks put forward for closure or addition this month.
Route to meeting	• This is presented to this meeting only
Recommendation(s)	• **Discussion - Consider the implications of a matter**

Corporate Risk and Assurance Report

Diane Smith
16/04/2026

1. Situation

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

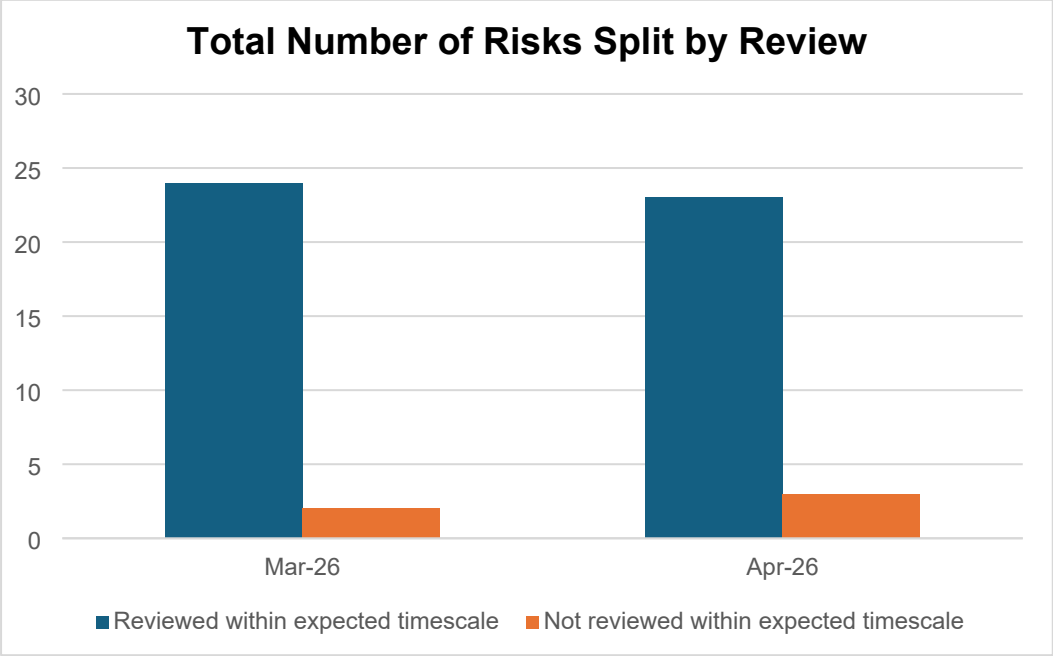
2. Background

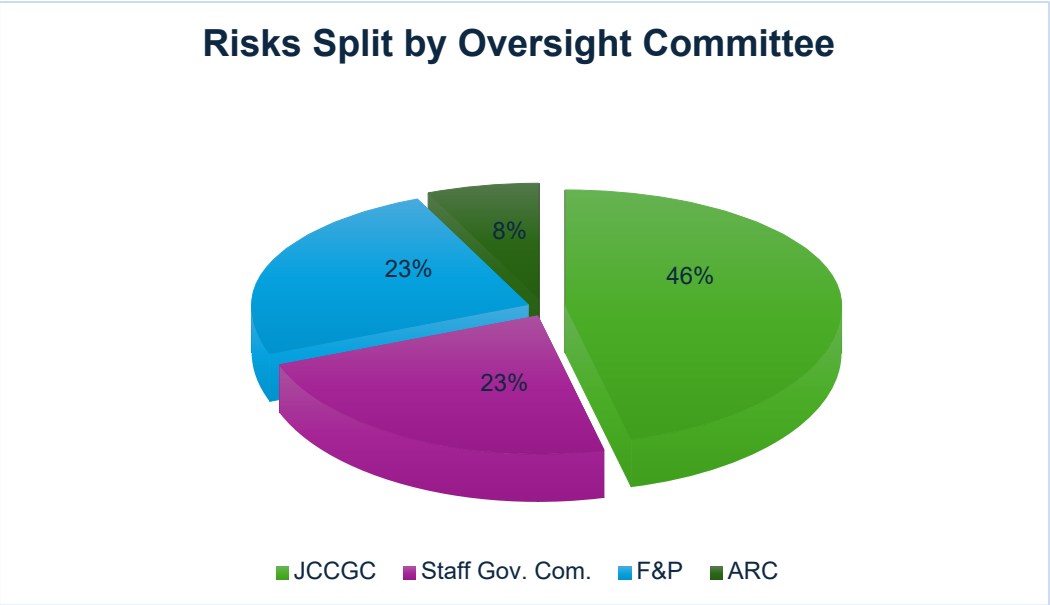
2.1 This report provides an at a glance view of what has changed over two months, and how the risks are shared across committees.

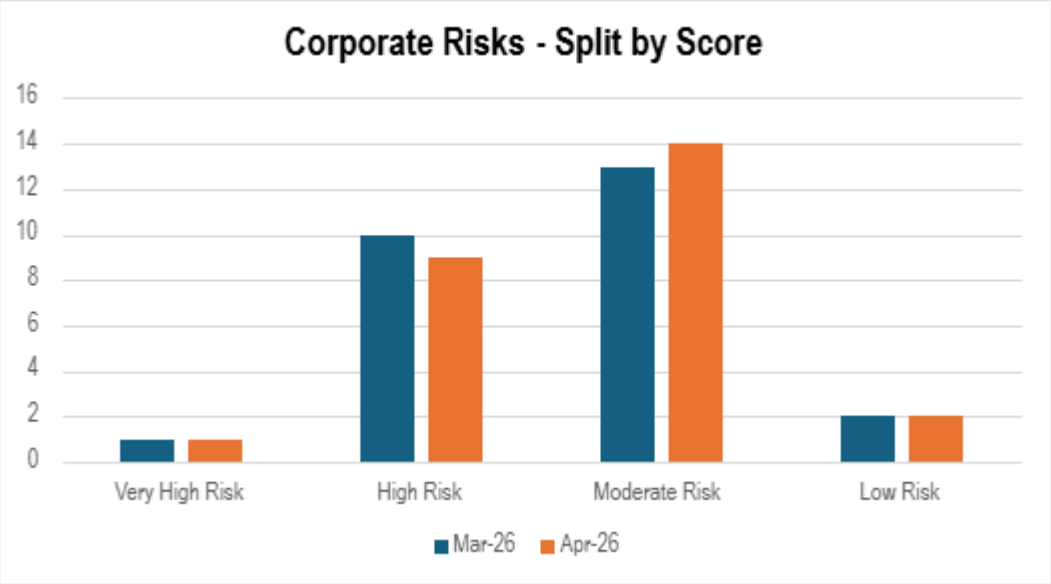
3. Assessment

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

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







3.3 Risk C-2025-05, Project Management and Change Management, has been updated and the score reduced from high to moderate. This is due to the mitigations now being complete or embedded as business as usual. The update was reviewed with the Risk Management Group with robust discussion around the mitigations.

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

NHS Orkney

Item 8

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 09/04/2026** - Year-end forecast deficit remains at the improved position of £2.6m and with the increase amount of transitional funding of a maximum of £2.9m in 2025/26 the risk of Section 22 qualification is mitigated. The financial plan for 2026/27 has been approved by the Board and SG with a forecast deficit of £2.4m at 31 March 2027. The savings target is around 4% of core RRL which is challenging for the Board. Transformational schemes will need to deliver in full to achieve this. Risk score to remain the same at this time **Update 17/03/2026** - Year-end forecast deficit remains at the improved position of £2.6m. Scottish Government have increased the amount of transitional funding to a maximum of £2.9m in 2025/26 which mitigates the risk of the Section 22 qualification. However, improvements over the past 2 months are non recurring so no benefit to future financial years. Risk score to remain the same at this time. **Update 23/02/2026 -** Year-end forecast deficit has improved to £2.6m which is £0.6m higher than the approved financial plan. Improvements over the past 2 months are non recurring so no benefit to future financial years. SG informed of the improved position and have confirmed that the transitional funding of £2m will be received in 2025/26. As the improvements are non-recurring the risk score to remain the same at this time. **Update 06/01/2026 -** Year-end forecast continues to be £4.2m which is £2.0m higher than the approved financial plan. SG informed of the deteriorated position and details are awaited on the implication for the receipt of the transitional funding. Revised approach to budget management is now implemented and Directors have an expenditure control target for the remainder of the year. Risk score to remain the same at this time. **Update 02/12/2025** - Year-end forecast has been revised to and estimate of £4.2m which includes delivery of the turnaround actions of £1.746m. This has been reported to SG and discussed at the Q2 review. Ongoing scrutiny of control

							targets and expenditure remains in place. Communication sent out confirming no discretionary spend should be incurred. Risk score to remain the same at this time. **Update 10/11/2025** - Year-end forecast has been revised to estimate a £6.2m deficit at 31 March 2026. This is £4.2m higher than the approved financial plan. Turnaround actions estimated at £1.746m have been identified, leaving circa £2.45m gap. A revised approach to budget management is being implemented with Directors being given an expenditure control target for the remainder of the year and monthly financial performance meetings with CEO and DoF. SG informed of the deteriorated position.
C-2024-01	Lack of senior leadership capacity and capability	4	**4**	16	4	8a – d leadership development programme and PDPs for all senior leaders SLT formal development programme 8c and d personal objectives set and agreed by Renumeration committee Interim Director of Finance commenced in post in September 2024 for 6 months Interviews for substantive Director of Finance are at the end of October Interim Head of Strategy in post on secondment for 6-month period	**Update 19/01/2026** - Interim Director of Finance appointed and substantive Chair and CEO recruitment being progressed with Scottish Government. **Update 21/11/25 -** Substantive Director of People and Culture has joined the organisation and will lead on the review of the leadership and development programme.
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	**Update 09/03/2026** Organisational capability to support senior clinical leadership has strengthened through clearer governance structures, revised terms of reference and more consistent assurance reporting from clinical governance and advisory groups. Dedicated administrative support is now in place, reducing reliance on senior clinicians for coordination. Recruitment and retention work has progressed, including

						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 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	focused medical recruitment activity, clearer ownership of onboarding, and early succession planning actions to reduce single points of failure. Workforce and leadership risks are being captured through statutory workforce reporting. However, senior clinical leadership capacity remains constrained, with Associate Medical Director roles for Primary Care, Acute Care and lead for Unscheduled Care vacant. The next quarter will focus on re-establishing an Area Medical Committee (AMC) to strengthen collective clinical leadership, engagement and succession planning. **Update 04/11/2025** Following three workshops earlier in the year, improvements and resource necessary to support the CAGs agreed. All groups now have administrative support for actions and compiling papers/agendas. Exec attendance consistent and has been reviewed as part of ACF agenda. Clinical governance escalation pathway prev agreed and feedback given to groups - template for escalation and return yet to be developed if required. Consultant recruitment now on rolling recurring advert if unsuccessful. Clinical leadership vacancies remain unchanged.

						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. 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.	**Update 27/03/2026** - Risk description reviewed and revised as per discussions and request. **Update 24/12/2025 -** Score reviewed remains at 16. Currently 13 DTOC on site. Current system wide pressures preventing transfer of care to appropriate placement. Older persons pathway and frailty remain key workstreams linked with strategic priorities. Agreement to review risk description following discussion at NHS Orkney Board, new risk description will be complete prior to next Board.

C-2026-01	Delivery of mandated digital projects	4	**4**	16	8	Executive management Team (EMT)to consider further investment in digital capabilities, either by allocating additional budget, exploring opportunities for temporary project support, shared services or pausing local digital priorities. This proactive approach will help ensure delivery timelines are met and organisational priorities are achieved. EMT to highlight NHS Orkney's digital debt at the sub-national groups as the opportunity arises. Head of Corporate Governance to request mutual aid/support from East sub regional planning group to support with delivery of local and national 'Must Do' Projects Must, Should, Could, Wont (MuSCOW) prioritisation exercise completed to ensure business critical projects are prioritised in 2026/27	**Update 13/04/2026** - Executive Lead and Head of Corporate Governance presented a paper to Board members 30 April 2026 setting out capacity and capability with the digital services, risks and opportunities. The Head of Corporate Governance continues to explore opportunities for temporary project support and shared services with the east of Scotland digital leads. NHS Orkney's digital debt has also been raised at sub-national groups as the opportunity arises. Head of Corporate Governance has asked for mutual aid/support from East sub regional planning group to support with delivery of local and national 'Must Do' Projects. **Update 12/01/2026** - Discussed and agreed for addition to the corporate risk register.

3.5 Impact Assessment

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

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

4. Recommendation(s)

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

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

5. List of appendices

5.1 The following appendices are included with this report:

i **Appendix 1,** Corporate Risk Register

NHS Orkney

Item 9

Integrated Performance Report (IPR) April 2026

Meeting	**NHS Orkney Board**
Meeting date	Thursday, 30 April 2026
Responsible Executive/Non-Executive	• Tammy Sharp, Director of Performance and Transformation
Report Author(s)	• Carrie Somerville, Head of Planning, Performance and Information
Purpose of report	• Assurance
Contribution to Strategic ambition	• Corporate Strategy 2024/28 • Annual Operational Plan • Emerging Issue • Government policy/directive • Legal requirement • Local policy • NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality
Key points for consideration	• Overall performance remains mixed, reflecting ongoing workforce, system flow and financial pressures. There is clear evidence of improvement in several key areas compared to the same period last year, providing assurance that recovery actions are beginning to have an impact. • Improvements have been delivered across Planned Care and Diagnostics, particularly in New Outpatients and priority specialties, supported by non-recurring investment and additional activity. Strong performance in cancer standards, incident management and avoidance of extended waits provides important patient safety assurance. However, compliance with several national standards remains below target, driven by ongoing constraints in capacity, workforce availability and delayed discharge, which continue to impact system flow and recovery pace • Workforce capacity and financial sustainability continue to present significant risk to organisational

	performance, with low appraisal compliance and continued reliance on medical and agency staffing contributing to an adverse forecast outturn. NHS Orkney remains at Level 3 of the NHS Scotland Support and Intervention Framework, reinforcing the need for continued focus on workforce stability, cost control and delivery of recovery actions to support sustainable improvement across services
Route to meeting	• The Integrated Performance Report has been considered by Senior Leadership Team on 1 April 2026. • The Integrated Performance Report has been approved by the Executive Team on 13 April 2026. • The Finance, Community and Operational chapters was presented to Finance and Performance Committee on 29 April 2026. • Patient Safety, Quality and Experience and Population Health chapters was presented to the Joint Clinical Care and Governance Committee on 8 April 2026.
Recommendation(s)	• **Assurance - For members assurance only**

Item 9

Integrated Performance Report (IPR) April 2026

Report Author – Carrie Somerville, Head of Planning, Performance and Information

19/04/2026

1. Situation

1.1 The Integrated Performance Report (IPR) – Senior Leadership Team - April 2026 (Appendix 1) summarises NHS Orkney's performance based on national and local reporting requirements as well as those indicators which matter to our patients and community. The IPR aligns to our Corporate Strategy 2024-28, Realistic Medicine Plan, Annual Delivery Plan 2025/26, Financial Recovery Plan and our Improving Together (efficiency) Programme.

Members are asked to receive the Integrated Performance Report (IPR) – April 2026. Noting where Key Performance Indicators (KPIs) are off track and the improvement actions in place to bring deliverables back on track.

2. Background

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

3. Assessment

3.1 Analysis

The report provides an overview of organisational performance across patient safety, operational standards, workforce, community services, and finance. The period covered by the performance data is generally up to the end of February 2026. However, there are some measures with a data time lag either due to their nature or when the information is published by Public Health Scotland.

3.2 Current Position

Overall performance across NHS Orkney remains mixed, reflecting the continued impact of workforce constraints, system flow pressures and financial position, alongside areas of sustained improvement and good practice. The Integrated Performance Report (IPR) demonstrates that risks are clearly understood and are subject to ongoing executive oversight. Work will be undertaken as part of the Performance Review Meeting process to build on the

existing action planning, which is part of the IPR, ensuring that there are deliverable actions agree within the reporting cycle to recover where performance is off-track.

While a number of national standards remain off track, there is evidence of material improvement in several key areas, particularly when compared with the same period last year, and assurance can be provided that the organisation remains focused on improving access, safety and sustainability for patients.

Performance against Planned Care standards remains challenging, particularly for New Outpatients (NOP), Treatment Time Guarantee (TTG) and diagnostics.

At the end of February 2026, there were 1,082 patients waiting for a new outpatient appointment, a significant reduction from 1,707 patients at the same point in 2025, reflecting the impact of targeted non-recurring investment and additional activity in priority specialties. Notable improvements include:

- ENT waiting lists reduced from 293 to 155, with patients waiting over 26 weeks reducing from 162 to 3
- Ophthalmology waiting lists reduced from 305 to 68, with patients waiting over 26 weeks reducing from 146 to 2
- Cardiology waiting lists reduced from 38 to 26, with those waiting over 12 weeks reducing from 10 to 2

Despite these improvements, compliance with the 12-week outpatient standard remains below target at 52.31%, and TTG performance at 48.99% continues to reflect downstream constraints, including theatre capacity, diagnostic availability and workforce pressures.

Diagnostic performance remains variable, with a mixed position across modalities.

- Diagnostic cardiology performance has improved significantly, with six-week compliance now at 96.65%, supported by substantive recruitment and reduced reliance on locum provision.
- Endoscopy waiting lists have reduced across all procedure types compared to 2025, for example:
  - Upper Endoscopy reduced from 49 to 14
  - Colonoscopy reduced from 68 to 28

However, overall compliance with the six-week diagnostic standard remains below target at 67.92% for endoscopy and 81.40% for imaging, reflecting reliance on visiting capacity and challenges in ultrasound and MRI provision.

Performance against the A&E four-hour standard remains below the 95% target, with compliance at 89.91% in February 2026. This reflects increased patient acuity and system flow pressures, particularly linked to delayed discharges.

Performance against the 12-hour standard remains strong at 99.66%, providing assurance that extended waits are being largely avoided.

Delayed Transfers of Care (DTOC) remain a significant area of concern, with continued impact on hospital flow and capacity.

As at February 2026:

- Only 20% of patients were discharged within two weeks, against a target of 100%
- 19 patients were experiencing a delay at the census point, compared to a target of 4
- 528 bed days were associated with delayed discharge during the month

Patient safety performance provides important assurance, with a number of core safety processes performing well.

- No inpatient-acquired pressure ulcers were reported in February 2026.
- Incident reporting and seven-day review compliance remains at 100%.
- Cancer performance remains strong, with 100% compliance against both the 31-day and 62-day standards in the latest reporting period.

However, inpatient falls increased to 23 in February, largely associated with patient frailty and acuity.

Workforce capacity remains a key risk.

- Sickness absence remains within acceptable SPC limits, providing some assurance.
- Appraisal compliance remains low at 39.51% and continues to be managed as a corporate risk.

The financial position remains challenging, with NHS Orkney continuing to operate at Level 3 of the NHS Scotland Support and Intervention Framework.

The forecast outturn remains adverse, driven primarily by:

- Medical and agency staffing costs
- Prescribing pressures
- Non-recurrent expenditure

3.3 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	Performance data relating to Patient Safety, Quality and Experience are reported through the Joint Clinical Care and Governance Committee. Whilst the process for the collection of the patient safety, quality and experience metrics is established and provided consistently, work to expand this dataset to provide the necessary assurance to the Board as some KPI's do not have targets set against them either locally or nationally.
People	Workforce	Yes	The Workforce improvement workstream within the Improving Together Programme is well developed with 8 areas of focus. These include sickness management, mandatory training and appraisals. Corporate Leads have been identified for each area to drive delivery.
Performance	Finance	Yes	The Board remains at level 3 of the Scottish Government's NHS Finance and Escalation Framework. Workforce transformation accounts for around one third of projected savings for this Financial Year.
Potential	Risk Management	Yes	There are six risks on the Corporate Risk Register that relate to Finance, Operational Standards or Community these include, Corporate Financial sustainability, Waiting Times data and Lack of organisational digital maturity.
	Digital	Yes	There is a significant risk that the lack of digital maturity, leadership, governance, and a digital strategy which is understood across the organisation will impact on the delivery of our corporate strategy, the delivery of safe patient care and the implementation of our improvement programme across health and social care.
Place	Equality and Diversity including health inequalities	Yes	Reducing health inequalities is a key priority as part of the Place strategic objective. Our Corporate Strategy takes into consideration local, regional, and national policy.
	Climate Change Sustainability	Yes	Specific metrics and objectives in relation to climate change and achieving our net zero targets are included in our corporate strategy under the Place strategic objective.

4. Recommendations

4.1 **Receive** the Integrated Performance Report (IPR) April 2026 and **note** where Key Performance Indicators (KPIs) are off track and the improvement actions in place to bring deliverables back on track.

4.2 Assurance - For members assurance only

5. List of Appendices

5.1 The following appendices are included with this report

i. **Appendix 1,** The Integrated Performance Report (IPR) April 2026

NHS Orkney

Integrated Performance Report

Interim Chief Executive:
James Goodyear

April 2026

HEALTH Intelligence

ORK.healthintelligence@nhs.scot

Introduction

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

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

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.

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.
↑	Value has increased, indicates improvement.
↓	Value has decreased, indicates improvement.
↓	Value has decreased, indicates deterioration.
↑	Value has increased, indicates deterioration.
↔	Performance has remained the same.
*	Insufficient data available to allow comparison.

Statistical Process Control

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

What is statistical process control (SPC)?

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

Key Facts about an SPC Chart

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

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

Variance

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

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

Assurance

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

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

NHS Orkney Performance Scorecard

Key Performance Indicators

	Section	Service Area	NHS Orkney KPI's	Executive Lead	Target	Actual	Latest RAG	↑ ↓	Data Up To
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	↔	28/02/2026
2	Patient Safety, Quality, and Experience	Excellence in Care	Inpatient falls (an event which results in a person coming to rest unintentionally on the ground or floor or other lower level)	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	0	23	Red	↑	28/02/2026
4	Patient Safety, Quality, and Experience	Complaints	Number of complaints received.	Medical Director	0	6	Grey	↓	28/02/2026
5	Patient Safety, Quality, and Experience	Complaints	Complaints Received - Stage 1 5 Working Day Response Compliance	Medical Director	100%	50.0%	Red	↓	28/02/2026
6	Patient Safety, Quality, and Experience	Complaints	Complaints Received - Stage 2 20 Working Day Response Compliance	Medical Director	100%	50.0%	Red	↓	28/02/2026
7	Patient Safety, Quality, and Experience	Complaints	Complaints upheld and partially upheld by SPSO	Medical Director	0	0	Green	↔	28/02/2026
8	Patient Safety, Quality, and Experience	Incident Reporting	Incident Reporting and 7 Working Day Review Compliance	Medical Director	100%	100%	Green	↔	28/02/2026
9	Patient Safety, Quality, and Experience	Significant Adverse Event Reviews	Significant Adverse Event Review Compliance (closed within target date)	Medical Director	100%	16.67%	Red	↓	28/02/2026
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	↑	31/01/2026
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	↑	31/01/2026
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%	95%	Green	↑	28/02/2026
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%	85%	Amber	↑	28/02/2026
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	95%	48.99%	Red	↑	28/02/2026
16	Operational Standards	Planned Care	10% reduction in waiting times for Treatment Time Guarantee patients	Medical Director	-10%	5.1%	Red	↓	28/02/2026
17	Operational Standards	Planned Care	10% reduction in waiting times for New Outpatients	Medical Director	-10%	16.82%	Red	↓	28/02/2026
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%	52.31%	Red	↑	28/02/2026
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%	67.92%	Red	↑	28/02/2026
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%	81.40%	Red	↑	28/02/2026
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%	96.65%	Amber	↑	28/02/2026
23	Operational Standards	Planned Care	0 patients waiting more than 52 weeks on a New Outpatient or Treatment Time Guarantee waiting list	Director of Performance and Transformation & Deputy Chief Executive	0	6	Amber	↓	28/02/2026
24	Operational Standards	Cancer	90% of those referred urgently with a suspicion of cancer are to begin treatment within 62 days of receipt of referral	Medical Director	90%	100%	Green	↑	31/01/2026
25	Operational Standards	Cancer	95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat	Medical Director	95%	100%	Green	↔	31/01/2026
26	Operational Standards	Theatre	Theatre Utilisation	Medical Director	N/A	77.0%	Grey	↓	28/02/2026
28	Operational Standards	Inpatients	Pre-noon discharges	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	25.0%	26.97%	Green	↑	28/02/2026
29	Operational Standards	Unscheduled Care	95% of patients wait no longer than four hours from arrival to admission, discharge, or transfer for A&E treatment. Boards work towards 98%.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	95%	89.91%	Amber	↓	28/02/2026
30	Operational Standards	Unscheduled Care	Patients wait less than 12 hours to admission, discharge, or transfer from A&E	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	99.5%	99.66%	Green	↓	28/02/2026
31	Operational Standards	Unscheduled Care	Scottish Ambulance Service Turnaround Times - 90th percentile within 60 minutes	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	60:00	00:27:34	Green	↓	28/02/2026
32	Operational Standards	Delayed Transfer of Care	Number of people experiencing a delay discharged within 2 weeks (excluding complex code 9 delays)	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	100%	20.0%	Red	↓	28/02/2026
33	Operational Standards	Delayed Transfer of Care	Number of people experiencing a delay of any length or reason in discharge from hospital at the monthly census point	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	4	19	Red	↑	28/02/2026
34	Operational Standards	Delayed Transfer of Care	Number of hospital bed days associated with delayed discharges (any length or reason) in the calendar month.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	56	528	Red	↑	28/02/2026
35	Operational Standards	Women and Children	90% of eligible patients to commence IVF treatment within 12 months of referral	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	90%	100%	Green	*	31/12/2025
36	Operational Standards	Women and Children	100% of women booking in a Board allocated to a primary midwife	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	100%	100%	Green	↔	28/02/2026
37	Operational Standards	Women and Children	50% of women receive care during the intrapartum period from the primary, buddy or member of the team who she has met.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	50%	63.64%	Green	↓	31/01/2026
38	Operational Standards	Women and Children	75% of scheduled antenatal care delivered by the primary and no more than one other midwife.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	75%	49.6%	Red	↓	31/01/2026
39	Operational Standards	Women and Children	75% of scheduled community based postnatal care delivered by the primary and no more than one other midwife.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	75%	16.67%	Red	↓	31/01/2026
41	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	65.22%	Amber	↓	31/12/2025
42	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led podiatry musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	85.71%	Amber	↓	31/12/2025
43	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led physiotherapy musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	69.44%	Amber	↑	31/12/2025
44	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led orthotics musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	30.77%	Red	↓	31/12/2025
46	Community	Child and Adolescent Mental Health Service (CAMHS)	90% of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral.	Chief Officer (Integration Joint Board)	90%	100%	Green	↔	28/02/2026
47	Community	Psychological Therapies	18 Week Referral to Treatment	Chief Officer (Integration Joint Board)	90%	95.45%	Green	↑	28/02/2026
48	Population Health	Promoting health and wellbeing outcomes	Increase smoking cessation active clients year-on-year	Medical Director	21	13	Red	↑	03/03/2026
49	Population Health	Promoting health and wellbeing outcomes	NHS Boards to sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas (60% in the Island Boards)	Medical Director	21	14	Red	↓	30/11/2025
50	Population Health	Prevention of Disease	Immunisation uptake rate 6-in-1 primary Course by 12 months (rolling 3-month average)	Medical Director	95.0%	96.13%	Green	↓	31/12/2025
51	Population Health	Prevention of Disease	Immunisation uptake rate MMR2 by 6 years of age (rolling 3-month average)	Medical Director	95.0%	94.40%	Red	↑	31/12/2025
52	Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered trisomy screening no later than 20+0 weeks gestation.	Medical Director	100.0%	92.3%	Amber	↓	28/02/2026
53	Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered haemoglobinopathies screening.	Medical Director	100.0%	100%	Green	↔	28/02/2026
54	Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered infectious diseases screening	Medical Director	100.0%	100%	Green	↔	28/02/2026
55	Population Health	Promoting health and wellbeing outcomes	Bloodspot Screening - 100% of newborn babies have bloodspot Screening completed by day 5	Medical Director	100.0%	80.0%	Red	↓	28/02/2026
57	Workforce	Sickness Absence	Sickness rates consistently below the national average of <6%	Director of People and Culture	5.99%	4.41%	Green	↓	28/02/2026
58	Workforce	Sickness Absence	Monthly comparison for previous 12 months NHS Scotland and NHS Orkney	Director of People and Culture	6.40%	5.85%	Green	↓	28/02/2026
59	Workforce	Appraisals	Appraisal compliance rate over the previous 12 months	Director of People and Culture	85.00%	39.51%	Red	↓	28/02/2026
60	Workforce	Hours Utilised	Agency hours used vs. average.	Director of People and Culture		1170	Grey	↓	28/02/2026
61	Workforce	Hours Utilised	Bank hours used vs. average.	Director of People and Culture		5200	Grey	↑	28/02/2026
62	Workforce	Hours Utilised	Overtime hours used vs. average.	Director of People and Culture		672	Grey	↑	28/02/2026
63	Workforce	Hours Utilised	Excess hours used vs. average.	Director of People and Culture		842	Grey	↑	28/02/2026
64	Finance	Finance	Financial performance against plan - YTD.	Director of Finance	£2,343,000	£2,441,000	Red	↑	28/02/2026
65	Finance	Finance	Financial performance against plan - Forecast.	Director of Finance	£2,176,000	£2,660,000	Red	↔	28/02/2026
66	Finance	Finance	Efficiency performance against plan - YTD.	Director of Finance	£3,135,000	£2,526,000	Red	↓	28/02/2026
67	Finance	Finance	Efficiency performance against plan - Forecast.	Director of Finance	£3,800,000	£2,526,000	Red	↑	28/02/2026
68	Finance	Finance	Efficiency programme recurrent savings against plan.	Director of Finance	£1,190,000	£1,654,000	Green	↑	28/02/2026
69	Finance	Finance	Capital performance against plan - YTD.	Director of Finance	£1,851,000	£763,000	Red	*	28/02/2026
70	Finance	Finance	Capital performance against plan - Forecast.	Director of Finance	£2,010,000	£2,010,000	Green	↑	28/02/2026
71	Finance	Finance	75% of invoices to be paid within 10 days of receipt - local target	Director of Finance	75.00%	71.58%	Red	↑	28/02/2026
72	Finance	Finance	90% of invoices to be paid within 30 days of receipt - local target	Director of Finance	90.00%	90.39%	Green	↑	28/02/2026

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 June 2026.

	Section	Service Area	NHS Orkney KPI's	Executive Lead	Target	Actual	Latest RAG	↑ ↓
27	Operational Standards	Inpatients	Ensure that acute receiving occupancy is 95% or less.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	95%			*
40	Community	Drug and Alcohol Treatment	90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.	Chief Officer (Integration Joint Board)	90%			*
45	Community	Dementia Post-Diagnostic Support	People newly diagnosed with dementia will have a minimum of one years post-diagnostic support	Chief Officer (Integration Joint Board)	100%			*

NHS Orkney

Patient Safety, Quality, and Experience

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

What's Going Well?

The target for the number of complaints is set at zero to ensure this is consistently reported on. The number of stage one complaints continues to reduce, and is recognised as staff undertaking to resolve more issues as a concern raised at a ward level.

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

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

RAG Status Values

RED	Key performance indicator not achieved, and performance below average.
AMBER	Key performance indicator not achieved, but performance above average.
GREEN	Key performance indicator achieved.

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

Areas of Concern

The small numbers that can be reported on monthly continue to limit the utility of reporting Key Performance Indicators (KPIs) to identify trends. The updated control chart methodology now better shows where changes over time are significant.

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

Inpatient falls (without harm) remain high in Inpatients 1, a high proportion of these falls recorded are due to single patients with known falls risks who have multiple falls despite increased observation and safety measures.

Patient Safety, Quality, and Experience
Complaints Received

Data Source
Patient Experience Officer

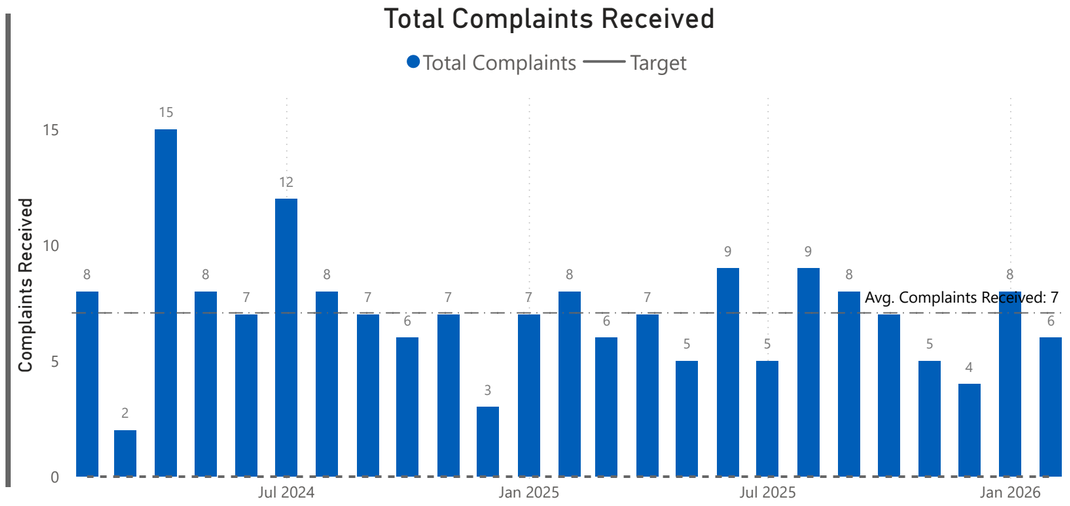
Latest Data
February 2026

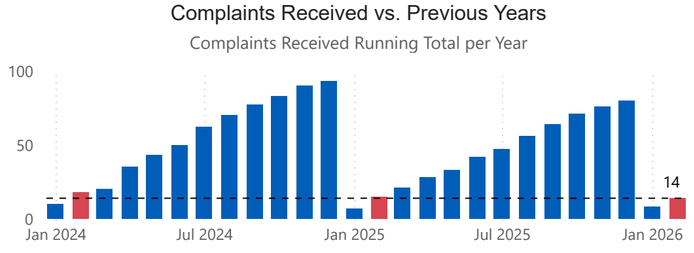
Compliance

KPI	Target	Actual	RAG Value
Number of complaints received.	0	6	Grey

Action	Target Date	Owner	Status

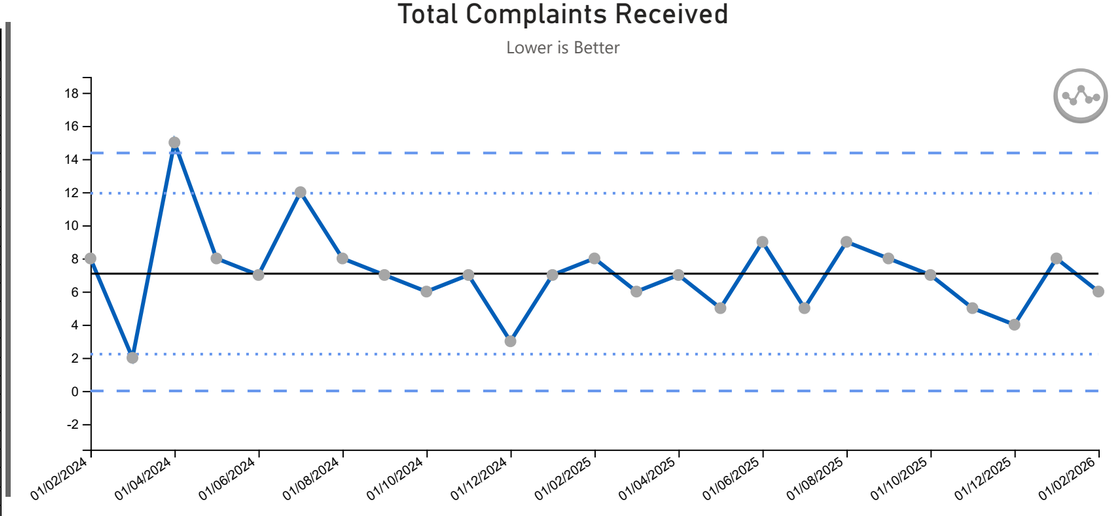
No target set, actions and target to be updated.





Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	8	7	0	14	2	12	NONE
01/03/2024	2	7	0	14	2	12	NONE
01/04/2024	15	7	0	14	2	12	NONE
01/05/2024	8	7	0	14	2	12	NONE
01/06/2024	7	7	0	14	2	12	NONE
01/07/2024	12	7	0	14	2	12	NONE
01/08/2024	8	7	0	14	2	12	NONE
01/09/2024	7	7	0	14	2	12	NONE
01/10/2024	6	7	0	14	2	12	NONE
01/11/2024	7	7	0	14	2	12	NONE
01/12/2024	3	7	0	14	2	12	NONE
01/01/2025	7	7	0	14	2	12	NONE
01/02/2025	8	7	0	14	2	12	NONE
01/03/2025	6	7	0	14	2	12	NONE
01/04/2025	7	7	0	14	2	12	NONE
01/05/2025	5	7	0	14	2	12	NONE
01/06/2025	9	7	0	14	2	12	NONE
01/07/2025	5	7	0	14	2	12	NONE
01/08/2025	9	7	0	14	2	12	NONE
01/09/2025	8	7	0	14	2	12	NONE
01/10/2025	7	7	0	14	2	12	NONE
01/11/2025	5	7	0	14	2	12	NONE
01/12/2025	4	7	0	14	2	12	NONE
01/01/2026	8	7	0	14	2	12	NONE
01/02/2026	6	7	0	14	2	12	NONE



Comments From Executive Lead

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

Dr Anna Lamont, Medical Director

Patient Safety, Quality, and Experience
Stage One Complaints

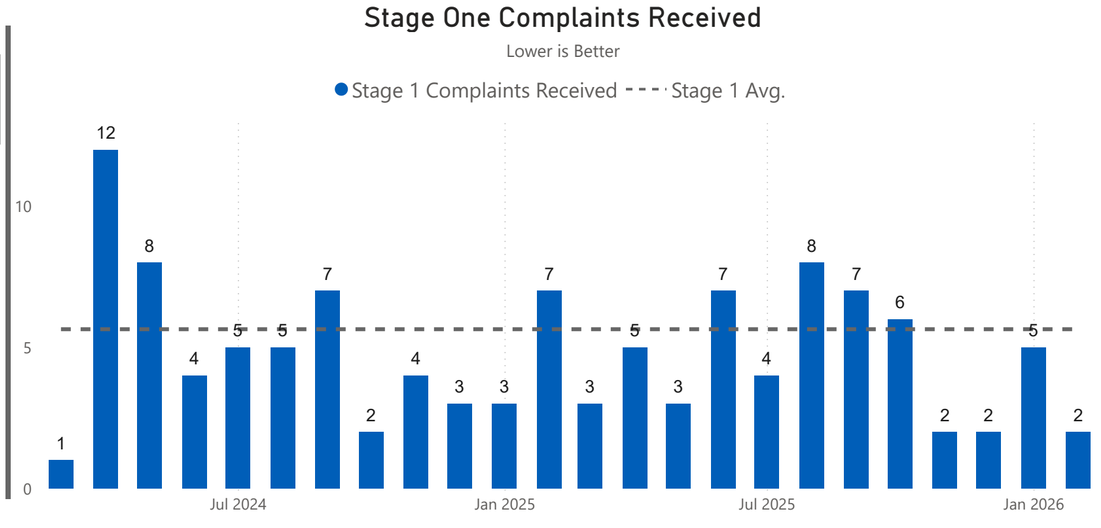
Data Source
Patient Experience Officer

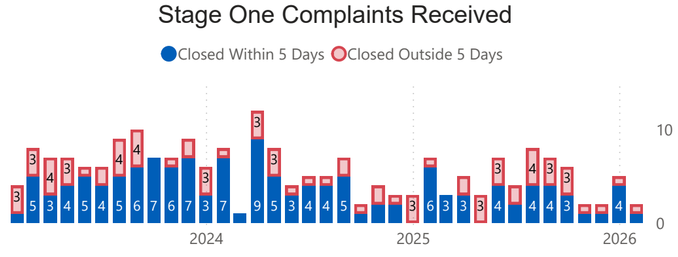
Latest Data
February 2026

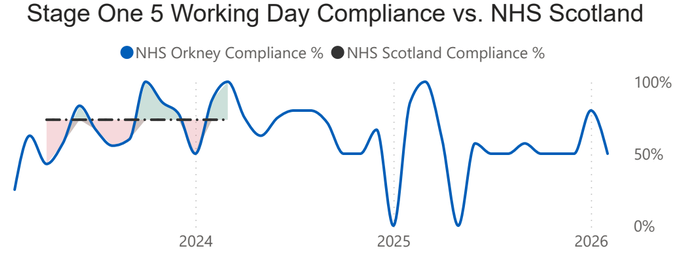
Compliance

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

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

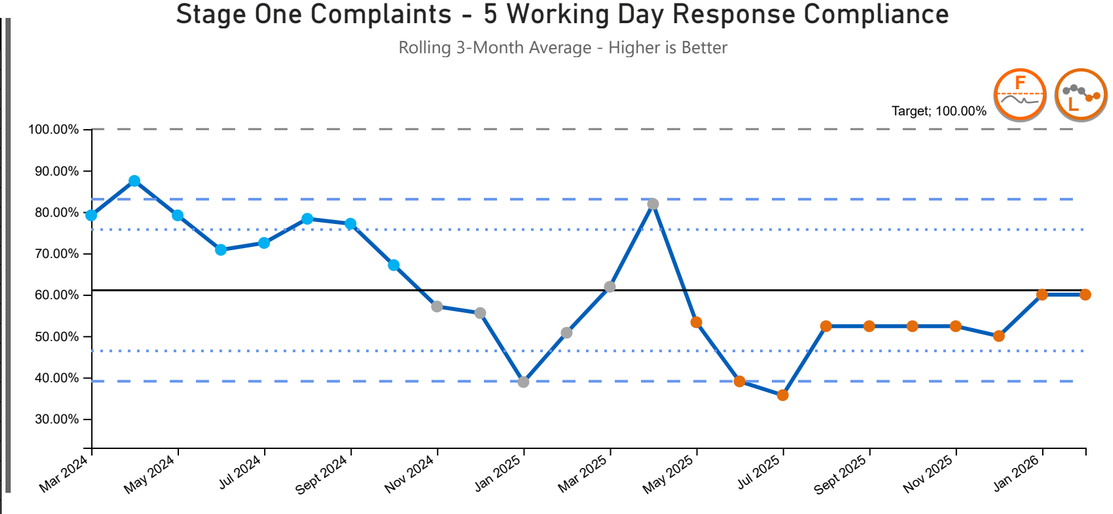






Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/03/2024	79.17	61.07	39.07	83.06	46.40	75.73	IMPROVEMENT
01/04/2024	87.50	61.07	39.07	83.06	46.40	75.73	IMPROVEMENT
01/05/2024	79.17	61.07	39.07	83.06	46.40	75.73	IMPROVEMENT
01/06/2024	70.83	61.07	39.07	83.06	46.40	75.73	IMPROVEMENT
01/07/2024	72.50	61.07	39.07	83.06	46.40	75.73	IMPROVEMENT
01/08/2024	78.33	61.07	39.07	83.06	46.40	75.73	IMPROVEMENT
01/09/2024	77.14	61.07	39.07	83.06	46.40	75.73	IMPROVEMENT
01/10/2024	67.14	61.07	39.07	83.06	46.40	75.73	IMPROVEMENT
01/11/2024	57.14	61.07	39.07	83.06	46.40	75.73	NONE
01/12/2024	55.56	61.07	39.07	83.06	46.40	75.73	NONE
01/01/2025	38.89	61.07	39.07	83.06	46.40	75.73	NONE
01/02/2025	50.79	61.07	39.07	83.06	46.40	75.73	NONE
01/03/2025	61.90	61.07	39.07	83.06	46.40	75.73	NONE
01/04/2025	81.90	61.07	39.07	83.06	46.40	75.73	NONE
01/05/2025	53.33	61.07	39.07	83.06	46.40	75.73	DETERIORATION
01/06/2025	39.05	61.07	39.07	83.06	46.40	75.73	DETERIORATION
01/07/2025	35.71	61.07	39.07	83.06	46.40	75.73	DETERIORATION
01/08/2025	52.38	61.07	39.07	83.06	46.40	75.73	DETERIORATION
01/09/2025	52.38	61.07	39.07	83.06	46.40	75.73	DETERIORATION
01/10/2025	52.38	61.07	39.07	83.06	46.40	75.73	DETERIORATION
01/11/2025	52.38	61.07	39.07	83.06	46.40	75.73	DETERIORATION
01/12/2025	50.00	61.07	39.07	83.06	46.40	75.73	DETERIORATION
01/01/2026	60.00	61.07	39.07	83.06	46.40	75.73	DETERIORATION
01/02/2026	60.00	61.07	39.07	83.06	46.40	75.73	DETERIORATION



Comments From Executive Lead

There were two Stage One complaints recorded in February 2026. 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

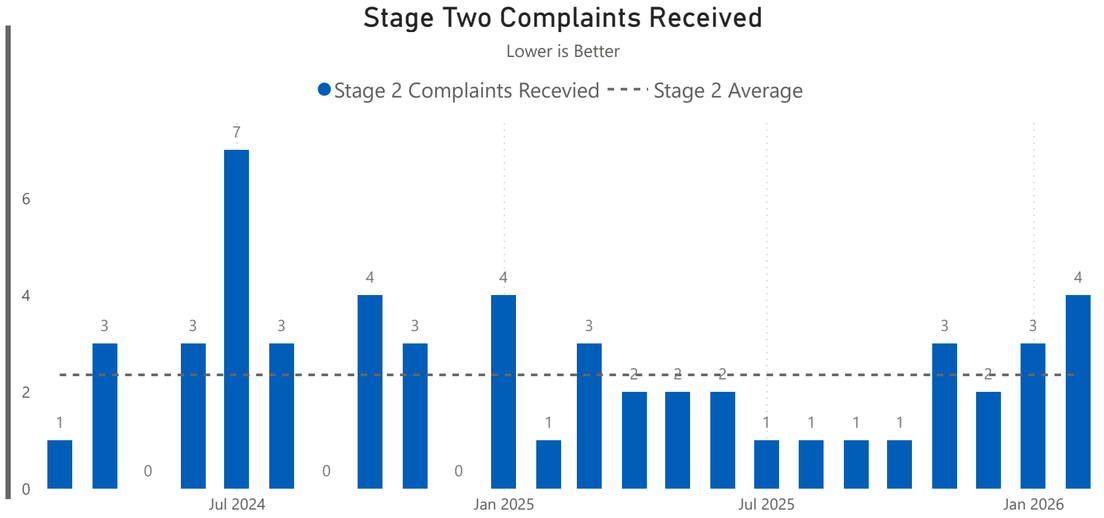
Data Source
Patient Experience Officer

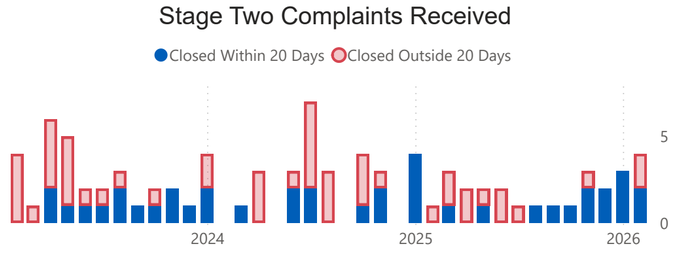
Latest Data
February 2026

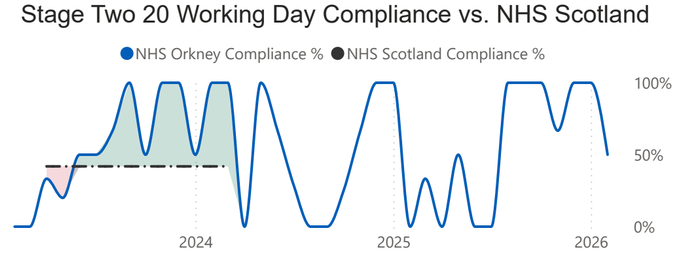
Compliance

KPI	Target	Actual	RAG Value
Complaints Received - Stage 2 20 Working Day Response Compliance	100%	50.0%	Red

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

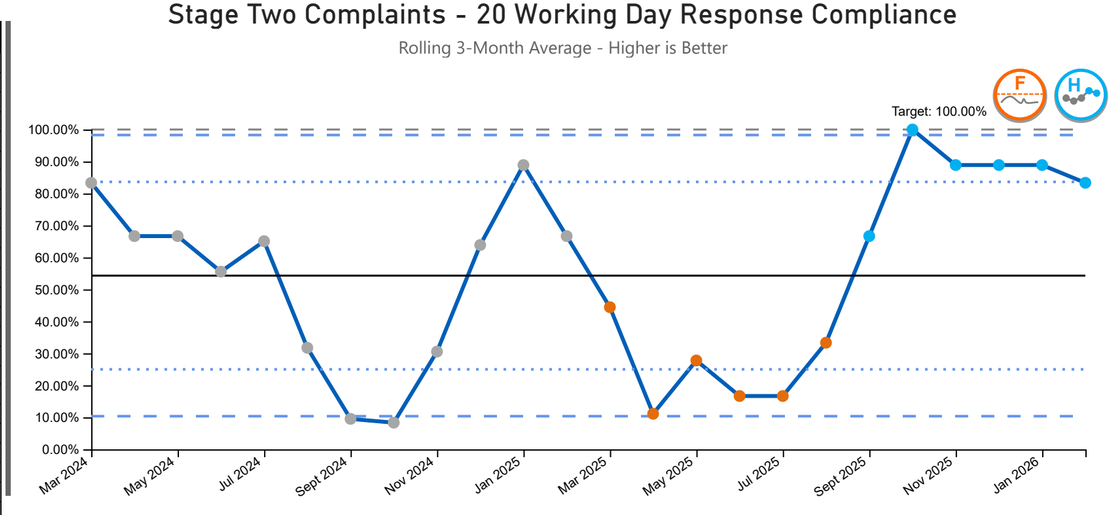






Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/03/2024	83.33	54.32	10.36	98.27	25.01	83.62	NONE
01/04/2024	66.67	54.32	10.36	98.27	25.01	83.62	NONE
01/05/2024	66.67	54.32	10.36	98.27	25.01	83.62	NONE
01/06/2024	55.56	54.32	10.36	98.27	25.01	83.62	NONE
01/07/2024	65.08	54.32	10.36	98.27	25.01	83.62	NONE
01/08/2024	31.75	54.32	10.36	98.27	25.01	83.62	NONE
01/09/2024	9.52	54.32	10.36	98.27	25.01	83.62	NONE
01/10/2024	8.33	54.32	10.36	98.27	25.01	83.62	NONE
01/11/2024	30.56	54.32	10.36	98.27	25.01	83.62	NONE
01/12/2024	63.89	54.32	10.36	98.27	25.01	83.62	NONE
01/01/2025	88.89	54.32	10.36	98.27	25.01	83.62	NONE
01/02/2025	66.67	54.32	10.36	98.27	25.01	83.62	NONE
01/03/2025	44.44	54.32	10.36	98.27	25.01	83.62	DETERIORATION
01/04/2025	11.11	54.32	10.36	98.27	25.01	83.62	DETERIORATION
01/05/2025	27.78	54.32	10.36	98.27	25.01	83.62	DETERIORATION
01/06/2025	16.67	54.32	10.36	98.27	25.01	83.62	DETERIORATION
01/07/2025	16.67	54.32	10.36	98.27	25.01	83.62	DETERIORATION
01/08/2025	33.33	54.32	10.36	98.27	25.01	83.62	DETERIORATION
01/09/2025	66.67	54.32	10.36	98.27	25.01	83.62	IMPROVEMENT
01/10/2025	100.00	54.32	10.36	98.27	25.01	83.62	IMPROVEMENT
01/11/2025	88.89	54.32	10.36	98.27	25.01	83.62	IMPROVEMENT
01/12/2025	88.89	54.32	10.36	98.27	25.01	83.62	IMPROVEMENT
01/01/2026	88.89	54.32	10.36	98.27	25.01	83.62	IMPROVEMENT
01/02/2026	83.33	54.32	10.36	98.27	25.01	83.62	IMPROVEMENT



Comments From Executive Lead

The number of Stage Two complaints remains low, with a slight increase seen in the past four 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
Complaints Upheld by Scottish Public Services Ombudsman (SPSO)

Data Source
Patient Experience Officer

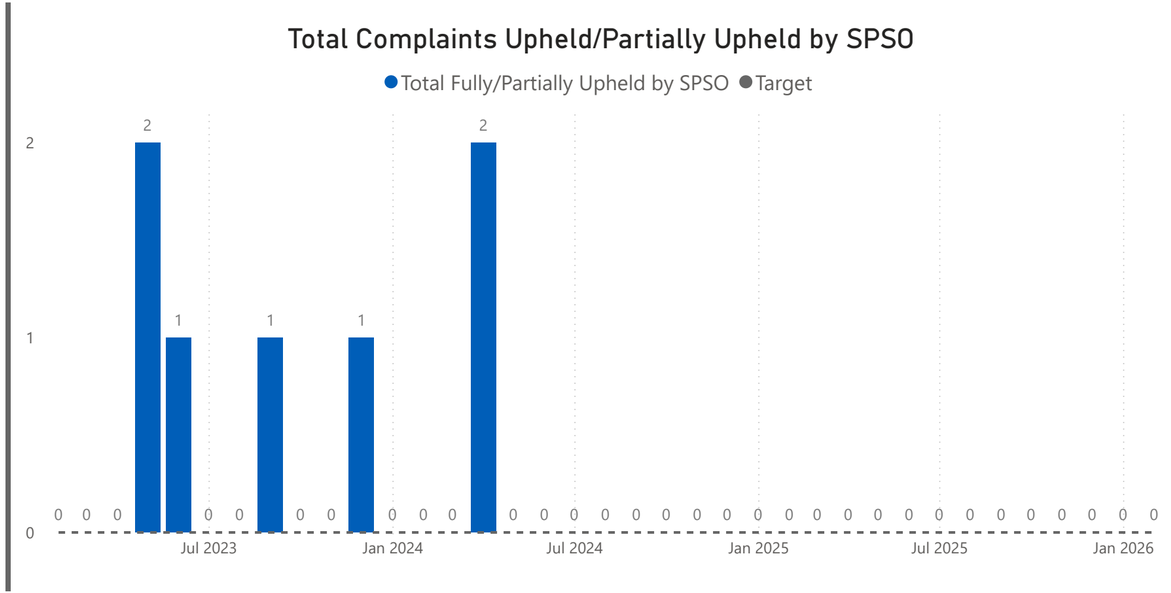
Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
Complaints upheld and partially upheld by SPSO	0	0	Green

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



Comments From Executive Lead

Dr Anna Lamont, Medical Director

Patient Safety, Quality, and Experience
Inpatient Falls

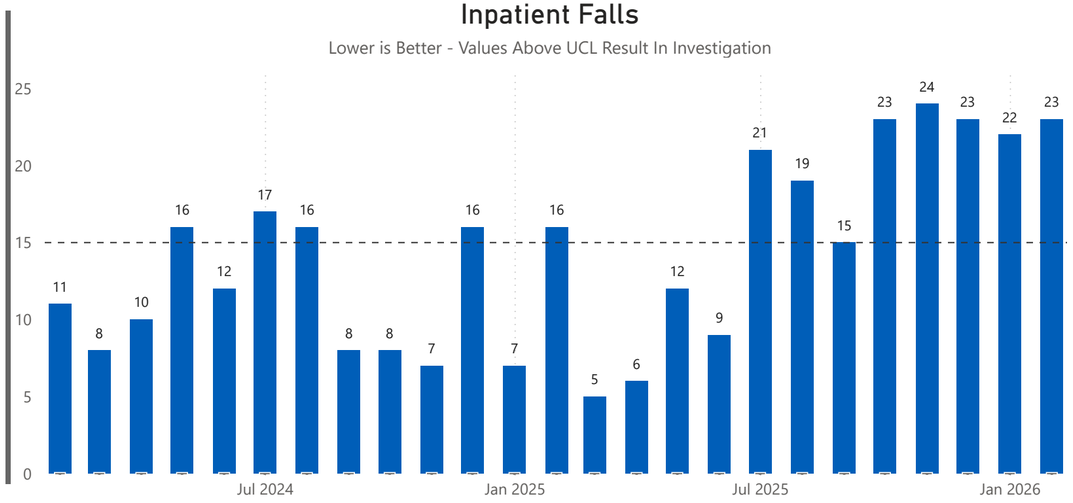
Data Source
Datix, Ward Documentation

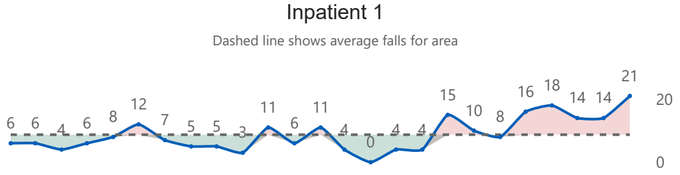
Latest Data
February 2026

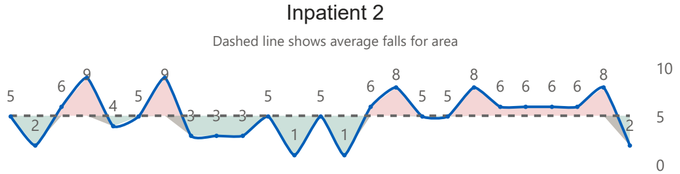
Compliance

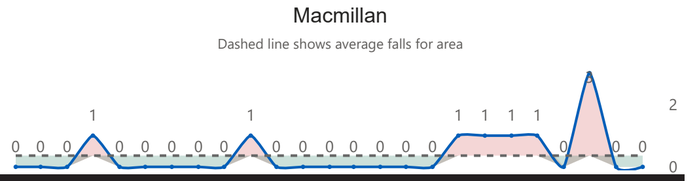
KPI	Target	Actual	RAG Value
Inpatient falls (an event which results in a person coming to rest unintentionally on the ground or floor or other lower level)	0	23	Red

Action	Target Date	Owner	Status
Deep dive data review of falls in the last 12 months	31/03/2026	S Thomas	Completed
Review of data presentation in the IPR for next Board meeting	29/05/2026	S Thomas	Off Track
Improvement work continues with close links with the Scottish Patient Safety Programme (SPSP) falls initiative.	30/06/2026	S Thomas	In Progress



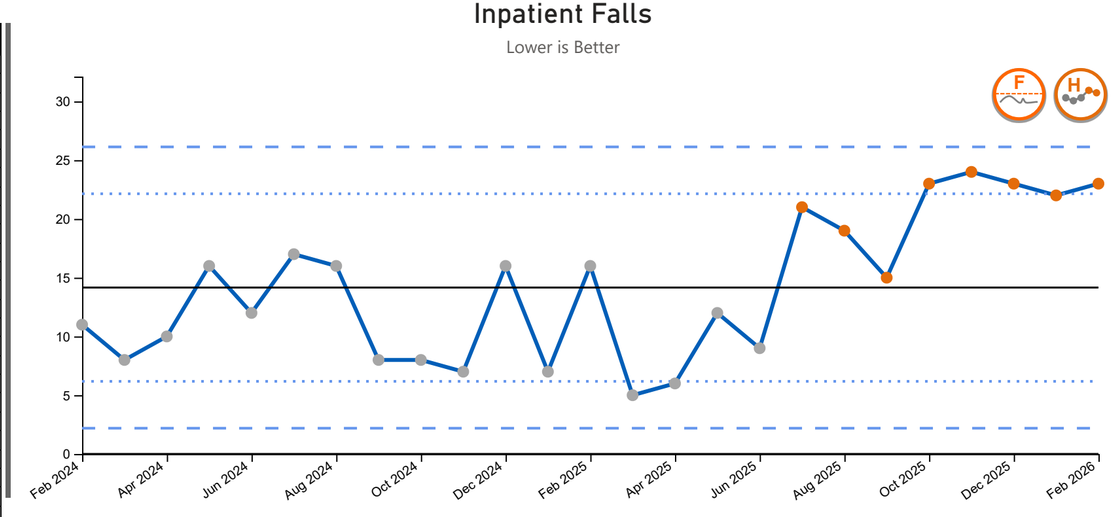






Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	11.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/03/2024	8.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/04/2024	10.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/05/2024	16.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/06/2024	12.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/07/2024	17.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/08/2024	16.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/09/2024	8.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/10/2024	8.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/11/2024	7.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/12/2024	16.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/01/2025	7.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/02/2025	16.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/03/2025	5.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/04/2025	6.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/05/2025	12.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/06/2025	9.00	14.16	0.00	2.19	26.13	6.18	22.14	NONE
01/07/2025	21.00	14.16	0.00	2.19	26.13	6.18	22.14	DETERIORATION
01/08/2025	19.00	14.16	0.00	2.19	26.13	6.18	22.14	DETERIORATION
01/09/2025	15.00	14.16	0.00	2.19	26.13	6.18	22.14	DETERIORATION
01/10/2025	23.00	14.16	0.00	2.19	26.13	6.18	22.14	DETERIORATION
01/11/2025	24.00	14.16	0.00	2.19	26.13	6.18	22.14	DETERIORATION
01/12/2025	23.00	14.16	0.00	2.19	26.13	6.18	22.14	DETERIORATION
01/01/2026	22.00	14.16	0.00	2.19	26.13	6.18	22.14	DETERIORATION
01/02/2026	23.00	14.16	0.00	2.19	26.13	6.18	22.14	DETERIORATION



Comments From Executive Lead

A high proportion of these falls recorded are due to single patients with known falls risks who have multiple falls despite increased observation and safety measures.

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

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

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

Patient Safety, Quality, and Experience
Pressure Ulcers

Data Source
Datix, Ward Documentation

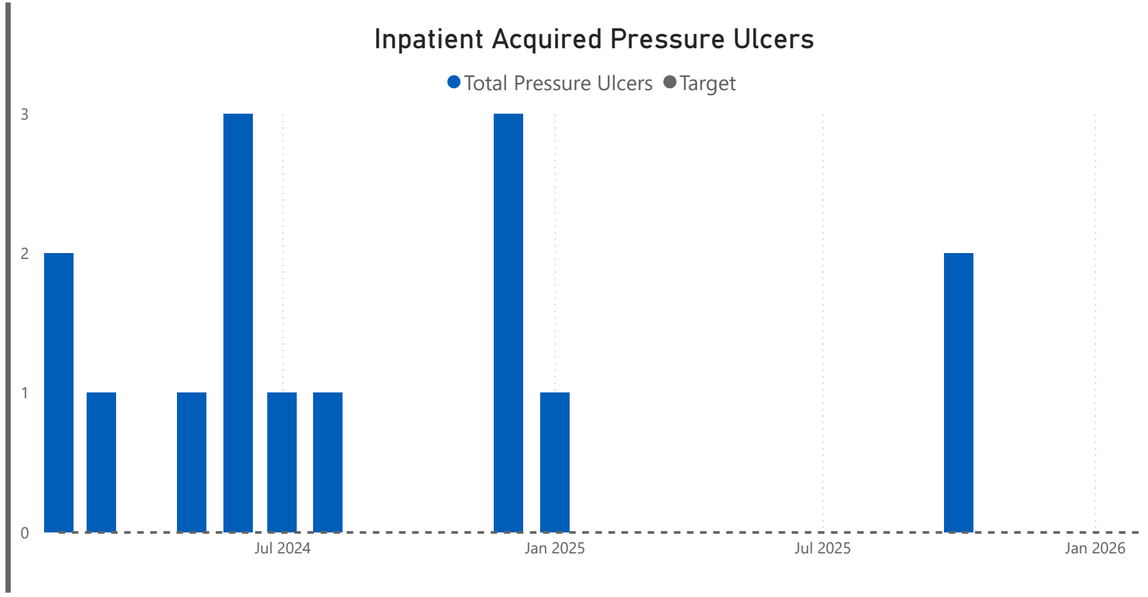
Latest Data
February 2026

Compliance

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

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



Comments From Executive Lead

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

Patient Safety, Quality, and Experience
Incident Reporting and Review

Data Source
Datix

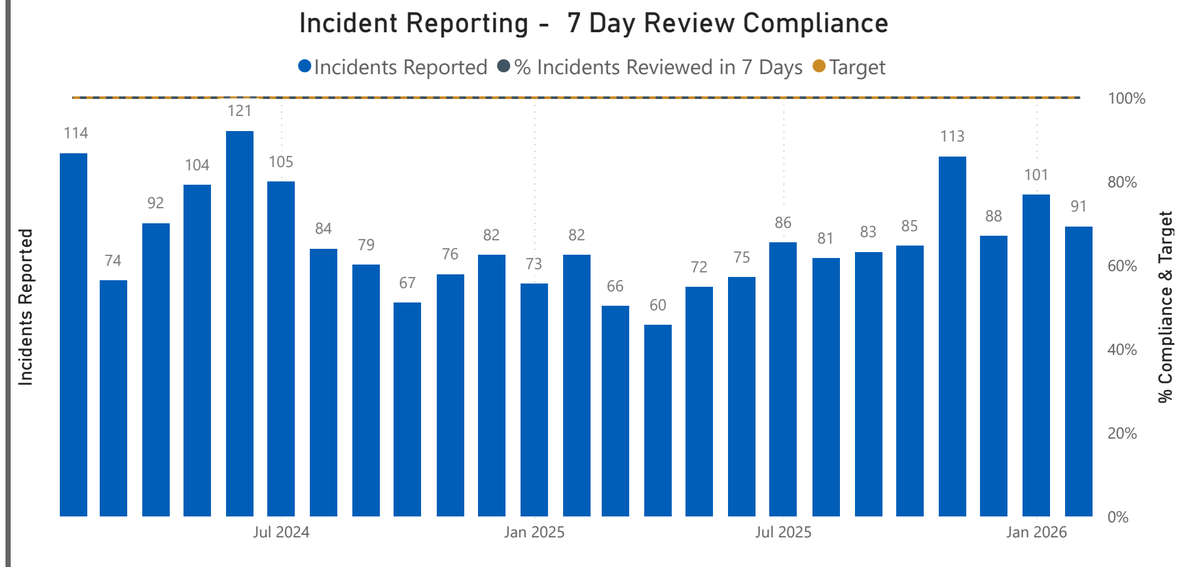
Latest Month
February 2026

Compliance

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

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



Comments From Executive Lead

Dr Anna Lamont, Medical Director

Patient Safety, Quality, and Experience
Significant Adverse Event Reviews (SAERs)

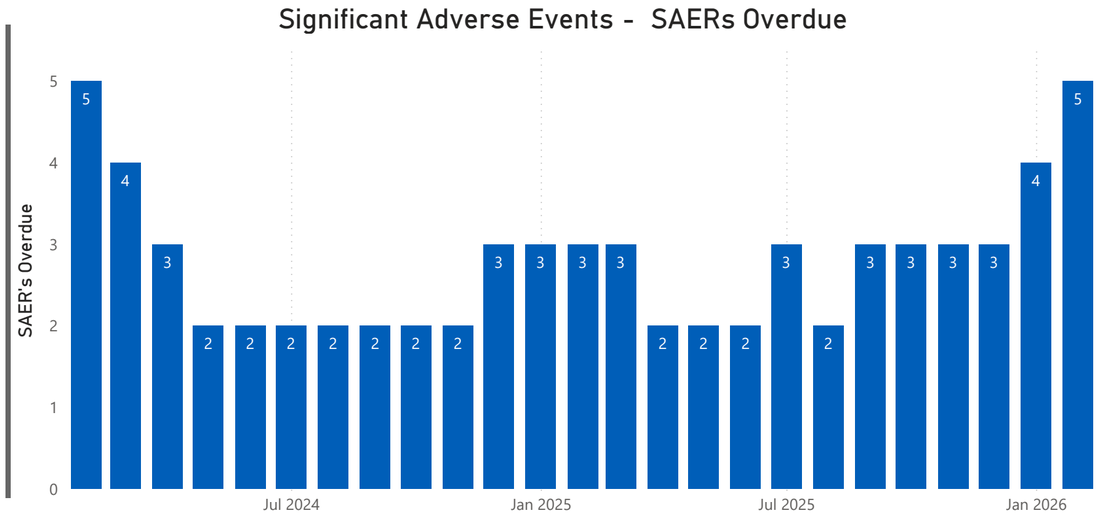
Data Source: Datix

Latest Data: February 2026

Compliance

KPI	Target	Actual	RAG Value
Significant Adverse Event Review Compliance (closed within target date)	100%	16.67%	Red

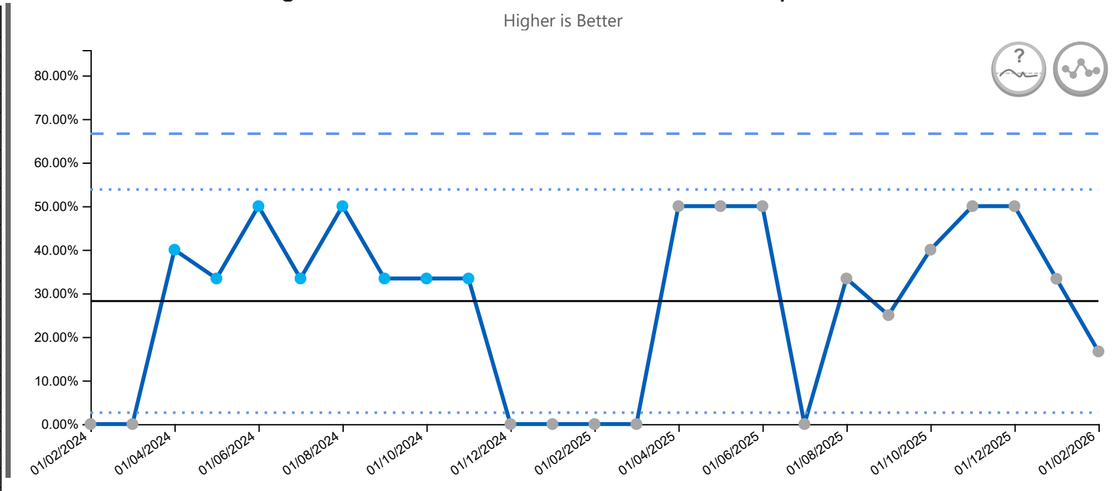
Action	Target Date	Owner	Status
Monitor and support the timely closure of currently open SAERs via the Clinical Governance Group	31/12/2025	A Lamont	Off Track



Month	SAER's commissioned	SAER's overdue	% SAER Compliance	Target
November 2024	0	2	33.40%	100.00%
December 2024	0	3	0.00%	100.00%
January 2025	0	3	0.00%	100.00%
February 2025	0	3	0.00%	100.00%
March 2025	0	3	0.00%	100.00%
April 2025	2	2	50.00%	100.00%
May 2025	0	2	50.00%	100.00%
June 2025	0	2	50.00%	100.00%
July 2025	0	3	0.00%	100.00%
August 2025	0	2	33.40%	100.00%
September 2025	1	3	25.00%	100.00%
October 2025	1	3	40.00%	100.00%
November 2025	1	3	50.00%	100.00%
December 2025	0	3	50.00%	100.00%
January 2026	0	4	33.34%	100.00%
February 2026	0	5	16.67%	100.00%

Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	0.00	28.22	0.00	66.62	2.62	53.82	NONE
01/03/2024	0.00	28.22	0.00	66.62	2.62	53.82	NONE
01/04/2024	40.00	28.22	0.00	66.62	2.62	53.82	IMPROVEMENT
01/05/2024	33.40	28.22	0.00	66.62	2.62	53.82	IMPROVEMENT
01/06/2024	50.00	28.22	0.00	66.62	2.62	53.82	IMPROVEMENT
01/07/2024	33.40	28.22	0.00	66.62	2.62	53.82	IMPROVEMENT
01/08/2024	50.00	28.22	0.00	66.62	2.62	53.82	IMPROVEMENT
01/09/2024	33.40	28.22	0.00	66.62	2.62	53.82	IMPROVEMENT
01/10/2024	33.40	28.22	0.00	66.62	2.62	53.82	IMPROVEMENT
01/11/2024	33.40	28.22	0.00	66.62	2.62	53.82	IMPROVEMENT
01/12/2024	0.00	28.22	0.00	66.62	2.62	53.82	NONE
01/01/2025	0.00	28.22	0.00	66.62	2.62	53.82	NONE
01/02/2025	0.00	28.22	0.00	66.62	2.62	53.82	NONE
01/03/2025	0.00	28.22	0.00	66.62	2.62	53.82	NONE
01/04/2025	50.00	28.22	0.00	66.62	2.62	53.82	NONE
01/05/2025	50.00	28.22	0.00	66.62	2.62	53.82	NONE
01/06/2025	50.00	28.22	0.00	66.62	2.62	53.82	NONE
01/07/2025	0.00	28.22	0.00	66.62	2.62	53.82	NONE
01/08/2025	33.40	28.22	0.00	66.62	2.62	53.82	NONE
01/09/2025	25.00	28.22	0.00	66.62	2.62	53.82	NONE
01/10/2025	40.00	28.22	0.00	66.62	2.62	53.82	NONE
01/11/2025	50.00	28.22	0.00	66.62	2.62	53.82	NONE
01/12/2025	50.00	28.22	0.00	66.62	2.62	53.82	NONE
01/01/2026	33.34	28.22	0.00	66.62	2.62	53.82	NONE
01/02/2026	16.67	28.22	0.00	66.62	2.62	53.82	NONE



Comments From Executive Lead

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

Dr Anna Lamont, Medical Director

Patient Safety, Quality, and Experience
Maternal Early Warning Score Escalation

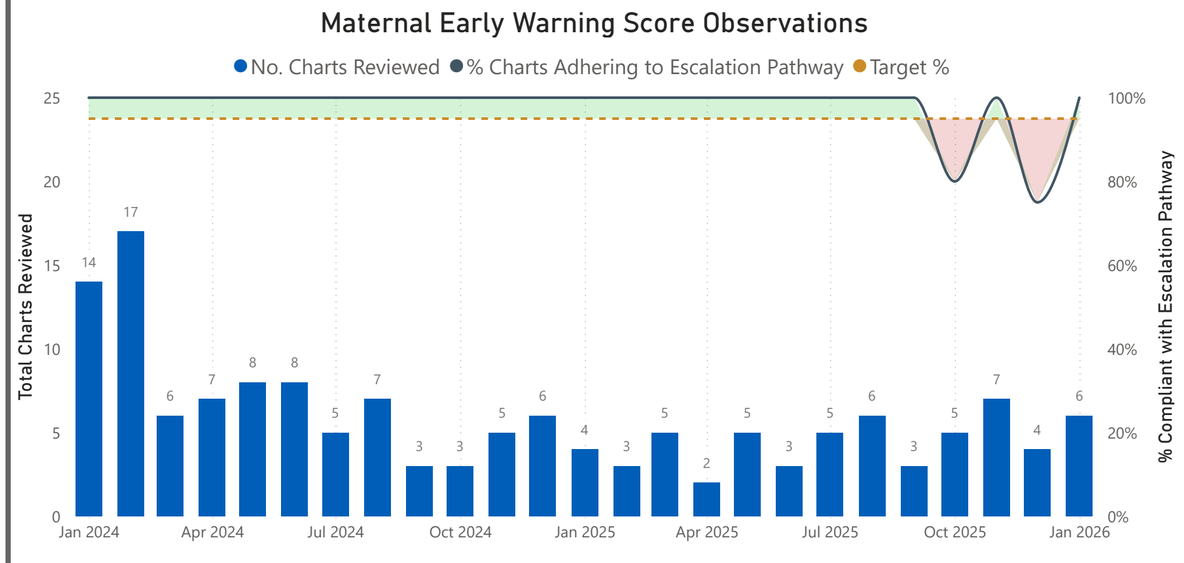
Data Source
Clinical Records

Latest Data
January 2026

Compliance

KPI	Target	Actual	RAG Value
Maternal Early Warning Score Escalation	95%	100%	Green

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



Comments From Executive Lead

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

Patient Safety, Quality, and Experience
Maternal Early Warning Score Observations

Data Source
Clinical Records

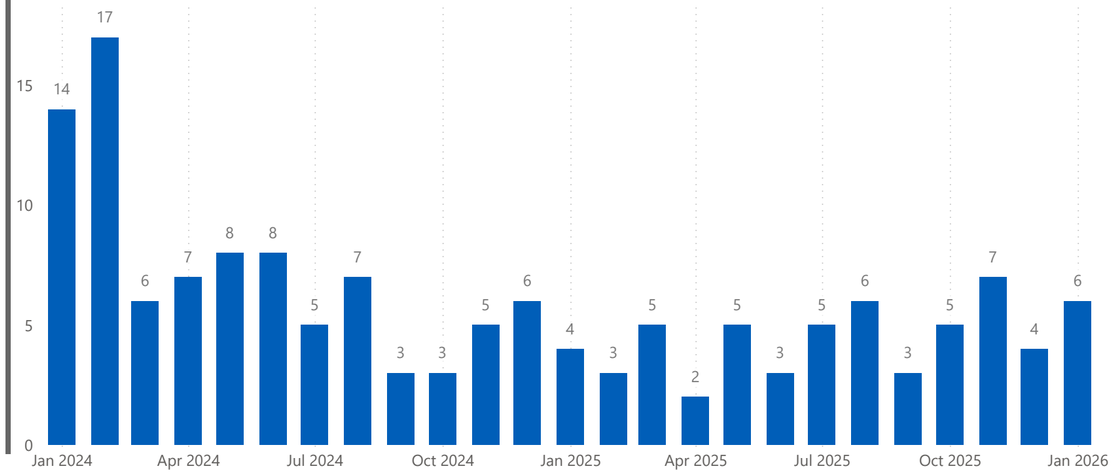
Latest Data
January 2026

Compliance

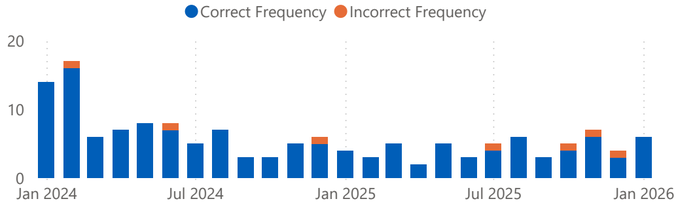
KPI	Target	Actual	RAG Value
Maternal Early Warning Score Observations	95%	100%	Green

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

Maternal Early Warning Scores - Charts Reviewed



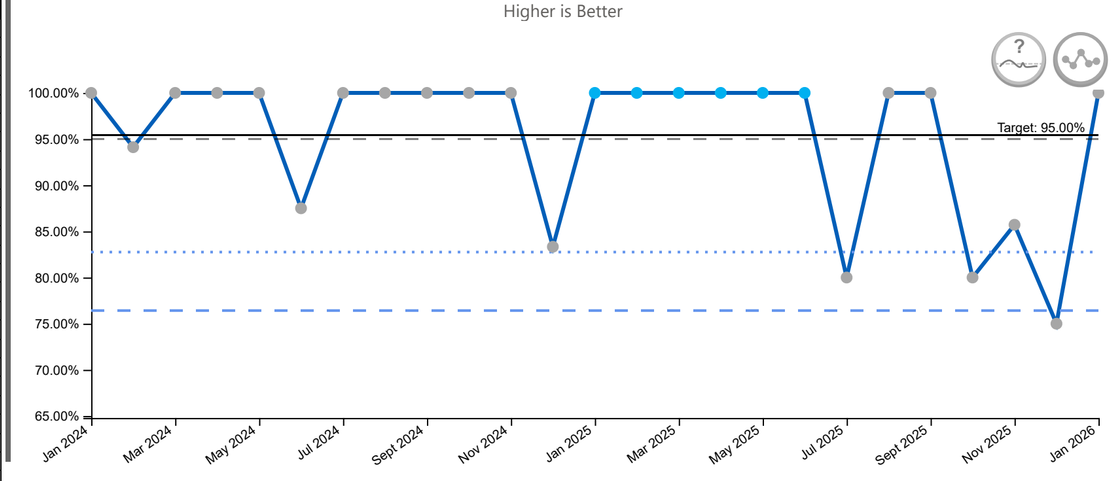
Maternal Early Warning Scores - Frequencies



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/01/2024	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/02/2024	94.12	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/03/2024	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/04/2024	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/05/2024	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/06/2024	87.50	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/07/2024	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/08/2024	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/09/2024	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/10/2024	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/11/2024	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/12/2024	83.33	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/01/2025	100.00	95.43	95.00	78.48	100.00	84.13	100.00	IMPROVEMENT
01/02/2025	100.00	95.43	95.00	78.48	100.00	84.13	100.00	IMPROVEMENT
01/03/2025	100.00	95.43	95.00	78.48	100.00	84.13	100.00	IMPROVEMENT
01/04/2025	100.00	95.43	95.00	78.48	100.00	84.13	100.00	IMPROVEMENT
01/05/2025	100.00	95.43	95.00	78.48	100.00	84.13	100.00	IMPROVEMENT
01/06/2025	100.00	95.43	95.00	78.48	100.00	84.13	100.00	IMPROVEMENT
01/07/2025	80.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/08/2025	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/09/2025	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/10/2025	80.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/11/2025	85.71	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/12/2025	75.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE
01/01/2026	100.00	95.43	95.00	78.48	100.00	84.13	100.00	NONE

Maternal Early Warning Scores - Observation Compliance



Comments From Executive Lead

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

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

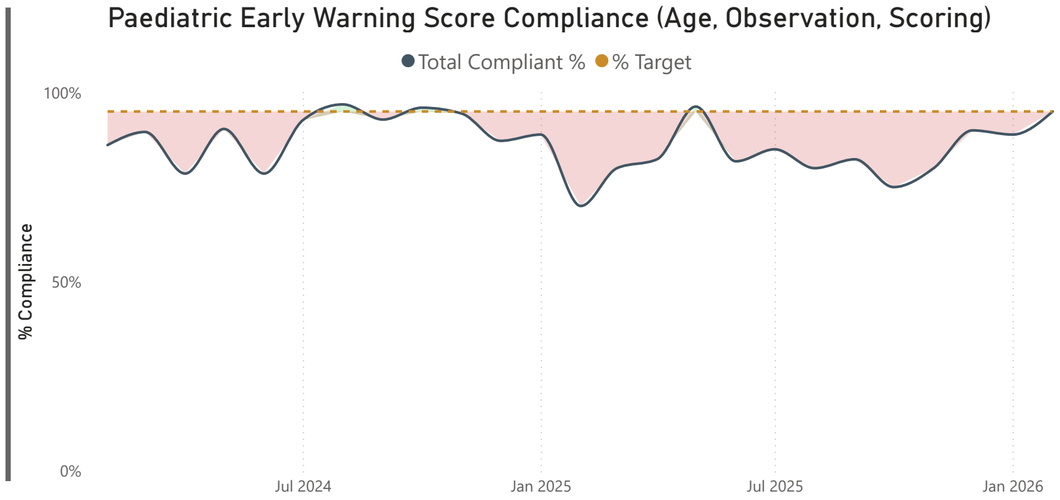
Data Source
Clinical Records

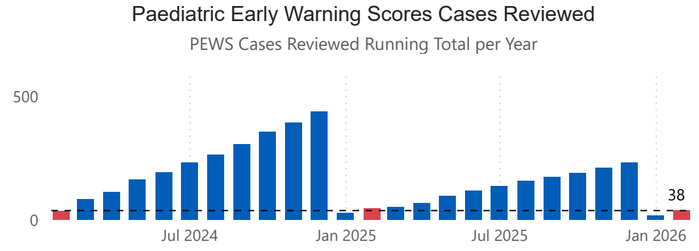
Latest Data
February 2026

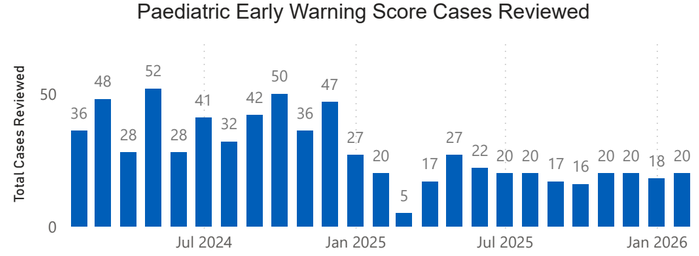
Compliance

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

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

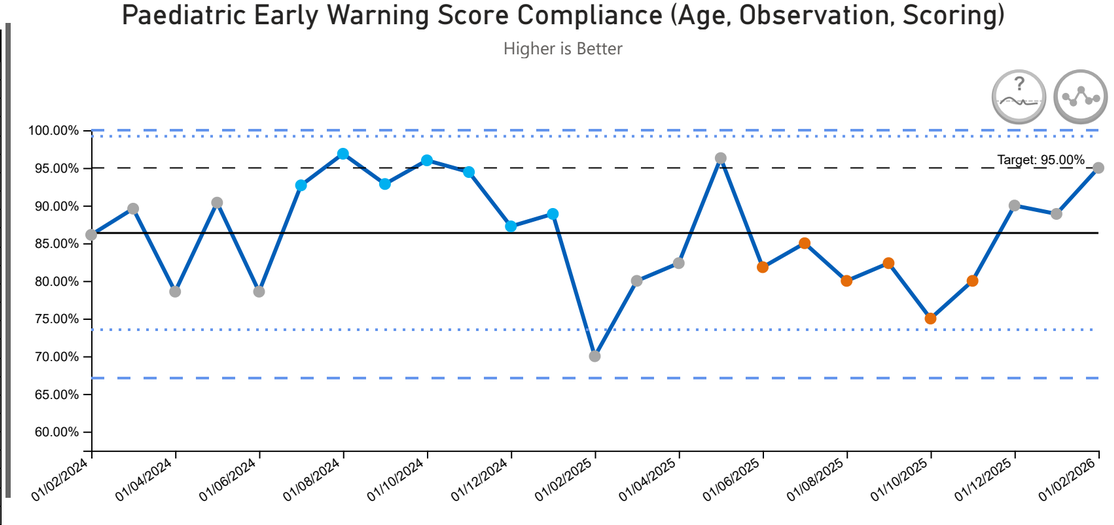






Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	86.11	86.36	67.10	100.00	73.52	99.19	NONE
01/03/2024	89.58	86.36	67.10	100.00	73.52	99.19	NONE
01/04/2024	78.57	86.36	67.10	100.00	73.52	99.19	NONE
01/05/2024	90.38	86.36	67.10	100.00	73.52	99.19	NONE
01/06/2024	78.57	86.36	67.10	100.00	73.52	99.19	NONE
01/07/2024	92.68	86.36	67.10	100.00	73.52	99.19	IMPROVEMENT
01/08/2024	96.88	86.36	67.10	100.00	73.52	99.19	IMPROVEMENT
01/09/2024	92.86	86.36	67.10	100.00	73.52	99.19	IMPROVEMENT
01/10/2024	96.00	86.36	67.10	100.00	73.52	99.19	IMPROVEMENT
01/11/2024	94.44	86.36	67.10	100.00	73.52	99.19	IMPROVEMENT
01/12/2024	87.23	86.36	67.10	100.00	73.52	99.19	IMPROVEMENT
01/01/2025	88.89	86.36	67.10	100.00	73.52	99.19	IMPROVEMENT
01/02/2025	70.00	86.36	67.10	100.00	73.52	99.19	NONE
01/03/2025	80.00	86.36	67.10	100.00	73.52	99.19	NONE
01/04/2025	82.35	86.36	67.10	100.00	73.52	99.19	NONE
01/05/2025	96.30	86.36	67.10	100.00	73.52	99.19	NONE
01/06/2025	81.82	86.36	67.10	100.00	73.52	99.19	DETERIORATION
01/07/2025	85.00	86.36	67.10	100.00	73.52	99.19	DETERIORATION
01/08/2025	80.00	86.36	67.10	100.00	73.52	99.19	DETERIORATION
01/09/2025	82.35	86.36	67.10	100.00	73.52	99.19	DETERIORATION
01/10/2025	75.00	86.36	67.10	100.00	73.52	99.19	DETERIORATION
01/11/2025	80.00	86.36	67.10	100.00	73.52	99.19	DETERIORATION
01/12/2025	90.00	86.36	67.10	100.00	73.52	99.19	NONE
01/01/2026	88.89	86.36	67.10	100.00	73.52	99.19	NONE
01/02/2026	95.00	86.36	67.10	100.00	73.52	99.19	NONE



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

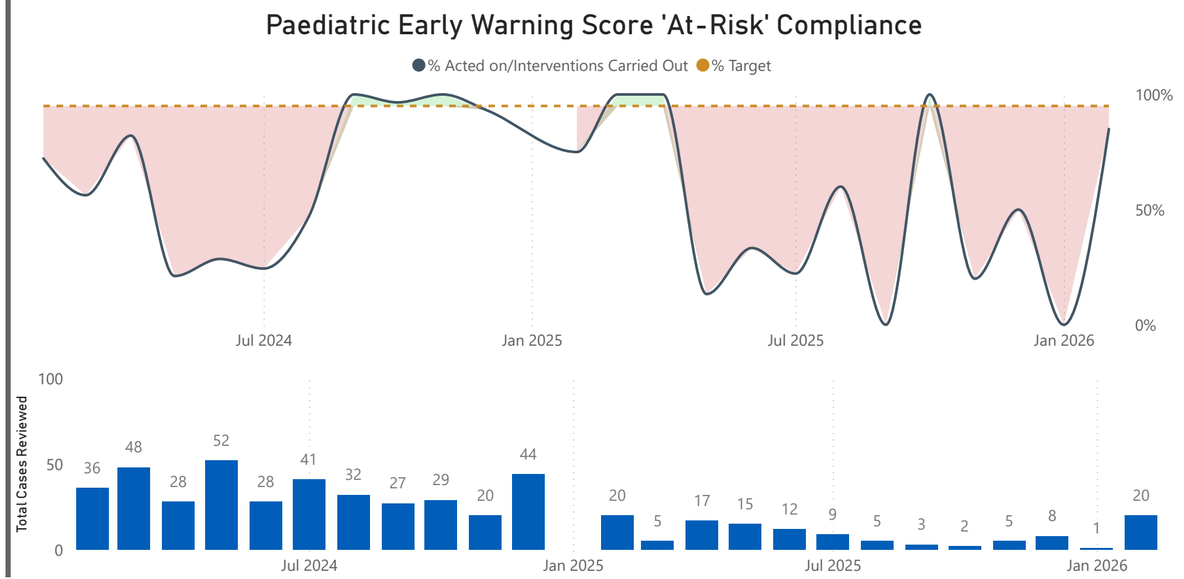
Data Source
Clinical Records

Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
Paediatric Early Warning Score (PEWs) - % 'at-risk' observations identified and acted upon	95%	85%	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	Completed
Educational programme to be delivered on processes around completion of PEWS	31/03/2026	S Thomas	Completed



Comments From Executive Lead

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

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

Operational Standards Acute

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

What's Going Well?

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

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

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

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

RAG Status Values

RED	Key performance indicator not achieved, and performance below lower threshold.
AMBER	Key performance indicator not achieved, but performance above lower threshold.
GREEN	Key performance indicator achieved.

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

Areas of Concern

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

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

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

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

Operational Standards
Accident & Emergency 4-Hour Compliance

Data Source
PHS A&E Publication, TrakCare

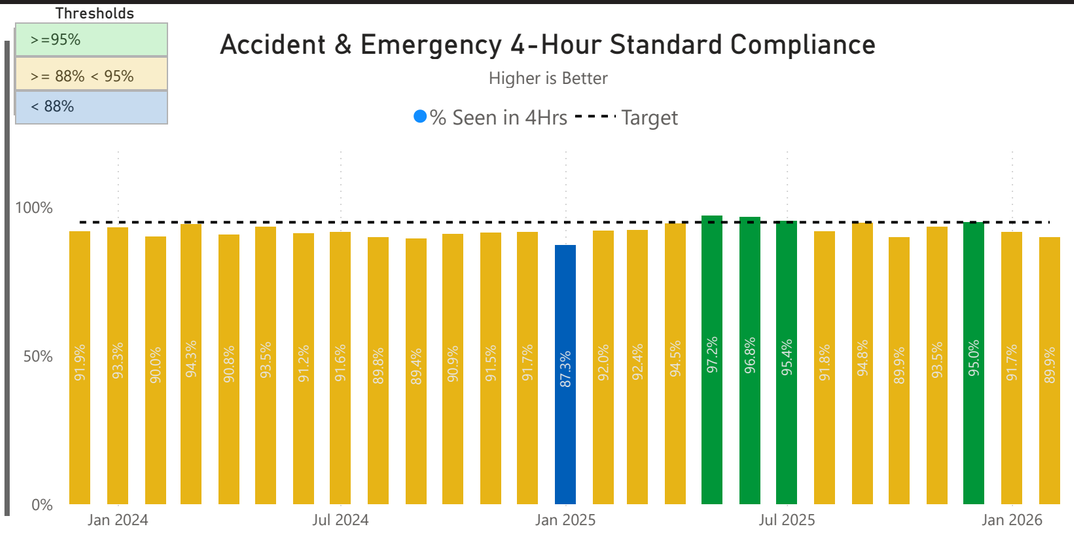
Latest Data
February 2026

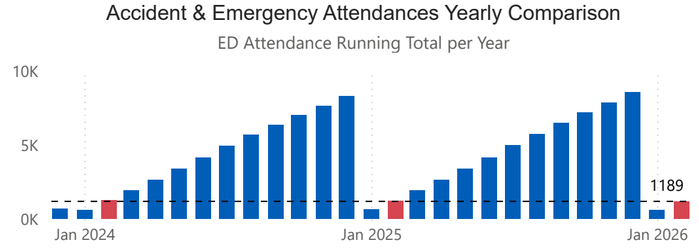
Compliance

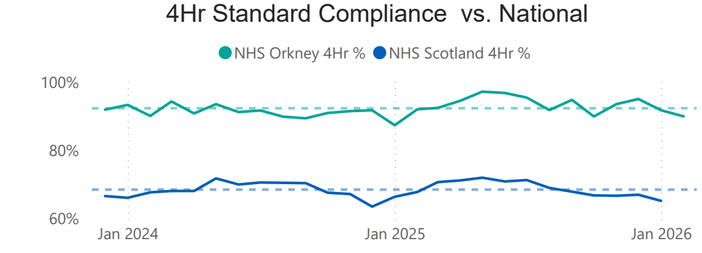
KPI	Target	Actual	RAG Value
95% of patients wait no longer than four hours from arrival to admission, discharge, or transfer for A&E treatment. Boards work towards 98%.	95%	89.91%	Amber

Action	Target Date	Owner	Status

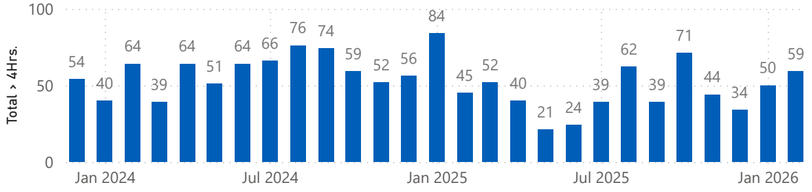
All current actions completed/closed.



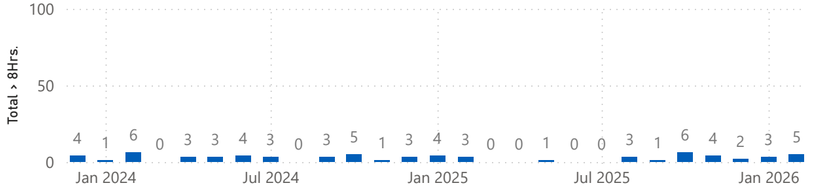




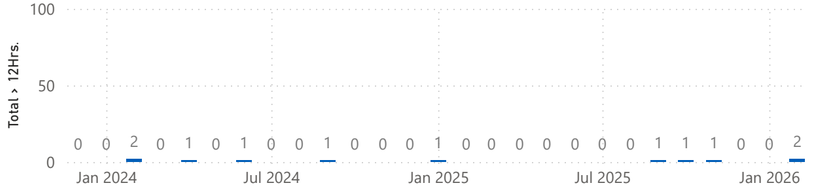
No. of Attendances > 4 Hours



No. of Attendances > 8 Hours

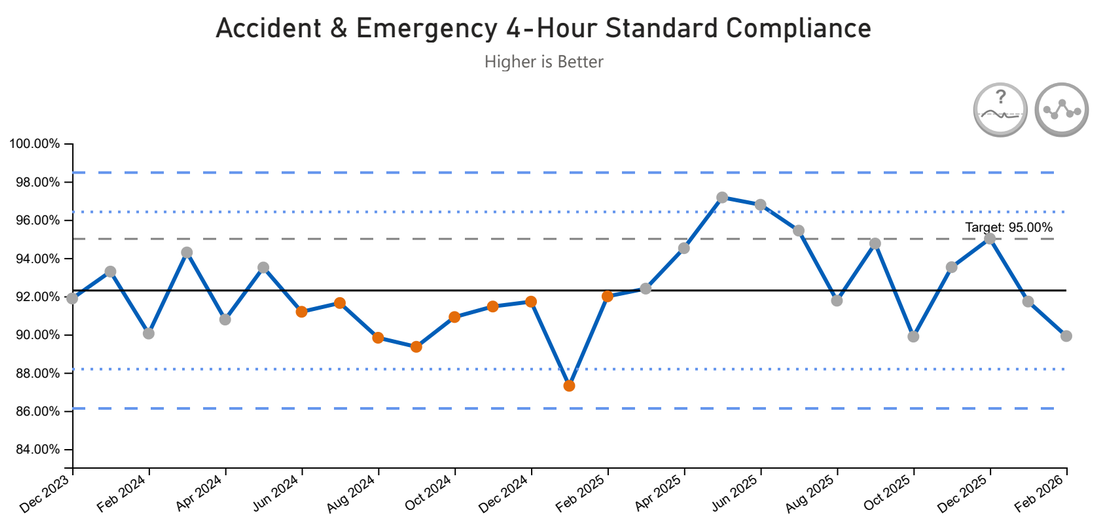


No. of Attendances > 12 Hours



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/12/2023	91.88	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/01/2024	93.29	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/02/2024	90.05	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/03/2024	94.29	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/04/2024	90.78	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/05/2024	93.50	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/06/2024	91.18	92.30	95.00	86.13	98.47	88.18	96.41	DETERIORATION
01/07/2024	91.65	92.30	95.00	86.13	98.47	88.18	96.41	DETERIORATION
01/08/2024	89.83	92.30	95.00	86.13	98.47	88.18	96.41	DETERIORATION
01/09/2024	89.35	92.30	95.00	86.13	98.47	88.18	96.41	DETERIORATION
01/10/2024	90.91	92.30	95.00	86.13	98.47	88.18	96.41	DETERIORATION
01/11/2024	91.46	92.30	95.00	86.13	98.47	88.18	96.41	DETERIORATION
01/12/2024	91.72	92.30	95.00	86.13	98.47	88.18	96.41	DETERIORATION
01/01/2025	87.31	92.30	95.00	86.13	98.47	88.18	96.41	DETERIORATION
01/02/2025	91.99	92.30	95.00	86.13	98.47	88.18	96.41	DETERIORATION
01/03/2025	92.40	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/04/2025	94.51	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/05/2025	97.17	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/06/2025	96.79	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/07/2025	95.43	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/08/2025	91.77	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/09/2025	94.76	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/10/2025	89.89	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/11/2025	93.52	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/12/2025	95.01	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/01/2026	91.72	92.30	95.00	86.13	98.47	88.18	96.41	NONE
01/02/2026	89.91	92.30	95.00	86.13	98.47	88.18	96.41	NONE



Comments From Executive Lead

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

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

Operational Standards
Accident & Emergency 12-Hour Compliance

Data Source
PHS A&E Publication, TrakCare

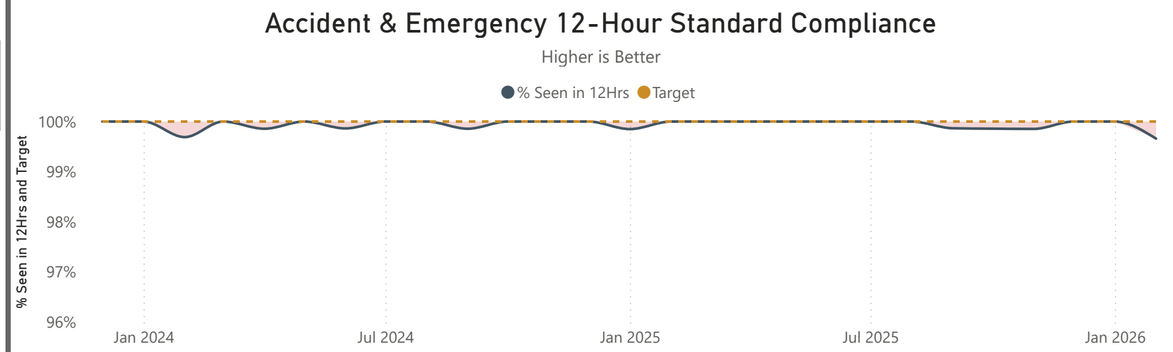
Latest Data
February 2026

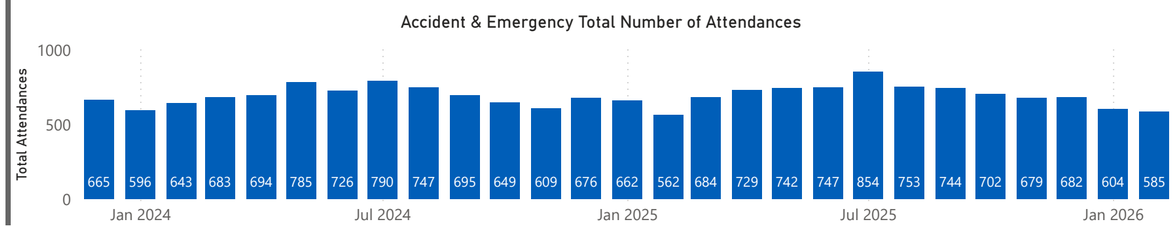
Compliance

KPI	Target	Actual	RAG Value
Patients wait less than 12 hours to admission, discharge, or transfer from A&E	99.5%	99.66%	Green

Action	Target Date	Owner	Status

All current actions completed/closed.





Comments From Executive Lead

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

Operational Standards
Scottish Ambulance Service Turnaround Times

Data Source
SAS Weekly Operational Statistics

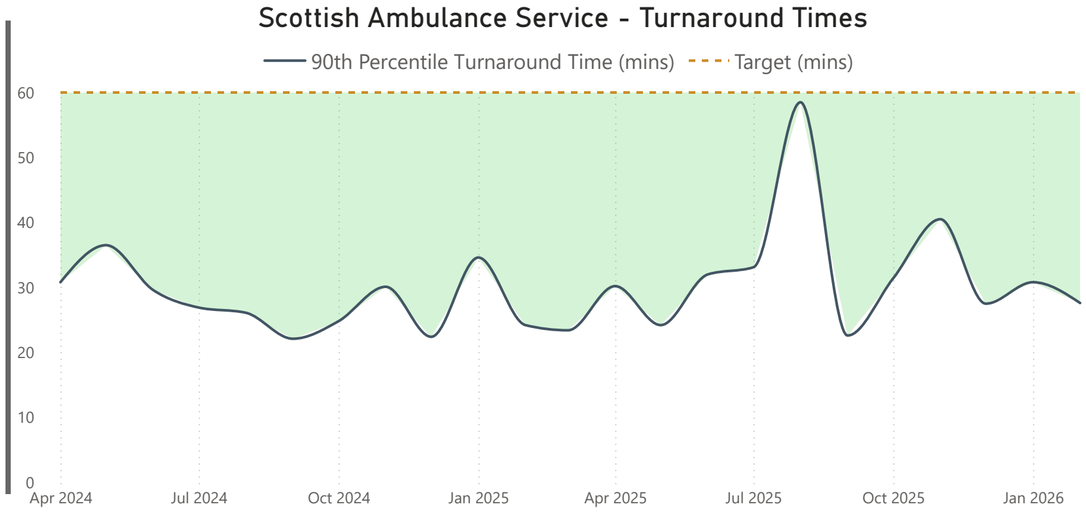
Latest Data
February 2026

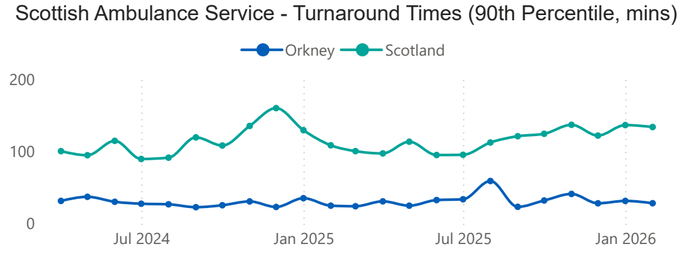
Compliance

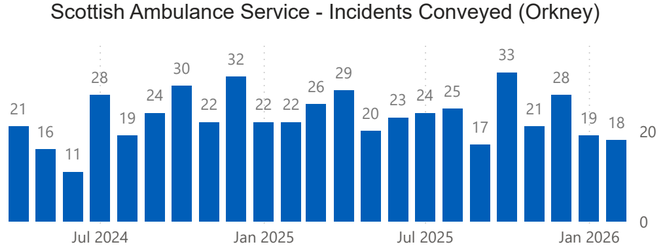
KPI	Target	Actual	RAG Value
Scottish Ambulance Service Turnaround Times - 90th percentile within 60 minutes	60:00	00:27:34	Green

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.







Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
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01/05/2024	37	30	60	12	48	18	42	NONE
01/06/2024	30	30	60	12	48	18	42	NONE
01/07/2024	27	30	60	12	48	18	42	NONE
01/08/2024	26	30	60	12	48	18	42	NONE
01/09/2024	22	30	60	12	48	18	42	NONE
01/10/2024	25	30	60	12	48	18	42	NONE
01/11/2024	30	30	60	12	48	18	42	NONE
01/12/2024	22	30	60	12	48	18	42	NONE
01/01/2025	35	30	60	12	48	18	42	NONE
01/02/2025	24	30	60	12	48	18	42	NONE
01/03/2025	23	30	60	12	48	18	42	NONE
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01/05/2025	24	30	60	12	48	18	42	NONE
01/06/2025	32	30	60	12	48	18	42	NONE
01/07/2025	33	30	60	12	48	18	42	NONE
01/08/2025	59	30	60	12	48	18	42	NONE
01/09/2025	23	30	60	12	48	18	42	NONE
01/10/2025	31	30	60	12	48	18	42	NONE
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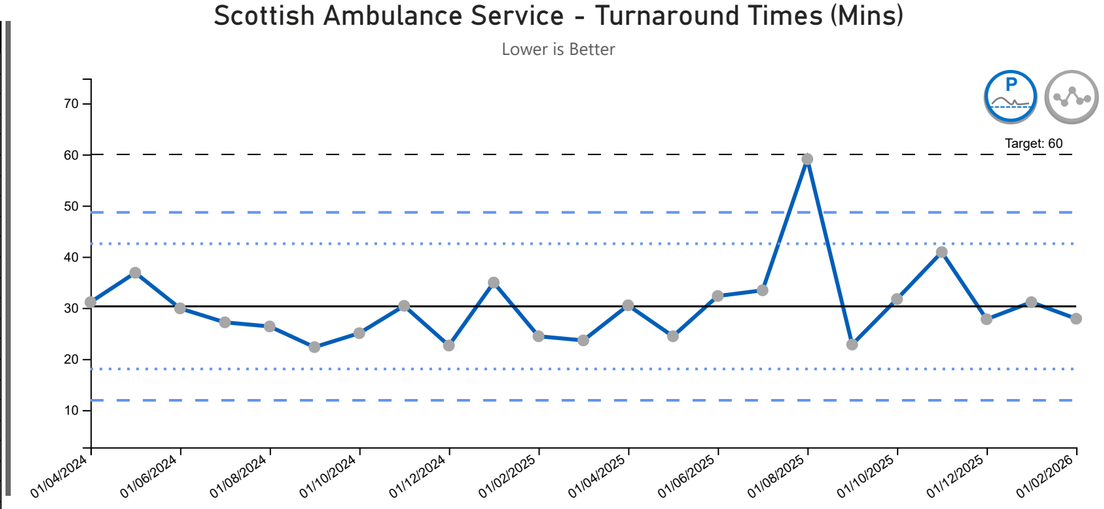
01/12/2025	28	30	60	12	48	18	42	NONE
01/01/2026	31	30	60	12	48	18	42	NONE
01/02/2026	28	30	60	12	48	18	42	NONE



Comments From Executive Lead

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

Operational Standards
52-Week Waits Summary (NOP & TTG)

Data Source
OP Recovery Weekly Return, TrakCare

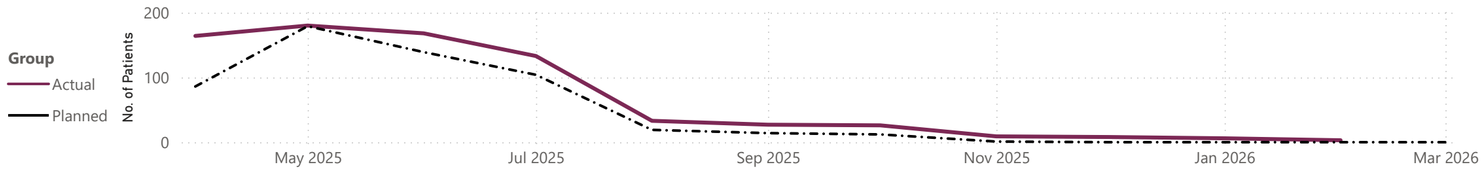
Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
0 patients waiting more than 52 weeks on a New Outpatient or Treatment Time Guarantee waiting list	0	6	Amber

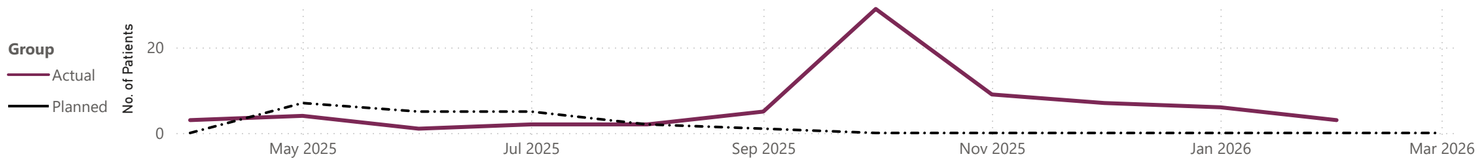
Action	Target Date	Owner	Status
Agree a plan to address identified demand and capacity gaps for 2026/27, covering the next 12 months.	30/06/2026	C Somerville	In Progress
External Capacity Review – Service Level Agreements being reviewed to ensure they meet demand and reduce delays	31/03/2027	C Somerville	In Progress
Internal Capacity Review – Theatre and Outpatient capacity reviews to ensure clinic/theatre utilisation maximised – consider additional or change to schedules	31/03/2027	C Somerville	In Progress
NECU Validation – results from validation to be clinical reviewed and acted on	31/03/2027	C Somerville	In Progress
Waiting Times meeting - review long waits, escalate and track progress	30/05/2027	C Somerville	In Progress

New Outpatients



Specialty	Area	Category	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
All Specialties	New Outpatients	> 52 Weeks	Planned	86	179	139	104	19	14	12	1	0	0	0	0
			Actual	164	180	168	133	33	27	26	9	8	6	3	
			+/-	78	1	29	29	14	13	14	8	8	6	3	0

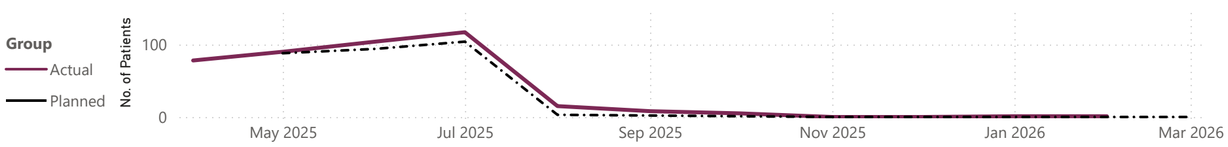
Treatment Time Guarantee



Specialty	Area	Category	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
All Specialties	Treatment Time Guarantee	> 52 Weeks	Planned	0	7	5	5	2	1	0	0	0	0	0	0
			Actual	3	4	1	2	2	5	29	9	7	6	3	
			+/-	3	-3	-4	-3	0	4	29	9	7	6	3	0

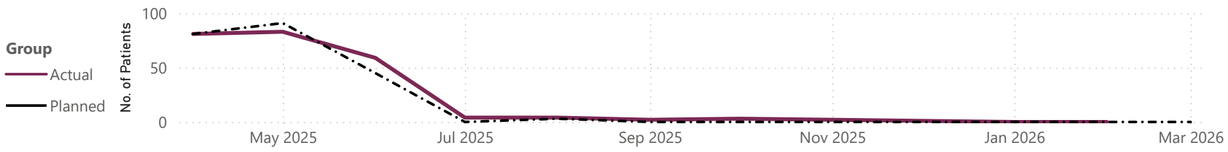
New Outpatients

Ear, Nose, and Throat 52-Week Waits



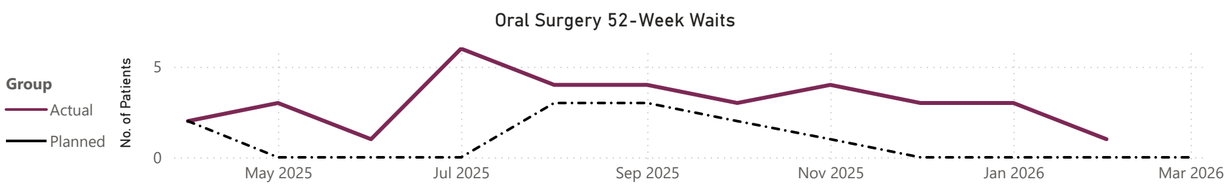
Specialty	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Ear, Nose, and Throat	Planned		88	94	104	3	2	1	0	0	0	0	0
	Actual	78	90	104	117	15	8	5	0	0	1	1	
	+/-	78	2	10	13	12	6	4	0	0	1	1	

Ophthalmology 52-Week Waits



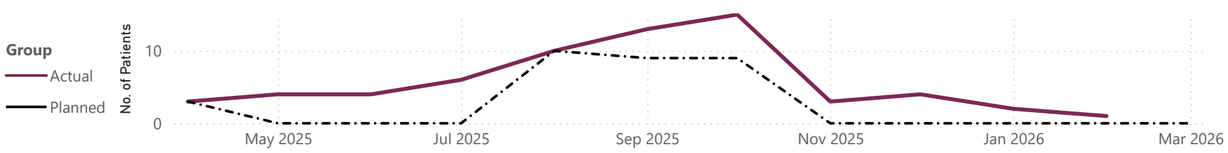
Specialty	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Ophthalmology	Planned	81	91	45	0	3	0	0	0	0	0	0	0
	Actual	81	83	59	4	4	2	3	2	1	0	0	
	+/-	0	-8	14	4	1	2	3	2	1	0	0	

Oral Surgery 52-Week Waits



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

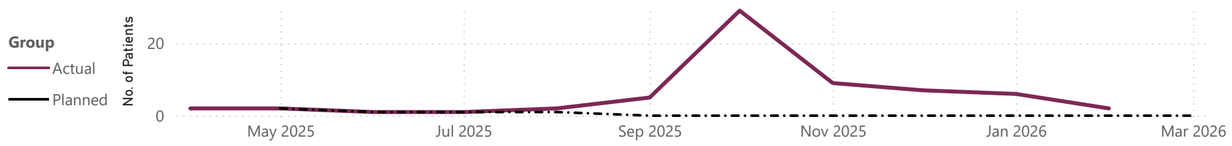
Trauma & Orthopaedic 52-Week Waits



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	15	3	4	2	1	
	+/-	0	4	4	6	0	4	6	3	4	2	1	

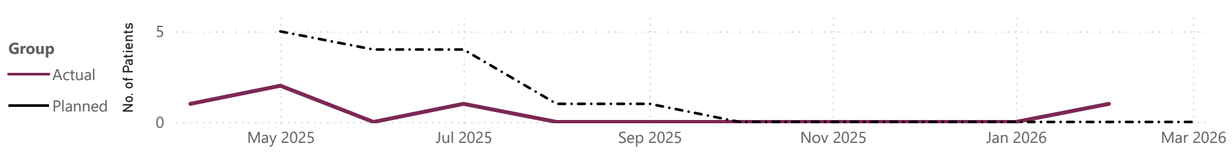
Treatment Time Guarantee

Ophthalmology 52-Week Waits



Specialty	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Ophthalmology	Planned		2	1	1	1	0	0	0	0	0	0	0
	Actual	2	2	1	1	2	5	29	9	7	6	2	
	+/-	2	0	0	0	1	5	29	9	7	6	2	

Trauma & Orthopaedic 52-Week Waits



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

Comments From Executive Lead

At the end of February, and in line with the national commitment to eliminate waits over 52 weeks, we were tracking six patients across all specialties. Targeted additional funding has enabled increased outpatient activity in Ophthalmology and ENT, leading to a substantially improved position in both areas. Ongoing collaboration with the Golden Jubilee continues to support access for the longest waiting Trauma and Orthopaedic TTG patients, with progress resulting in only one patient currently unavailable and awaiting appointment. Ophthalmology TTG patients continue to represent the largest cohort waiting over 52 weeks. There is also one Trauma and Orthopaedic patient, currently unavailable.
For New Outpatients, three patients remain over 52 weeks, and appointments have been offered to all.

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

Operational Standards
New Outpatients (NOP) 12 Week Compliance

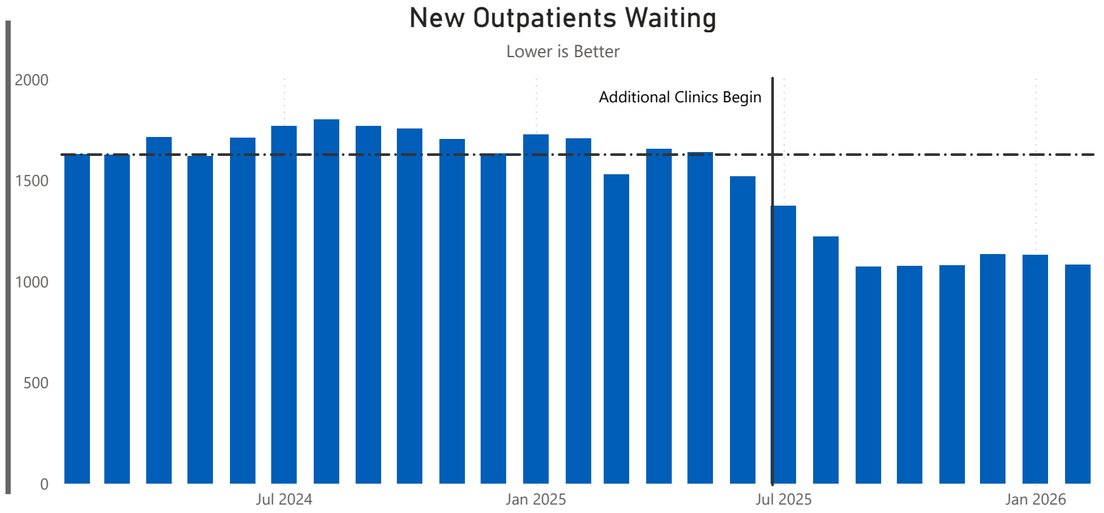
Data Source
OP Recovery Weekly Return

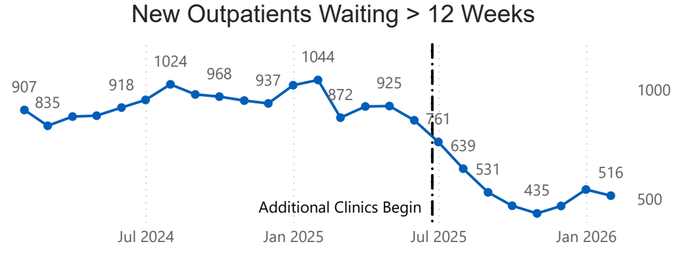
Latest Data
February 2026

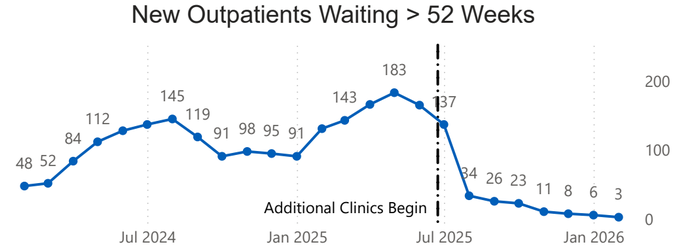
Compliance

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%	52.31%	Red

Action	Target Date	Owner	Status
Demand and Capacity Planning templates to be agreed and reviewed by speciality for 2026/27 activity.	30/05/2026	C Somerville	Completed
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	30/05/2026	C Somerville	In Progress
Explore a one stop cataract assessment clinic to free consultant capacity for specialist activity	30/06/2026	C Somerville	In Progress







Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
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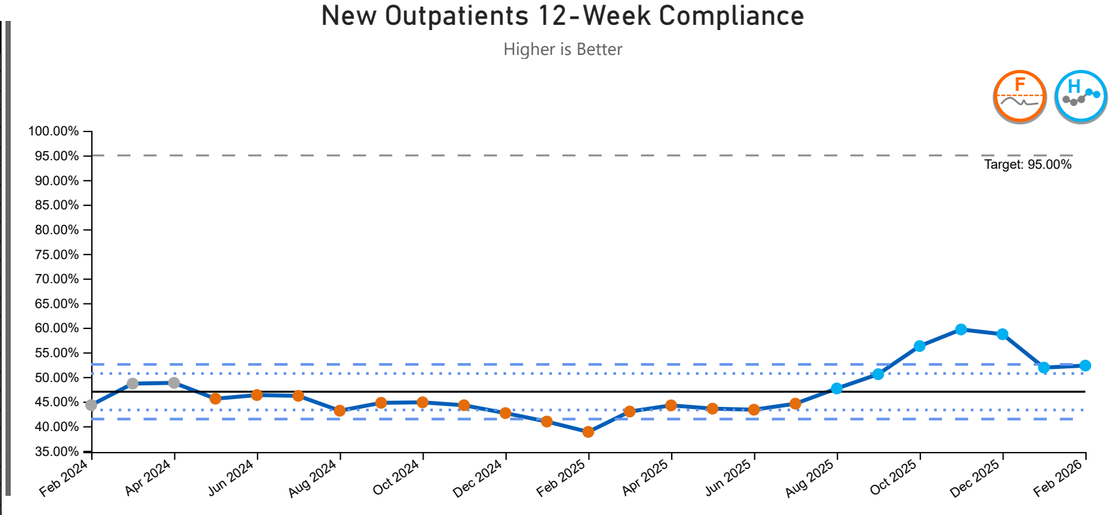
01/03/2024	49	47	41	53	43	51	NONE
01/04/2024	49	47	41	53	43	51	NONE
01/05/2024	46	47	41	53	43	51	DETERIORATION
01/06/2024	46	47	41	53	43	51	DETERIORATION
01/07/2024	46	47	41	53	43	51	DETERIORATION
01/08/2024	43	47	41	53	43	51	DETERIORATION
01/09/2024	45	47	41	53	43	51	DETERIORATION
01/10/2024	45	47	41	53	43	51	DETERIORATION
01/11/2024	44	47	41	53	43	51	DETERIORATION
01/12/2024	43	47	41	53	43	51	DETERIORATION
01/01/2025	41	47	41	53	43	51	DETERIORATION
01/02/2025	39	47	41	53	43	51	DETERIORATION
01/03/2025	43	47	41	53	43	51	DETERIORATION
01/04/2025	44	47	41	53	43	51	DETERIORATION
01/05/2025	44	47	41	53	43	51	DETERIORATION
01/06/2025	43	47	41	53	43	51	DETERIORATION
01/07/2025	45	47	41	53	43	51	DETERIORATION
01/08/2025	48	47	41	53	43	51	IMPROVEMENT
01/09/2025	51	47	41	53	43	51	IMPROVEMENT
01/10/2025	56	47	41	53	43	51	IMPROVEMENT
01/11/2025	60	47	41	53	43	51	IMPROVEMENT
01/12/2025	59	47	41	53	43	51	IMPROVEMENT
01/01/2026	52	47	41	53	43	51	IMPROVEMENT
01/02/2026	52	47	41	53	43	51	IMPROVEMENT



Comments From Executive Lead

At the end of February 2026, there were 1,082 patients waiting for a new outpatient appointment, compared to 1,707 at the same point in 2025.

Ophthalmology and ENT have benefited from additional funding, supporting reductions in both overall waiting list size and longer waits. ENT waiting lists reduced from 293 to 155, with the number of patients waiting over 26 weeks decreasing from 162 in 2025 to 3 in 2026. Ophthalmology waiting lists reduced from 305 to 68, with patients waiting over 26 weeks reducing from 146 to 2 over the same period.

Local service improvements have also contributed to reductions in other specialties. Cardiology reduced from 38 to 26 patients waiting, with those waiting over 12 weeks decreasing from 10 to 2. General Surgery reduced from 146 to 31 patients, with no patients waiting over 12 weeks.These improvements reflect targeted investment and local service actions. Performance is monitored through regular review of patient level waits via weekly Waiting Times meetings, and ongoing Service Level Agreement discussions with partner Boards are focused on identifying further service improvement opportunities to support sustainable access for patients.

Dr Anna Lamont, Medical Director

Operational Standards
New Outpatients (NOP) Local Improvement Target

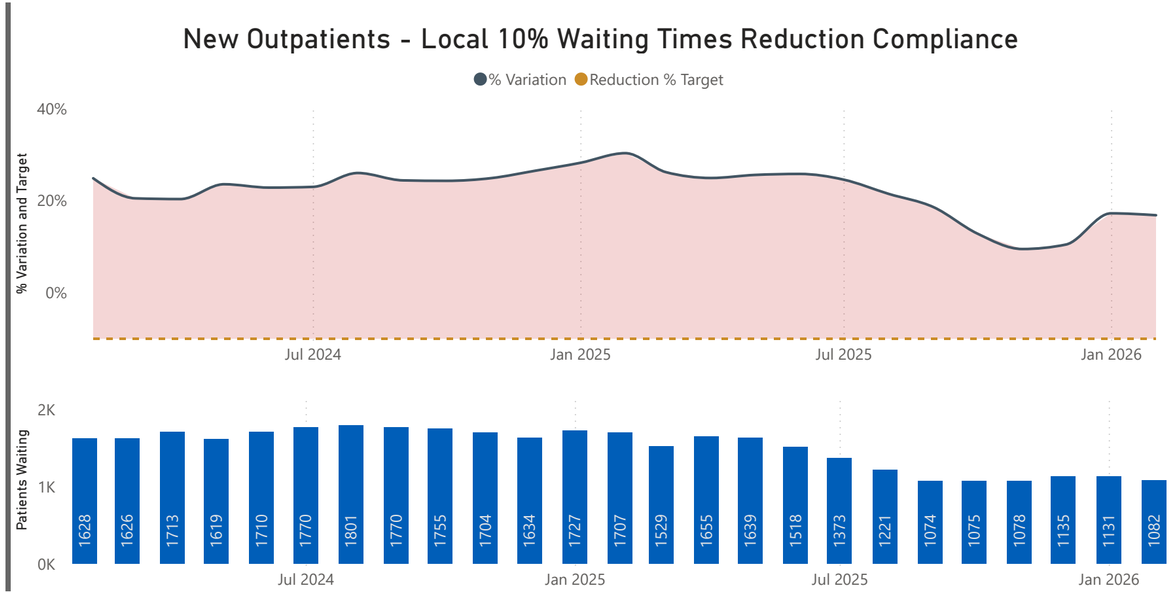
Data Source
OP Recovery Weekly Return

Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
10% reduction in waiting times for New Outpatients	-10%	16.82%	Red

Action	Target Date	Owner	Status
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	30/05/2026	C Somerville	In Progress



Comments From Executive Lead

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

Dr Anna Lamont, Medical Director

Operational Standards
Treatment Time Guarantee (TTG) 12 Week Compliance

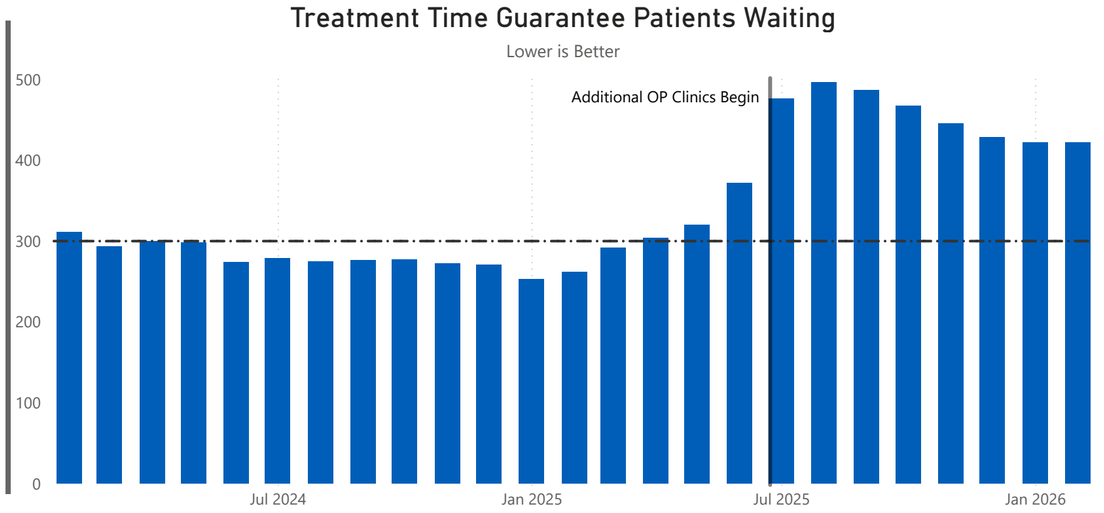
Data Source
TTG Weekly Return

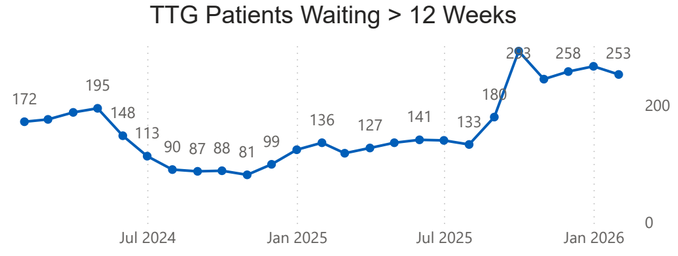
Latest Data
February 2026

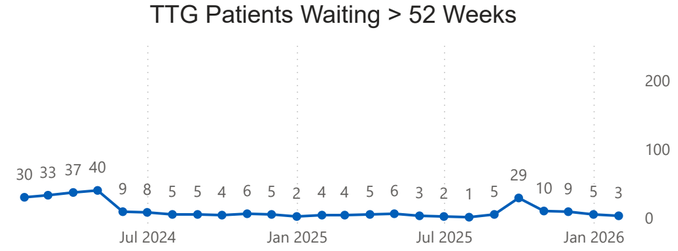
Compliance

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)	95%	48.99%	Red

Action	Target Date	Owner	Status
Demand and Capacity Planning templates to be agreed and reviewed by speciality for 2026/27 activity.	30/05/2026	C Somerville	Completed
Review the process for checking pre admission requirements, including pre operative assessment and biometry, to ensure patients are admission ready and allocated without delay.	30/06/2026	C Somerville	In Progress
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	30/05/2026	C Somerville	In Progress

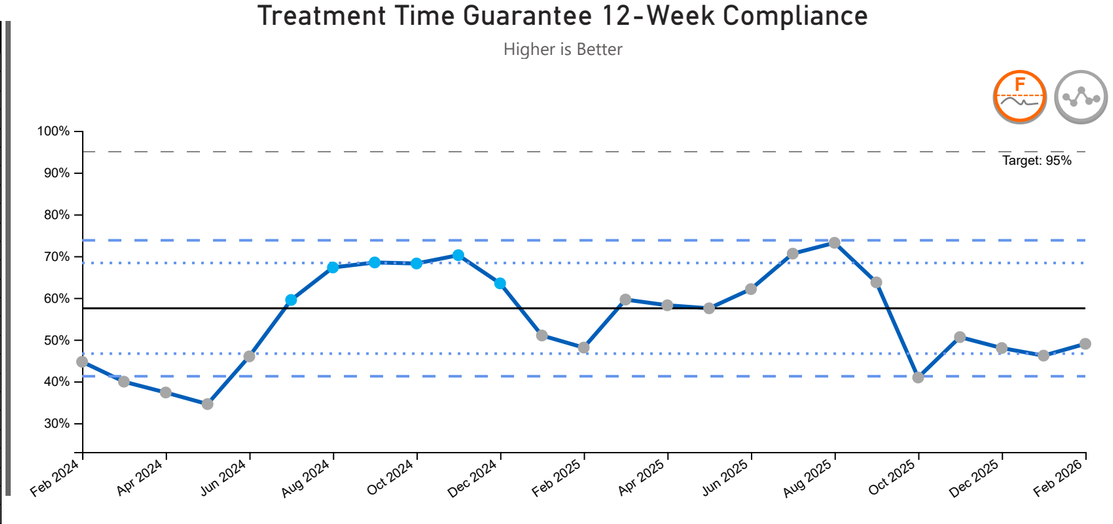






Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	45	57	95	41	74	47	68	NONE
01/03/2024	40	57	95	41	74	47	68	NONE
01/04/2024	37	57	95	41	74	47	68	NONE
01/05/2024	35	57	95	41	74	47	68	NONE
01/06/2024	46	57	95	41	74	47	68	NONE
01/07/2024	59	57	95	41	74	47	68	IMPROVEMENT
01/08/2024	67	57	95	41	74	47	68	IMPROVEMENT
01/09/2024	68	57	95	41	74	47	68	IMPROVEMENT
01/10/2024	68	57	95	41	74	47	68	IMPROVEMENT
01/11/2024	70	57	95	41	74	47	68	IMPROVEMENT
01/12/2024	63	57	95	41	74	47	68	IMPROVEMENT
01/01/2025	51	57	95	41	74	47	68	NONE
01/02/2025	48	57	95	41	74	47	68	NONE
01/03/2025	60	57	95	41	74	47	68	NONE
01/04/2025	58	57	95	41	74	47	68	NONE
01/05/2025	57	57	95	41	74	47	68	NONE
01/06/2025	62	57	95	41	74	47	68	NONE
01/07/2025	71	57	95	41	74	47	68	NONE
01/08/2025	73	57	95	41	74	47	68	NONE
01/09/2025	64	57	95	41	74	47	68	NONE
01/10/2025	41	57	95	41	74	47	68	NONE
01/11/2025	51	57	95	41	74	47	68	NONE
01/12/2025	48	57	95	41	74	47	68	NONE
01/01/2026	46	57	95	41	74	47	68	NONE
01/02/2026	49	57	95	41	74	47	68	NONE



Comments From Executive Lead

At the end of February, there were 422 patients waiting for inpatient or day case treatment. To support the timely scheduling of these patients from the inpatient waiting list, we are reviewing outpatient activity that may impact theatre capacity and scheduling, including requirements such as biometries and pre assessment.

Dr Anna Lamont, Medical Director

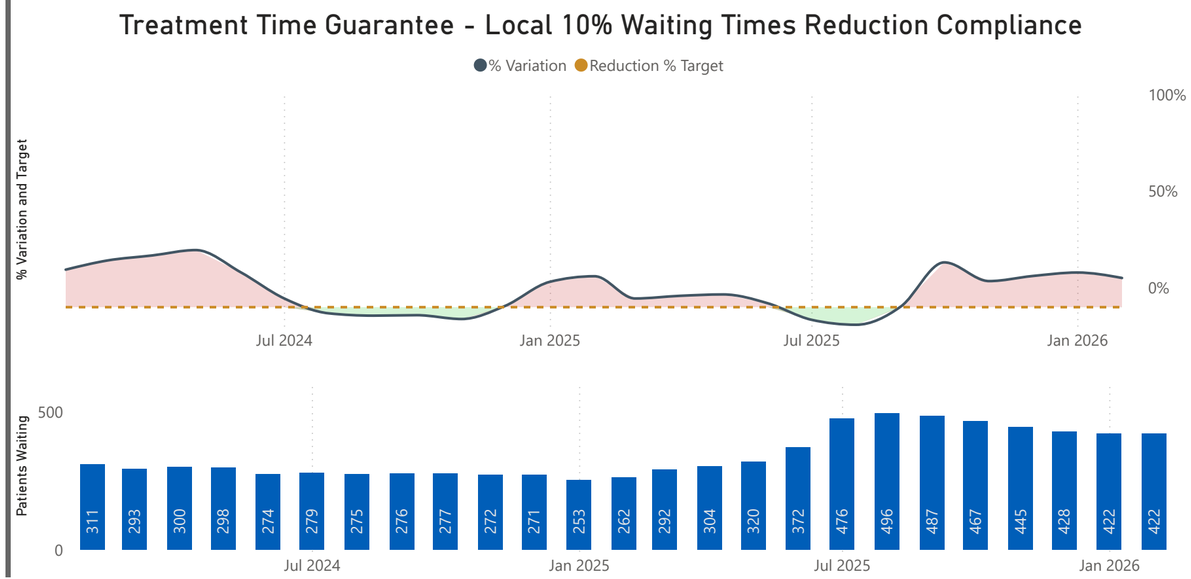
Operational Standards
Treatment Time Guarantee (TTG) Local Improvement Target

Data Source	Latest Data
TTG Weekly Return	02/03/2026

Compliance

KPI	Target	Actual	RAG Value
10% reduction in waiting times for Treatment Time Guarantee patients	-10%	5.1%	Red

Action	Target Date	Owner	Status
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	30/05/2026	C Somerville	In Progress
Weekly Waiting Times to review ongoing inpatient demand following additional outpatient clinics, to address gaps in capacity	30/05/2026	C Somerville	Completed



Comments From Executive Lead

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

Dr Anna Lamont, Medical Director

Operational Standards
Diagnostic Endoscopy 6 Week Compliance

Data Source: DMMI Monthly Return

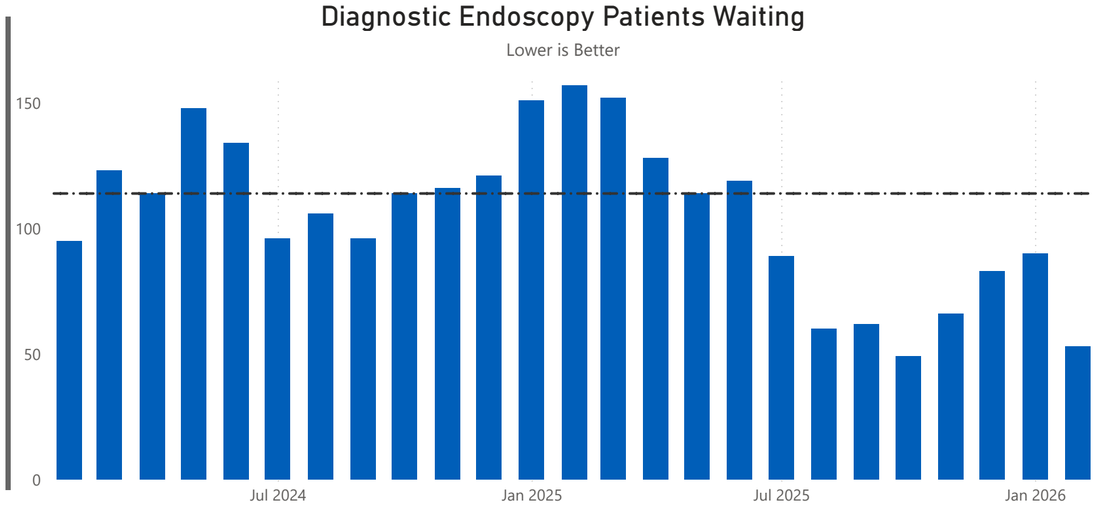
Latest Data: February 2026

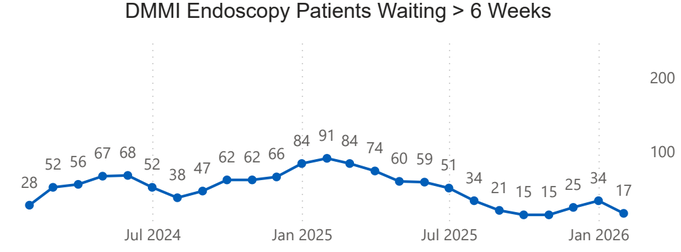
Compliance

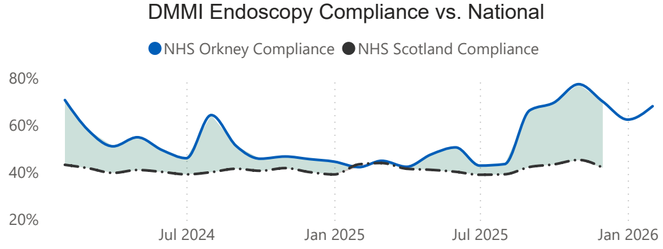
KPI	Target	Actual	RAG Value
100% of patients waiting for key endoscopy diagnostic tests and investigations should wait no longer than six weeks (42 days).	100%	67.92%	Red

Action	Target Date	Owner	Status

All current actions completed/closed.







Statistical Process Control

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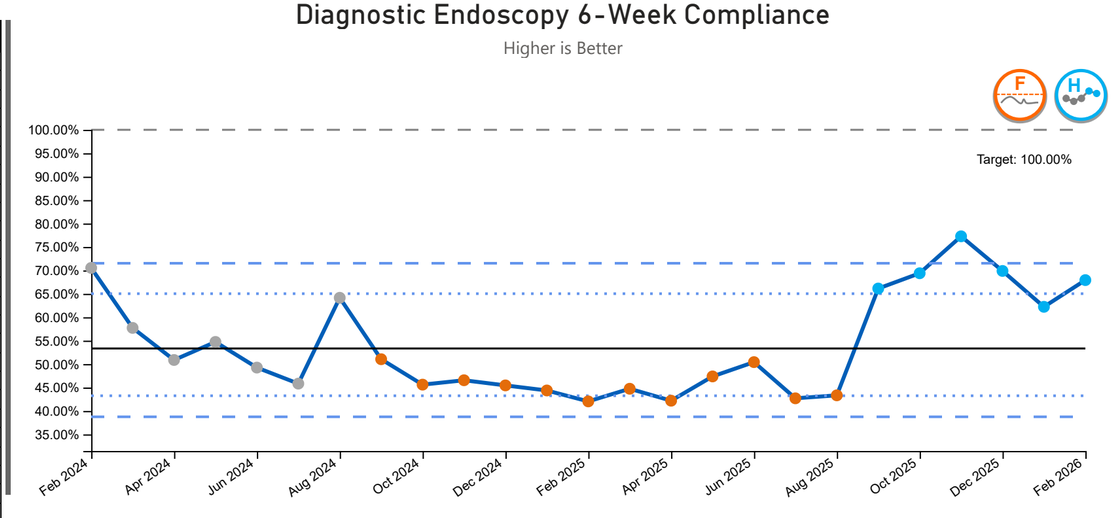
01/02/2024	70.53	53.34	100.00	38.75	71.52	43.24	65.03	NONE
01/03/2024	57.72	53.34	100.00	38.75	71.52	43.24	65.03	NONE
01/04/2024	50.88	53.34	100.00	38.75	71.52	43.24	65.03	NONE
01/05/2024	54.73	53.34	100.00	38.75	71.52	43.24	65.03	NONE
01/06/2024	49.25	53.34	100.00	38.75	71.52	43.24	65.03	NONE
01/07/2024	45.83	53.34	100.00	38.75	71.52	43.24	65.03	NONE
01/08/2024	64.15	53.34	100.00	38.75	71.52	43.24	65.03	NONE
01/09/2024	51.04	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/10/2024	45.61	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/11/2024	46.55	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/12/2024	45.45	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/01/2025	44.37	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/02/2025	42.04	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/03/2025	44.74	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/04/2025	42.19	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/05/2025	47.37	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/06/2025	50.42	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/07/2025	42.70	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/08/2025	43.33	53.34	100.00	38.75	71.52	43.24	65.03	DETERIORATION
01/09/2025	66.13	53.34	100.00	38.75	71.52	43.24	65.03	IMPROVEMENT
01/10/2025	69.39	53.34	100.00	38.75	71.52	43.24	65.03	IMPROVEMENT
01/11/2025	77.27	53.34	100.00	38.75	71.52	43.24	65.03	IMPROVEMENT
01/12/2025	69.88	53.34	100.00	38.75	71.52	43.24	65.03	IMPROVEMENT
01/01/2026	62.22	53.34	100.00	38.75	71.52	43.24	65.03	IMPROVEMENT
01/02/2026	67.92	53.34	100.00	38.75	71.52	43.24	65.03	IMPROVEMENT



Comments From Executive Lead

Endoscopy waiting lists have reduced across all procedure types compared to 2025. Upper Endoscopy reduced from 49 to 14 patients waiting, Lower Endoscopy from 20 to 5, Colonoscopy from 68 to 28, and Cystoscopy from 16 to 6. Ongoing monitoring is in place to support sustained access to services

Dr Anna Lamont, Medical Director

Operational Standards
Diagnostic Imaging 6 Week Compliance

Data Source: DMMI Monthly Return

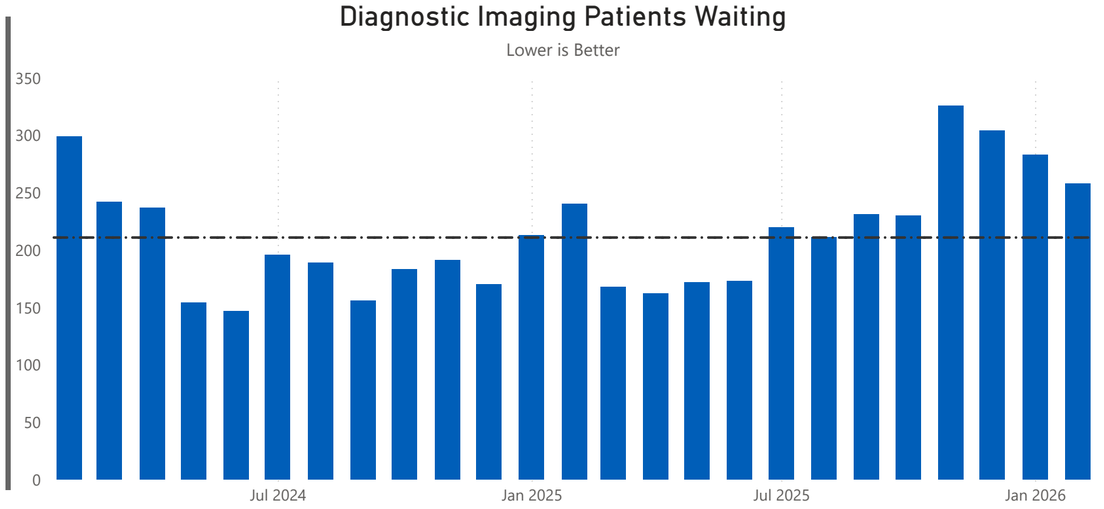
Latest Data: February 2026

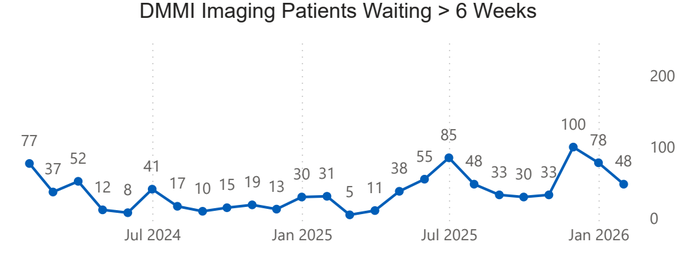
Compliance

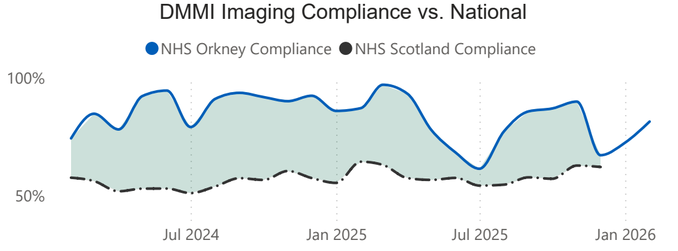
KPI	Target	Actual	RAG Value
100% of patients waiting for key imaging diagnostic tests and investigations should wait no longer than six weeks (42 days).	100%	81.40%	Red

Action	Target Date	Owner	Status

All current actions completed/closed.

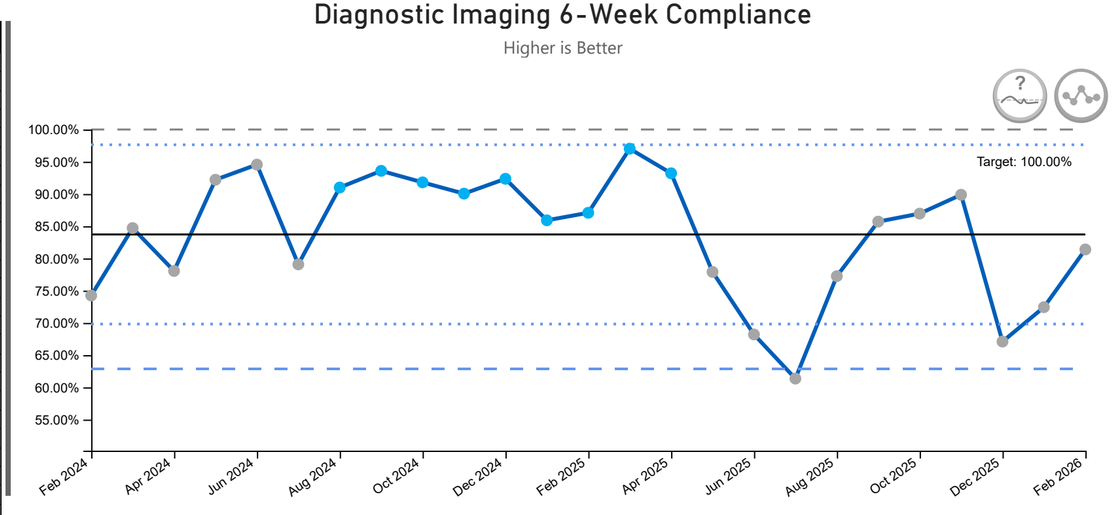






Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	74.25	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/03/2024	84.71	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/04/2024	78.06	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/05/2024	92.21	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/06/2024	94.56	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/07/2024	79.08	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/08/2024	91.01	83.72	100.00	62.87	104.58	69.82	97.63	IMPROVEMENT
01/09/2024	93.59	83.72	100.00	62.87	104.58	69.82	97.63	IMPROVEMENT
01/10/2024	91.80	83.72	100.00	62.87	104.58	69.82	97.63	IMPROVEMENT
01/11/2024	90.05	83.72	100.00	62.87	104.58	69.82	97.63	IMPROVEMENT
01/12/2024	92.35	83.72	100.00	62.87	104.58	69.82	97.63	IMPROVEMENT
01/01/2025	85.92	83.72	100.00	62.87	104.58	69.82	97.63	IMPROVEMENT
01/02/2025	87.08	83.72	100.00	62.87	104.58	69.82	97.63	IMPROVEMENT
01/03/2025	97.02	83.72	100.00	62.87	104.58	69.82	97.63	IMPROVEMENT
01/04/2025	93.21	83.72	100.00	62.87	104.58	69.82	97.63	IMPROVEMENT
01/05/2025	77.91	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/06/2025	68.21	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/07/2025	61.36	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/08/2025	77.25	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/09/2025	85.71	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/10/2025	86.96	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/11/2025	89.88	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/12/2025	67.11	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/01/2026	72.44	83.72	100.00	62.87	104.58	69.82	97.63	NONE
01/02/2026	81.40	83.72	100.00	62.87	104.58	69.82	97.63	NONE



Comments From Executive Lead

Radiology - Currently there is a challenge around the provision of ultrasound and this will have an effect on those waiting for a scan. MRI is catching up on patients post-Christmas due to staffing. National Target is 95%
(Stats as of Jan 26) - 94% for CT - 87% for Ultrasound - 40% for MRI

Dr Anna Lamont, Medical Director

Operational Standards
Diagnostic Cardiology 6 Week Compliance

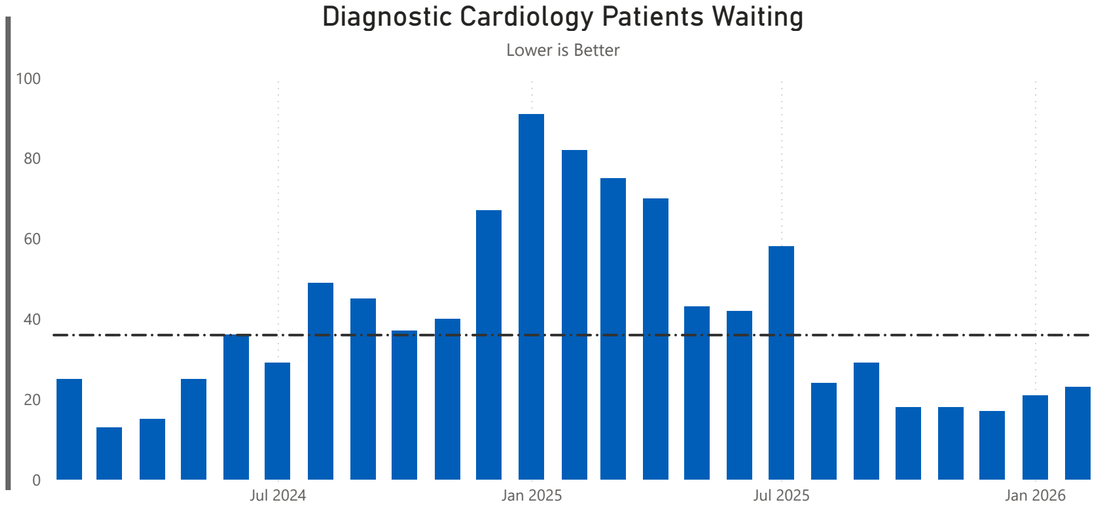
Data Source
DMMI Monthly Return

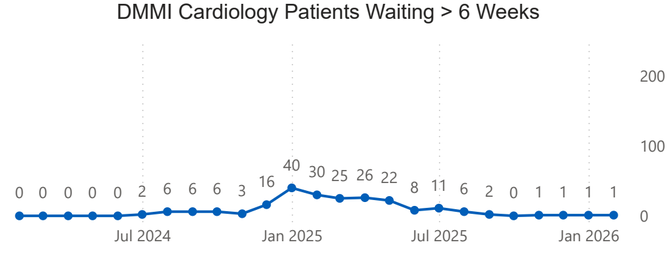
Latest Data
February 2026

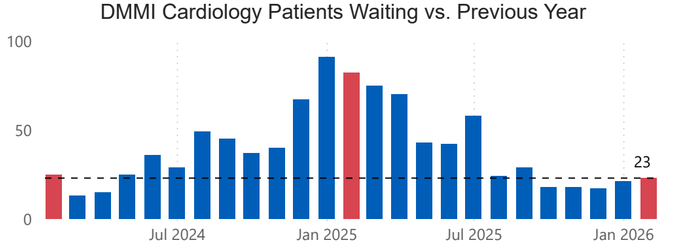
Compliance

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%	96.65%	Amber

Action	Target Date	Owner	Status
Continue proactive monitoring of waiting lists and rapid adjustment of locum support to avoid future backlog.	31/03/2027	A Lamont	In Progress
Maintain close liaison between operational managers and clinical leads to anticipate and respond to any capacity constraints	31/03/2027	A Lamont	In Progress

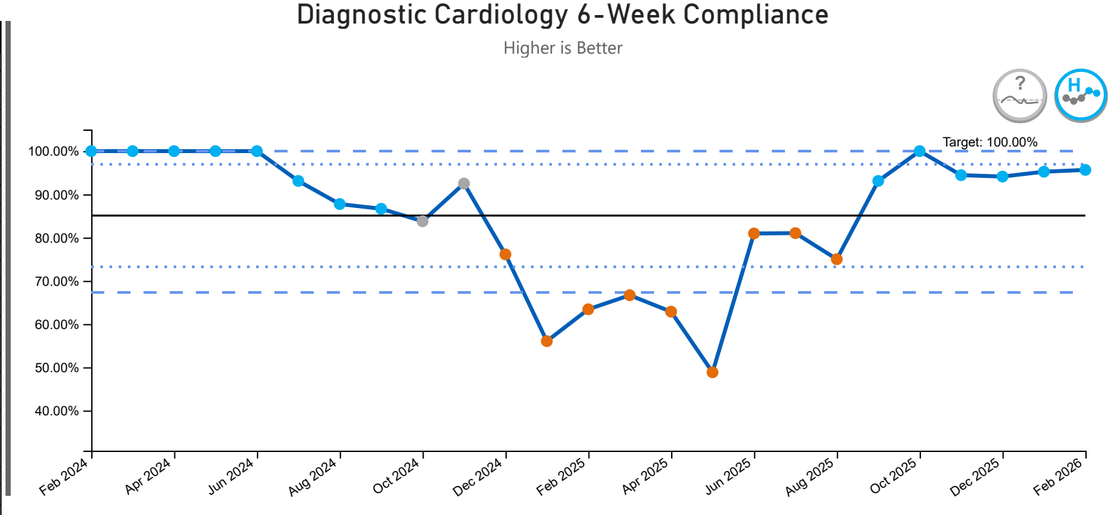






Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	100.00	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/03/2024	100.00	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/04/2024	100.00	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/05/2024	100.00	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/06/2024	100.00	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/07/2024	93.10	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/08/2024	87.76	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/09/2024	86.67	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/10/2024	83.78	85.09	100.00	67.31	102.88	73.24	96.95	NONE
01/11/2024	92.50	85.09	100.00	67.31	102.88	73.24	96.95	NONE
01/12/2024	76.12	85.09	100.00	67.31	102.88	73.24	96.95	DETERIORATION
01/01/2025	56.04	85.09	100.00	67.31	102.88	73.24	96.95	DETERIORATION
01/02/2025	63.41	85.09	100.00	67.31	102.88	73.24	96.95	DETERIORATION
01/03/2025	66.67	85.09	100.00	67.31	102.88	73.24	96.95	DETERIORATION
01/04/2025	62.86	85.09	100.00	67.31	102.88	73.24	96.95	DETERIORATION
01/05/2025	48.84	85.09	100.00	67.31	102.88	73.24	96.95	DETERIORATION
01/06/2025	80.95	85.09	100.00	67.31	102.88	73.24	96.95	DETERIORATION
01/07/2025	81.03	85.09	100.00	67.31	102.88	73.24	96.95	DETERIORATION
01/08/2025	75.00	85.09	100.00	67.31	102.88	73.24	96.95	DETERIORATION
01/09/2025	93.10	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/10/2025	100.00	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/11/2025	94.44	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/12/2025	94.12	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/01/2026	95.24	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT
01/02/2026	95.65	85.09	100.00	67.31	102.88	73.24	96.95	IMPROVEMENT



Comments From Executive Lead

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

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

Dr Anna Lamont, Medical Director

Operational Standards
Cancer Waiting Times 31-Day Standard

Data Source
Discovery

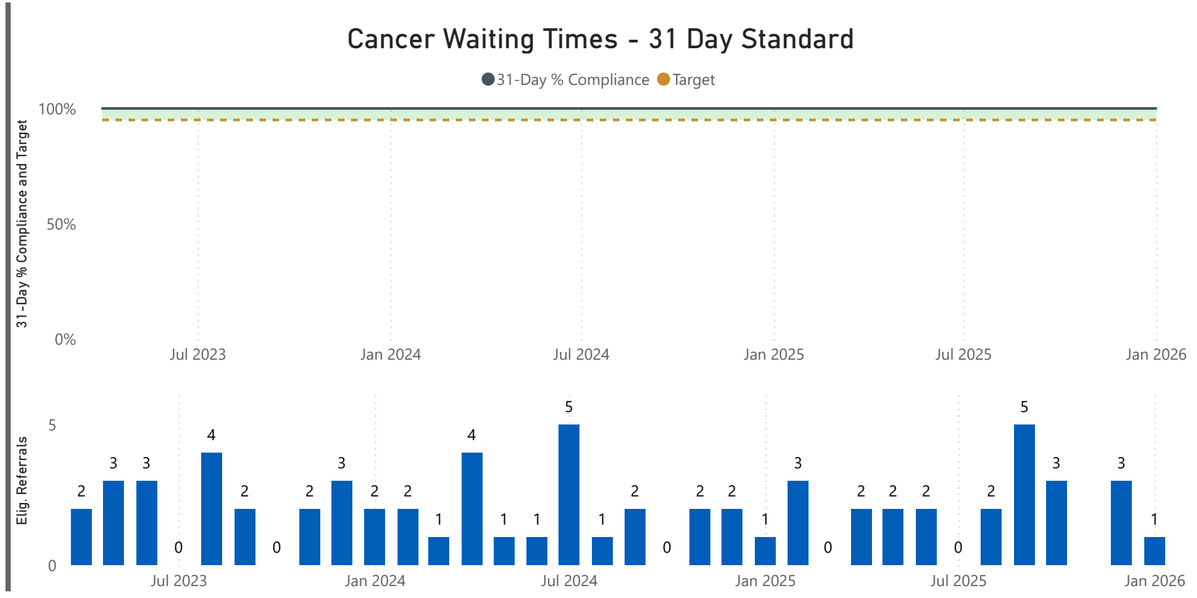
Latest Data
January 2026

Compliance

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

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



Comments From Executive Lead

Performance consistently 100% against 31-day standard. This is largely due to the following being undertaken in Orkney, excision biopsies, chemotherapy, hormone and supportive care treatment.

Dr Anna Lamont, Medical Director

Operational Standards
Cancer Waiting Times 62-Day Standard

Data Source
Discovery

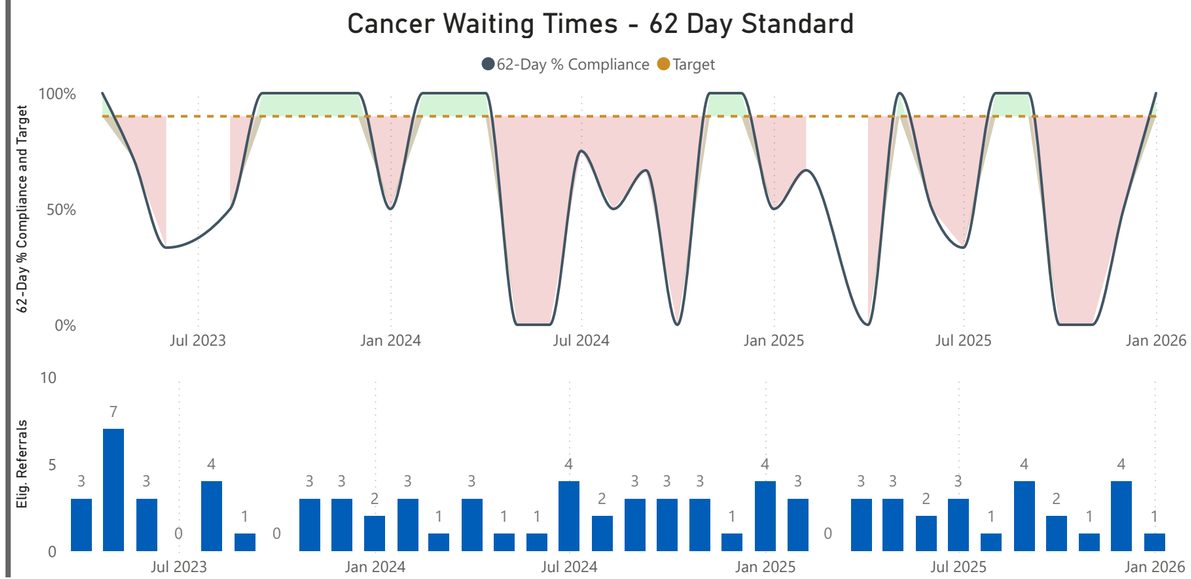
Latest Data
January 2026

Compliance

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

Action	Target Date	Owner	Status

All current actions completed/closed.



Comments From Executive Lead

Projected performance at the end of February highlights continued challenges in meeting pathway times for Urology (Prostate). Work is underway with the Service Level Agreement provider to review arrangements and support timely treatment for Orkney residents.

Dr Anna Lamont, Medical Director

Operational Standards
Inpatient Pre-Noon Discharges

Data Source: TrakCare

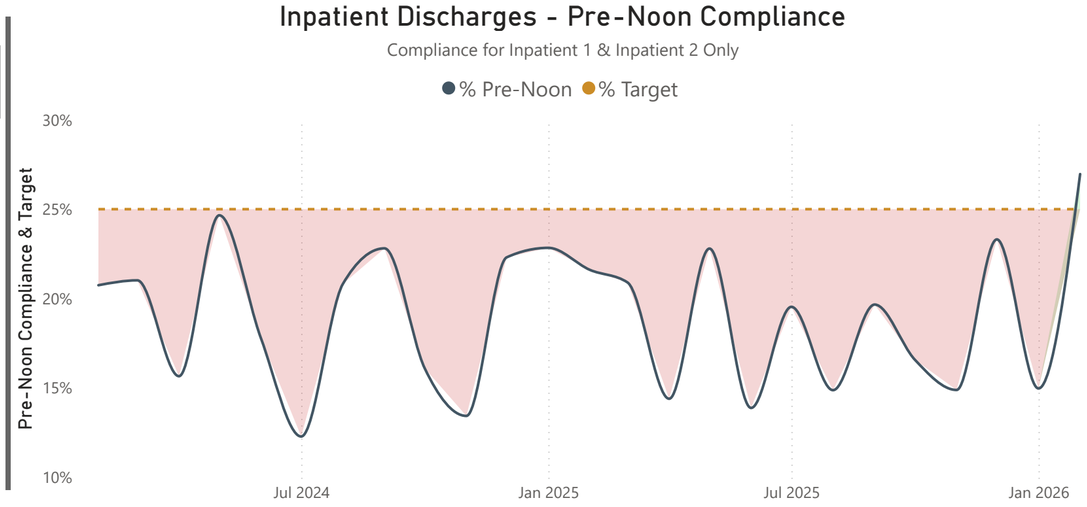
Latest Data: February 2026

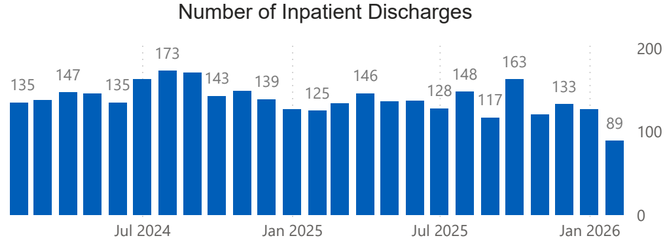
Compliance

KPI	Target	Actual	RAG Value
Pre-noon discharges	25.0%	26.97%	Green

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



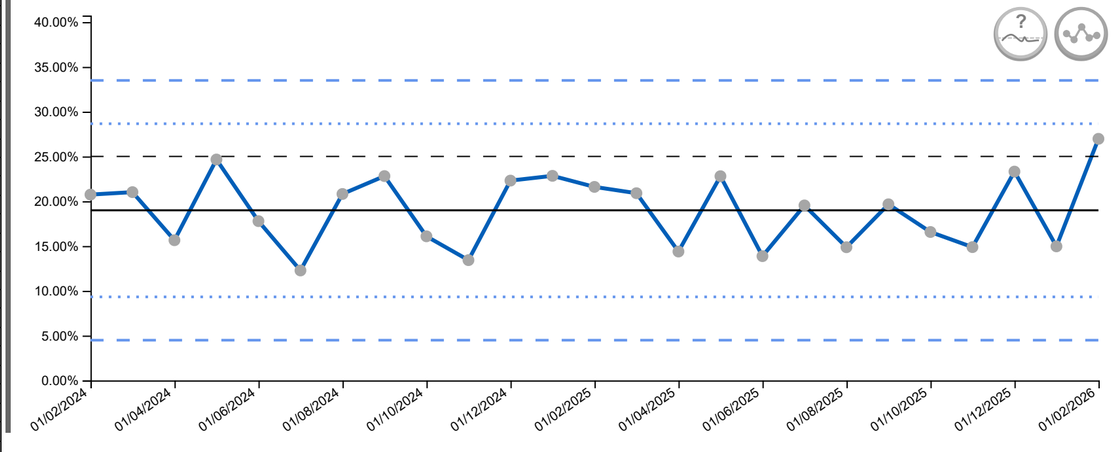


Pre-Noon Discharges - Last 6 Months

Month	Discharges	% Pre-Noon	RAG Value
September 2025	117	19.66%	Amber
October 2025	163	16.56%	Amber
November 2025	121	14.88%	Red
December 2025	133	23.31%	Amber
January 2026	127	14.96%	Red
February 2026	89	26.97%	Green

Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	20.74	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/03/2024	21.01	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/04/2024	15.65	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/05/2024	24.66	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/06/2024	17.78	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/07/2024	12.27	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/08/2024	20.81	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/09/2024	22.81	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/10/2024	16.08	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/11/2024	13.42	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/12/2024	22.30	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/01/2025	22.83	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/02/2025	21.60	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/03/2025	20.90	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/04/2025	14.38	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/05/2025	22.79	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/06/2025	13.87	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/07/2025	19.53	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/08/2025	14.86	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/09/2025	19.66	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/10/2025	16.56	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/11/2025	14.88	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/12/2025	23.31	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/01/2026	14.96	18.99	25.00	4.49	33.49	9.32	28.65	NONE
01/02/2026	26.97	18.99	25.00	4.49	33.49	9.32	28.65	NONE



Comments From Executive Lead

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

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

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

Operational Standards
Delayed Transfers of Care Discharge Compliance

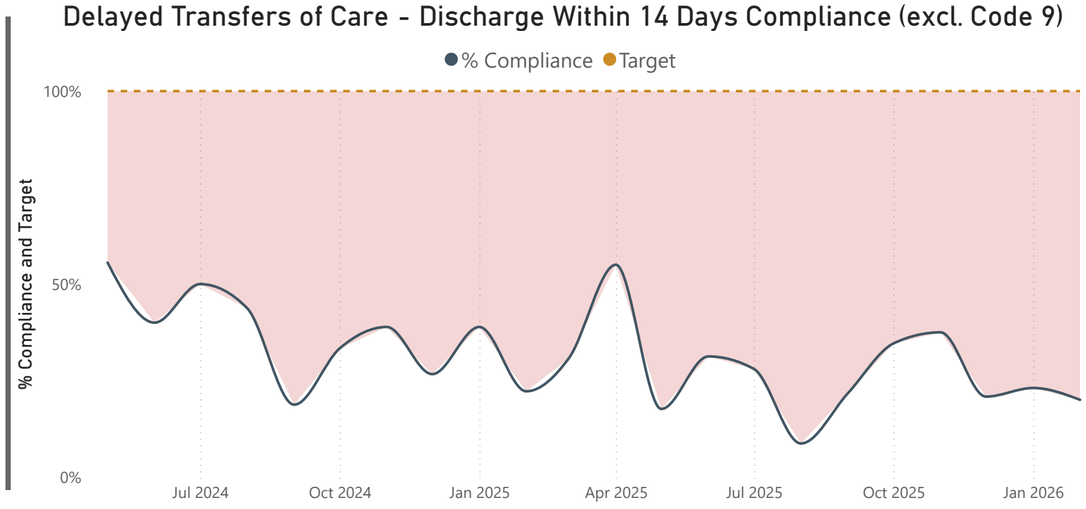
Data Source
Delayed Discharges Monthly Return

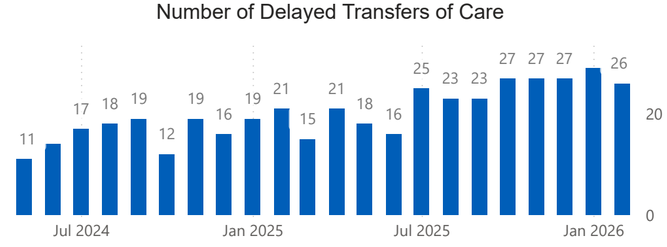
Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
Number of people experiencing a delay discharged within 2 weeks (excluding complex code 9 delays)	100%	20.0%	Red

Action	Target Date	Owner	Status
Recruitment to social care vacancies. Recruitment date extended due to availability of suitable substantive candidates and agency recruitment.	28/02/2026	S Thomas	Completed



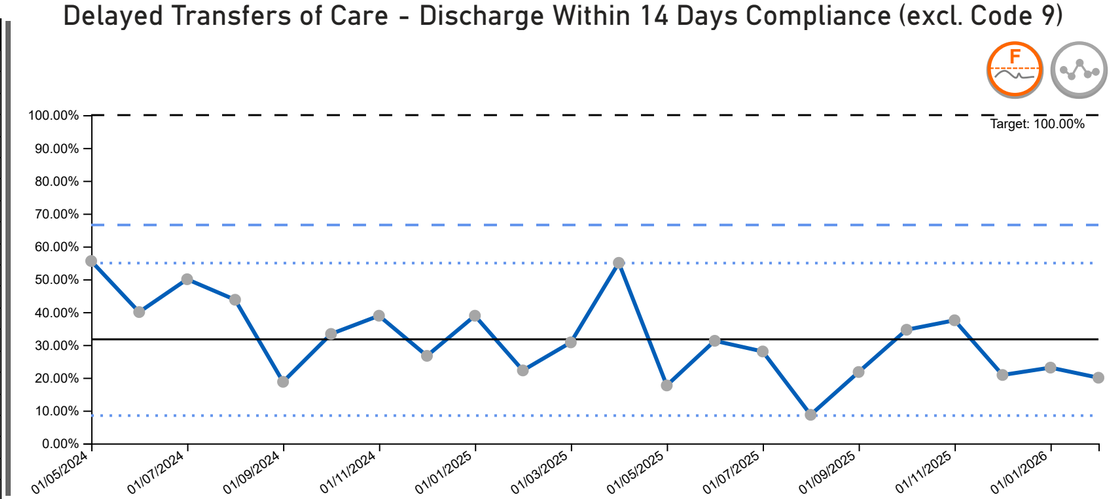


DToC 2 Week Discharge Compliance - Last 6 Months

Month	Total Delays	Delayed >2Wks.	% Compliance	RAG Value
September 2025	23	18	21.74%	Red
October 2025	27	17	34.62%	Red
November 2025	27	15	37.50%	Red
December 2025	27	19	20.83%	Red
January 2026	29	20	23.08%	Red
February 2026	26	20	20.00%	Red

Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/05/2024	55.56	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/06/2024	40.00	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/07/2024	50.00	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/08/2024	43.75	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/09/2024	18.75	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/10/2024	33.33	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/11/2024	38.89	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/12/2024	26.67	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/01/2025	38.89	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/02/2025	22.22	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/03/2025	30.77	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/04/2025	55.00	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/05/2025	17.65	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/06/2025	31.25	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/07/2025	28.00	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/08/2025	8.70	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/09/2025	21.74	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/10/2025	34.62	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/11/2025	37.50	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/12/2025	20.83	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/01/2026	23.08	31.69	100.00	0.00	66.53	8.46	54.92	NONE
01/02/2026	20.00	31.69	100.00	0.00	66.53	8.46	54.92	NONE



Comments From Executive Lead

As of 17th April there were 6 Delayed Transfers of Care with 3 of those waiting beyond two weeks, these are complex cases.

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

Operational Standards
Delayed Transfers of Care at Census Date

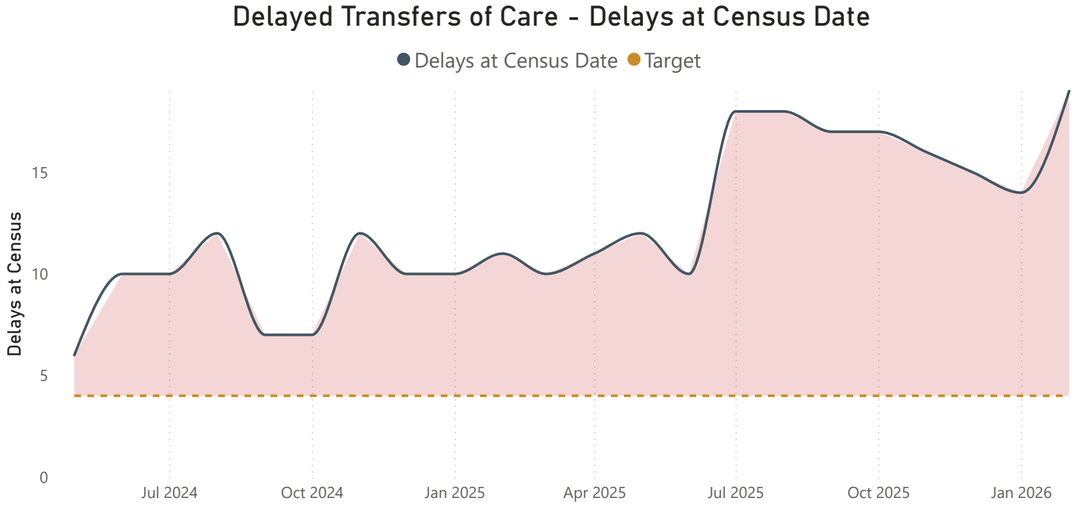
Data Source
Delayed Discharges Monthly Return

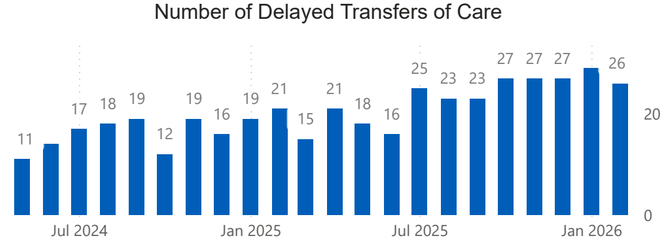
Latest Data
February 2026

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	19	Red

Action	Target Date	Owner	Status
Recruitment to social care vacancies. Recruitment date extended due to availability of suitable substantive candidates and agency recruitment.	28/02/2026	S Thomas	Completed



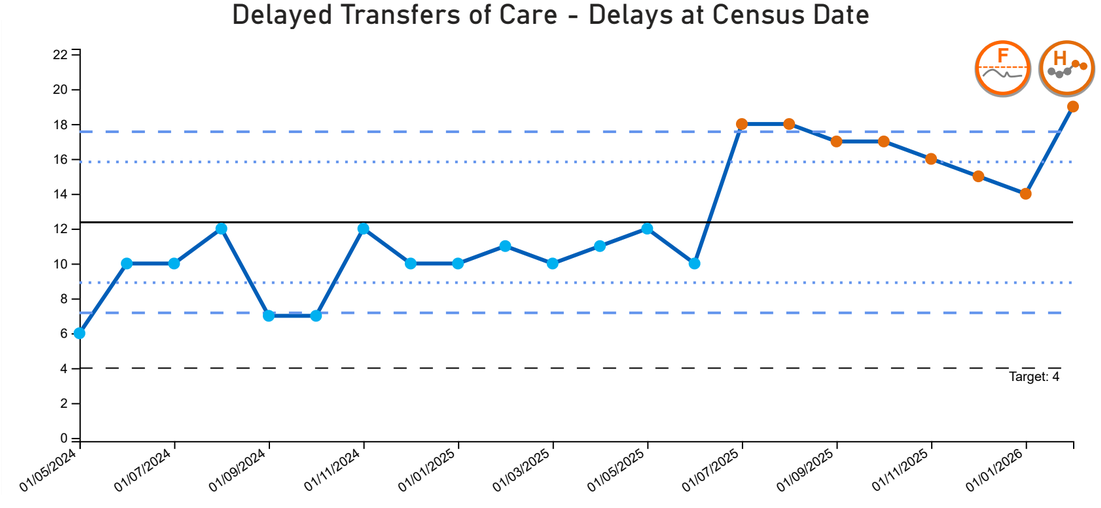


DToC 2 Week Discharge Compliance - Last 6 Months

Month	Total Delays	Census Delays	Target	RAG Value
September 2025	23	17	4	Red
October 2025	27	17	4	Red
November 2025	27	16	4	Red
December 2025	27	15	4	Red
January 2026	29	14	4	Red
February 2026	26	19	4	Red

Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/05/2024	6	12	7	18	9	16	IMPROVEMENT
01/06/2024	10	12	7	18	9	16	IMPROVEMENT
01/07/2024	10	12	7	18	9	16	IMPROVEMENT
01/08/2024	12	12	7	18	9	16	IMPROVEMENT
01/09/2024	7	12	7	18	9	16	IMPROVEMENT
01/10/2024	7	12	7	18	9	16	IMPROVEMENT
01/11/2024	12	12	7	18	9	16	IMPROVEMENT
01/12/2024	10	12	7	18	9	16	IMPROVEMENT
01/01/2025	10	12	7	18	9	16	IMPROVEMENT
01/02/2025	11	12	7	18	9	16	IMPROVEMENT
01/03/2025	10	12	7	18	9	16	IMPROVEMENT
01/04/2025	11	12	7	18	9	16	IMPROVEMENT
01/05/2025	12	12	7	18	9	16	IMPROVEMENT
01/06/2025	10	12	7	18	9	16	IMPROVEMENT
01/07/2025	18	12	7	18	9	16	DETERIORATION
01/08/2025	18	12	7	18	9	16	DETERIORATION
01/09/2025	17	12	7	18	9	16	DETERIORATION
01/10/2025	17	12	7	18	9	16	DETERIORATION
01/11/2025	16	12	7	18	9	16	DETERIORATION
01/12/2025	15	12	7	18	9	16	DETERIORATION
01/01/2026	14	12	7	18	9	16	DETERIORATION
01/02/2026	19	12	7	18	9	16	DETERIORATION



Comments From Executive Lead

As of 17th April there were 6 Delayed Transfers of Care with 3 of those waiting beyond two weeks, these are complex cases.

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

Operational Standards
Delayed Transfers of Care Bed Days Occupied

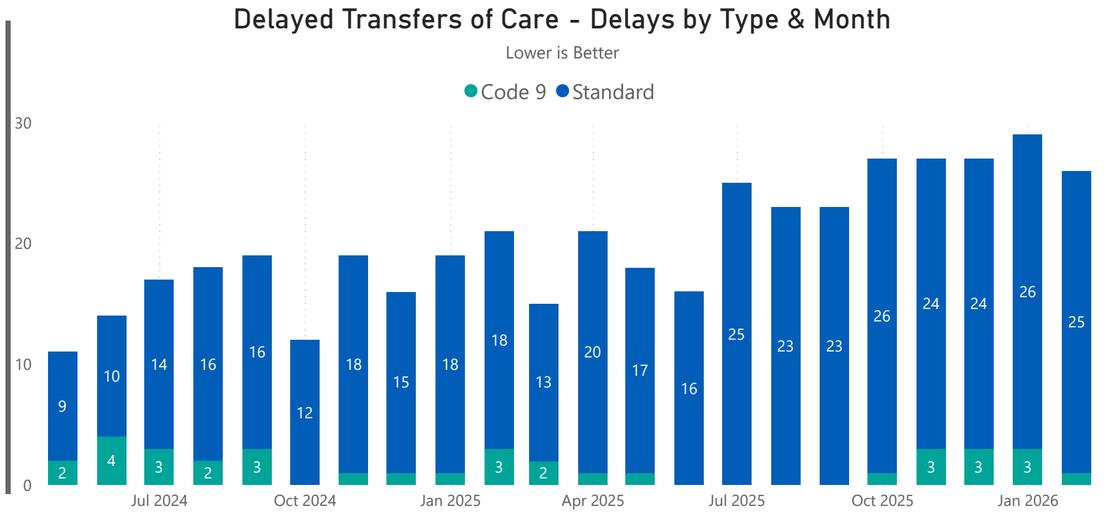
Data Source
Delayed Discharges Monthly Return

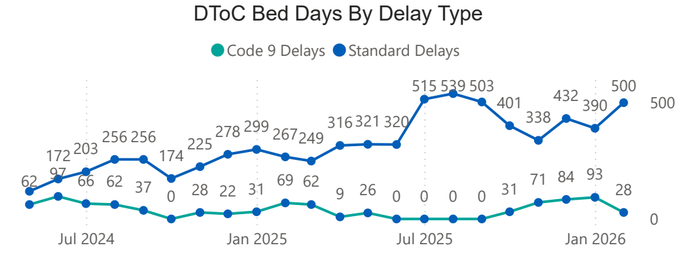
Latest Data
February 2026

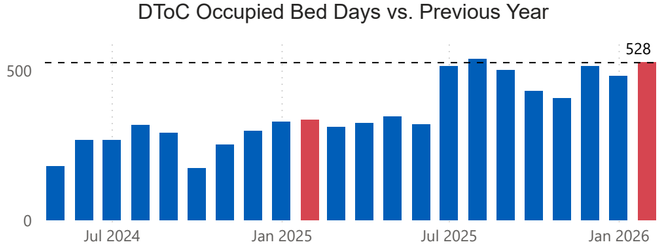
Compliance

KPI	Target	Actual	RAG Value
Number of hospital bed days associated with delayed discharges (any length or reason) in the calendar month.	56	528	Red

Action	Target Date	Owner	Status
Recruitment to social care vacancies. Recruitment date extended due to availability of suitable substantive candidates and agency recruitment.	28/02/2026	S Thomas	Completed

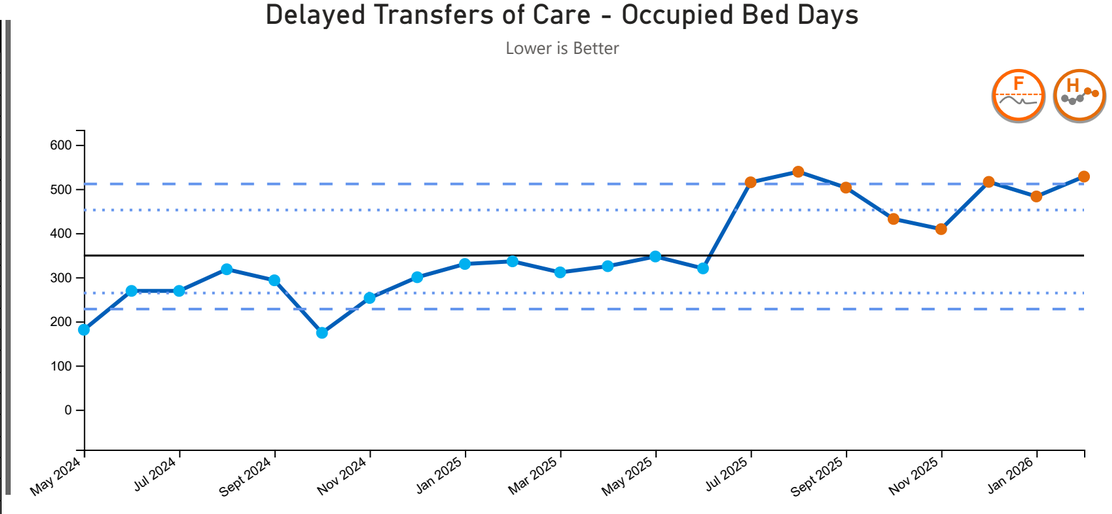






Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/05/2024	181	349	56	240	490	273	439	IMPROVEMENT
01/06/2024	269	349	56	240	490	273	439	IMPROVEMENT
01/07/2024	269	349	56	240	490	273	439	IMPROVEMENT
01/08/2024	318	349	56	240	490	273	439	IMPROVEMENT
01/09/2024	293	349	56	240	490	273	439	IMPROVEMENT
01/10/2024	174	349	56	240	490	273	439	IMPROVEMENT
01/11/2024	253	349	56	240	490	273	439	IMPROVEMENT
01/12/2024	300	349	56	240	490	273	439	IMPROVEMENT
01/01/2025	330	349	56	240	490	273	439	IMPROVEMENT
01/02/2025	336	349	56	240	490	273	439	IMPROVEMENT
01/03/2025	311	349	56	240	490	273	439	IMPROVEMENT
01/04/2025	325	349	56	240	490	273	439	IMPROVEMENT
01/05/2025	347	349	56	240	490	273	439	IMPROVEMENT
01/06/2025	320	349	56	240	490	273	439	IMPROVEMENT
01/07/2025	515	349	56	240	490	273	439	DETERIORATION
01/08/2025	539	349	56	240	490	273	439	DETERIORATION
01/09/2025	503	349	56	240	490	273	439	DETERIORATION
01/10/2025	432	349	56	240	490	273	439	DETERIORATION
01/11/2025	409	349	56	240	490	273	439	DETERIORATION
01/12/2025	516	349	56	240	490	273	439	DETERIORATION
01/01/2026	483	349	56	240	490	273	439	DETERIORATION
01/02/2026	528	349	56	240	490	273	439	DETERIORATION



Comments From Executive Lead

This number will continue to rise as Delayed Transfers of Care remain in hospital, however the number of hospital bed days added will decrease reflecting discharges facilitated.

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

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

Data Source
IVF Waiting Times Publication

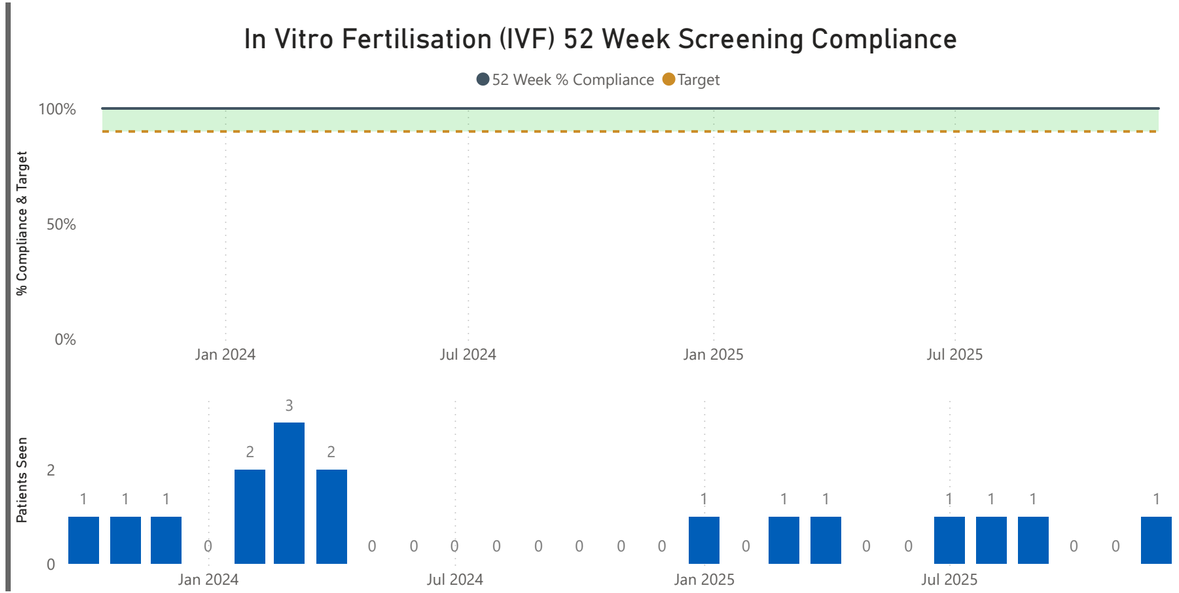
Latest Data
December 2025

Compliance

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

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



Comments From Executive Lead

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

Operational Standards
Women Booked to Named Midwife

Data Source
Maternity Staff

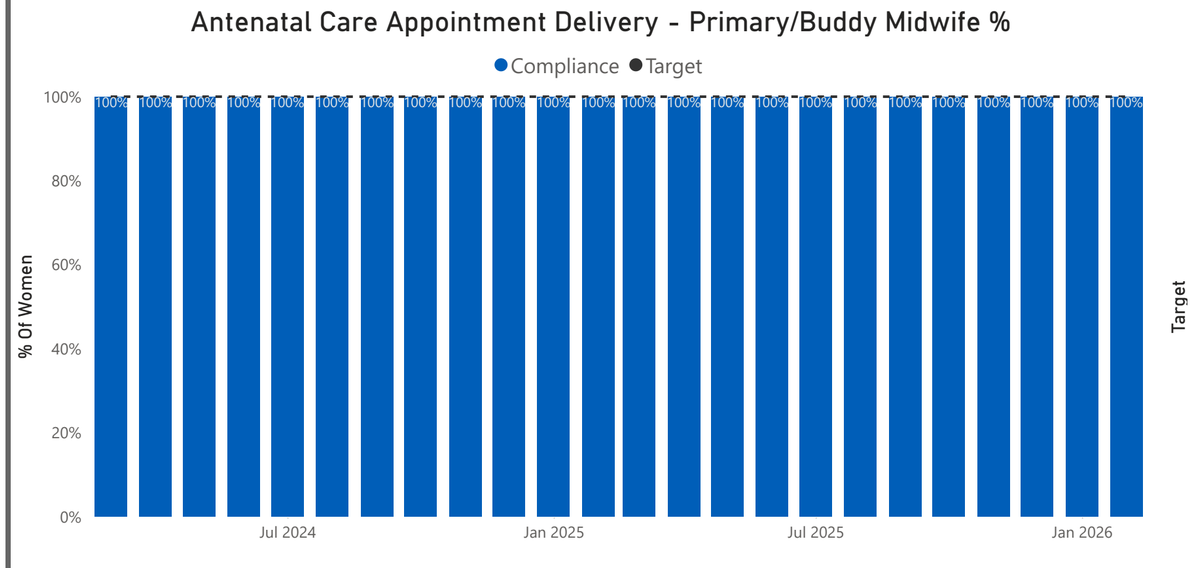
Latest Data
January 2026

Compliance

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

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



Comments From Executive Lead

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

Community

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

What's Going Well?

The part time Associate Specialist Doctor post recruited to work on Neurodiversity diagnosis for children commenced in April 2026.

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

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

A draft Neurodevelopmental pathway has now been developed.

Additional capacity in Care at Home, funded via unscheduled care money, has seen delayed discharges reduce from 20 to 6 over the last three weeks.

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

RAG Status Values

RED	Key performance indicator not achieved, and performance below lower threshold.
AMBER	Key performance indicator not achieved, but performance above lower threshold.
GREEN	Key performance indicator achieved.

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

Areas of Concern

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

Community
Child & Adolescent Mental Health 18 Week Compliance

Data Source
CAMHS Monthly Return

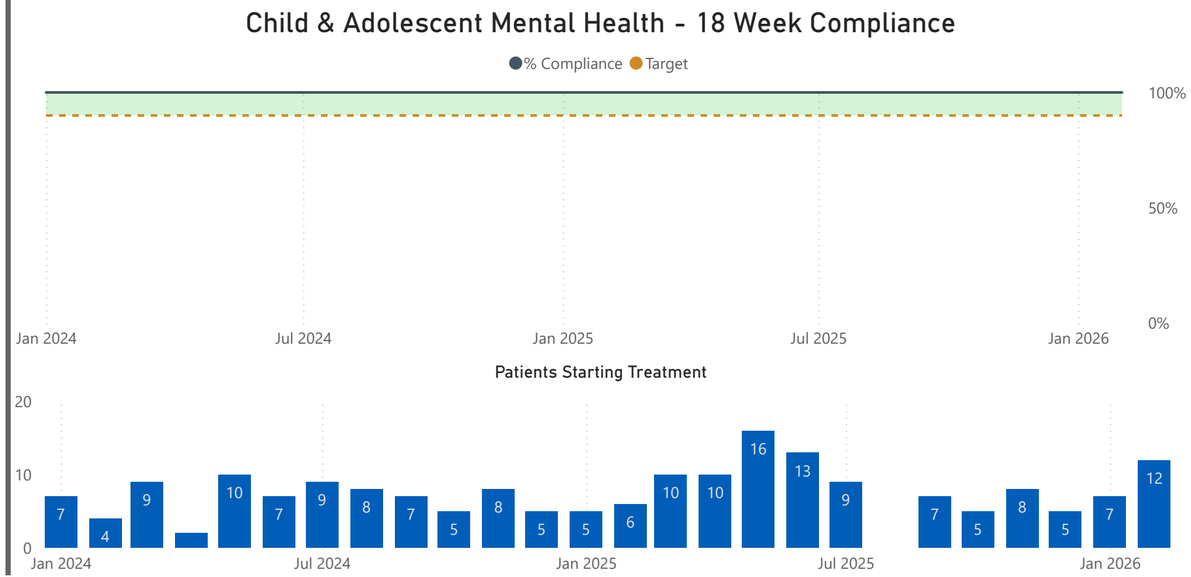
Latest Data
February 2026

Compliance

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

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



Comments From Executive Lead

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

Stephen Brown, Chief Officer of the Integration Joint Board

Community
Psychological Therapies 18 Week Compliance

Data Source
PT Monthly Return

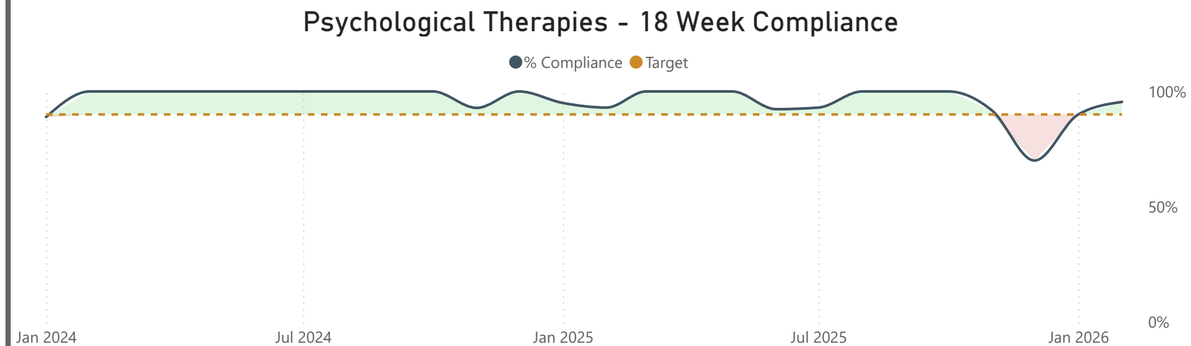
Latest Data
February 2026

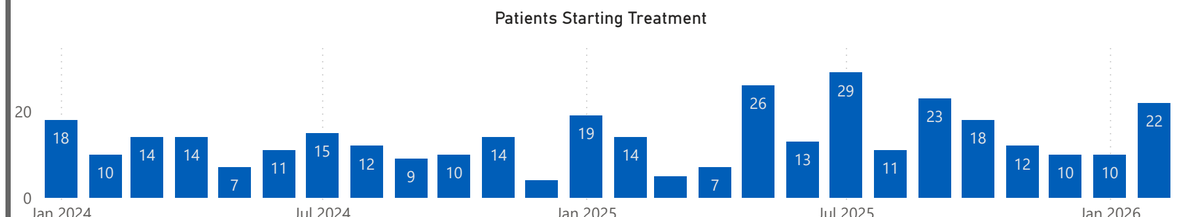
Compliance

KPI	Target	Actual	RAG Value
18 Week Referral to Treatment	90%	95.45%	Green

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.





Comments From Executive Lead

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

Stephen Brown, Chief Officer of the Integration Joint Board

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

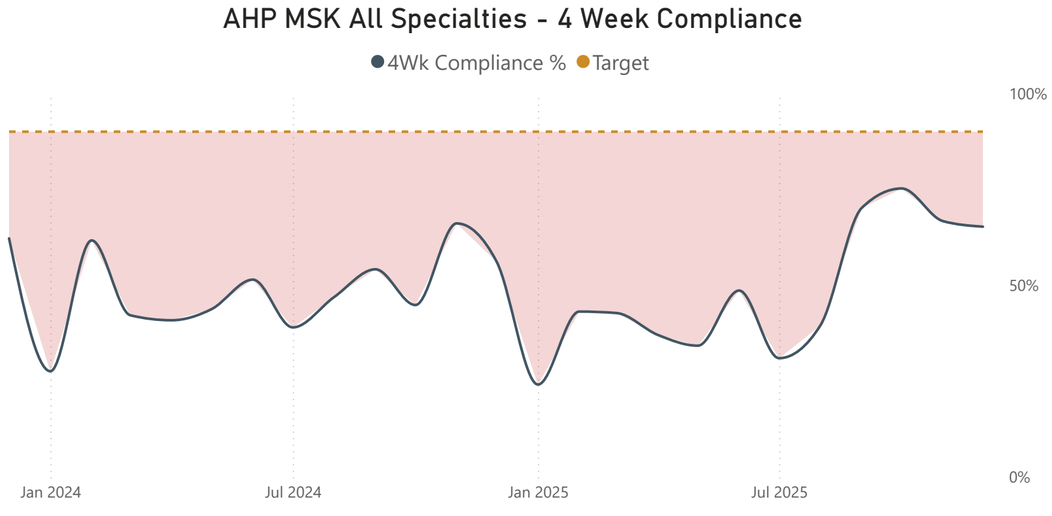
Data Source
TrakCare

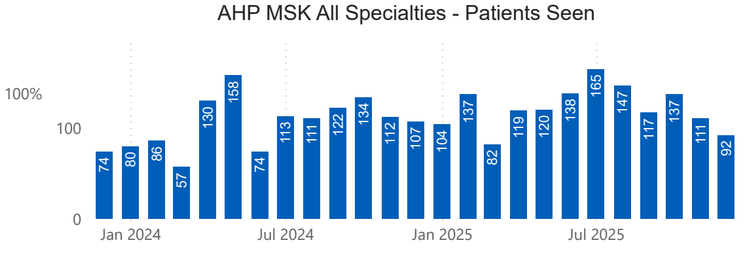
Latest Data
December 2025

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%	65.22%	Amber

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



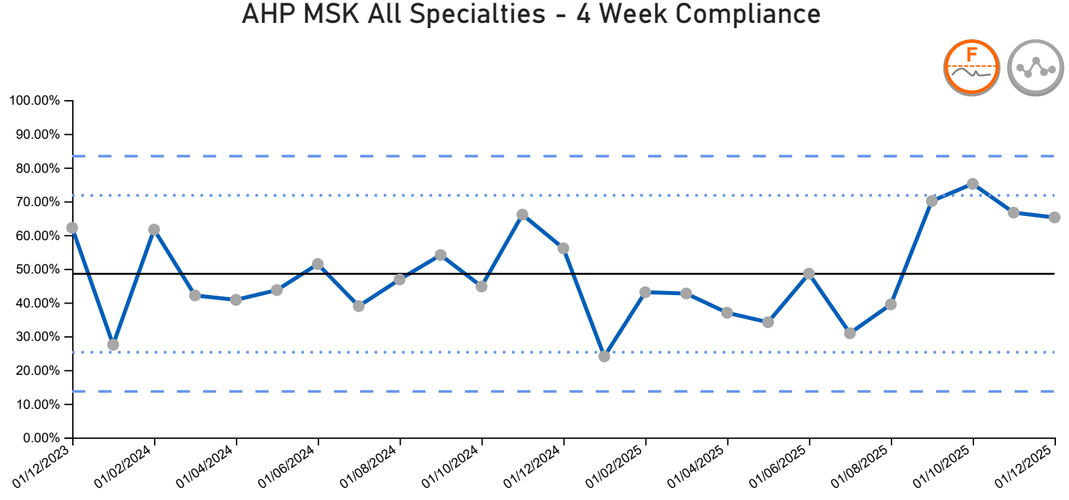


AHP MSK All Specialties - Last 6 Months

Month	Patients Seen	0 - 4 weeks (%)	Target	RAG Value
July 2025	165	30.91%	90.00%	Red
August 2025	147	39.46%	90.00%	Red
September 2025	117	70.09%	90.00%	Red
October 2025	137	75.18%	90.00%	Red
November 2025	111	66.67%	90.00%	Red
December 2025	92	65.22%	90.00%	Red

Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/12/2023	62.16	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/01/2024	27.50	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/02/2024	61.63	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/03/2024	42.11	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/04/2024	40.80	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/05/2024	43.70	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/06/2024	51.40	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/07/2024	38.94	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/08/2024	46.85	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/09/2024	54.10	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/10/2024	44.78	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/11/2024	66.07	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/12/2024	56.07	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/01/2025	24.04	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/02/2025	43.07	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/03/2025	42.68	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/04/2025	36.97	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/05/2025	34.17	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/06/2025	48.55	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/07/2025	30.91	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/08/2025	39.46	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/09/2025	70.09	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/10/2025	75.18	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/11/2025	66.67	48.52	90.00	13.65	83.40	25.28	71.77	NONE
01/12/2025	65.22	48.52	90.00	13.65	83.40	25.28	71.77	NONE



Comments From Executive Lead

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

Stephen Brown, Chief Officer of the Integration Joint Board

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

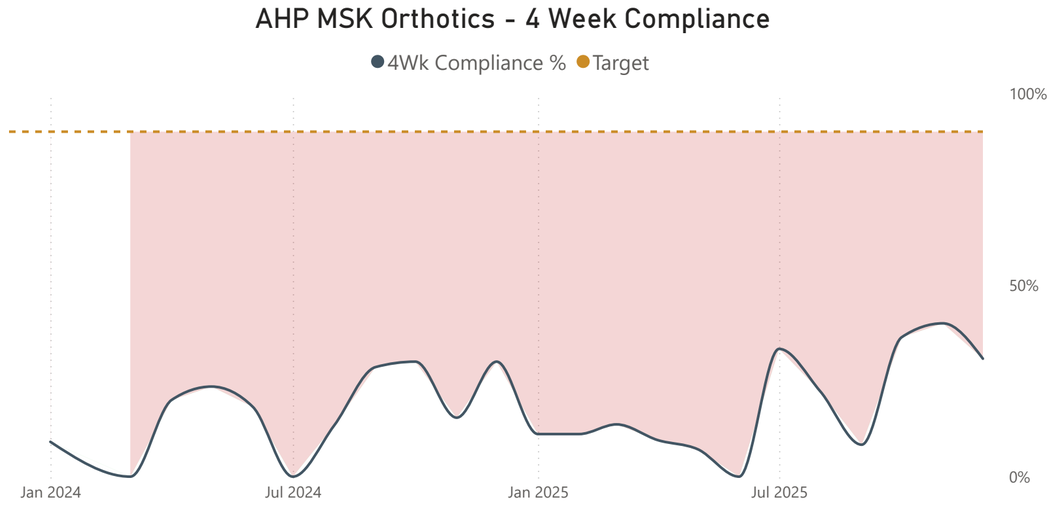
Data Source: TrakCare

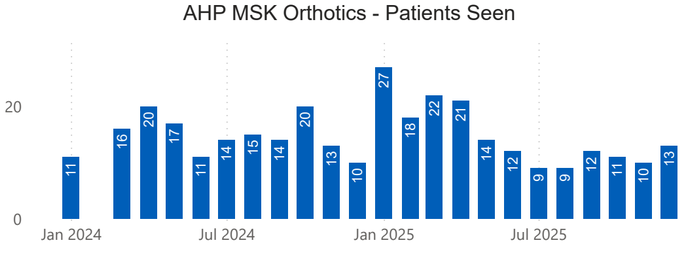
Latest Data: December 2025

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%	30.77%	Red

Action	Target Date	Owner	Status
Monitor referral numbers and performance	31/12/2025	R Lea	Off Track



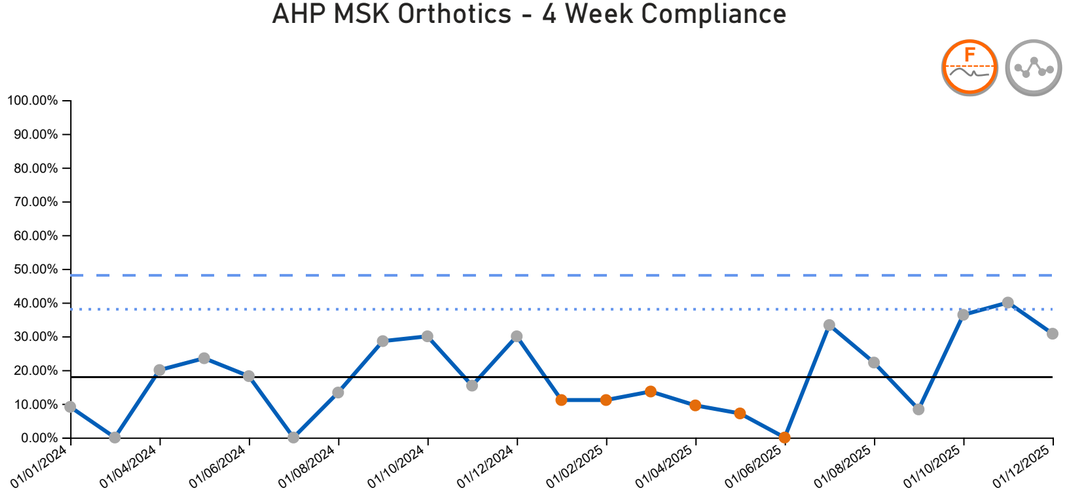


AHP MSK Orthotics - Last 6 Months

Month	Patients Seen	0 - 4 weeks (%)	Target	RAG Value
July 2025	9	33.33%	90.00%	Red
August 2025	9	22.22%	90.00%	Red
September 2025	12	8.33%	90.00%	Red
October 2025	11	36.36%	90.00%	Red
November 2025	10	40.00%	90.00%	Red
December 2025	13	30.77%	90.00%	Red

Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/01/2024	9.09	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/03/2024	0.00	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/04/2024	20.00	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/05/2024	23.50	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/06/2024	18.20	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/07/2024	0.00	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/08/2024	13.33	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/09/2024	28.57	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/10/2024	30.00	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/11/2024	15.38	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/12/2024	30.00	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/01/2025	11.11	17.90	90.00	0.00	48.07	0.00	38.01	DETERIORATION
01/02/2025	11.11	17.90	90.00	0.00	48.07	0.00	38.01	DETERIORATION
01/03/2025	13.64	17.90	90.00	0.00	48.07	0.00	38.01	DETERIORATION
01/04/2025	9.52	17.90	90.00	0.00	48.07	0.00	38.01	DETERIORATION
01/05/2025	7.14	17.90	90.00	0.00	48.07	0.00	38.01	DETERIORATION
01/06/2025	0.00	17.90	90.00	0.00	48.07	0.00	38.01	DETERIORATION
01/07/2025	33.33	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/08/2025	22.22	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/09/2025	8.33	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/10/2025	36.36	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/11/2025	40.00	17.90	90.00	0.00	48.07	0.00	38.01	NONE
01/12/2025	30.77	17.90	90.00	0.00	48.07	0.00	38.01	NONE



Comments From Executive Lead

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

Stephen Brown, Chief Officer of the Integration Joint Board

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

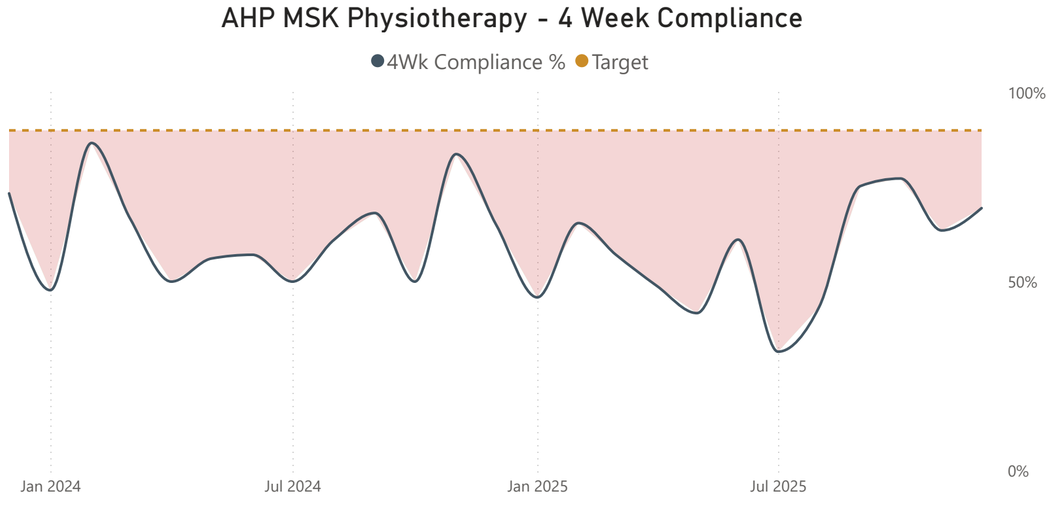
Data Source: TrakCare

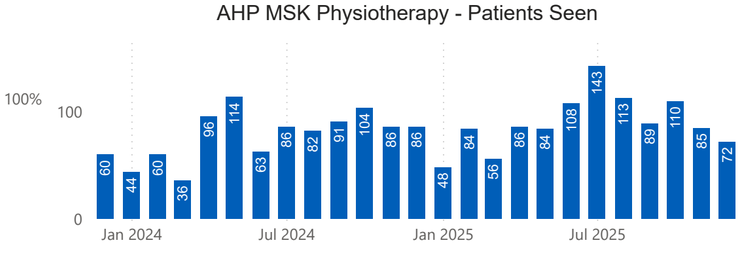
Latest Data: December 2025

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%	69.44%	Amber

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



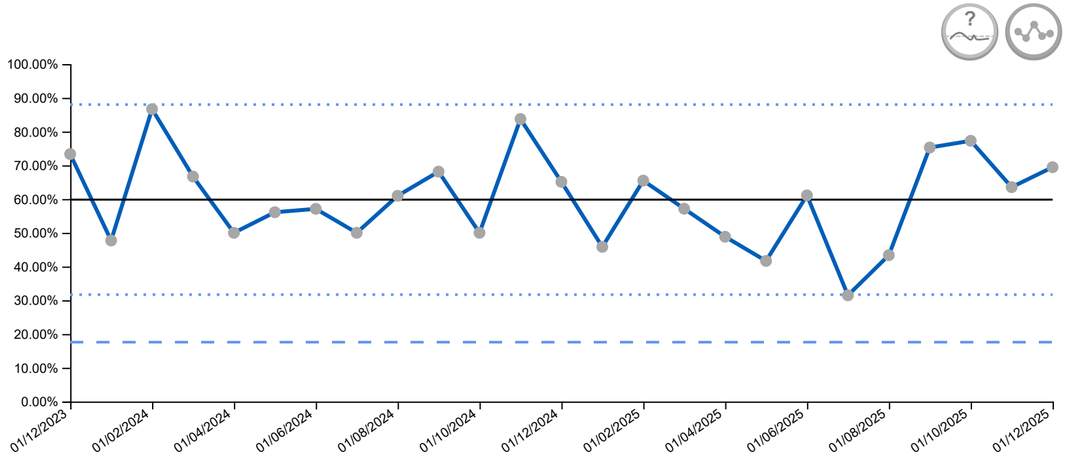


AHP MSK Physiotherapy - Last 6 Months

Month	Patients Seen	0 - 4 weeks (%)	Target	RAG Value
July 2025	143	31.47%	90.00%	Red
August 2025	113	43.36%	90.00%	Red
September 2025	89	75.28%	90.00%	Red
October 2025	110	77.27%	90.00%	Red
November 2025	85	63.53%	90.00%	Red
December 2025	72	69.44%	90.00%	Red

Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/12/2023	73.33	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/01/2024	47.73	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/02/2024	86.67	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/03/2024	66.67	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/04/2024	50.00	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/05/2024	56.10	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/06/2024	57.10	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/07/2024	50.00	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/08/2024	60.98	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/09/2024	68.13	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/10/2024	50.00	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/11/2024	83.72	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/12/2024	65.12	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/01/2025	45.83	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/02/2025	65.48	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/03/2025	57.14	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/04/2025	48.84	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/05/2025	41.67	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/06/2025	61.11	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/07/2025	31.47	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/08/2025	43.36	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/09/2025	75.28	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/10/2025	77.27	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/11/2025	63.53	59.84	90.00	17.59	100.00	31.67	88.01	NONE
01/12/2025	69.44	59.84	90.00	17.59	100.00	31.67	88.01	NONE



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%. The Band 7 post has been recruited to and has commenced working in October. Capacity previously provided via the Primary Care First Point of Contact Practitioners is not currently available. As anticipated there has been a steady rise in MSK referrals given that the wait times are now around 20 weeks for routine, as opposed to the 60 weeks prior to the improvement work. There continues to be a steady flow of patients going through PHIO though with good uptake across all of the GP practices. 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

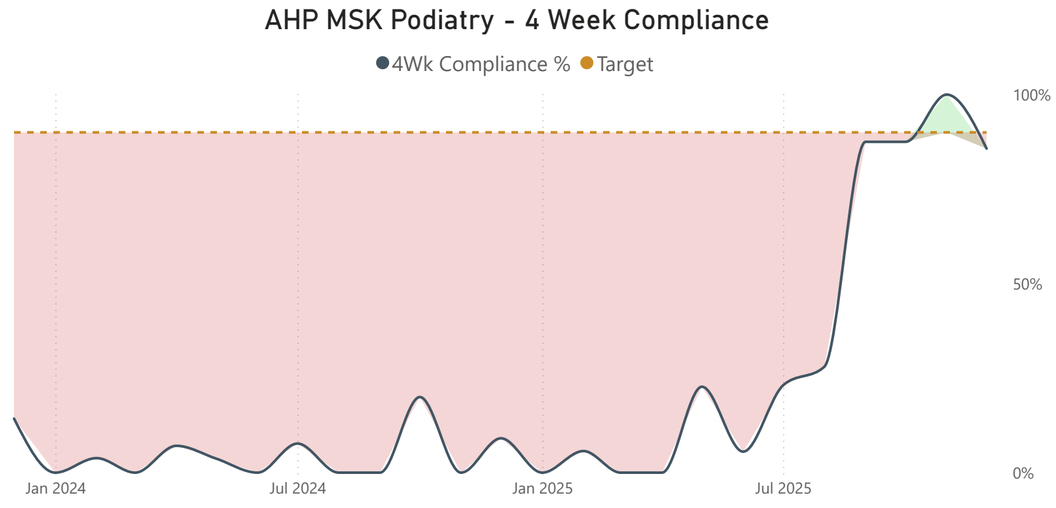
Data Source: TrakCare

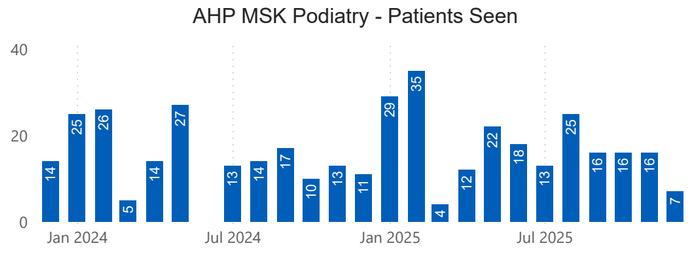
Latest Data: December 2025

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%	85.71%	Amber

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



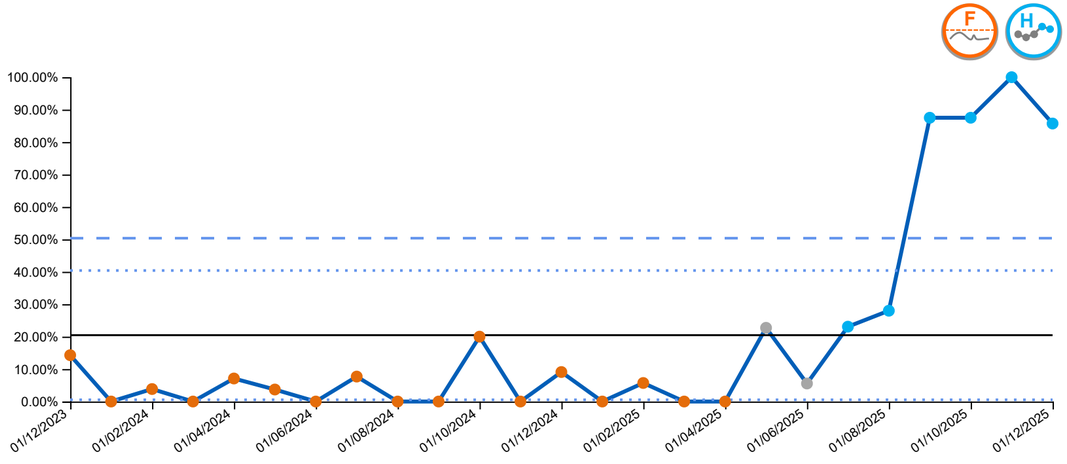


AHP MSK Podiatry - Last 6 Months

Month	Patients Seen	0 - 4 weeks (%)	Target	RAG Value
July 2025	13	23.08%	90.00%	Red
August 2025	25	28.00%	90.00%	Red
September 2025	16	87.50%	90.00%	Amber
October 2025	16	87.50%	90.00%	Amber
November 2025	16	100.00%	90.00%	Green
December 2025	7	85.71%	90.00%	Amber

Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/12/2023	14.29	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/01/2024	0.00	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/02/2024	3.85	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/03/2024	0.00	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/04/2024	7.10	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/05/2024	3.70	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/06/2024	0.00	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/07/2024	7.69	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/08/2024	0.00	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/09/2024	0.00	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/10/2024	20.00	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/11/2024	0.00	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/12/2024	9.09	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/01/2025	0.00	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/02/2025	5.71	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/03/2025	0.00	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/04/2025	0.00	20.46	90.00	0.00	44.78	4.25	36.67	DETERIORATION
01/05/2025	22.73	20.46	90.00	0.00	44.78	4.25	36.67	NONE
01/06/2025	5.56	20.46	90.00	0.00	44.78	4.25	36.67	NONE
01/07/2025	23.08	20.46	90.00	0.00	44.78	4.25	36.67	IMPROVEMENT
01/08/2025	28.00	20.46	90.00	0.00	44.78	4.25	36.67	IMPROVEMENT
01/09/2025	87.50	20.46	90.00	0.00	44.78	4.25	36.67	IMPROVEMENT
01/10/2025	87.50	20.46	90.00	0.00	44.78	4.25	36.67	IMPROVEMENT
01/11/2025	100.00	20.46	90.00	0.00	44.78	4.25	36.67	IMPROVEMENT
01/12/2025	85.71	20.46	90.00	0.00	44.78	4.25	36.67	IMPROVEMENT



Comments From Executive Lead

There remains a concerted effort to keep down MSK 'new' as well as 'return' waiting times, so that effective outcomes and discharge are achieved. Regrettably in a small team when there are unplanned absences there is the need to prioritise the main activity that of Active Foot Disease management due to the number of 'foot protection' patients, identified as being at high risk of Active Foot Disease. Attempts to recruit to a Podiatry bank post to utilise the spare hours were unsuccessful although contact has been made with some local workers and will continue to explore opportunities. An additional half day of clinic availability has been identified but staffing levels have not allowed full utilisation to date.

Stephen Brown, Chief Officer of the Integration Joint Board

Population Health

Section Lead:
Director of Public Health

What's Going Well?

Childhood immunisation uptake of MMR2 remains high.

Maternity screening metrics show 100% compliance for Haemoglobinopaties and Infectious Diseases. Trisomy and Bloodspot screening uptake rates were slightly under 100% because of patient circumstance or recording accuracy. The Pregnancy and Newborn Screening Network is monitoring these closely and will implement actions as appropriate.

Over 107 referrals to the smoking cessation over the year.

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

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

Areas of Concern

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

Meeting the deprivation focused target for successful smoking quits remains challenging but engagement work with in-patient wards has been occurring. A 12 month follow up has been initiated to re-engage those who have returned to smoking.

Population Health
Immunisation Uptake Rate MMR by 6 Years of Age

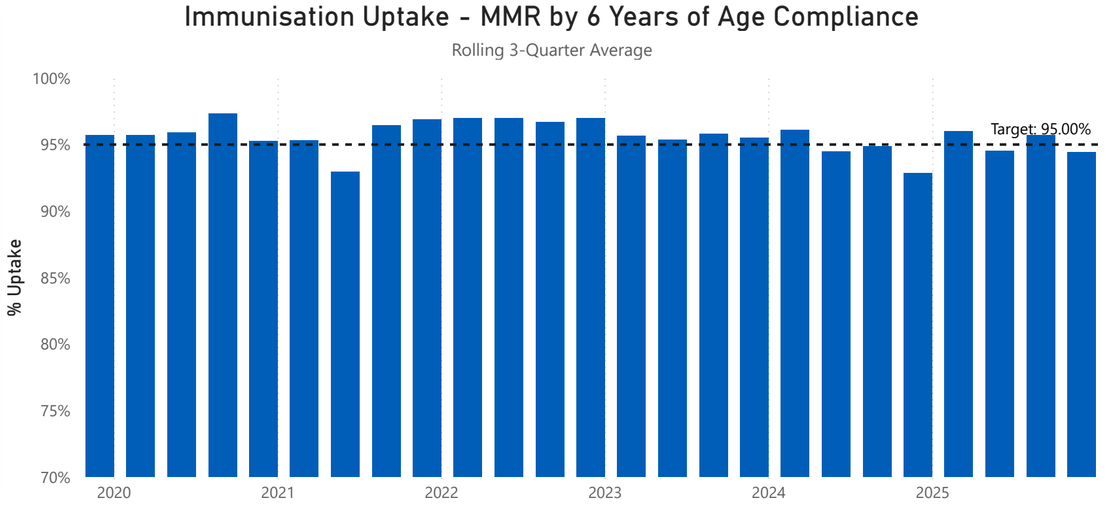
Data Source
PHS Childhood Immunisation Publication

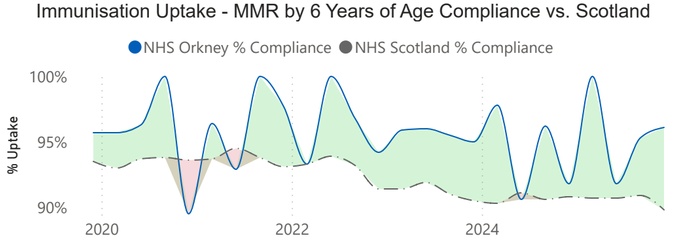
Latest Data
December 2025

Compliance

KPI	Target	Actual	RAG Value
Immunisation uptake rate MMR2 by 6 years of age (rolling 3-month average)	95.0%	94.40%	Red

Action	Target Date	Owner	Status
Review of process for children who do not attend vaccination appointments with health visiting team.	31/05/2026	E Garcia	In Progress



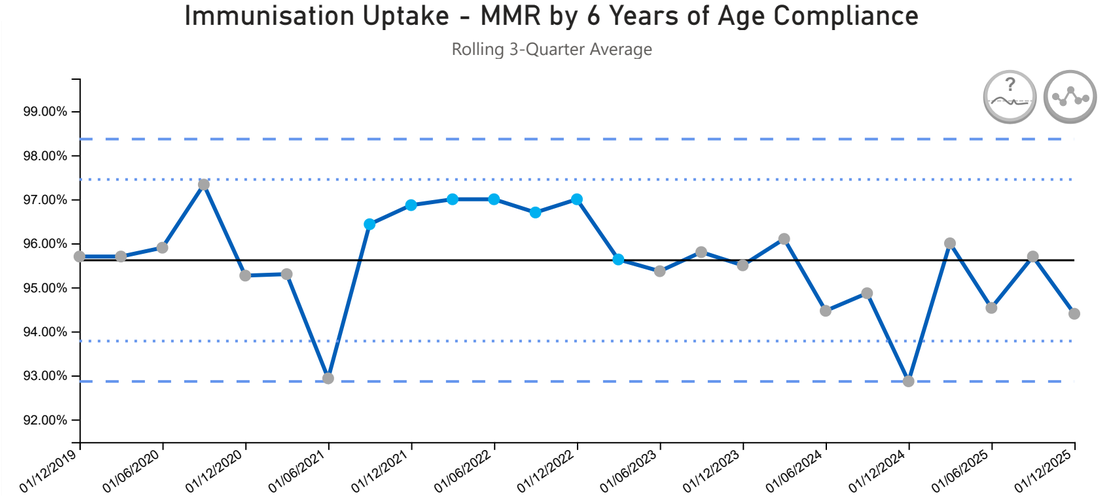


MMR Immunisation Uptake - Last 6 Quarters

End Of Quarter	Orkney	3-Quarter Avg.	Target	RAG Value
September 2024	96.20%	94.87%	95.00%	Red
December 2024	91.80%	92.87%	95.00%	Red
March 2025	100.00%	96.00%	95.00%	Green
June 2025	91.80%	94.53%	95.00%	Red
September 2025	95.30%	95.70%	95.00%	Green
December 2025	96.10%	94.40%	95.00%	Red

Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/12/2019	95.70	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/03/2020	95.70	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/06/2020	95.90	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/09/2020	97.33	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/12/2020	95.27	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/03/2021	95.30	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/06/2021	92.93	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/09/2021	96.43	95.61	95.00	92.86	98.37	93.78	97.45	IMPROVEMENT
01/12/2021	96.87	95.61	95.00	92.86	98.37	93.78	97.45	IMPROVEMENT
01/03/2022	97.00	95.61	95.00	92.86	98.37	93.78	97.45	IMPROVEMENT
01/06/2022	97.00	95.61	95.00	92.86	98.37	93.78	97.45	IMPROVEMENT
01/09/2022	96.70	95.61	95.00	92.86	98.37	93.78	97.45	IMPROVEMENT
01/12/2022	97.00	95.61	95.00	92.86	98.37	93.78	97.45	IMPROVEMENT
01/03/2023	95.63	95.61	95.00	92.86	98.37	93.78	97.45	IMPROVEMENT
01/06/2023	95.37	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/09/2023	95.80	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/12/2023	95.50	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/03/2024	96.10	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/06/2024	94.47	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/09/2024	94.87	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/12/2024	92.87	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/03/2025	96.00	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/06/2025	94.53	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/09/2025	95.70	95.61	95.00	92.86	98.37	93.78	97.45	NONE
01/12/2025	94.40	95.61	95.00	92.86	98.37	93.78	97.45	NONE



Comments From Executive Lead

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

Dr. Louise Wilson, Director of Public Health

Population Health
6-in-1 Immunisation Uptake

Data Source
PHS Childhood Immunisation Publication

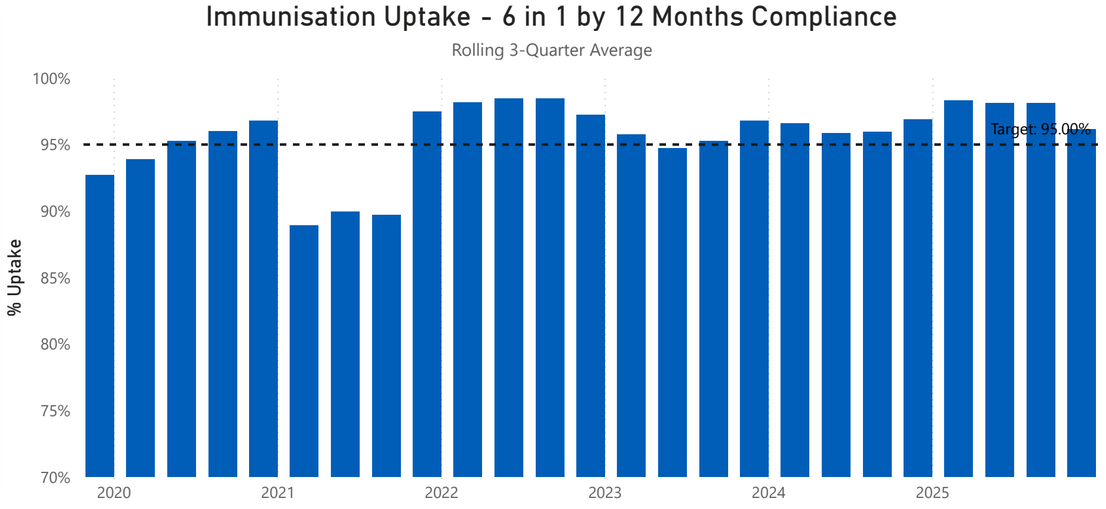
Latest Data
December 2025

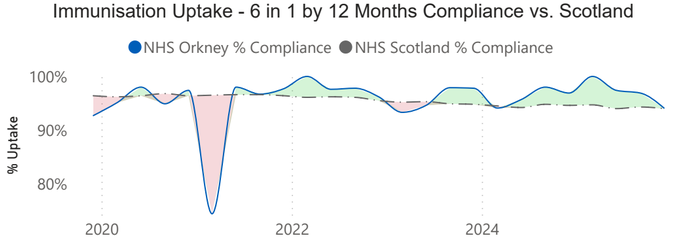
Compliance

KPI	Target	Actual	RAG Value
Immunisation uptake rate 6-in-1 primary Course by 12 months (rolling 3-month average)	95.0%	96.13%	Green

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



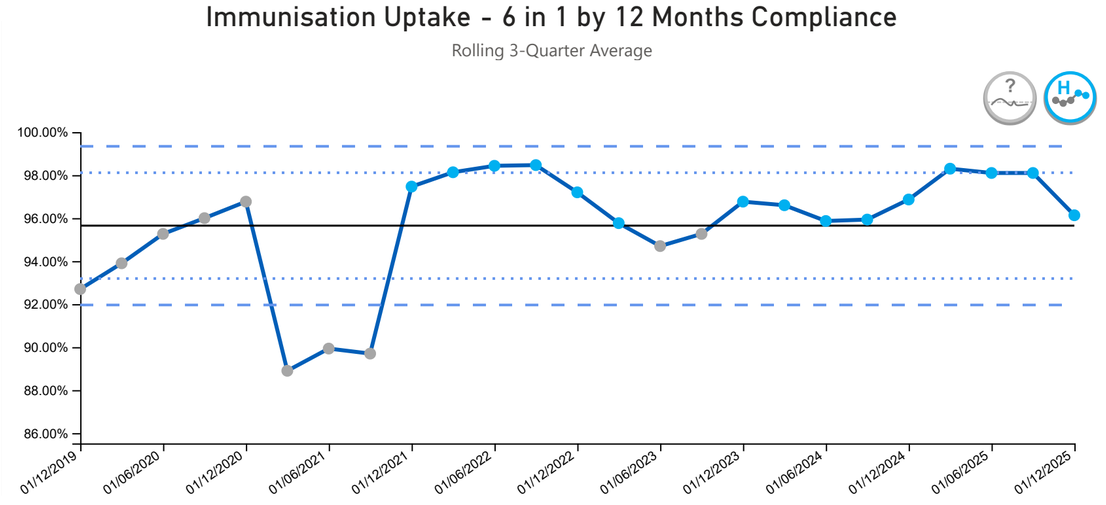


6-in-1 Immunisation Uptake - Last 6 Quarters

End Of Quarter	Orkney	3-Quarter Avg.	Target	RAG Value
September 2024	98.00%	95.93%	95.00%	Green
December 2024	96.90%	96.87%	95.00%	Green
March 2025	100.00%	98.30%	95.00%	Green
June 2025	97.40%	98.10%	95.00%	Green
September 2025	96.90%	98.10%	95.00%	Green
December 2025	94.10%	96.13%	95.00%	Green

Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/12/2019	92.70	95.65	95.00	91.96	99.34	93.19	98.11	NONE
01/03/2020	93.90	95.65	95.00	91.96	99.34	93.19	98.11	NONE
01/06/2020	95.27	95.65	95.00	91.96	99.34	93.19	98.11	NONE
01/09/2020	96.00	95.65	95.00	91.96	99.34	93.19	98.11	NONE
01/12/2020	96.77	95.65	95.00	91.96	99.34	93.19	98.11	NONE
01/03/2021	88.90	95.65	95.00	91.96	99.34	93.19	98.11	NONE
01/06/2021	89.93	95.65	95.00	91.96	99.34	93.19	98.11	NONE
01/09/2021	89.70	95.65	95.00	91.96	99.34	93.19	98.11	NONE
01/12/2021	97.47	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/03/2022	98.13	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/06/2022	98.43	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/09/2022	98.47	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/12/2022	97.20	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/03/2023	95.77	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/06/2023	94.70	95.65	95.00	91.96	99.34	93.19	98.11	NONE
01/09/2023	95.27	95.65	95.00	91.96	99.34	93.19	98.11	NONE
01/12/2023	96.77	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/03/2024	96.60	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/06/2024	95.87	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/09/2024	95.93	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/12/2024	96.87	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/03/2025	98.30	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/06/2025	98.10	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/09/2025	98.10	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT
01/12/2025	96.13	95.65	95.00	91.96	99.34	93.19	98.11	IMPROVEMENT



Comments From Executive Lead

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

Dr. Louise Wilson, Director of Public Health

Population Health
Smoking Cessation Active Clients

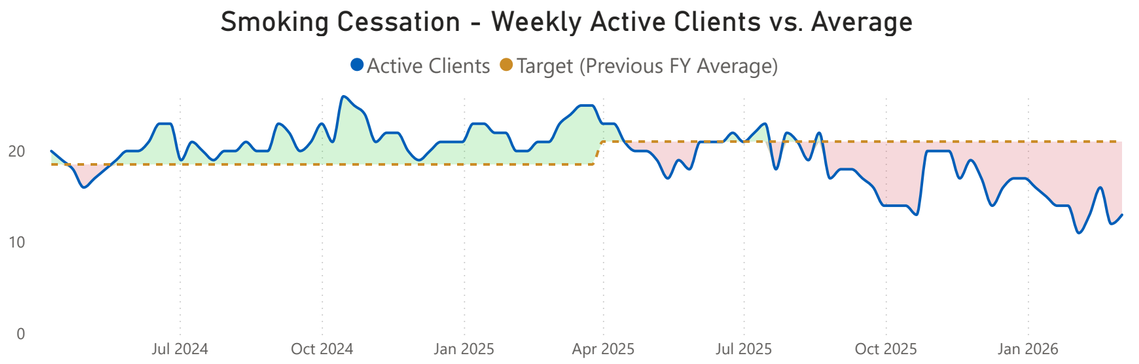
Data Source
Public Health Team

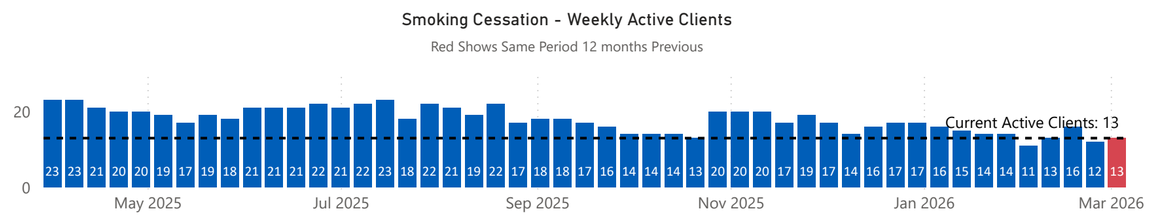
Latest Data
03/03/2026

Compliance

KPI	Target	Actual	RAG Value
Increase smoking cessation active clients year-on-year	21	13	Red

Action	Target Date	Owner	Status
Continued delivery of a sustainable model for specialist stop smoking service (Quit Your Way Orkney)	01/06/2026	J Strawson	In Progress
Engagement work with wards	01/05/2026	J Strawson	In Progress
Very brief intervention training delivered to staff groups in Orkney	01/06/2026	J Strawson	In Progress





Comments From Executive Lead

Engagement work with inpatients wards undertaken.

Dr. Louise Wilson, Director of Public Health

Population Health
Smoking Cessation 12-Week Quits

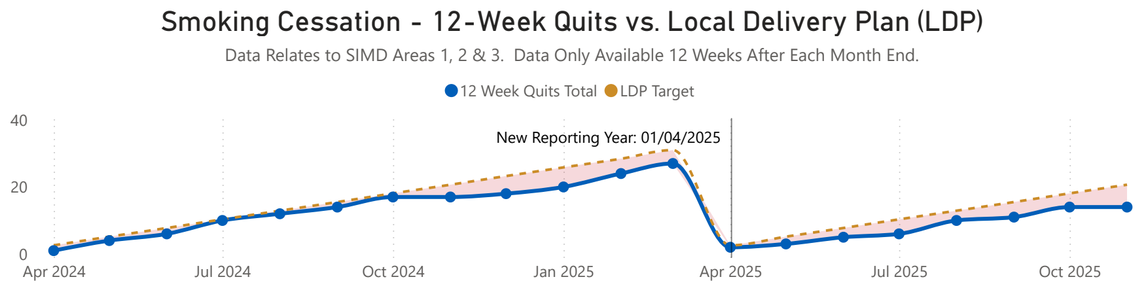
Data Source
Public Health Team

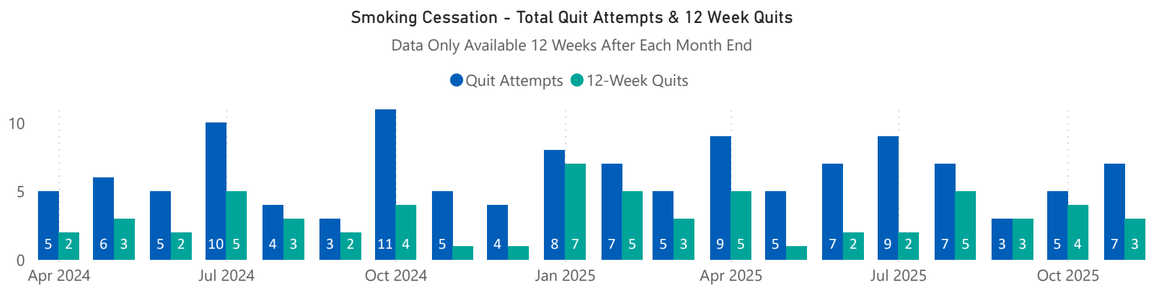
Latest Data
November 2025

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)	21	14	Red

Action	Target Date	Owner	Status
Continued delivery of a sustainable model for specialist stop smoking service (Quit Your Way Orkney)	01/06/2026	J Strawson	In Progress
Engagement work with wards	01/05/2026	J Strawson	In Progress
Very brief intervention training delivered to staff groups in Orkney	01/06/2026	J Strawson	In Progress





Comments From Executive Lead

Smoking prevalence has declined which has made achieving the target increasingly difficult. Work underway to ensure every patient letter informs recipient of smoke free site status, and how to access support. Engagement work with inpatients wards undertaken.

Dr. Louise Wilson, Director of Public Health

Population Health
Pregnancy Screening - Haemoglobinopathies

Data Source
Maternity Team

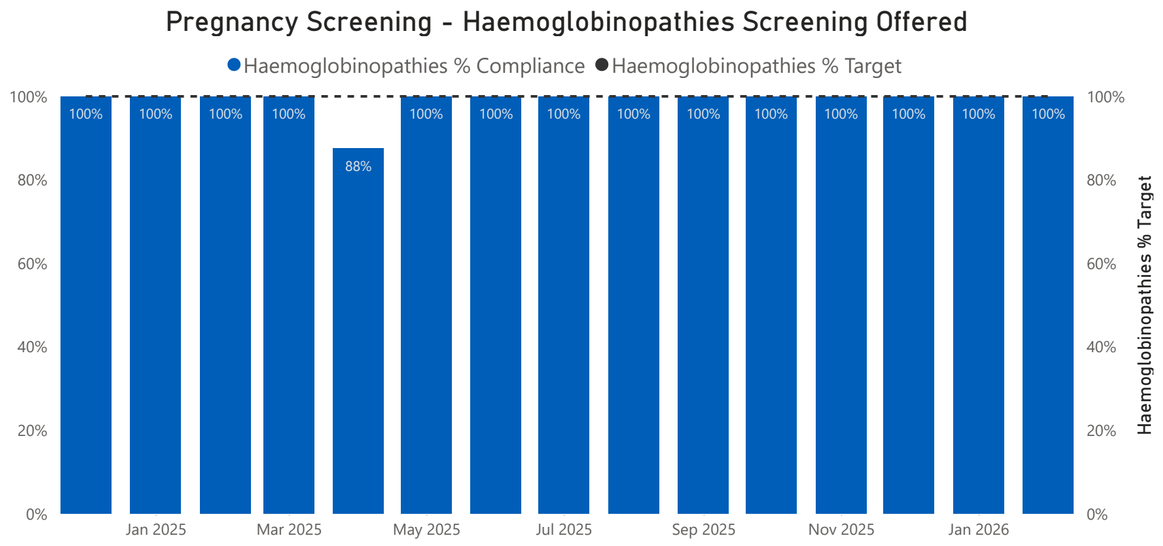
Latest Data
February 2026

Compliance

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

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



Comments From Executive Lead

Dr. Louise Wilson, Director of Public Health

Population Health
Pregnancy Screening - Infectious Diseases

Data Source
Maternity Team

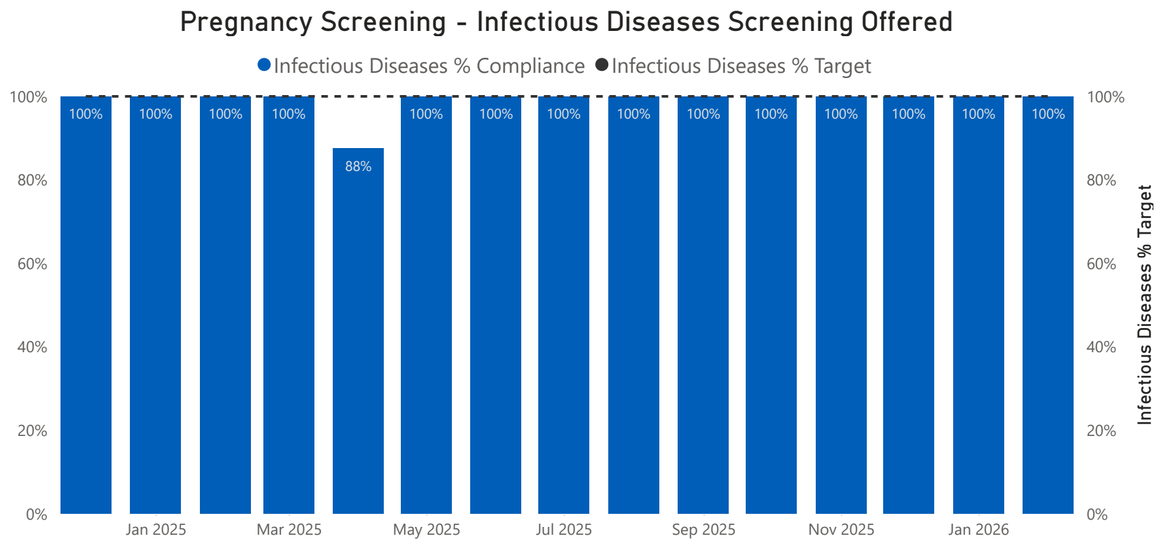
Latest Data
February 2026

Compliance

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

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



Comments From Executive Lead

Dr. Louise Wilson, Director of Public Health

Population Health
Pregnancy Screening - Trisomy

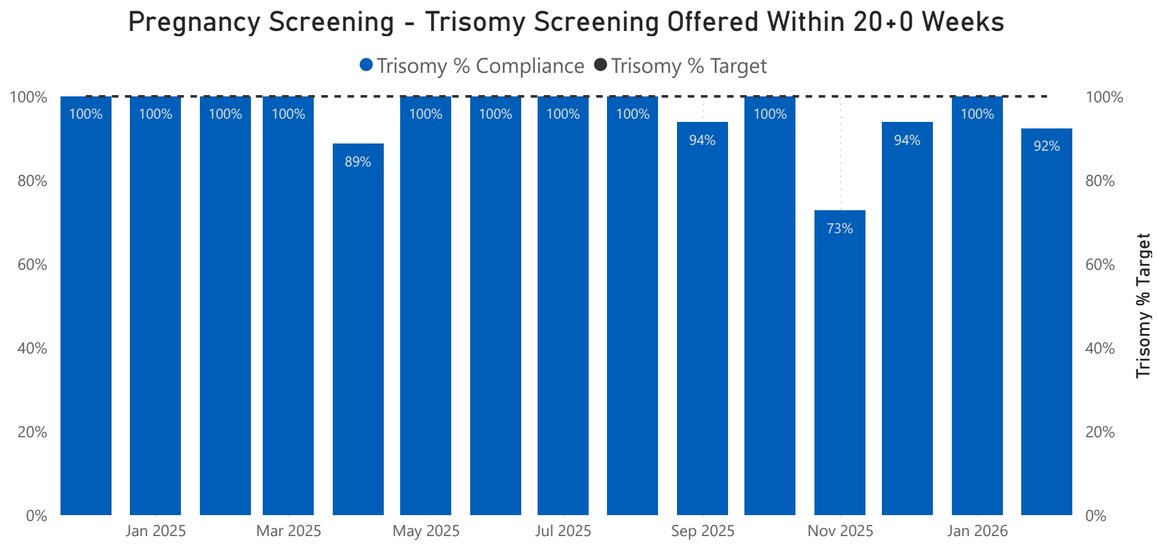
Data Source
Maternity Team

Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
Pregnancy Screening - All eligible pregnant women are offered trisomy screening no later than 20+0 weeks gestation.	100.0%	92.3%	Amber

Action	Target Date	Owner	Status
Pregnancy & Newborn Screening Oversight Group to review variance in this KPI and implement actions as appropriate.	30/04/2026	E Garcia	In Progress



Comments From Executive Lead

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

Dr. Louise Wilson, Director of Public Health

Population Health
Blood Spot Screening Compliance

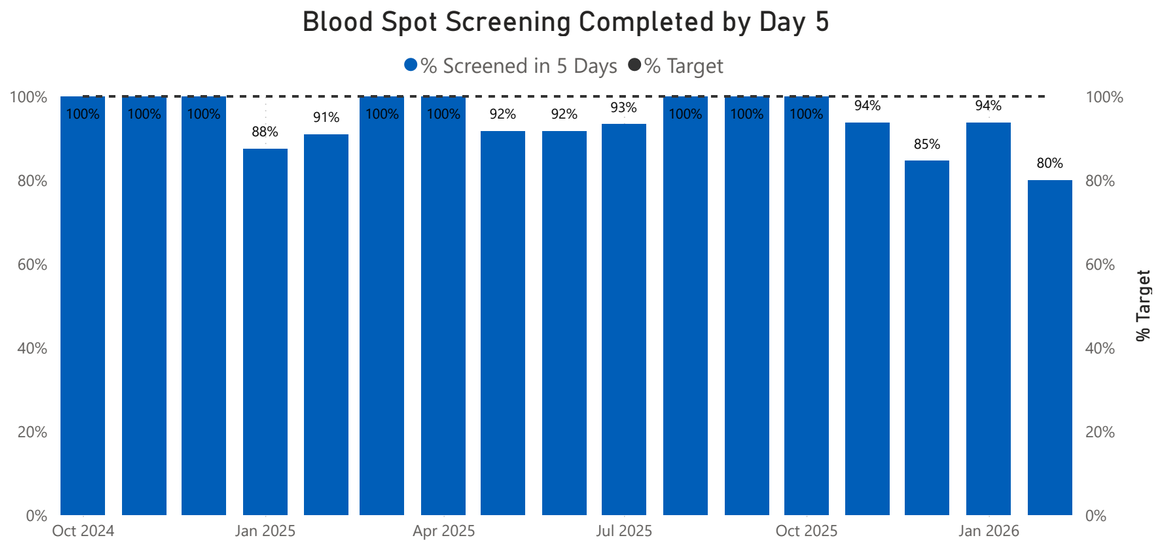
Data Source
Maternity Team

Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
Bloodspot Screening - 100% of newborn babies have bloodspot Screening completed by day 5	100.0%	80.0%	Red

Action	Target Date	Owner	Status
Pregnancy & Newborn Screening Oversight Group to review variance in this KPI and implement actions as appropriate.	30/04/2026	E Garcia	In Progress



Comments From Executive Lead

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

Dr. Louise Wilson, Director of Public Health

People & Culture

Section Lead(s):
Director of People and Culture

What's Going Well?

Business as Usual People Services continue to be delivered alongside support for transformational change. The Reduction in Working Week changes have been implemented. All existing people initiatives are being brought into one People Delivery Plan, set within the Staff Governance Standards. Sick Absence rates have reduced. An upgraded Occupational Health system is being procured which should lead to improved visibility on service delivery and patterns of attendance and illness.

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

Appraisal rates continue to be below expectations. Specific actions are being taken to address this. More generally there is a concern that as the transformational work starts to take hold there will be a lack of capacity to support business as usual and the implementation of sustainable change. This risk is being addressed via a proposal for short-term increase in change capability.

People & Culture
NHS Orkney Sickness Absence

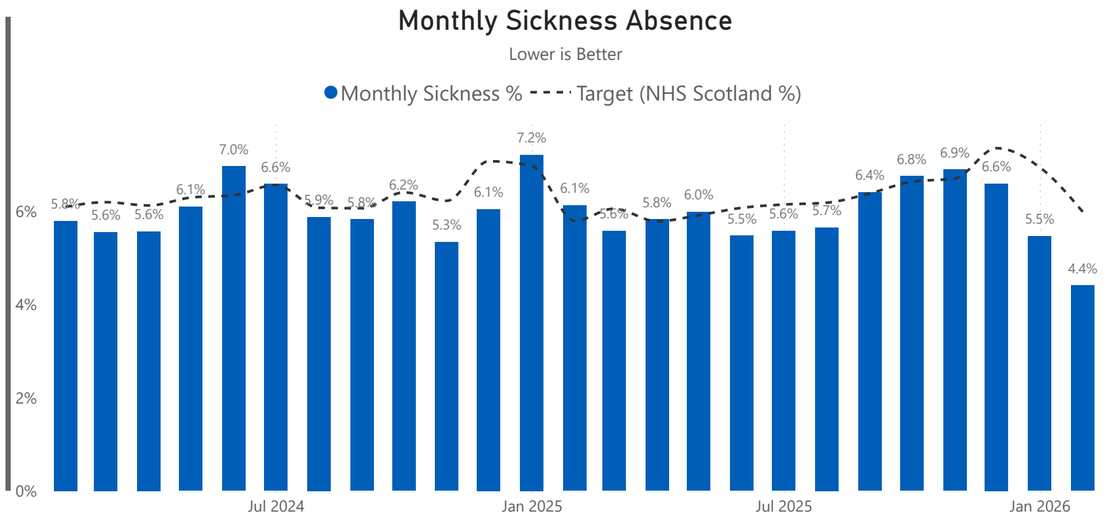
Data Source
SSTS/eESS National

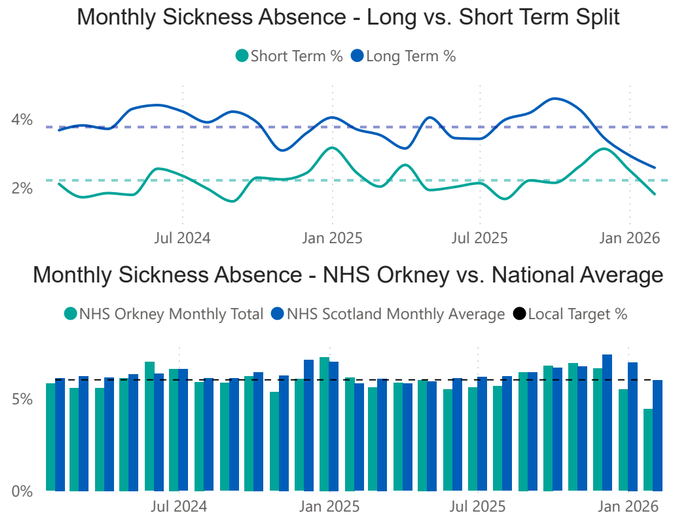
Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
Sickness rates consistently below the national average of <6%	5.99%	4.41%	Green

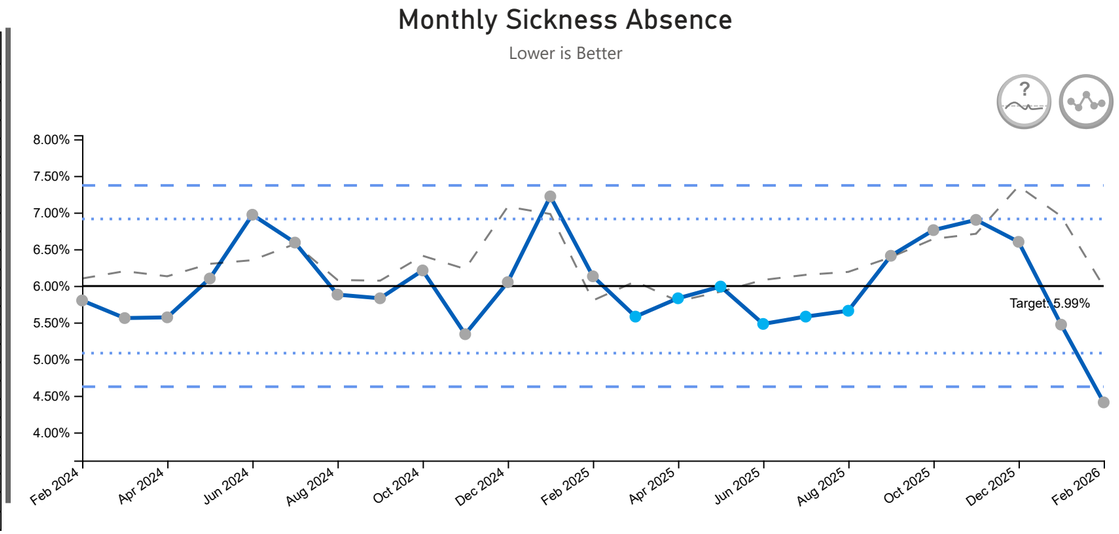
Action	Target Date	Owner	Status
Heads of Service will be held accountable for sickness rates at the Performance Review Meetings and, where relevant, asked to provide details on improvement actions.	31/05/2026	Heads of Service	In Progress
Sickness absence is being scrutinised and discussed with Heads of Department at the People Operational People Group.	30/06/2026	Head of People and Culture	In Progress
The People and Culture team continue to support managers across the organisation in sickness management, in line with the Once for Scotland Workforce Policy. The Occupational Health Nurse Manager has been engaging with managers to assist them in helping individuals return to work	30/06/2026	Head of People and Culture, OH Manager	In Progress





Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	5.80	6.00	6.10	4.62	7.37	5.08	6.91	NONE
01/03/2024	5.56	6.00	6.20	4.62	7.37	5.08	6.91	NONE
01/04/2024	5.57	6.00	6.13	4.62	7.37	5.08	6.91	NONE
01/05/2024	6.10	6.00	6.30	4.62	7.37	5.08	6.91	NONE
01/06/2024	6.97	6.00	6.35	4.62	7.37	5.08	6.91	NONE
01/07/2024	6.59	6.00	6.57	4.62	7.37	5.08	6.91	NONE
01/08/2024	5.88	6.00	6.08	4.62	7.37	5.08	6.91	NONE
01/09/2024	5.83	6.00	6.07	4.62	7.37	5.08	6.91	NONE
01/10/2024	6.21	6.00	6.41	4.62	7.37	5.08	6.91	NONE
01/11/2024	5.34	6.00	6.23	4.62	7.37	5.08	6.91	NONE
01/12/2024	6.05	6.00	7.08	4.62	7.37	5.08	6.91	NONE
01/01/2025	7.22	6.00	6.98	4.62	7.37	5.08	6.91	NONE
01/02/2025	6.13	6.00	5.80	4.62	7.37	5.08	6.91	NONE
01/03/2025	5.58	6.00	6.06	4.62	7.37	5.08	6.91	IMPROVEMENT
01/04/2025	5.83	6.00	5.79	4.62	7.37	5.08	6.91	IMPROVEMENT
01/05/2025	5.99	6.00	5.92	4.62	7.37	5.08	6.91	IMPROVEMENT
01/06/2025	5.48	6.00	6.08	4.62	7.37	5.08	6.91	IMPROVEMENT
01/07/2025	5.58	6.00	6.15	4.62	7.37	5.08	6.91	IMPROVEMENT
01/08/2025	5.66	6.00	6.19	4.62	7.37	5.08	6.91	IMPROVEMENT
01/09/2025	6.41	6.00	6.39	4.62	7.37	5.08	6.91	NONE
01/10/2025	6.76	6.00	6.64	4.62	7.37	5.08	6.91	NONE
01/11/2025	6.90	6.00	6.71	4.62	7.37	5.08	6.91	NONE
01/12/2025	6.60	6.00	7.36	4.62	7.37	5.08	6.91	NONE
01/01/2026	5.47	6.00	6.95	4.62	7.37	5.08	6.91	NONE
01/02/2026	4.41	6.00	5.99	4.62	7.37	5.08	6.91	NONE



Comments From Executive Lead

Recent months have seen an improved position.

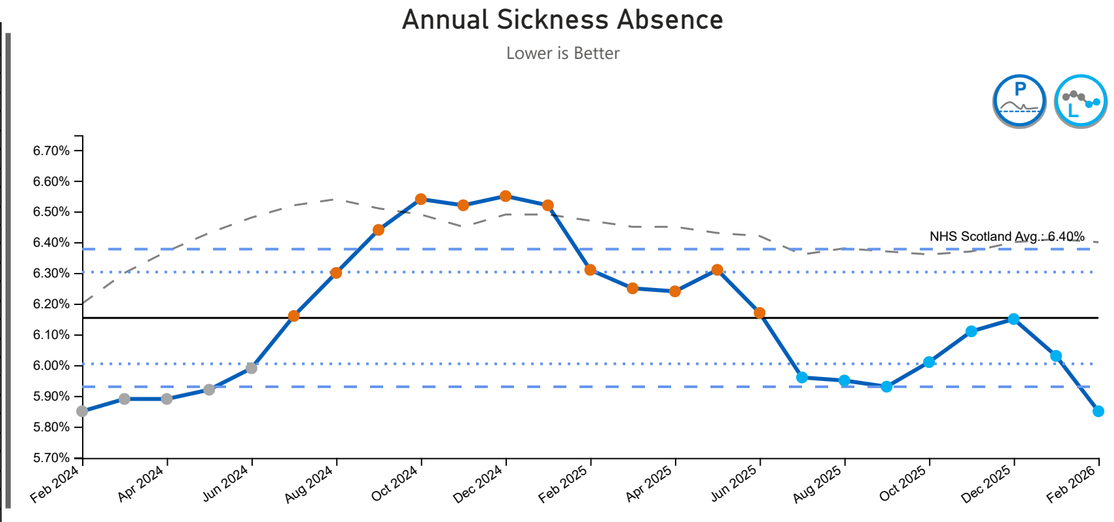
The People and Culture team continue to support managers across the organisation in sickness management, in line with the Once for Scotland Workforce Policy. The Occupational Health Nurse Manager has been engaging with managers to assist them in helping individuals return to work. Sickness absence and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

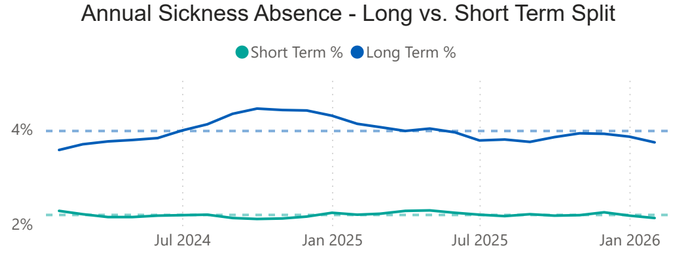
Due to the significant reduction in February 2026, it has been requested that managers/SSTS authorisers review their sickness absence/roster data.

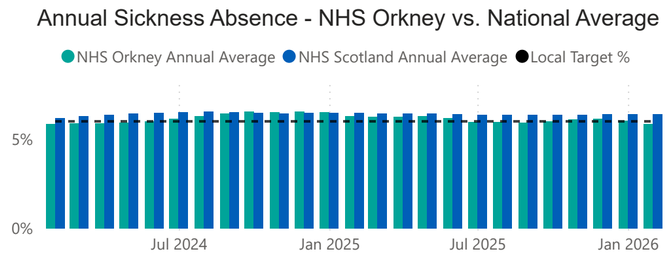
Dave Harris, Director of People and Culture

Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	5.85	6.15	6.20	5.93	6.38	6.00	6.30	NONE
01/03/2024	5.89	6.15	6.30	5.93	6.38	6.00	6.30	NONE
01/04/2024	5.89	6.15	6.37	5.93	6.38	6.00	6.30	NONE
01/05/2024	5.92	6.15	6.43	5.93	6.38	6.00	6.30	NONE
01/06/2024	5.99	6.15	6.48	5.93	6.38	6.00	6.30	NONE
01/07/2024	6.16	6.15	6.52	5.93	6.38	6.00	6.30	DETERIORATION
01/08/2024	6.30	6.15	6.54	5.93	6.38	6.00	6.30	DETERIORATION
01/09/2024	6.44	6.15	6.51	5.93	6.38	6.00	6.30	DETERIORATION
01/10/2024	6.54	6.15	6.49	5.93	6.38	6.00	6.30	DETERIORATION
01/11/2024	6.52	6.15	6.45	5.93	6.38	6.00	6.30	DETERIORATION
01/12/2024	6.55	6.15	6.49	5.93	6.38	6.00	6.30	DETERIORATION
01/01/2025	6.52	6.15	6.49	5.93	6.38	6.00	6.30	DETERIORATION
01/02/2025	6.31	6.15	6.47	5.93	6.38	6.00	6.30	DETERIORATION
01/03/2025	6.25	6.15	6.45	5.93	6.38	6.00	6.30	DETERIORATION
01/04/2025	6.24	6.15	6.45	5.93	6.38	6.00	6.30	DETERIORATION
01/05/2025	6.31	6.15	6.43	5.93	6.38	6.00	6.30	DETERIORATION
01/06/2025	6.17	6.15	6.42	5.93	6.38	6.00	6.30	DETERIORATION
01/07/2025	5.96	6.15	6.36	5.93	6.38	6.00	6.30	IMPROVEMENT
01/08/2025	5.95	6.15	6.38	5.93	6.38	6.00	6.30	IMPROVEMENT
01/09/2025	5.93	6.15	6.37	5.93	6.38	6.00	6.30	IMPROVEMENT
01/10/2025	6.01	6.15	6.36	5.93	6.38	6.00	6.30	IMPROVEMENT
01/11/2025	6.11	6.15	6.37	5.93	6.38	6.00	6.30	IMPROVEMENT
01/12/2025	6.15	6.15	6.40	5.93	6.38	6.00	6.30	IMPROVEMENT
01/01/2026	6.03	6.15	6.41	5.93	6.38	6.00	6.30	IMPROVEMENT
01/02/2026	5.85	6.15	6.40	5.93	6.38	6.00	6.30	IMPROVEMENT







People & Culture
NHS Orkney Appraisal Rates

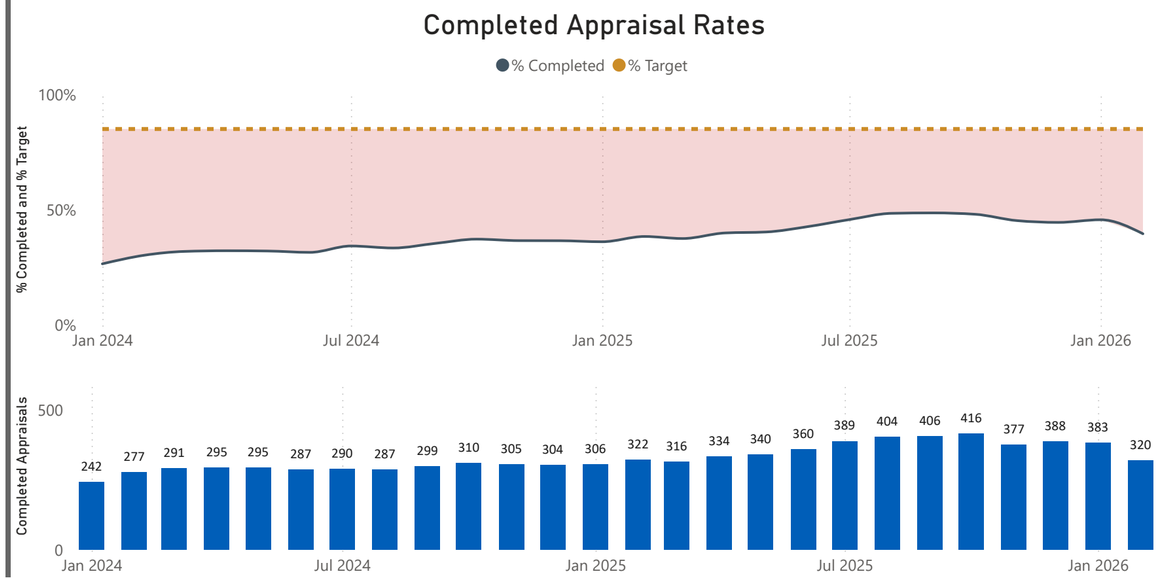
Data Source
Workforce Systems

Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
Appraisal compliance rate over the previous 12 months	85.00%	39.51%	Red

Action	Target Date	Owner	Status
Executive Directors to be set appraisal objective which includes achieving improved performance for appraisals.	31/05/2026	Interim CEO	In Progress
Heads of Service will be held accountable for appraisal rates at the Performance Review Meetings and, where relevant, asked to provide details on improvement actions.	31/05/2026	Heads of Service	In Progress
Other improvement actions being explored included changing to an organisational window for completion rather than individual annual cycles and line managers being given an appraisal objective on being an effective manager, which includes ensuring appraisals are completed.	31/03/2026	Head of People and Culture	In Progress



Comments From Executive Lead

Performance is not where the organisation expects it to be. A renewed focus on appraisals will continue over the coming year. Actions include:

Executive Directors will be held accountable for appraisal rates within their directorates as part of their own appraisal objectives.

Performance Review Meetings will ask each Head of Service to account for appraisal rates in their area and, where appropriate, provide details on improvement actions.

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

Dave Harris, Director of People and Culture

People & Culture
Agency Hours Utilised

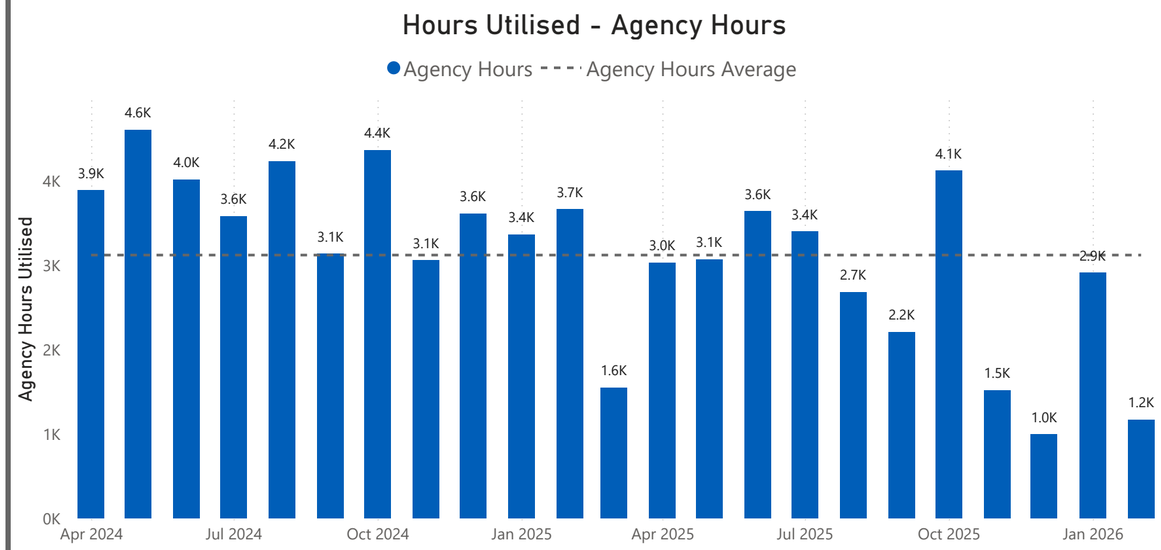
Data Source
Plus Us MI Report

Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
Agency hours used vs. average.		1170	Grey

Action	Target Date	Owner	Status
Reduce use of NMAHP agency use, where indicated utilise on framework rates.	31/05/2026	S Thomas	In Progress



Comments From Executive Lead

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

Dave Harris, Director of People and Culture

People & Culture
Bank Hours Utilised

Data Source
Workforce Systems

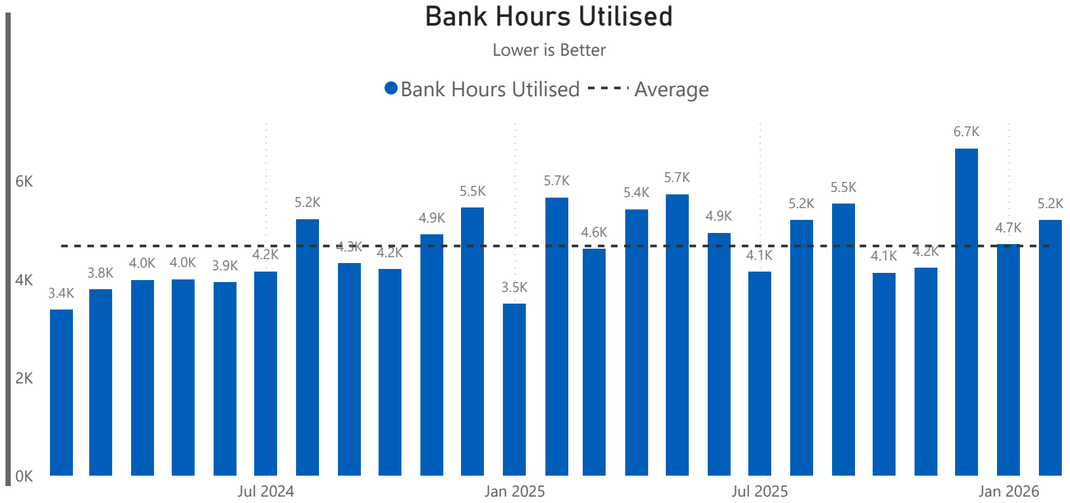
Latest Data
February 2026

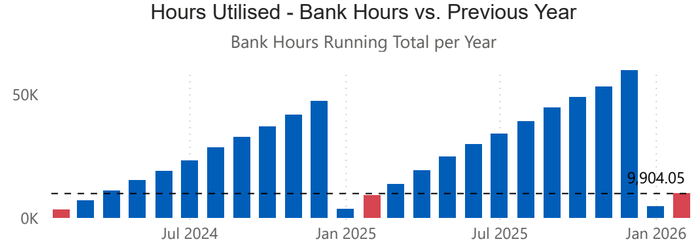
Compliance

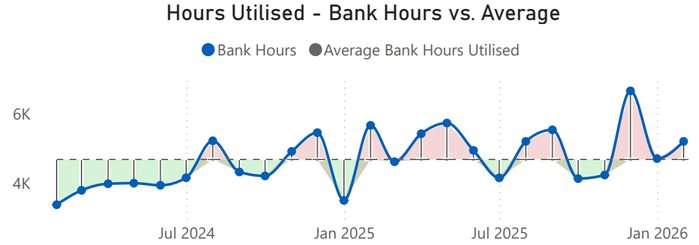
KPI	Target	Actual	RAG Value
Bank hours used vs. average.		5200	Grey

Action	Target Date	Owner	Status

No target set, actions and target to be updated.

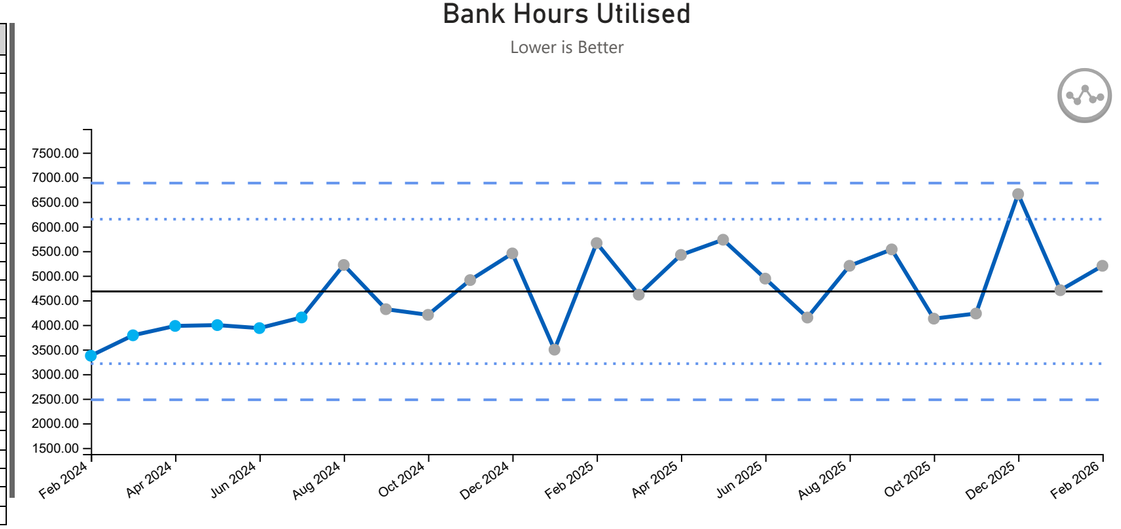






Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	3372.92	4679.30	2477.50	6881.09	3211.43	6147.16	IMPROVEMENT
01/03/2024	3787.95	4679.30	2477.50	6881.09	3211.43	6147.16	IMPROVEMENT
01/04/2024	3978.42	4679.30	2477.50	6881.09	3211.43	6147.16	IMPROVEMENT
01/05/2024	3994.97	4679.30	2477.50	6881.09	3211.43	6147.16	IMPROVEMENT
01/06/2024	3934.05	4679.30	2477.50	6881.09	3211.43	6147.16	IMPROVEMENT
01/07/2024	4150.83	4679.30	2477.50	6881.09	3211.43	6147.16	IMPROVEMENT
01/08/2024	5217.01	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/09/2024	4318.52	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/10/2024	4203.55	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/11/2024	4910.18	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/12/2024	5451.71	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/01/2025	3496.18	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/02/2025	5662.32	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/03/2025	4612.93	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/04/2025	5421.05	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/05/2025	5729.95	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/06/2025	4939.92	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/07/2025	4148.52	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/08/2025	5200.02	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/09/2025	5533.22	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/10/2025	4126.30	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/11/2025	4230.32	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/12/2025	6657.52	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/01/2026	4704.16	4679.30	2477.50	6881.09	3211.43	6147.16	NONE
01/02/2026	5199.89	4679.30	2477.50	6881.09	3211.43	6147.16	NONE



Comments From Executive Lead

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

Dave Harris, Director of People and Culture

People & Culture
Overtime Hours Utilised

Data Source
Workforce Systems

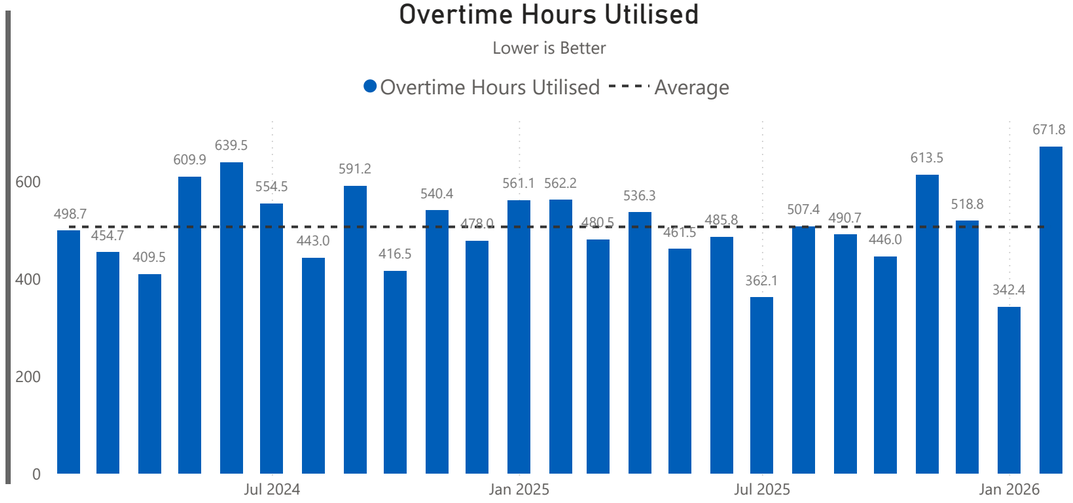
Latest Data
February 2026

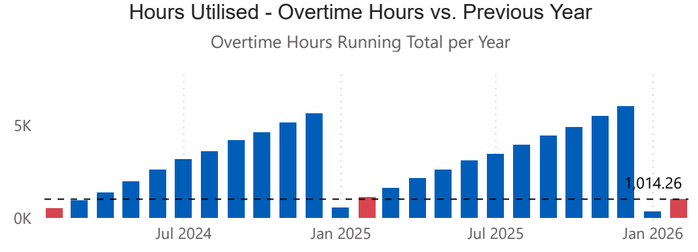
Compliance

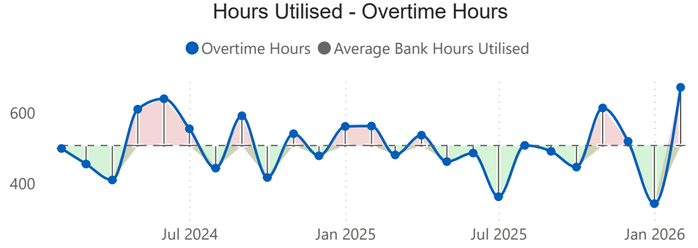
KPI	Target	Actual	RAG Value
Overtime hours used vs. average.		672	Grey

Action	Target Date	Owner	Status

No target set, actions and target to be updated.

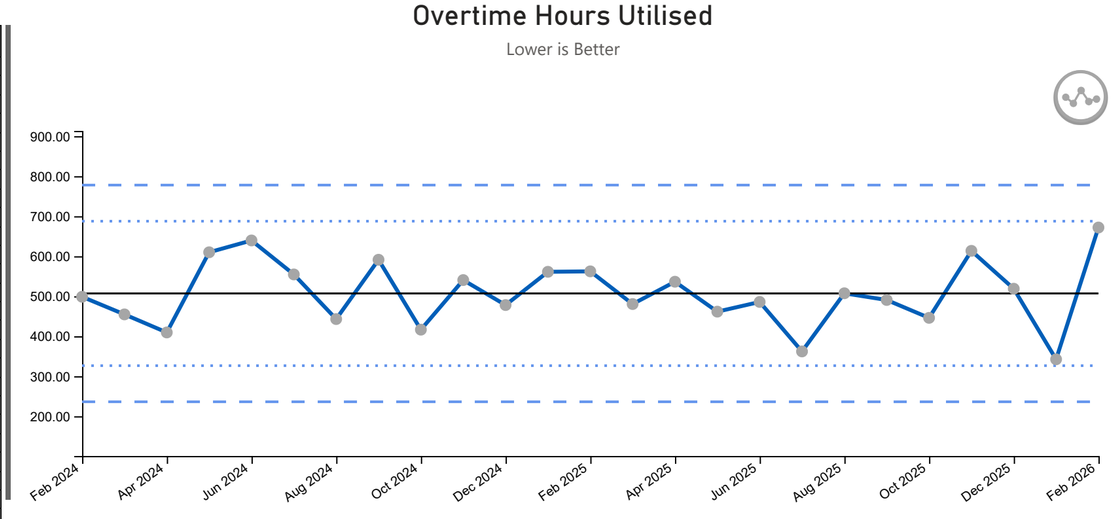






Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	498.68	507.04	236.21	777.87	326.49	687.59	NONE
01/03/2024	454.67	507.04	236.21	777.87	326.49	687.59	NONE
01/04/2024	409.50	507.04	236.21	777.87	326.49	687.59	NONE
01/05/2024	609.92	507.04	236.21	777.87	326.49	687.59	NONE
01/06/2024	639.45	507.04	236.21	777.87	326.49	687.59	NONE
01/07/2024	554.54	507.04	236.21	777.87	326.49	687.59	NONE
01/08/2024	443.00	507.04	236.21	777.87	326.49	687.59	NONE
01/09/2024	591.23	507.04	236.21	777.87	326.49	687.59	NONE
01/10/2024	416.50	507.04	236.21	777.87	326.49	687.59	NONE
01/11/2024	540.44	507.04	236.21	777.87	326.49	687.59	NONE
01/12/2024	478.00	507.04	236.21	777.87	326.49	687.59	NONE
01/01/2025	561.09	507.04	236.21	777.87	326.49	687.59	NONE
01/02/2025	562.24	507.04	236.21	777.87	326.49	687.59	NONE
01/03/2025	480.50	507.04	236.21	777.87	326.49	687.59	NONE
01/04/2025	536.28	507.04	236.21	777.87	326.49	687.59	NONE
01/05/2025	461.51	507.04	236.21	777.87	326.49	687.59	NONE
01/06/2025	485.75	507.04	236.21	777.87	326.49	687.59	NONE
01/07/2025	362.08	507.04	236.21	777.87	326.49	687.59	NONE
01/08/2025	507.42	507.04	236.21	777.87	326.49	687.59	NONE
01/09/2025	490.67	507.04	236.21	777.87	326.49	687.59	NONE
01/10/2025	446.00	507.04	236.21	777.87	326.49	687.59	NONE
01/11/2025	613.46	507.04	236.21	777.87	326.49	687.59	NONE
01/12/2025	518.80	507.04	236.21	777.87	326.49	687.59	NONE
01/01/2026	342.44	507.04	236.21	777.87	326.49	687.59	NONE
01/02/2026	671.82	507.04	236.21	777.87	326.49	687.59	NONE



Comments From Executive Lead

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

Dave Harris, Director of People and Culture

People & Culture
Excess Hours Utilised

Data Source
Workforce Systems

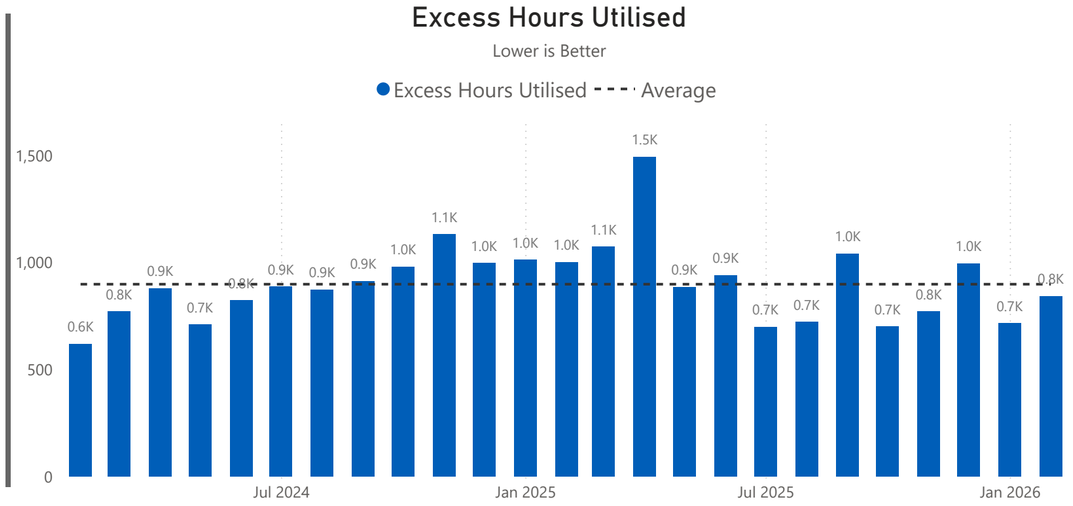
Latest Data
February 2026

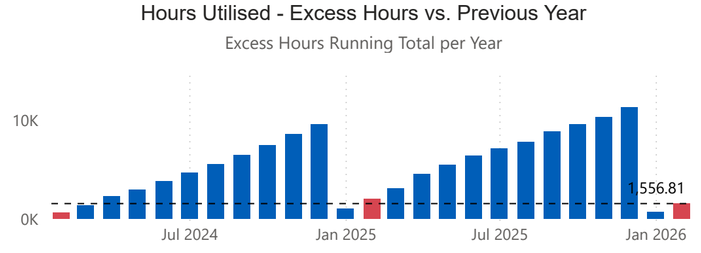
Compliance

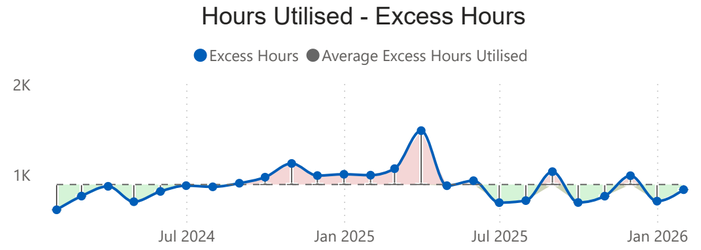
KPI	Target	Actual	RAG Value
Excess hours used vs. average.		842	Grey

Action	Target Date	Owner	Status

No target set, actions and target to be updated.

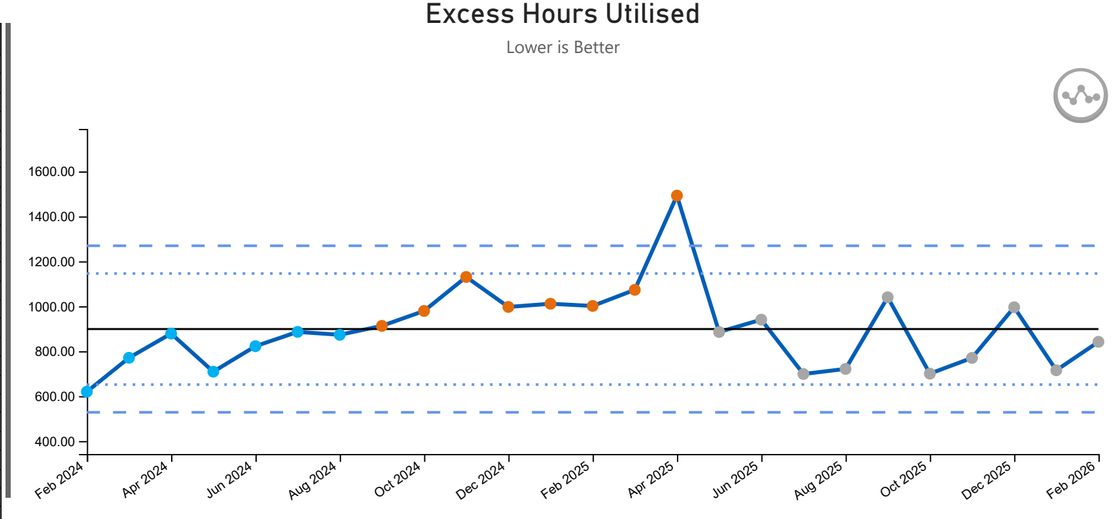






Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	619.73	898.59	527.97	1269.21	651.51	1145.67	IMPROVEMENT
01/03/2024	770.74	898.59	527.97	1269.21	651.51	1145.67	IMPROVEMENT
01/04/2024	878.47	898.59	527.97	1269.21	651.51	1145.67	IMPROVEMENT
01/05/2024	708.88	898.59	527.97	1269.21	651.51	1145.67	IMPROVEMENT
01/06/2024	822.30	898.59	527.97	1269.21	651.51	1145.67	IMPROVEMENT
01/07/2024	885.97	898.59	527.97	1269.21	651.51	1145.67	IMPROVEMENT
01/08/2024	873.00	898.59	527.97	1269.21	651.51	1145.67	IMPROVEMENT
01/09/2024	912.73	898.59	527.97	1269.21	651.51	1145.67	DETERIORATION
01/10/2024	979.15	898.59	527.97	1269.21	651.51	1145.67	DETERIORATION
01/11/2024	1130.39	898.59	527.97	1269.21	651.51	1145.67	DETERIORATION
01/12/2024	997.03	898.59	527.97	1269.21	651.51	1145.67	DETERIORATION
01/01/2025	1011.16	898.59	527.97	1269.21	651.51	1145.67	DETERIORATION
01/02/2025	1001.39	898.59	527.97	1269.21	651.51	1145.67	DETERIORATION
01/03/2025	1073.14	898.59	527.97	1269.21	651.51	1145.67	DETERIORATION
01/04/2025	1492.39	898.59	527.97	1269.21	651.51	1145.67	DETERIORATION
01/05/2025	885.48	898.59	527.97	1269.21	651.51	1145.67	NONE
01/06/2025	940.41	898.59	527.97	1269.21	651.51	1145.67	NONE
01/07/2025	698.58	898.59	527.97	1269.21	651.51	1145.67	NONE
01/08/2025	721.14	898.59	527.97	1269.21	651.51	1145.67	NONE
01/09/2025	1040.17	898.59	527.97	1269.21	651.51	1145.67	NONE
01/10/2025	700.06	898.59	527.97	1269.21	651.51	1145.67	NONE
01/11/2025	770.10	898.59	527.97	1269.21	651.51	1145.67	NONE
01/12/2025	995.52	898.59	527.97	1269.21	651.51	1145.67	NONE
01/01/2026	715.06	898.59	527.97	1269.21	651.51	1145.67	NONE
01/02/2026	841.75	898.59	527.97	1269.21	651.51	1145.67	NONE



Comments From Executive Lead

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

Dave Harris, Director of People and Culture

Finance

Section Lead(s):
Director of Finance

What's Going Well?

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

RAG Status Values

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

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

Areas of Concern

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

The month 11 position is £98k adverse to trajectory, driven by additional expenditure along with a reduction in allocated funding by SG. The savings programme is also £0.609m adverse to trajectory.

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

The financial position has improved over the past 3 months and the Year End Forecast is anticipated to be a deficit of £2.7m. Additional deficit support funding has been received which will mitigate the risk of a Section 22 Qualification for 2025/26.

Finance
Financial Position Summary

Data Source
Finance Performance Report

Latest Data
February 2026

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	-1,169	-1,020	-1,127	106	-172	-68	-104
Other	-491	-450	-1,131	682	-41	-80	39
Primary Care Patient Charges	-375	-393	-342	-51	-41	-36	-5
Total Income	-2,035	-1,863	-2,600		-254	-184	
Expenditure							
Pay							
Medical & Dental	9,268	8,495	11,440	-2,945	772	1,108	-335
Nursing & Midwifery	17,005	15,582	14,729	853	1,440	1,376	64
Other Staff Costs	28,181	25,799	21,053	4,746	2,498	2,008	490
Total Pay	54,453	49,876	47,222		4,711	4,492	
Non Pay							
Drugs - Primary Care	4,902	4,493	4,472	21	408	450	-42
Drugs - Secondary Care	3,698	3,389	3,008	381	308	287	21
General Dental Services	1,009	1,077	1,077	0	95	95	0
General Medical Services	5,244	4,807	4,798	9	431	432	-1
General Ophthalmic Services	316	283	284	0	23	23	0
Medical Supplies	1,594	1,461	1,703	-242	133	150	-17
Other Expenditure	9,992	9,049	14,843	-5,794	746	980	-235
Pharmaceutical Services	1,017	972	975	-3	89	80	9
Resource Transfer	2,334	2,140	2,134	6	195	194	1
SLA's & UNPACs	10,033	9,197	9,407	-210	836	943	-107
Total Non-Pay	40,139	36,868	42,701		3,264	3,634	
Total	92,558	84,881	87,322	-2,441	7,721	7,942	-221

Figures shown in the above table represent £000s

Finance
Financial Performance Against Plan

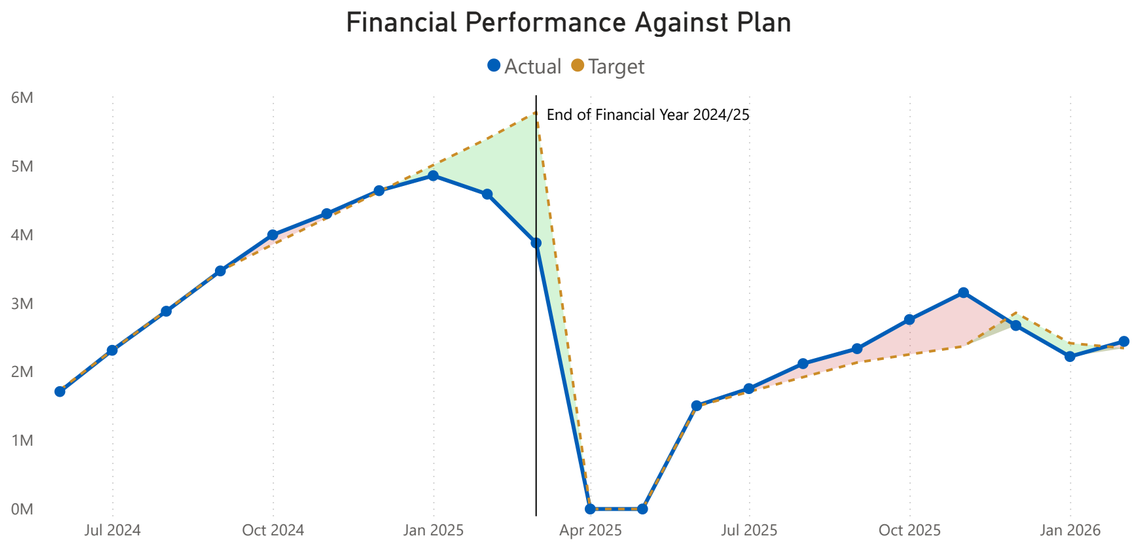
Data Source
Finance Performance Report

Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
Financial performance against plan - YTD.	£2,343,000	£2,441,000	Red

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



Comments From Executive Lead

The Month 11 financial position is an improved position, albeit still adverse against the planned trajectory. The reporting position is £0.098m higher than the planned overspend of £2.343m.

Melanie Barnes, Interim Director of Finance

Finance
Accounts Payable 10-Day Performance

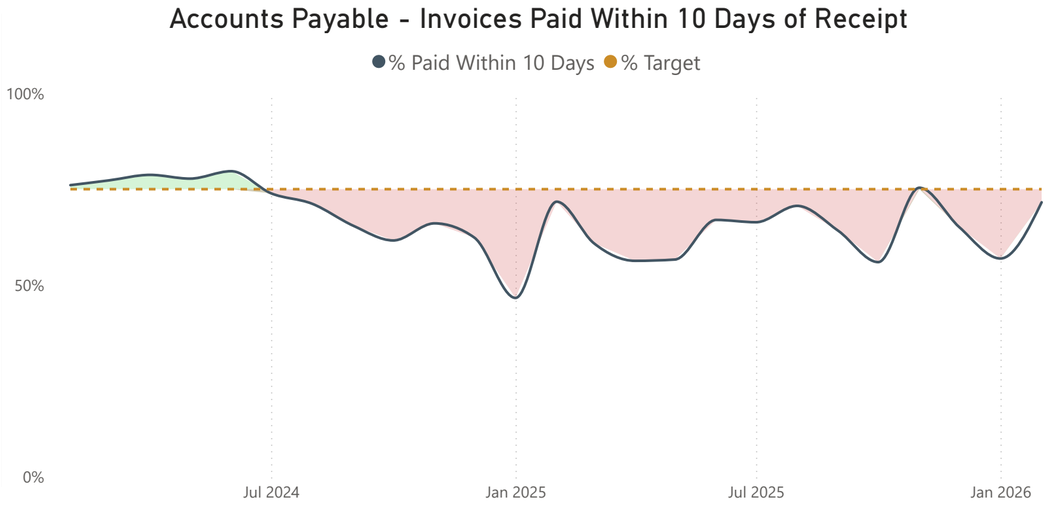
Data Source
AP Performance Report

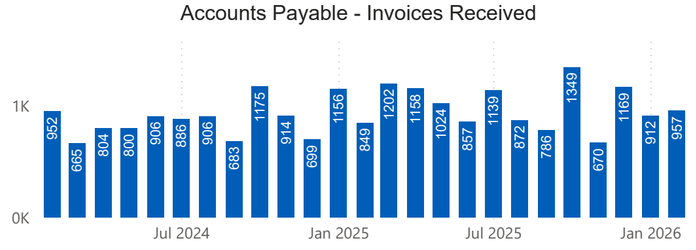
Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
75% of invoices to be paid within 10 days of receipt - local target	75.00%	71.58%	Red

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



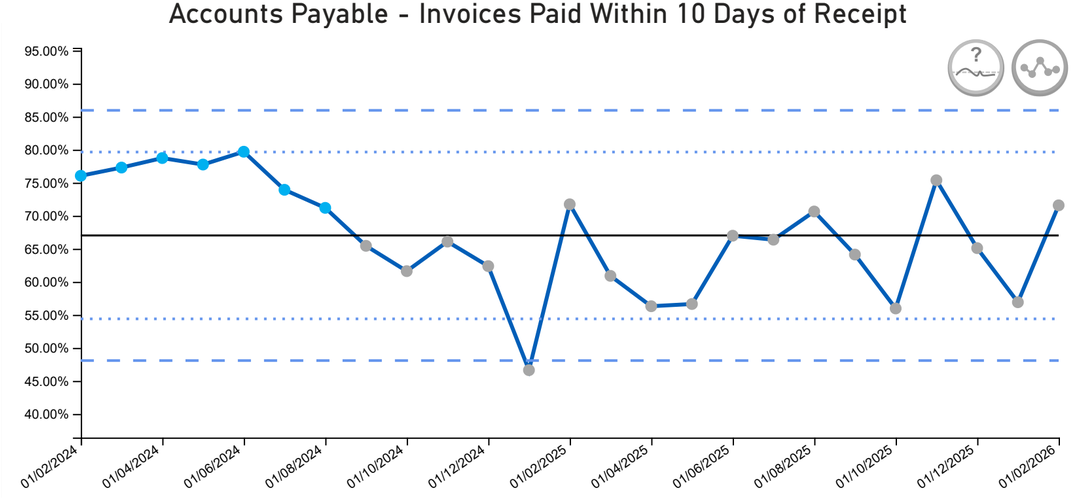


Accounts Payable 10-Day Target - Last 6 Months

Month	Received	Paid <=10 Days	% <=10 Days	Target	RAG Value
September 2025	786	504	64.12%	75.00%	Red
October 2025	1349	755	55.97%	75.00%	Red
November 2025	670	505	75.37%	75.00%	Green
December 2025	1169	761	65.10%	75.00%	Red
January 2026	912	519	56.91%	75.00%	Red
February 2026	957	685	71.58%	75.00%	Red

Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	76.05	67.02	75.00	48.08	85.95	54.39	79.64	IMPROVEMENT
01/03/2024	77.29	67.02	75.00	48.08	85.95	54.39	79.64	IMPROVEMENT
01/04/2024	78.73	67.02	75.00	48.08	85.95	54.39	79.64	IMPROVEMENT
01/05/2024	77.75	67.02	75.00	48.08	85.95	54.39	79.64	IMPROVEMENT
01/06/2024	79.69	67.02	75.00	48.08	85.95	54.39	79.64	IMPROVEMENT
01/07/2024	73.93	67.02	75.00	48.08	85.95	54.39	79.64	IMPROVEMENT
01/08/2024	71.19	67.02	75.00	48.08	85.95	54.39	79.64	IMPROVEMENT
01/09/2024	65.45	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/10/2024	61.62	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/11/2024	66.08	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/12/2024	62.37	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/01/2025	46.63	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/02/2025	71.73	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/03/2025	60.90	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/04/2025	56.30	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/05/2025	56.64	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/06/2025	66.98	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/07/2025	66.37	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/08/2025	70.64	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/09/2025	64.12	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/10/2025	55.97	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/11/2025	75.37	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/12/2025	65.10	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/01/2026	56.91	67.02	75.00	48.08	85.95	54.39	79.64	NONE
01/02/2026	71.58	67.02	75.00	48.08	85.95	54.39	79.64	NONE



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

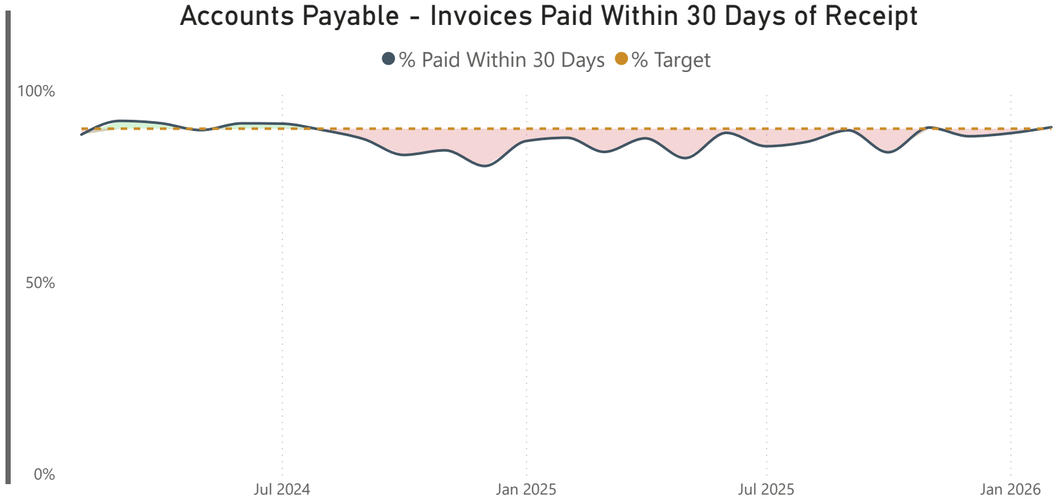
Data Source
AP Performance Report

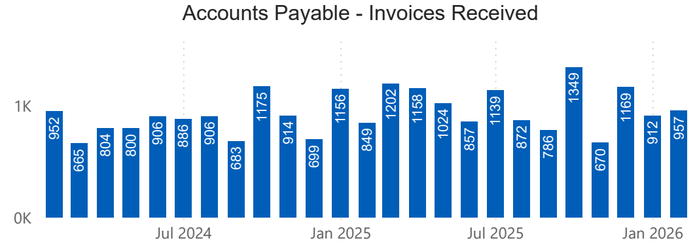
Latest Data
February 2026

Compliance

KPI	Target	Actual	RAG Value
90% of invoices to be paid within 30 days of receipt - local target	90.00%	90.39%	Green

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



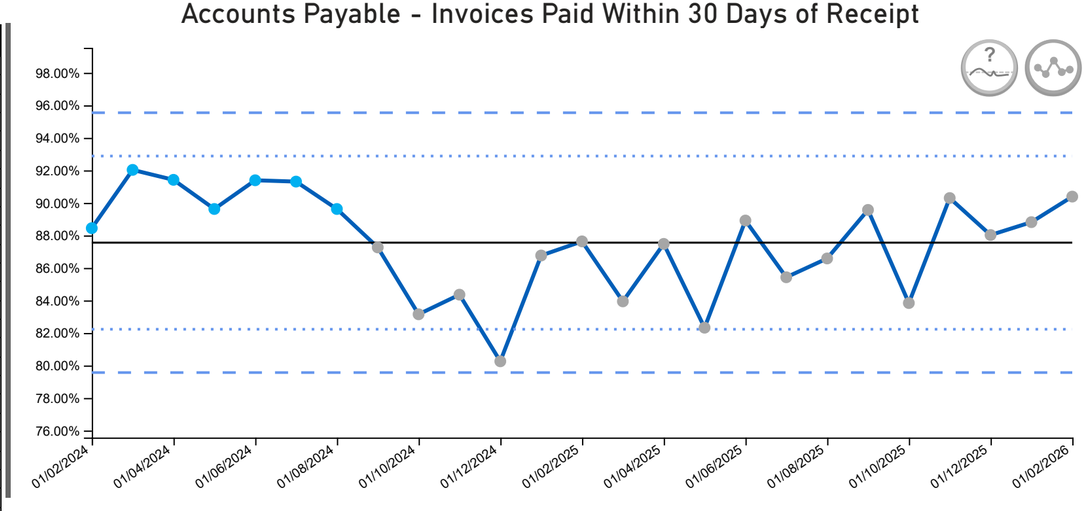


Accounts Payable 30-Day Target - Last 6 Months

Month	Received	Paid <=30 Days	% <=30 Days	Target	RAG Value
September 2025	786	704	89.57%	90.00%	Red
October 2025	1349	1131	83.84%	90.00%	Red
November 2025	670	605	90.30%	90.00%	Green
December 2025	1169	1029	88.02%	90.00%	Red
January 2026	912	810	88.82%	90.00%	Red
February 2026	957	865	90.39%	90.00%	Green

Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
01/02/2024	88.45	87.55	90.00	79.57	95.54	82.23	92.88	IMPROVEMENT
01/03/2024	92.03	87.55	90.00	79.57	95.54	82.23	92.88	IMPROVEMENT
01/04/2024	91.42	87.55	90.00	79.57	95.54	82.23	92.88	IMPROVEMENT
01/05/2024	89.63	87.55	90.00	79.57	95.54	82.23	92.88	IMPROVEMENT
01/06/2024	91.39	87.55	90.00	79.57	95.54	82.23	92.88	IMPROVEMENT
01/07/2024	91.31	87.55	90.00	79.57	95.54	82.23	92.88	IMPROVEMENT
01/08/2024	89.62	87.55	90.00	79.57	95.54	82.23	92.88	IMPROVEMENT
01/09/2024	87.26	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/10/2024	83.15	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/11/2024	84.35	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/12/2024	80.26	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/01/2025	86.76	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/02/2025	87.63	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/03/2025	83.94	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/04/2025	87.48	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/05/2025	82.32	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/06/2025	88.91	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/07/2025	85.43	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/08/2025	86.58	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/09/2025	89.57	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/10/2025	83.84	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/11/2025	90.30	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/12/2025	88.02	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/01/2026	88.82	87.55	90.00	79.57	95.54	82.23	92.88	NONE
01/02/2026	90.39	87.55	90.00	79.57	95.54	82.23	92.88	NONE



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

Item 10

Draft Board Development Plan 2026/27

Meeting	NHS Orkney Board
Meeting date	Thursday, 30 April 2026
Responsible Executive/Non-Executive	• Davie Campbell, Interim Board Chair
Report Author(s)	• Debs Crohn, Head of Corporate Governance
Purpose of report	• Decision
Contribution to Strategic ambition	• Corporate Strategy 2024-2028
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred • Sustainability
Key points for consideration	• A draft Board Development Programme for 2026/27 has been created, following The Blueprint for Good Governance in NHS Scotland (November 2022). This programme is designed to support ongoing improvement within both the organisation and the Board. • Building on previous years, this paper sets out a proposed three-strand approach to Board development for 2026/27 which is as follows 1. Organisational Development and Culture 2. Subject and topic specific development 3. Learning from others and sharing good practice • Following feedback from Board Development Sessions on 29 January and 19 March 2026, the Board is asked to approve the proposed 3-strand development approach for 2026/27 in Appendix 1.
Route to meeting	• Board Development session 29 January 2026 • Board Development Session 19 March 2026
Recommendation(s)	• **Decision - Reaching a conclusion considering the options**

NHS Orkney

Item 10

Board Development Plan 2026/27

Debs Crohn, Head of Corporate Governance
13/04/2026

1. Situation

1.1 This paper sets out a proposed Board Development Programme for 2026/27, following engagement with Board Members at the Board Development Sessions held 29 January and 19 March 2026.

2. Background

2.1 A draft Board Development Programme for 2026/27, guided by The Blueprint for Good Governance in NHS Scotland (November 2022), has been developed recognising such a programme contributes to the organisations and Board's continuous improvement.

2.2 The purpose of a board development plan is to enhance a board's overall effectiveness, ensuring members possess the necessary skills, knowledge, and behaviours to drive organisational strategy and improve performance. An effective Board Development Plan helps to foster high-performing teams through training, mentorship, and structured, continuous improvement, ensuring legal compliance and strategic alignment.

3. Assessment

3.1 Analysis

This paper proposes a three-part Board development plan for 2026/27. Each session will combine formal training and time to discuss culture, working methods, and relationships, with meetings lasting no longer than four hours.

Board Members indicated a preference for two sessions to be conducted in person and requested that, whenever feasible, sessions be held outside The Balfour.

Development sessions will be jointly delivered and designed by the Executive Lead and Non-Executive Board Member to ensure both operational and governance perspectives are considered. This collaborative approach supports well-rounded sessions that address organisational priorities and Board Members' needs, promotes shared ownership, encourages diverse viewpoints, and strengthens Board relationships.

3.2 Organisational Development and Culture

This strand of our Board Development Programme will focus on:

- Board members' relationships with one another and the relational work that is needed to build an effective and high performing team
- Organisational culture – recognising the role of NHS Boards in organisational culture in healthcare settings (Blueprint 2022)

3.3 Subject and topic specific development

These subject and topic specific sessions will help the Board to develop its capability (capacity, competence and confidence) to ensure we can effectively discharge our corporate governance responsibilities, with a focus on governance, leadership and quality improvement. ”

These sessions will align to our Strategic Objectives – and a proposal for themes in 2026/27 is below:

- **PLACE** – Population Health ambition/understanding our community and people’s health needs – and linking this to our Joint Strategic Needs Assesment and Orkney’s Routemap to Reform, sub national planning and potential changes to Health Policy post-election.
- **PEOPLE** – Patient and staff experience, planning with people, culture and further embedding Staff Governance Standards
- **PATIENT SAFETY** – Risk, integrated governance, resilience, Business Continuity Planning and how we assess the quality and safety of our services.
- **PERFORMANCE** – Using data for improvement and assurance and integrated governance and planning for 2027/28 Corporate Strategy Delivery Plan.
- **POTENIAL** – Education and collaboration/external relationships/partnerships, digital and cyber security

3.4 Learning from others and sharing good practice

In collaboration with National Education Scotland and our Director of People and Culture, we will select internal and external speakers to support delivery of the sessions outlined in Appendix 1.

3.5 Timing of sessions

Board members at the Development session 19 March 2026 asked for a space in the Board Development planner so that the sessions could be changed based on need.

Board is asked to note that session dates may change as issues arise.

3.6 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	No	No impact
People	Workforce	No	No impact.
Performance	Finance	No	No impact.
Potential	Risk Management	Yes	No impact.
	Digital	No	No impact.
Place	Equality and Diversity including	No	No impact.

	health inequalities		
	Climate Change Sustainability	No	No impact.

4. Recommendations

4.1 Decision - Reaching a conclusion considering options

The Board is asked to:

- Approve the 2026/27 Draft Board Development Plan

5. List of Appendices

5.1 The following appendices are included with this report

i. **Appendix 1 –** Draft Board Development Plan 2026/27

Item 10

Appendix 1 – Draft Board Development Plan 2026/27

Date	Aim of the session	Areas to be covered	Outcomes	Lead Executive(s)	Priority
28 May 2026	This session will provide time and space for Board Members to reflect on post-election implications and align on the 2026/27 financial outlook and public sector reform priorities.	• Reflections following Scottish Elections – May 2026 • 2026-2027 financial projections, assumptions and areas of transformational delivery. • Public Sector Reform – Orkney's Route map to Reform	Members will gain an understanding of the shared reflections (post-election) and be briefed on financial outlook & reform priorities	Interim CEO Interim Board Chair Director of Finance Chief Officer IJB	• Organisational Development and Culture • Subject and topic specific development • Learning from others and sharing good practice
23 July 2026	This session will focus on understanding and addressing the health needs of the population, which aligns with the objective of improving public health and ensuring equitable access to healthcare services. This session will focus on making difficult decisions, being brave and bold and agreeing our organisational priorities and their consequences	**Place - Health needs of population** • Population Health Organisation Framework • What are the strategic gaps?	Members will gain a comprehensive understanding of the health needs of the population, practical knowledge on addressing public sector reform and changes to health policy post-elections, and strategies for ensuring equitable access to healthcare services.	Director of Public Health Chief Officer IJB	• Organisational Development and Culture • Subject and topic specific development • Learning from others and sharing good practice
24 September 2026	The session will explore strategies for managing change within complex organisational structures, which supports the objective of fostering a resilient and adaptable workforce.	**People - Managing Change** • Cultural alignment to change • Planning with People • Workforce/succession planning • Embedding Staff Governance Standards	Members will leave with actionable strategies for managing change within complex organisational structures, a deeper understanding of how culture is influenced by behaviours and relationships within the organisation, and practical insights into workforce planning and embedding Staff Governance Standards.	Director of People and Culture People and Culture Institute	• Organisational Development and Culture • Subject and topic specific development. • Learning from others and sharing good practice

Item 10

Date	Aim of the session	Areas to be covered	Outcomes	Lead Executive(s)	Priority
	This session will discuss our approach to risk management, Business Continuity, Resilience and measuring quality and safety which are crucial for ensuring patient safety and maintaining high-quality healthcare services.	**Patient Safety, Quality and Experience** • Business Continuity/Resilience planning • Building a culture of *safe care and role of the board, Francis Review,* maternity reports) **Dedicated session** • How do we assess the quality and safety of our services?	Members will leave with enhanced skills in risk management, business continuity, and resilience planning, as well as improved methods for assessing the quality and safety of services.	Clinical Executive Leads	• Organisational Development and Culture • Subject and topic specific development
26 November 2026	The theme of this session is to focus on leveraging data to drive performance improvements and ensure accountability, which aligns with the objective of enhancing organisational efficiency and effectiveness.	**Performance – Strategic Planning** Joint session with Senior Leadership Team • Planning for 2027/28 – Corporate Strategy Delivery Plan	Members will have the opportunity to influence and inform the strategic plan for the upcoming year, aligned with the overall corporate strategy for 2027/28, and a comprehensive Corporate Strategy Delivery Plan.	Chief Executive Board Chair	• Organisational Development and Culture • Subject and topic specific development. •
28 January 2027	The theme of this session is to focus on leveraging data to drive performance improvements and ensure accountability, which aligns with the objective of enhancing organisational efficiency and effectiveness.	**Performance – Strategic Planning** • Planning for 2027/28 – Corporate Strategy Delivery Plan	Joint session with Senior Leadership Team Members will have the opportunity to influence and inform the strategic plan for the upcoming year, aligned with the overall corporate strategy for 2027/28, and a comprehensive Corporate Strategy Delivery Plan.	Chief Executive Board Chair	• Organisational Development and Culture • Subject and topic specific development.
18 March 2027	The theme of this session is to focus on leveraging digital and data to drive performance improvements and ensure accountability, which aligns with the objective of enhancing organisational efficiency and effectiveness	**Potential – Digital and Data** • How to use data for improvement and assurance • Digital and Cybersecurity Island Boards Benchmarking pack	Members will acquire the ability to leverage data to drive performance improvements, ensure accountability, and develop integrated governance and financial planning strategies for the upcoming year. Members will gain insights into the importance of digital transformation and cybersecurity, practical knowledge on enhancing service delivery, and strategies for protecting organisational data to support modernisation and resilience.	Director of Finance Stephen Rea (SG)	• Organisational Development and Culture • Subject and topic specific development. • Learning from others and sharing good practice.

NHS Orkney

Item 11.1

Audit and Risk Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Audit and Risk Committee	**Date of Meeting: 3 March 2026**
Prepared By:	Hazel Aim, Senior Corporate Governance Officer	
Approved By:	Jason Taylor, Chair Audit and Risk Committee	
Presented By:	Jason Taylor, Chair Audit and Risk Committee	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Audit and Risk Committee at its meeting on **3 March 2026.**		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. No matters of concern or key risks to escalate to the Board.	1. Director of Public Health invited to update the Committee on Business Continuity Risk 26 May 2026. 2. The Interim CEO to review enhancements in risk management with both the Medical Director and the Head of Patient Safety, Quality, and Risk; update to be presented at the meeting 26 May 2026. 3. Head of Corporate Governance to collaborate with the Board Chair to ensure a session is scheduled for the development of the Board Risk Appetite Statement.
Positive Assurances to Provide	**Decisions Made**
1. Committee noted and took assurance on the management of the Corporate Risk Register, acknowledging the progress on operational risk management arrangements. 2. Review of the Joint Clinical Care Governance Committee, Finance and Performance Committee, Remuneration Committee and Staff Governance Committee Workplans for 2026/27 meets the needs of the Boards Code of Corporate Governance. 3. Morbidity and Mortality Group update provided positive assurance that lessons learned are being embedded. 4. Standing Financial Instructions Waiver Report received and assurance on process noted. 5. Counter Fraud Services (CFS) Quarter 3 Report received and assurance provided in respect of both patient exemptions and National Fraud Initiative. 6. Re-assurance provided from Internal Auditors that good progress is	1. Approval of Audit and risk committee minute and Chairs Assurance Report 2 December 2026 2. Key estimates and judgements approved for the 2025/26 annual accounts. 3. Code of Corporate Governance version 20 for recommendation of approval by the Board at the 30 April 2026 meeting 4. Internal Audit 2023/24 following actions to be closed • Infection Prevention Control - addressing mandatory training rates • Business Continuity Planning - reporting of lessons learned. • Business Continuity Planning - evolving approach to Business Continuity Planning 6. Internal Audit 2024/25 actions to be closed • Sustainability action - clinical strategy to be removed

being made and on track to bring reports to 26 May 2006 meeting. 7. External Auditor re-assurance that audit work on track and draft audit plan to be presented to Committee 26 May 2026. 8. Internal Audit Recommendations 2023/24: 17 actions closed, 9 n progress, 2024/25: 25 actions closed, 7 in progress and 3 not yet due.	• Sustainability action - expanding the Chief Officers Group • Recruitment action - updating Recruitment and selection policy. 7. Internal Audit 2025/26 actions to be closed • Information Governance action - mandatory training. • Information Governance action - staff Serious Adverse Review information
Comments on Effectiveness of the Meeting	
• Members reflected on the chairing of the meeting, good attention to the relevant items on the agenda. • Quality of information received is improving year on year particularly the Internal Audit Report. • Committee is in a much more professional position in relation to the management of risk.	

NHS Orkney

11.2

Area Partnership Forum Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Area Partnership Forum	**Date of Meeting: 18 March 2026**
Prepared By:	Jade Rosie	
Approved By:	James Goodyear, Interim Chief Executive	
Presented By:	James Goodyear, Interim Chief Executive	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Area Partnership Forum at its meeting on **18 March 2026.**		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. Significant impact on staff due to rising fuel and heating costs linked to global events. Local staff experiencing increasing financial pressure. Risk of staff hardship and service impact. Work is underway to scope potential risk and impact, led by the DONMAHP. 2. The Financial Plan was discussed. Staff Side members felt they would only be able to scrutinise fully once more detail was provided. 3. UNISON launched national campaign highlighting the disparity between the Distant Islands Allowance paid to NHS Orkney staff compared with OIC staff, approximately £1,300 lower for NHS staff living on the same islands. The campaign has received national political attention and media coverage.	1. Details of 2026/27 savings schemes to be brought to the April meeting for discussion. 2. Short Life Working Group to be established to explore service and cost-of-living impacts of the ongoing crisis in the Middle East. Staff communications to be issued signposting available financial wellbeing support and resources. 3. Staff Side response to Financial Plan to be brought for discussion in April. 4. Further work to provide enhanced mileage data, subject to Payroll capacity, with an update scheduled for the April APF.
Positive Assurances to Provide	**Decisions Made**
1. Members were advised that Lawrence Green will be leaving NHS Orkney at the end of the month. The Forum expressed thanks for his significant contribution during his time with the organisation. 2. Continued progress with Band 5 Nurse Review submissions. 53 submissions have been received; 29 finalised, and further ongoing processing. 3. Reduced Working Week preparations progressing well in preparation for going live at the end of March. Members thanked Steven Phillips, Lewis Berston, Nathan Omand and Bruce Young for the amount of work they have carried out in relation to the RWW workload and data management.	1. The following policies will be circulated for consultation: • Medical Gas Policy • Fire Safety Policy • Ventilation Policy • Residential Accommodation Policy (subject to a more up-to-date draft being circulated). 2. A combined draft of the Security Policy and the Electronic Door Access Policy will be submitted to the April meeting for consultation. 3. The Forum will receive regular updates on the CSR and wider Improving Together work.

4. Operational People Group continues to strengthen, with productive discussions on absence management, RWW implementation, and improvements to corporate induction.	
Comments on Effectiveness of the Meeting	
•The meeting was well-attended, with active participation from members. •Agenda was completed efficiently, with clear decisions and actions agreed.	

NHS Orkney

Finance and Performance Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Finance and Performance Committee	**Date of Meeting: 25 February 2026**
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Melanie Barnes, Interim Director of Finance	
Presented By:	Fiona MacKay, Chair, Non-Executive Director	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Performance Committee at its meeting on **25 February 2026**		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. **Delayed Transfers of Care** - The number of patients experiencing delayed transfers of care (DTOC) continues to be a significant concern, with high levels now considered 'the norm'. The Chief Officer IJB and the Executive Director of Nursing, Midwifery and Allied Health Professions (EDoNMAHP) have been requested to develop and present a plan to improve system flow considering our specific demographic challenges. 2. **Financial Performance Month 10**: Whilst the forecast out-turn has improved from Month 10, Members acknowledged the ongoing risk of a Section 22 qualification if the financial plan is not delivered and the mitigations in place to manage this risk due to the confirmation from SG that no funding over and above the planned £2m transitional funding will be given.	1. Interim CEO will discuss Near Me by default with NHS Grampian's CEO 2. Medical Director to update Committee on GLP1 use at April 2026 meeting. **3.** EDoNMAHP to review the Risk 1225 (Social Care Capacity) prior to the upcoming Committee meeting. 4. Director of Performance and Transformation to confirm reporting cycle for the deep dive and medical Staffing action plan reporting to Committee.
Positive Assurances to Provide	**Decisions Made**
1. There has been a significant improvement in the Year To Date position at Month 10 which is predominantly due to the release of reserves by the Integration Joint Board. 2. At present, 70% of consultations make use of Near Me (Virtual appointments 3. Committee took assurance on the progress and mitigations presented on the latest Corporate Risk Register 4. Assurance provided on the priorities for 2026/27 from the Clinical Services Review. 5. A clear plan is in place for addressing the challenges associated with our current Medical Staffing Model.	1. Minutes and Chair's Assurance Report approved from meeting held 28 January 2025. 2. Code of Corporate Governance Standing Financial Instructions/Scheme of Delegation approved for onward approval by the Audit and Risk Committee.

6. The Subnational Planning and Delivery Committee (East) is advancing the development of the East of Scotland regional plan, with assurance given that a draft will be submitted to the Scottish Government by March 31, 2026 7. The committee received assurance on performance of the Corporate Strategy Delivery Plan for Quarter 3, Year 2.	
Comments on Effectiveness of the Meeting	
• One of the stronger Finance and Performance Committee Meetings • Agreed that the meeting should be extended to 3 hours • Astute discussions took place	

Item 11.3.2

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: 25 March 2026**
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Melanie Barnes, Interim Director of Finance	
Presented By:	Fiona MacKay, Chair, Non-Executive Director	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Performance Committee at its meeting on **25 March 2026**		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. **Month 11 Financial Performance**: Financial results have declined slightly compared to Month 10. Although the Board has approved the 2026/27 financial plan, there is still a need to achieve £3.865m in savings (about 4.5% of baseline RRL). The Board should be aware that failing to meet the financial plan may result in high delivery pressure and a Section 22 qualification, though measures are in place to help mitigate these risks. 2. **Robertsons Facilities Management Contract** - The Board continues to experience ongoing issues with the Robertsons contract, specifically related to staffing challenge and Planned Preventative Maintenance (PPMs). These concerns have been formally raised with NHS Assure for further review and support.	1. Interim Director of Finance to review the risk in relation to financial sustainability to assess whether it should be expanded as we move forward into 2026/27. 2. Interim Director of Finance to ensure Risks in relation to digital and Robertsons contract are included in the Corporate Risk Register update April 2026. 3. Interim Director of Finance to provide a further update at the April 2026 meeting on RFM contract and work undertaken on Planned Maintenance.
Positive Assurances to Provide	**Decisions Made**
1. Committee took assurance on the progress and mitigations presented on the latest Corporate Risk Register 2. Assurance provided that we will meet the requirements of our deficit support funding conditions from Scottish Government in 2025/26. 3. Committee supported continued engagement with Scottish Government and Scotland East partners to identify further opportunities for collaborative savings and service redesign 4. Assurance provided by the Improving Together Programme Board on our Efficiency Savings Programme 5. Assurance provided by the Planned Care Programme Board on our waiting times performance.	4. Minutes and Chair's Assurance Report approved from meeting held 25 February 2026. 5. Monthly highlight reports for each of the transformational priorities (Medical Staffing, Older People/Frailty, Isles Model of Care and Out of Hours GP's) to be presented to Committee. 6. Committee approved the 2026/27 Financial Plan for NHS Orkney for onward submission to the Board.
Comments on Effectiveness of the Meeting	
• Healthy and open discussions took place	

Item 11.4

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: 08 April 2026**
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Fiona Mackay, Vice-Chair and Non-Executive Board Member	
Presented By:	Fiona Mackay, Vice-Chair and Non-Executive Board Member	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Joint Clinical and Care Governance Committee at its meeting on **8 April 2026**		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. Due to staffing shortages, the Board cannot provide a safe ultrasound service. Risk assessments are completed, and weekly updates go to the Executive Management Team. Temporary support from NHS Shetland and a bank sonographer is in place, but a national shortage continues. NHS Grampian is assisting, and bringing in a radiologist is being considered.	1. Director of Public Health to bring an update on weight management services to the July 2026 JCCGC meeting noting a national position has not yet been agreed. 2. The Head of Patient Safety, Quality and Risk should ensure that Orkney Islands' Council is effectively managing the risk related to insufficient social care capacity and provide an update before the next meeting. 3. Chief Officer IJB to discuss the social care risk register's visibility at Committee with the Head of Children's Services. 4. The Interim Deputy Director of Nursing and Lead Midwife will present the Maternity External Review Action Plan to the Committee in July 2026.
Positive Assurances to Provide	**Decisions Made**
1. Assurance provided on the Corporate Risks aligned to the JCCGC. Paediatric Early Warnings Scores (PEWs) compliance has shown a month-on-month improvement. 2. Compliance with stage 2 complaints was celebrated as an area of improvement with thanks being offered to the Patient Safety and clinical Teams. 3. Following a deep dive, Maternity Early Warning Scores (MEWs) compliance is now at 100% 4. Assurance taken from the Chairs Assurance Reports (CARs) for Area Drugs and Therapeutics Committee (4 March), Infection Control Committee (4 February) Clinical Governance Group (10 March) and the Improving Together Programme Board (27 February).	1. Minute and Chairs Assurance Report of Meeting 4 February 2025 approved. 2. JCCGC Annual Report 2025/26 approved for onward submission to Audit and Risk Committee May 2026. 3. Realistic Medicine Year-end Report 2025/26 and Action Plan 2026/27 approved.

5. Committee noted the positive work being undertaken within the Public Health Service in relation to impact assessments as part of East Regional Planning which is being led by Orkney. 6. Funding has been awarded to implement the NASH sexual health system. 7. Members received assurance on the Realistic Medicine Year-end Report 2025/26 and Action Plan 2026/27. 8. Assurance provided through the Quarter 3 Safety, Quality and Experience Report 2025/26 9. Committee received assurance from the Quality Impact Assessment Quarterly Report. 10. Key reportable targets for treatment continue to be met in respect of waiting times for CAMHS, Psychological Therapies; access to treatment for substance misuse and post diagnostic dementia support. 11. Assurance provided on Mental Health Services. 12. Assurance provided through the Children's Health Assurance Update 13. Committee noted the progress being made in relation to the children's neuro developmental assessment pathway.	

Comments on Effectiveness of the Meeting

- Recurrent theme that critical items are rushed, there is a need to review the frequency of the JCCGC going forward.
- Excellent papers presented to Committee, supported in depth conversations.

NHS Orkney

Item 11.5.1

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

Title of Report:	Chair's Assurance report from the Senior Leadership Team	**Date of Meeting: 13 March 2026**
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Sam Thomas, EDoNMAHP/Chief Officer Acute	
Presented By:	James Goodyear, Interim CEO	

Purpose

The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on **Friday 13 March 2026.**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. **Financial Position Month 10**: Performance improved notably by Month 10. SLT were reminded to submit all orders, invoices, and commitments to finance. Transitional funding from the Scottish Government will enable a balanced year-end, preventing a Section 22 from Audit Scotland.	1. Population Health Framework Update and Priority Focus – the 3 areas of focus for Orkney are healthy weight, brain health and equalities. Improvement plan for each of the priorities are being developed for with governance via the Joint Clinical Care Governance Committee and Community Planning Partnership. 2. Head of Corporate Governance to circulate feedback from self-effectiveness discussion to SLT to inform the review of Senior Leadership Team's Terms of Reference.
Positive Assurances to provide	**Decisions Made**
1. The Corporate Risk Register has been updated in accordance with our Risk Management Strategy, ensuring the latest information is available to Governance Committees. 2. Positive assurance provided on the Reduced Working Week Implementation Plan which will go live Monday 30 March 2026. 3. Corporate Strategy Year 2 Quarter 3 update: delivery is progressing well. 4. SLT welcomed sight of the MRI High Level Business Case 5. Engagement with the Improvement Team to identify savings schemes for 2026/27 has been positive and well received by those who have participated. 6. The Swan2 migration has been successfully completed and is now fully operational.	1. Minutes and Chair's Assurance Report approved from meeting held on 12 January 2026. 2. Following policies approved following approval by clinical advisory groups • NHSO Resuscitation, life support and trauma training Policy • First Aid Policy

Feedback about meeting

- Open, honest frank conversations took place in relation to the effectiveness of the Senior Leadership Team
- Well attended, appropriate time allocated to discussion items on the agenda

Item 11.5.2

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

Title of Report:	Chair's Assurance report from the Senior Leadership Team	**Date of Meeting: 1 April 2026**
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	James Goodyear, Interim CEO	
Presented By:	James Goodyear, Interim CEO	

Purpose

The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on Wednesday **1 April 2026.**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. No matters of concern or key risks to escalate.	1. Public Sector Reform - A stakeholder session for NHS Orkney, Orkney Islands Council, the Integration Joint Board, and senior leaders is scheduled for 8 June 2026 at St Magnus, to update on progress and begin co-designing Orkney's Routemap to Reform.
Positive Assurances to provide	**Decisions Made**
1. Senior Leaders took time to celebrate successes achieved over the past 12 months particularly in relation to • Planned care performance • Performance Review Meetings • Feeling of positivity and collaboration • The number of Daisy Awards received from the public • There being a culture of being a better partner • Work undertaken in pharmacy, • Embedding realistic medicine across the organisation 2. Positive assurance provided via the Integrated Performance Report (April 2026). This includes • Continuing to exceed national targets for timely access to CAMHS and Psychological Therapies Services • Improvements in our cardiological diagnostics six-week compliance target. Our performance is currently 96.65% • Adherence to the 12-hour standard remains robust at 99.66%,	1. Minutes and Chair's Assurance Report approved from meeting held on 13 March 2026 2. Refreshed Terms of Reference for the SLT approved for onward assurance to the Board in April 2026 3. Optima roll out approved across all clinical areas.

• 100% compliance against both the 31-day and 62-day standards in the latest reporting period. 3. Assurance provided on the roll-out of Optima following a pilot on inpatient 1. Governance for the roll out will be via the Operational People's Group. 4. SLT discussed and welcomed the East of Scotland sub-regional plan and the implications on service delivery.	
Feedback about meeting - SLT agreed it would be helpful to have a theme for meetings going forward	

NHS Orkney

Item 11.6

Staff Governance Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Staff Governance Committee	**Date of Meeting: 12 February 2026**
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Joanna Kenny – Chair	
Presented By:	Joanna Kenny – Chair	

Purpose

The report summarises the assurances received, approvals, recommendations and decisions made by the Staff Governance Committee at its meeting on **12 February 2026**.

Matters of Concern or Key Risks to Escalate

1. The risk associated with insufficient senior capacity and leadership is being actively managed. An Interim Director of Finance will join the Board on 16 March 2026, and discussions with the Scottish Government regarding the recruitment of a substantive Chief Executive Officer are ongoing.
2. Appraisal rates remain an issue. To address this, the Director of People & Culture is introducing a three-month period (April - June) for managers to complete staff annual appraisals.
3. The number of staff participating in face fit testing has decreased. EDoNMAHP is working with the Infection Control team to improve engagement and increase participation.

Major Actions Commissioned / Work Underway

1. Integrated Performance Report – Director of People & Culture and Director of Performance and Transformation are meeting to review workforce indicators presented in the IPR. Update to be brought to the next meeting.
2. Use of Bank/agency staff – an analysis of bank/agency usage and staffing establishments are being undertaken by the Area Partnership Forum - assurance will be provided to Committee 14 May 2026 meeting.
3. Lack of resuscitation training – EDoNMAHP taking this forward with Senior Charge Nurses, assurance to be provided by the Operational People Group.
4. The Director of People and Culture is overseeing the development of a consolidated 'People' Plan that will include the Your Employee Journey Programme.
5. Interim CEO to meet with the Medical Director and EDoNMAHP to discuss concerns about insufficient medical staff involvement in the Board Level Clinicians' Internal Healthcare Staffing Compliance Report for Year 2, Quarter 3.
6. Director of People and Culture is developing a full Business Case for the Education and Improvement focusing on the wider impacts and engagement with all stakeholders.

Positive Assurances to Provide

1. General Practice now codes veterans when seeing patients, and this information is passed to Secondary Care as part of our commitment to the Armed Forces Veteran Covenant.
2. The Committee completed all actions in the action log before the meeting, showing its growing maturity.
3. Positive assurance provided by the Operational People Group and the Area Partnership Forum Chair's Assurance Reports.
4. Committee acknowledged the Integrated Performance Report noting work underway to review workforce Key Performance Indicators.
5. Positive assurance provided on some improvement on Health and Safety compliance.

Decisions Made

1. Minutes and Chairs Assurance Report from meeting 3 December 2025 approved.
2. Quarter 3 Whistleblowing report approved for submission to the INWO and for publication on the Boards Website.
3. Board Level Clinician(s) Internal Healthcare Staffing Compliance Report Year 2 Quarter 3 approved for onward submission to Healthcare Improvement Scotland
4. Committee Business Cycle and Workplan 2026/27 approved.

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

NHS Orkney

Item 12.1

Integration Joint Board (IJB) Key Items and Discussions

Meeting	**NHS Orkney Board**
Meeting date	Thursday, 30 April 2026
Responsible Executive/ Non-Executive	• Stephen Brown, Chief Officer IJB
Report Author(s)	• **Stephen Brown, Chief Officer IJB**.
Purpose of report	• Assurance
Contribution to Strategic ambition	• Government policy/directive • Local policy • NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Person Centred
Key points for consideration	• The report gives a brief overview of the agenda and discussion at the Integration Joint Board Meeting on 18 February 2026 and 22 April.
Route to meeting	• Not applicable.
Recommendation(s)	• Assurance - For members assurance only

Integration Joint Board (IJB) Key Items and Discussions

Stephen Brown, Chief Officer
22/04/2026

1. Situation

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

2. Background

2.1 Integration Joint Boards arose from the Public Bodies (Joint Working) (Scotland) Act 2014 which required integration of certain aspects of adult health and social services. As well as prescribed functions that had to be delegated additional functions could be included and these are captured in the Integration Scheme.

2.2 Since the last report there has been a meeting of the Integration Joint Board on 18 February and 22 April 2026.

3. Assessment

3.1 **Key Points** from **the February 2026 meeting include:**

i The Integration Joint Board received a report on the Revenue Expenditure Monitoring for the period to 31 December 2026. It was noted that the year end position in relation to NHS Orkney commissioned services is an underspend of £974k as the £2,400k historic savings target had now been stripped out. In respect of Set Aside, Members were advised that an additional £1,328k budget had been required to match the actual spend. Of the full year projected variance on delegated services (£2,006k), there was a £1,194k underspend on NHS Orkney commissioned services.

ii The Board approved the principle of the utilisation of the fourth wing (Brinkies) at Hamnavoe House as a dedicated 10 bed short breaks facility. Once financial and staffing resources be secured, the Board approved that the short breaks provision current at Hamnavoe House, Smiddybrae House and St Rognvald House and/or Kirkjuvagr House be allocated as permanent places. A report will be taken back to the Board for approval once funding has been identified.

iii Members noted significant progress made in stabilising the Community Nursing Service staffing and leadership and the planned development of an integrated mainland Community Nursing structure. The Board agreed to support continued

investment in training, development and skill-mix changes to improve services resilience in the service and endorsed the ongoing work to review compensatory rest arrangements in line with national guidance. It was agreed that a report would be taken back to the Committee once the full establishment review had been completed.

iv Following a report on Distress Brief Interventions, following an amendment the Board approved funding the service for an additional two years during which recurring funding should be secured. It was agreed that the draft Direction would be amended before submitting to NHS Orkney. Following discussion, it was also agreed that Officers would provide referral numbers from isles GPs, that an exit strategy is developed and a select test pilot with mainland GP practice be undertaken to gauge level of referrals.

v The Integration Joint Board received a report on the Kirkwall Care Facility progress. The report advised that the Care Inspectorate had undertaken an inspection and will provide formal feedback once the Completion Certificate has been issued. It was also noted that service commissioning and familiarisation tasks are continue apace.

vi The Performance Management Framework was presented for approval for the period 2026 to 2028, which would be in line with the new Strategic Plan cycle. Members requested that in future iterations include further information could be included such as capturing governance routes. Following a query in relation to third sector information and the use it was agreed that Officers would revert to the Board.

vii Members received a report on the annual Climate Change Duties for the Integration Joint Board alongside the returns from both NHS Orkney and Orkney Islands Council.

viii The Integration Joint Board received a report in private in relation to the Primary Care Improvement Plan. Following discussions, it was agreed that a further report would be presented to the June Board meeting.

3.2 Key Points from **22 April 2026 meeting include:**

i The Board approved the Joint Clinical and Care Governance Committee Work Plan for the period 2026/27. It was suggested that it would be helpful to have a list of acronyms which accompanies the Work Plan for ease of readers.

ii The Integration Joint Board had a report presented in respect of the Financial Recovery Plan and Budget. Following an in-depth discussion the Financial Recovery Plan and budget were approved.

iii Following a report on the appointment of Internal Audit, the Integration Joint Board approved the Council's Chief Internal Auditor to be the Board's Chief Internal Auditor for a period of two years.

iv The Board was presented a report on Governance, which included Role Descriptors, Induction for Integration Joint Board Members and Sub-Committees of the Integration Joint Board, which was approved.

v The Strategic Plan Delivery Plan 2026/27 was presented to Members for approval. The annual plan details the Milestones and Actions which will be carried out in the second year of the Strategic Plan 2025 – 2028. Pending some amendments to address Members comments and questions, the Strategic Plan Delivery Plan 2026/27 was approved and agreed the amended document would be issued to Members via briefing note.

vi The Integration Joint Board approved the revised Financial Regulations for the period 2026 to 2029.

vii Members approved the revised Reserves Policy for the period 2026 to 2029.

viii The Integration Joint Board approved the Market Facilitation Statement for the period 2026 to 2028, noting that on this occasion the period was two years to enable this to align to the Strategic Plan cycle.

ix An update on the progress in implementing the Records Management Plan 2024 was provided to Members and the revised Records Management Plan for the period 2026 to 2028 was approved.

x Members noted a report on the Subnational Planning and Delivery Committee (East) Update.

xi Members received a report the first Annual Unpaid Carers Update which provided a breakdown of the progress of actions contained within the Orkney Unpaid Carers Strategy, the Strategic Plan Delivery Plan 2022 – 2025 and the Strategic Plan Delivery Plan 2025/26.

3.3 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	The Integration Joint Board aims to improve quality of care through joined up provision of services.
People	Workforce	No	There are no workforce implications directly arising as a result of this report.
Performance	Finance	No	There are no financial implications directly arising as a result of this report. There are close links between NHS Orkney's finance department and the Chief Officer and Chief Finance Officer.
Potential	Risk Management	No	There are no risk implications directly arising as a result of this report.
	Digital	No	There are no digital implications directly arising as a result of this report.

Place	Equality and Diversity including health inequalities	No	There are no equality or diversity implications directly arising as a result of this report.
	Climate Change Sustainability	*No*	There are no climate change implications directly arising as a result of this report.

4. Recommendation

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

5. Appendices

There are now appendices included with the report.

NHS Orkney

Item 12.2

Community Planning Partnership Key Items and Discussion

Meeting	**NHS Orkney Board**
Meeting date	Thursday, 30 April 2026
Responsible Executive/ Non-Executive	• Stephen Brown, Chief Officer IJB
Report Author(s)	• Stephen Brown, Chief Officer IJB
Purpose of report	• Assurance
Contribution to Strategic ambition	• Annual Operational Plan • Legal requirement • Local policy
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Person Centred
Key points for consideration	• The report gives a brief overview of the agenda and discussion at the Community Planning Partnership Meeting on 23 March 2026.
Route to meeting	• Not applicable.
Recommendation(s)	• Assurance - For members assurance only

Community Planning Partnership Key Items and Discussion

Stephen Brown, Chief Officer IJB
15/04/2026

1. Situation

1.1 NHS Orkney is a member of the Community Planning Partnership known locally as the Orkney Partnership Board, and this paper aims to provide members with an update of key issues being considered by the Orkney Partnership Board at its last meeting. Since the last report there has been a which was held on 23 March 2025.

2. Background

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

3. Assessment

3.1 Key Highlights from the March 2026 meeting include:

i Members received a presentation on the work of the Workforce North. It was noted that Workforce North was established following a Convention of the Highlands and Islands decision in Autumn 2024. It was established in response to the potential workforce demands from the once in a generation investment opportunity in renewables and infrastructure projects across multiple sites in the Highlands and Islands. Workforce North proposes a new way of working with industry and public partners collaborating to expand the regional workforce through a system-wide place-based approach.

ii Following a discussion on the new Locality Plan 2026-2028, Members agreed that a workshop would be arranged to explore locality plan options in detail. It was also agreed that a paper would be brought to the next Community Planning Partnership meeting outlining options and recommendations.

iii Members were provided an update on Orkney Matters 2 noting that work is underway to produce updated ‘You Said / We Did” outputs. It was agreed that a full report would be presented at a future meeting.

iv The chair provided an update to members on the Public Sector Reform and advised that a joint workshop with NHS Board, Integration Joint Board and Elected Members is scheduled for June 2026.

v An update was provided was provided from the Transformational Opportunities Group. It was advised that the Group had been created to coordinate early engagement with major renewable energy developers.

vi Members were advised that Section 10 duty in the Good Food Nation Plan was expected to be triggered in April 2027 with a plan needing to be produced within 12 months.

vii Members were provided an update on the Third Sector Working Group with updates from Advocacy Orkney, Relationship Scotland Orkney, Orkney Rape and Sexual Assault Services, THAW Orkney and Crossroads Care Orkney including Orkney Young Carers.

viii Following discussions, members approved a governance review paper being brought to the next meeting which would include CLD representation and the wider Community Planning Partnership structure.

3.2 Impact Assessment

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

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

4. Recommendation

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

5. Appendices

There are no appendices included with the report.

NHS Orkney

Item 13.1

Update on Equality Outcomes for 2026-2029

Meeting	**NHS Orkney Board**
Meeting date	Thursday, 30 April 2026
Responsible Executive/ Non-Executive	• Dave Harris, Director of People and Culture
Report Author(s)	• Dave Harris, Director of People and Culture
Purpose of report	• Decision
Contribution to Strategic ambition	• Corporate Strategy 2024/28 • Annual Operational Plan • Emerging Issue • Government policy/directive • Legal requirement • Local policy • NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred
Key points for consideration	• **Statutory compliance and assurance -** Approval of the Equality Outcomes for 2026–2029 is required to meet NHS Orkney's statutory duties under the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012. As the previous outcomes have expired, agreement at this point is necessary to restore compliance and reduce governance and reputational risk. • **Strategic focus and proportional ambition -** The three proposed Equality Outcomes provide a clear and proportionate strategic framework, focusing on workforce inclusion and culture, reducing inequalities in access and outcomes within Orkney's island context, and strengthening NHS Orkney's approach to anti-discrimination, leadership and equality impact assessment. The outcomes reflect Board feedback and balance ambition with organisational capacity. • **Deliverability and next steps -** While consultation has been completed with little feedback received, delivery will require prioritisation, ownership and integration into existing planning and governance arrangements. Establishing a Short Life Working Group is proposed to translate the approved outcomes into a realistic, monitored action plan, providing assurance on delivery without creating additional structural burden.
Route to meeting	• Executive Team Meeting 16 February 2026 • Public Board Meeting 26 February 2026
Recommendation(s)	• **Decision - Reaching a conclusion considering the options**

Update on Equality Outcomes for 2026-2029

Dave Harris
27/03/2026

1. Situation

1.1 This paper provides the Board with an update on progress since the February 2026 Board discussion on NHS Orkney's proposed Equality Outcomes for 2026–2029.

1.2 It summarises actions taken since that meeting, including public and internal consultation on the draft Equality Outcomes, and sets out proposed next steps to move from agreed outcomes to delivery.

1.3 The paper seeks Board approval of the proposed Equality Outcomes and support for the establishment of a Short Life Working Group (SLWG) to translate the approved Equality Outcomes into a prioritised, realistic delivery plan aligned to existing governance and planning arrangements.

2. Background

2.1 NHS Orkney is required, under the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, to publish a set of Equality Outcomes every four years demonstrating how the organisation will meet the Public Sector Equality Duty (PSED).

2.2 In February 2026, the Board considered a draft set of three Equality Outcomes for 2026–2029, developed to meet NHS Orkney's statutory duties.

2.3 The Board discussed the strategic focus, ambition, deliverability and governance of the proposed outcomes and supported further engagement prior to finalisation and approval.

2.4 Board feedback emphasised:

- the importance of meaningful consultation and involvement
- the need for outcomes to be ambitious but deliverable within NHS Orkney's scale and capacity
- clarity on how outcomes would be translated into practical actions with clear ownership

3. Assessment

3.1 Actions Taken Since February Board

3.1.1 Public Consultation

Following the February Board discussion, NHS Orkney published the draft Equality Outcomes 2026–2029 for public comment, inviting feedback on:

- the three proposed Equality Outcomes
- the associated deliverables and areas of focus

The consultation was promoted through NHS Orkney's website and existing engagement channels, with comments invited from staff, patients, partners and the wider community. To date, one instance of substantial internal feedback has been received, and this has been incorporated where possible into the outcomes.

3.1.2 Refinement of Outcomes

Prior to circulation for consultation the draft Equality Outcomes were updated to reflect Board feedback as much as possible.

The three Equality Outcomes, as consulted upon, are:

- **Outcome 1:** NHS Orkney becomes a more inclusive, safe, and respectful workplace for all colleagues and patients, advancing equality of opportunity between persons who share a relevant protected characteristic and those who do not.
- **Outcome 2**: Improved health outcomes and access for groups experiencing disadvantage in Orkney's island setting.
- **Outcome 3:** NHS Orkney continues to make progress in becoming an anti-discrimination organisation.

Appendix 1 sets out the full Equality Outcomes for 2026–2029.

3.1.3 Moving from Outcomes to Action

While the Equality Outcomes set the strategic direction (the 'what'), it is acknowledged that further work is required on the 'how' in order to:

- prioritise deliverables
- identify clear ownership
- integrate actions into existing plans and performance frameworks
- ensure progress can be measured and reported transparently
- address the capacity challenge identified in the February report

It is therefore proposed that a Short Life Working Group (SLWG) be established to lead this next phase by 30th June 2026. Membership would be drawn from a minimum of:

- People & Culture
- Public Health
- Service and clinical representation
- Colleagues with lived-experience
- Staff-side / partnership colleagues

The SLWG would operate on a time-limited basis, reporting through the Staff Governance Committee, with progress and outcomes reported to the Board.

The SLWG will produce a delivery plan which sets out:

- Outputs
- Deliverables
- Timescales
- Owners

Each Executive Director will also be given a specific appraisal objective in relation to the delivery of the Equality Outcomes.

3.1.3 Anti-Racism Requirements

In September 2024, Scottish Government issued guidance (DL23 (2024)) requiring NHS Boards to develop and deliver anti-racism plans covering both workforce experience and equity-focused service delivery. NHS Orkney has adopted a proportionate approach to this requirement, embedding anti-racism activity within existing governance, statutory equality planning and organisational strategies rather than developing a standalone plan.

The Equality Outcomes for 2026–2029 provide NHS Orkney's primary mechanism for meeting these national anti-racism expectations alongside wider Public Sector Equality Duty requirements. Delivery of the Equality Outcomes, including anti-racism commitments, will be overseen through existing governance arrangements, with the proposed Short Life Working Group supporting prioritisation and integration of actions, and progress reported through the Staff Governance Committee and to the Board.

3.2 Impact Assessment

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

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

4 Recommendation(s)

Decision – Reaching a conclusion after the consideration of options.

4.1 It is recommended that Board:

- Note the actions taken since the February 2026 Board meeting, including public consultation on the draft Equality Outcomes.
- Approve the publication of the updated Equality Outcomes for 2026–2029.
- Approve the establishment of a Short Life Working Group to translate the Equality Outcomes into a deliverable action plan. Action plan updates will be submitted via Staff Governance Committee with a formal update report on progress to Board by mid-2027.

5 List of appendices

The following appendix is included with this report:

5.1 **Appendix 1,** Equality Outcomes 2026-2029

Appendix 1 - NHS Orkney Equality Outcomes 2026–2029

NHS Orkney is sharing our **draft Equality Outcomes for 2026–2029** and we want to hear your views. These outcomes set out what we aim to improve for our patients, our workforce and our communities over the next three years.

We are specifically asking for comments on:

- the **three proposed Equality Outcomes**, and
- the **deliverables** (the actions we plan to take to achieve them).

Your feedback will help us ensure these commitments reflect the needs, experiences and priorities of people across Orkney.

Please send your comments to: ORK.feedback@nhs.scot

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1. Introduction

Every four years, NHS Orkney must publish new Equality Outcomes under the Equality Act 2010 (Specific Duties) (Scotland). These outcomes help us fulfil our duties to:

- eliminate unlawful discrimination,
- advance equality of opportunity, and
- foster good relations between people.

Our draft outcomes for 2026–2029 draw on:

- progress and challenges from the past reporting cycle (2021–2025),
- what we know about health and workforce inequalities in Orkney, and
- our organisational priorities and capacity.

We aim for commitments that are ambitious but deliverable, realistic for an island health board, and aligned with our Corporate Strategy 2024–28.

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2. Background and Context

Legislative Framework

The outcomes are based on:

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

Strategic Alignment

Our Equality Outcomes support NHS Orkney's strategic priorities, including:

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

Organisational Reality

NHS Orkney has limited specialist Equality, Diversity and Inclusion (EDI) capacity. This means equality must be mainstreamed across the organisation, with clear expectations, realistic commitments and shared responsibility.

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3. Progress Since 2021

What has gone well

- Continued delivery of EDI-related training.
- Annual workforce monitoring on key characteristics (e.g., ethnicity, sex, disability, age).
- Improvements in some data completeness (notably disability and sexual orientation).
- Better equal pay reporting and occupational segregation analysis.

What we need to improve

- Some equality outcomes have remained unchanged since 2017.
- Equality Impact Assessments (EQIAs) must be used more consistently and meaningfully not as a "tick-box" exercise.
- Stronger performance management and clearer ownership are required.
- Leadership behaviours and organisational culture need continued focus.
- Better measures are needed to track progress.
- Governance arrangements require strengthening.

- Line managers need clearer tools and guidance.
- Data quality must improve, particularly ethnicity and disability declarations.

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4. Evidence Base for the New Outcomes

Workforce Inequalities

Key challenges include:

- A predominantly White workforce reflecting local demographics, limiting lived experience of racial diversity and organisational confidence on anti-racism.
- Low disability declaration rates, restricting understanding of staff needs.
- An ageing workforce, affecting sustainability and recruitment.
- Ongoing issues around speaking up, inclusion and staff experience.

Patient and Population Inequalities

Key themes include:

- Orkney's ageing population.
- Barriers linked to island geography, travel, access to specialists and rural isolation.
- Limited consultation in the previous cycle, highlighting the need for stronger engagement with patients and communities.

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5. Proposed Equality Outcomes for 2026–2029

Below are the three draft outcomes and their associated deliverables.

Outcome 1: NHS Orkney becomes a more inclusive, safe, and respectful workplace for all colleagues and patients, advancing equality of opportunity between persons who share a relevant protected characteristic and those who do not.

Deliverables

- Improve the quality and completeness of workforce Equality, Diversity, Inclusion (EDI) data through a joint campaign with trade unions.
- Reduce incidents related to harassment or discrimination.
- Increase participation in EDI training (including anti-racism and cultural humility).
- Establish a staff network.
- Provide Mentally Healthy Workplaces training locally.
- Apply Living Wage considerations to regulated procurement.
- Contribute NHS Orkney data to local gender pay gap research.
- Strengthen use of the NHS Orkney behavioural framework and values, with improvements in iMatter results.
- Improve staff survey results on bullying, speaking up and team working.

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

Deliverables

- Make better use of existing engagement channels with communities.
- Improve access indicators (waiting times, screening uptake, digital access, complaints).
- Carry out equality impact assessments for Type 2 Diabetes and cardiovascular disease services.
- Develop frailty prevention activities that consider the needs of ferry-linked isles.
- Establish consistent follow-up processes for non-attenders with learning disabilities or autism in Primary Care.
- Embed reasonable adjustments across all Orkney screening services.
- Explore barriers and facilitators to breast screening uptake among eligible women in Orkney.

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

Deliverables

- Deliver anti-racism education for staff and leaders.
- Publish NHS Orkney's anti-racism commitments.
- Improve race-related staff experience reporting.
- Provide sexual harassment in the workplace training.
- Embed anti-racism planning in the Annual Delivery Plan cycle.
- Deliver the National Framework for Spiritual Care.
- Review and strengthen the EQIA process, including monitoring of key actions.

NHS Orkney

Item 13.2

Agenda for Change Reform update- Reduced Working Week

Meeting	NHS Orkney Board
Meeting date	Thursday, 30 April 2026
Responsible Executive/Non-Executive	• Dave Harris, Director of People and Culture
Report Author(s)	• Steven Phillips, Head of People and Culture
Purpose of report	• Assurance
Contribution to Strategic ambition	• Government policy/directive
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred
Key points for consideration	• Implementation of the Reduction in the Working Week (RWW) has been undertaken across NHS Orkney, with services implementing the 36-hour week model. • 319 part-time colleagues retained their pre-1 April 2026 hours. • A review of the reduced working week will be planned by the RWW SLWG.
Route to meeting	• Direct to Board 30 April 2026
Recommendation(s)	• **Assurance - For members assurance only**

Agenda for Change Reform update - Reduced Working Week

1. Situation

1.1 NHS Orkney has implemented the national Reduction in the Working Week (RWW) to a 36-hour standard, in line with Scottish Government policy. Work has been underway across the organisation, with local plans to support phased implementation. Partnership working with recognised Trade Unions has supported the delivery. Board is asked to take assurance that the implementation of this has delivered the plan, and that work will continue to review the implementation, particularly as the department and those colleagues continue to deliver their services.

2. Background

2.1 The Scottish Government confirmed the reduction in the standard working week for Agenda for Change (AfC) staff from 37.5 to 36 hours as part of the wider pay review and workforce reform programme. This phased approach began in April 2024 with an initial reduction to 37 hours and will conclude with full implementation by April 2026.

2.2 NHS Orkney established a Reduced Working Week (RWW) Oversight Group to ensure robust governance and partnership working throughout the process. The group reported to the Area Partnership Forum (APF) and Staff Governance Committee, with regular updates provided to the Senior Leadership Team and the Executive Team for assurance and the final approval of the plan.

2.3 Directorates submitted detailed assessments of the operational impact of the reduction, including service redesign proposals, retention of part-time hours, and backfill requirements. These assessments highlight significant variance across services, with frontline and 24/7 areas facing the greatest challenges in maintaining safe staffing levels. Financial modelling and workforce planning have been reviewed to ensure compliance with the Health and Care (Staffing) (Scotland) Act 2019.

3. Assessment

3.1 Analysis

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

Services across the organisation created plans to support the transition to a 36-hour working week. Engagement with recognised Trade Unions was continuous to ensure that the implementation approach was developed in partnership.

3.2 Current Position

All services have implemented their locally developed plans to deliver the reduced working week. All plans received approval from the Executive Directors on Monday 26 January 2026, allowing managers to progress their local plans. A further meeting also took place with partnership colleagues on Wednesday 4 February 2026, to discuss the plans teams across the organisation had created.

In line with the criteria set out, those part-time colleagues who were to retain their original hours were identified. It was confirmed that some of the colleagues had decided not to retain their hours. However, several additional departments also saw an increase in requests to retain part-time hours. This led to a further review by the Executive Directors, who confirmed that these additional departments met the criteria to retain the part-time hours and should be included, as they were deemed critical to service delivery.

As a result of the inclusion of additional departments and the identification of colleagues who no longer wish to retain their part-time hours, the table below shows the number of colleagues who retained hours and the equivalent WTE across each directorate. This total is a reduction from the previously anticipated 6.30 WTE in the plan presented to the Board in February 2026.

	Headcount	WTE
Chief Executive (div)	1	0.01
Chief Officer (div)	84	1.58
Director of Finance (div)	66	1.04
Director of Nursing & AHP and Acute Services (div)	146	2.73
Director of Performance Transformation and Deputy CEO (div)	5	0.08
Director of Public Health (div)	1	0.01
Medical Director (div)	16	0.29
Grand Total	**319**	**5.75**

As well as identifying colleagues to retain hours, managers have also been undertaking recruitment to backfill across the departments. This has been led at a local level, with teams taking a number of different approaches, including part-time colleagues increasing their hours and recruiting internally and externally. Where external recruitment processes have been

undertaken, it is known that some candidates are yet to join, and teams have taken the appropriate steps to ensure adequate cover is in place.

The total reduction in hours across the organisation for Agenda for Change colleagues, as a result of the working week reduction, was 15.86 WTE. As an organisation, we have approved 5.75 WTE to be retained by part-time colleagues and 5.53 WTE to be recruited. This is a total of 11.28 WTE, which represents 71% backfill of the reduction across Agenda for Change colleagues.

3.3 Review Process

As the implementation has only just been achieved, it is too early to assess the wider implications of the reduced working week for service delivery. However, the short-life working group will undertake a review across services at the six-month stage. This will provide managers with an opportunity to review their approach and provide feedback, and, in particular, will give us an opportunity to understand whether NHS Orkney has been able to achieve the ambition of the reduced working week by taking into account service requirements whilst supporting the aim of an effective work-life balance and flexibility within the working week. This will be reported via the Staff Governance Committee.

3.4 Impact Assessment

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

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

Place	Equality and Diversity including health inequalities	No	NA
	Climate Change Sustainability	No	NA

4. Recommendations

Note the delivery and achievement of teams in implementing the national Reduction in the Working Week (RWW) across NHS Orkney, whilst taking assurance that services have implemented their plans to deliver the reduced working week.

4.1 Assurance - For members assurance only

5. List of Appendices

5.1 No Appendices attached.

NHS Orkney

Item 13.3

Year 2 Annual Report – Health and Care (Staffing) (Scotland) Act 2019

Meeting	**NHS Orkney Board Meeting**
Meeting date	Thursday, 30 April 2026
Responsible Executive/Non-Executive	• Dave Harris, Director of People and Culture • Sam Thomas, Executive Director of Nursing, Midwifery & AHPs / Chief Officer Acute Services • Anna Lamont, Medical Director • Louise Wilson, Director of Public Health
Report Author(s)	• Dave Harris, Director of People and Culture • Sam Thomas, Executive Director of Nursing, Midwifery & AHPs / Chief Officer Acute Services • Anna Lamont, Medical Director • Lynn Adam, Clinical Lead for Workforce
Purpose of report	• **Assurance**
Contribution to Strategic ambition	• Corporate Strategy 2024/28 • Annual Operational Plan • Government policy/directive • Legal requirement • NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred
Key points for consideration	• Legislative requirement for NHS Boards to publish and submit an annual report to Scottish Ministers by 30 April each year[1]. • Second year of reporting under the Act which applies to 808 staff (389.14 WTE), 70.6% of the workforce, including Integrated Joint Board personnel employed by NHS Orkney. • Reasonable Assurance

[1] The annual report is also requested by the Scottish Patient Safety Commissioner and Healthcare Improvement Scotland Healthcare Staffing Programme.

	• Workforce planning is challenged by both vacancies and financial pressures, resulting in the freezing of some posts. • The Common Staffing Method (CSM) was followed at the required frequency by only 17.39% of relevant healthcare types, largely due to leadership and structural constraints. • Efforts to integrate patient quality and safety data with staffing information are ongoing, but full implementation has not yet been achieved at local levels. Board-level integration is supported by clinical governance and specific programmes for nursing and midwifery.
Route to meeting	• Staff Governance Committee
Recommendation(s)	• **Assurance** – For members assurance only

Year 2 Annual Report – Health and Care (Staffing) (Scotland) Act 2019

1. Situation

1.1 Health Boards are required under the Health and Care (Staffing) (Scotland) Act 2019 to produce and publish an annual report, including any functions delegated to Integration Authorities. The report, covering all NHS functions and professional disciplines for the period from 1 April to 31 March, must be submitted to the Scottish Ministers by 30 April each year. It outlines how Boards have fulfilled their statutory duties, ensuring comprehensive accountability and transparency in healthcare staffing and related functions (Appendix 1).

2. Background

2.1 The Act, effective from 1 April 2024, is a Scottish Government measure responding to the Francis Report, Vale of Leven and Morecambe Bay inquiries, and other major policy initiatives. Its goal is to provide NHS Boards, clinical leaders, and service users with practical tools for measuring and enhancing the impact of clinical and social care across all professions. The Act aims to ensure that appropriately skilled staff are available in the right areas at the right times, improving outcomes for patients and service users while also promoting staff wellbeing.

2.2 Section 12IM of the Act mandates relevant organisations to publish and send an annual report to the Scottish Ministers outlining how they have fulfilled their duties under specific sections of the Act:

- 12IA: Duty to ensure appropriate staffing (including related responsibilities in section 2 of the Act);
- 12IC: Duty to maintain real-time staffing assessments
- 12ID: Duty to have processes for escalating risks
- 12IE: Duty to address severe and recurring risks
- 12IF: Duty to seek clinical advice on staffing matters
- 12IH: Duty to give clinical leaders enough time for their roles
- 12II: Duty to provide proper staffing training
- 12IJ and 12IL: Duty to use the common staffing method, including staff training and consultation.

2.3 The annual report must also discuss any challenges or risks encountered in meeting these duties and detail the steps being taken to resolve them.

2,4 Section 2(1) of the Act directs relevant organisations to follow the guiding principles for health and care staffing when meeting their obligations under section 12IA (Duty to ensure appropriate staffing). Section 2(3) requires these organisations to submit annual information to the Scottish Ministers detailing their compliance with this requirement, and Section 2(4) states that this must include evidence of how these actions have improved services for users.

2.5 Additionally, Section 2(2) requires organisations arranging healthcare through third parties under the 1978 Act to consider the guiding principles in section 1 and ensure third parties have suitable staffing arrangements. Sections 2(3) and 2(4) also require annual reports to the Scottish Ministers on these actions and their positive outcomes for service users (Appendix 1).

3. Assessment

3.1 The Scottish Government Annual Report template requires Health Boards to confirm adherence to the Act (see Appendix 1). NHS Orkney provides reasonable assurance, which marks progress compared to Year 1.

1.3.1.1 How the information provided in this report has been used or will be used to inform workforce plans,

1.3.1.2 The Act covers 808 employed staff (389.14 WTE), an increase of 10 (7.89 WTE) from Y2 Q2, accounting for 70.6% of the total workforce, including personnel within the Integrated Joint Board where NHS Orkney remains the employer.

1.3.1.3 Workforce planning is a capacity issue due to vacancy and financial pressures across the organisation, including the freezing of some vacancies.

1.3.1.4 The Common Staffing Method (CSM) was followed at the required frequency by 17.39% of the six types of health care listed in duty 12IK applicable to NHS Orkney. This was for several reasons, including leadership capacity and incomplete structures.

and

1.3.1.5 How your compliance to the Act has led to improved outcomes for service users

1.3.1.6 Integrating patient quality and safety data with staffing information is still under development. Clinical governance reviews patient outcomes, feedback, experience, and safety data, but combining this with workforce insights is not fully implemented at local levels. At Board level, integration occurs through clinical governance representation in the Operational People Group and professional lead roles. For nursing and midwifery, this process is supported by the Excellence in Care (EiC) programme and CAIR Dashboard, which combine

national care measures with workforce data at service/ward level.

1.3.1.7 Quality and safety are also examined via systems like Care Opinion and incident reviews, including those identifying staffing as a factor; however, limited data is available for trend analysis. No moderate or severe harm linked to staffing has been reported in adverse event data. Improving understanding of the clinical benefits and patient outcomes associated with staffing and digital support systems will be a key focus next year, as data collection and analysis frameworks are further developed.

1.3.1.8 The Excellence in Care (EiC) submission rate has increased from 35% in Q1 to 55% in Q3. However, until the inclusion of overtime, excess coverage, and support from bank and agency staff data, it is unlikely that this percentage will improve.

1.3.1.9 Anxiety, stress, depression, or other psychiatric illness were the main causes of staff sickness in Q3, making up 27.39% of lost hours; roles covered by the Act saw a comparable figure at 28.41%.

1.3.1.10 In Y2 Quarters 1–3, NHS Scotland Once for Scotland investigations found no cases related to staffing capability or capacity, and complaints rarely referenced staffing, with one complaint in Q2 referenced perceived staffing pressures, which was not substantiated upon review. Significant Adverse Events (SAER) did not highlight staffing or training issues, except for one Q1 recommendation on training. Incident reports varied by quarter (seven in Q1, three in Q2, four in Q3 and 10 in Q4) but consistently included a small number of cases related to staff shortages, skill mix, and training qualifications. These incidents spanned various service, such as outpatient clinics, ophthalmology, administrative support, radiography, and inpatient care, and resulted in operational challenges like delayed appointments, reduced service capacity, increased workload, and, on occasion, heightened patient safety risks. Notably, several incidents recorded each quarter did not fall under the Health and Care Staffing Act's remit. No whistleblowing concerns tied to staffing or training were reported at any point during the year. The anonymous reporting form launched during the previous year received minimal submissions, none of which pertained to staffing or training matters. Overall, while staffing and skill mix issues were documented throughout the reporting periods, there was limited evidence to suggest these directly contributed to adverse outcomes or significant events within the organisation.

3.2 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	The guiding principles for health and care staffing are to provide safe and high-quality services, and to ensure the best health care or (as the case may be) care outcomes for service users, e.g. anticipated higher service user standards, greater regard for each individual's needs and rights.
People	Workforce	Yes	It is the duty of every Health Board to ensure that all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as are appropriate for the health, wellbeing and safety of patients; the provision of safe and high-quality health care; in so far as it effects either of those matters, the wellbeing of staff, e.g. fair and open staffing decisions, good rostering practice etc.
Performance	Finance	Yes	The legislation assists NHSO to be responsive to known workload variations, including predicted absence allowance (PAA), and through the application of workload tools and resources, plan for future workforce requirements, e.g. time to lead, facilitating efficient and cost-effective use of staff.
Potential	Risk Management	Yes	The implementation of robust arrangements to deliver the general principles and duties as laid down in the legislation, including an auditable framework to inform workforce planning, ensures appropriate staffing in the day-to-day running of services is effectively managed through the identification, reporting, escalating and mitigation of risk caused by staffing levels.
	Digital	Yes	Access to a digital platform from which to draw data to underpin the legislation would be a significant advantage.
Place	Equality and Diversity including health inequalities	Yes	NHS Orkney is committed to advancing equality, diversity, and inclusion across health and care staffing, in accordance with the Health and Care Staffing Scotland Act. We recognise that a diverse workforce is essential to delivering consistently high-quality care to all individuals.
	Climate Change Sustainability	No	N/A

4. Recommendations

4.1 The Year two Annual Report is submitted to the NHS Orkney Board for **Assurance.**

5. List of Appendices

5.1 The following appendix is included with this report

i. **Appendix 1,** NHS Orkney's Year Two Annual Report (Health and Care (Staffing) (Scotland) Act 2019

APPENDIX 1

HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 – NHSO ORKNEY ANNUAL REPORT YEAR 2[2]

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Summary 5
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Duty 12IF: Duty to Seek Clinical Advice on Staffing. 25
Duty 12IH: Duty to ensure adequate time given to clinical leaders. 29
Duty 12II: Duty to ensure appropriate staffing: training of staff. 32
Duty 12IJ: Duty to follow the common staffing method. 36
Duty 12IL: Training and consultation of staff 40
Planning and Securing Services 43

Report approval

1. The box below should be completed by the person signing off the report. An electronic signature is acceptable.

[2] 1 April 2025 to 31 March 2026

2. The Act requires the annual reports to be published by relevant organisations. Please enter a hyperlink to the webpage where the report can be found in the boxes below.

Name of organisation:	NHS Orkney
Report authorised by:	Dave Harris
	Director of People and Culture
	1 April 2026
Location where report is published:	*[hyperlink]*

GUIDANCE ON USING THIS TEMPLATE

Purpose

This guidance has been developed to support relevant organisations in the completion of the below template which will form their annual report detailing compliance with the requirements of the Health and Care (Staffing) (Scotland) Act 2019 (the Act). Completed reports must be returned to hcsa@gov.scot by 30 April 2026.

Additional resources can be accessed here: Health and Care (Staffing) (Scotland) Act 2019: statutory guidance - gov.scot

If you require further assistance or have any queries, please contact hcsa@gov.scot.

Summary Section

3. The summary asks for an overview of how the relevant organisation has carried out all of the duties and requirements of the Act. This should include all NHS functions provided by all professional disciplines covered under the Act. You will be asked to provide an assurance level in respect of your overall compliance with the Act. Definitions for these assurance levels can be found at point seven.

4. Following receipt, the Scottish Ministers must collate reports from relevant organisations and lay a combined report before Parliament, along with an accompanying statement setting out how the information will be taken into account in policies for staffing of the health service. To enable this process, the information provided by relevant organisations should be comprehensive and pertinent to the staffing of the health service. To enable this, please complete the questions contained in the reporting template in sufficient detail, setting out the key achievements, outcomes, learning and risks and how this information has been used to inform workforce planning at the local level.

Individual duties / requirements

5. Following the summary section, the template seeks detail on individual duties/requirements of the Act in turn, asking relevant organisations to provide an assessment of compliance, and to provide details. Again, this should include all NHS functions, provided by all professional disciplines covered under the Act. Relevant organisations should provide detail to explain the assurance level in respect of the Duty, detailing evidence of compliance where appropriate, or gaps and areas of ongoing focus.
   Evidence could, for example, include details of the organisational structures, systems and/or processes being used.

6. The duty description contains the legislative wording of the Act, outlining the duty requirements.

7. As outlined at paragraph 3, the template requests an overall level of assurance with regard to the relevant organisation's compliance with the Act/Duties, using the assurance categories as detailed below:

Level of assurance	System adequacy	Controls
Substantial assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable assurance	There is a generally sound system of governance, risk management, and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non- compliance.
Limited assurance	Significant gaps, weaknesses, or non- compliance were identified. Improvement is required to the system of governance, risk management, and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

8. The relevant organisation is asked to provide details of areas of success, achievement and learning associated with the particular duty or requirement, along with indicating how this could be used in the future. Again, in order to provide meaningful information that can inform healthcare staffing policy, relevant organisations are asked to complete this with an appropriate level of detail.

9. The relevant organisation is then asked to provide details of any areas of risk where they have been unable to achieve or maintain compliance with the particular duty or requirement, or where they have faced any challenges or risks in carrying out their duties or requirements. In this section, relevant organisations are also asked what actions have been or are being taken to address this. Again, in

order to provide meaningful information that can inform healthcare staffing policy, relevant organisations are asked to provide an appropriate level of detail.

ANNUAL REPORTING TEMPLATE

Summary
Please answer the following questions, to provide an overall assessment of how the organisation has carried out its duties under sections 12IA, 12IC, 12ID, 12IE, 12IF, 12IH, 12II, 12IJ and 12IL of the National Health Service (Scotland) Act 1978 (inserted by section 4 of the Act), and in line with Sections 1 and 2 of the Act : Guiding principles for health and care staffing and Guiding principles etc. in health and care staffing and planning.

Please advise how the information provided in this report has been used or will be used to inform workforce plans.
1. The Act covers **808 employed staff** (389.14 WTE), an increase of 10 (7.89 WTE) from Y2 Q2, accounting for **70.6%** of the total workforce, including personnel within the Integrated Joint Board where NHS Orkney remains the employer. 2. Workforce planning is a capacity issue due to vacancy and financial pressures across the organisation, including the freezing of some vacancies. 3. The Common Staffing Method (CSM) was followed at the required frequency by 17.39% of the six types of health care listed in duty 12IK applicable to NHS Orkney. This was for several reasons, including leadership capacity and incomplete structures.
Please provide information on how your compliance to the Health and Care Staffing Act has led to improved outcomes for service users and workforce
1. Integrating patient quality and safety data with staffing information is still under development. Clinical governance reviews patient outcomes, feedback, experience, and safety data, but combining this with workforce insights is not fully implemented at local levels. At Board level, integration occurs through clinical governance representation in the Operational People Group and professional lead roles. For nursing and midwifery, this process is supported by the Excellence in Care (EiC) programme and CAIR Dashboard, which combine national care measures with workforce data at service/ward level. 2. Quality and safety are also examined via systems like Care Opinion and incident reviews, including those identifying staffing as a factor; however, limited data is available for trend analysis. No moderate or severe harm linked to staffing has been reported in adverse event data. Improving understanding of the clinical benefits and patient outcomes associated with staffing and digital support systems will be a key focus next year, as data collection and analysis frameworks are further developed.

3. The Excellence in Care (EiC) submission rate has increased from 35% in Q1 to 55% in Q3. However, until the inclusion of overtime, excess coverage, and support from bank and agency staff data, it is unlikely that this percentage will improve.

4. Anxiety, stress, depression, or other psychiatric illness were the main causes of staff sickness in Q3, making up 27.39% of lost hours; roles covered by the Act saw a comparable figure at 28.41%.

5. In Y2 Quarters 1–3, NHS Scotland Once for Scotland investigations found no cases related to staffing capability or capacity, and complaints rarely referenced staffing, with one complaint in Q2 referenced perceived staffing pressures, which was not substantiated upon review. Significant Adverse Events (SAER) did not highlight staffing or training issues, except for one Q1 recommendation on training. Incident reports varied by quarter (seven in Q1, three in Q2, four in Q3 and 10 in Q4) but consistently included a small number of cases related to staff shortages, skill mix, and training qualifications. These incidents spanned various service, such as outpatient clinics, ophthalmology, administrative support, radiography, and inpatient care, and resulted in operational challenges like delayed appointments, reduced service capacity, increased workload, and, on occasion, heightened patient safety risks. Notably, several incidents recorded each quarter did not fall under the Health and Care Staffing Act's remit. No whistleblowing concerns tied to staffing or training were reported at any point during the year. The anonymous reporting form launched during the previous year received minimal submissions, none of which pertained to staffing or training matters. Overall, while staffing and skill mix issues were documented throughout the reporting periods, there was limited evidence to suggest these directly contributed to adverse outcomes or significant events within the organisation.

Health and Care Staffing Act Health Board Duty Compliance Assurance Levels

Please complete the table below with your Health Boards compliance assurance level for each duty.

DUTY	COMPLIANCE ASSURANCE LEVEL
Duty 12IA: Duty To Ensure Appropriate Staffing	Limited Assurance
Duty 12IC: Duty To Have Real-Time Staffing Assessment In Place.	**Reasonable Assurance**
Duty 12ID: Duty To Have Risk Escalation Process In Place.	**Reasonable Assurance**
Duty 12IE: Duty To Have Arrangements To Address Severe And Recurrent Risks.	Limited Assurance
Duty 12IF: Duty To Seek Clinical Advice On Staffing.	Reasonable Assurance
Duty 12II: Duty To Ensure Appropriate Staffing: Training Of Staff	Reasonable Assurance
Duty 12IH: Duty To Ensure Adequate Time Given To Clinical Leaders.	**Reasonable Assurance**
Duty 12IJ: Duty To Follow The Common Staffing Method (CSM)	**Limited Assurance**
Duty 12IL: Training And Consultation Of Staff	**Limited Assurance**
Planning And Securing Services	**Reasonable Assurance**
PLEASE INDICATE THE OVERALL LEVEL OF ASSURANCE OF THE ORGANISATION'S COMPLIANCE	
Reasonable Assurance	

Duty Description	**2 Guiding principles etc. in health care staffing and planning** (1) In carrying out the duty relating to staffing imposed by section 12IA of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to the guiding principles for health and care staffing. **Duty 12IA: Duty to ensure appropriate staffing.** (**1) It is the duty of every Health Board and the Agency to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as are appropriate** for— (a) the health, wellbeing, and safety of patients, (b) the provision of safe and high-quality health care, and (c) in so far as it affects either of those matters, the wellbeing of staff. (**2) In determining what, in a particular kind of health care provision, constitutes appropriate numbers for the purposes of subsection (1), regard is to be had to—** (a) the nature of the particular kind of health care provision, (b) the local context in which it is being provided, (c) the number of patients being provided it, (d) the needs of patients being provided it, and (e) appropriate clinical advice.

Please provide information on the steps taken to comply with Duty 12IA.

1. Annual Report to Scottish Ministers, NHS Orkney Board and published on the board website. Board Level Clinician(s) Quarterly Internal Compliance report to Staff Governance Committee and Area Partnership forum.

2. Internal governance committee(s) report template impact assessment includes assessment of impact of the Act under corporate strategy objective people > workforce.

3. Reduced Working Week

NHS Orkney is progressing the implementation of the national Reduction in the Working Week (RWW), which will reduce Agenda for Change (AfC) full-time hours to 36 by 1 April 2026. Work to implement the change is ongoing in line with national policy requirements, with services developing and submitting plans that outline how they will accommodate the reduction. These plans were approved by the Executive Directors, enabling departments to move forward with local arrangements. Engagement has been continuous with partnership colleagues to discuss departmental plans. In some areas departments are retaining the part time hours, some are recruiting additional colleagues and in other areas they are adjusting how they deliver their service. Overall, services across NHS Orkney have plans in place and are taking agreed actions to support delivery of care while implementing the reduced working week.

4. Recruitment
    a. Attraction: *Where Compassion Meets Adventure* is NHS Orkney's campaign highlighting professional fulfilment, community engagement, and island lifestyle. Launched during the International Island Games, it promotes Orkney as an excellent place to live and work, with an inclusive community, stunning nature, and diverse career options.
    b. International Recruited Staff: 32 individuals recruited (Q4 100% retention rate)

5. Clinical Services Review: Following receipt of the final Clinical Services Review report, several pressing workforce challenges have been identified that require strategic attention:
    a. *Workforce fragility and shortages in critical areas such as Nursing and Midwifery, driven by a limited pool of trained professionals. Persistent gaps in the locum medical workforce, where substantive recruitment has proven difficult, highlight the need for innovative, collaborative solutions across health systems.*
    b. *Leadership instability at the tier below the Executive Team, which undermines continuity, strategic delivery, and operational resilience.*
    c. *Housing constraints, particularly in remote areas, continue to adversely affect recruitment and retention efforts, limiting the ability to attract and retain skilled professionals.*

6. The eRostering Officer post was vacant for the first 6-months of the reporting year impacting on NHS Orkney's ability to access and utilise the data held within the SafeCare system. These limitations have affected data extraction, analysis and reporting.

7. For quarter 3, anxiety, stress, depression, or other psychiatric illness were the main causes of staff sickness, making up 27.39% of lost hours; roles covered by the Act saw a comparable figure at 28.41%.

8.	Pharmacy Services conducted an in-year review of skill mix, management and leadership structures and workforce analysis, a bench marking exercise with other island, remote and rural boards, and utilisation of national professional frameworks for staff development and training.

Please provide Information on your methods of monitoring compliance with Duty 12IA
1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum. 2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72% compliance). 3. Statutory and Mandatory training and Appraisal completion has continued to improve during the year, in all key areas reflecting the significant efforts made by teams across NHS Orkney and increased Senior Leadership oversight. As of 31 March 2026: a. eLearning compliance has risen from 78.24% in April to 83.47% b. Resuscitation training (now tracked with new metrics) stands at 51.73%. c. Manual Handling training improved from 54.7% to 71.64%. d. Safety Intervention training increased from 66.07% to 75.36%. e. Appraisal completion has increased from 39.86% to 45.60%. 4. eLearning (Core Statutory and Mandatory Modules only): Compliance remains above 80% with trend holding consistently strong with only minimal variation from the previous quarter.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Optima Health Care roll out	1. NHS Orkney is transitioning to Optima Health Care, including phase implementation of SafeCare for all roles in scope of the legislation.	1. Learning from the roll out and implementation is being used to inform the roll out to other professional groups / services, with feedback to the national team. An implementation plan for eRostering in 2026/27 with a view to implementing across all services and professions by 31 March 2027.

2. Review of skill mix completed to help meet service demands. Training frameworks ongoing and completed for Pharmacy support workers, Pharmacy Technicians and Pharmacists.	2. Pharmacist professional frameworks supporting staff development across the four pillars of pharmacy practice. Pharmacy Support workers undertaking Scottish Vocational Qualification (SVQ) and in-house training to develop specialist roles for Pharmacists and Pharmacy Technicians to meet clinical demand, improve patient care and safety.	2. Upskilling of team members to meet service need and clinical demand. Continued work to complete training which is ongoing Continued re-evaluation of skill mix and service development.
3. Community nursing: skill mix and service review	3. A change in skill-mix and a move to better integrate the mainland teams improving recruitment and retention reducing the vacancy rate from 46% to 23% improving patient care, safety and staff wellbeing.	3. Share the learning across the organisation, specifically with other under-pressure services.
4. Consultant medical staff recruitment	4. A detailed analysis on medical staffing spend was shared with the executive in February, with a programme for improvement leading on from that with a specific action to define the safe staffing establishment for senior medical roles.	4. A consultant recruitment workshop took place in February, resulting in the successful appointment of a fixed-term consultant surgeon, with further and consultant advertisements underway to decrease the reliance on locum staff.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. NHS Scotland: support and intervention framework - NHS Orkney escalated to Level 3	1. NHS Orkney is currently at Level 3 escalation under the NHS Scotland Support and Intervention Framework and aims to achieve financial balance over the medium term. Our modelling indicates that reaching a financial balance will require a comprehensive transformation of both clinical and non-clinical services across the system.	1. NHS Scotland Action Plan in place.
2. Roles in Scope of the legislation	2. Recruiting across all professional groups to an island Board continues to pose a challenge. Attracting individuals with the depth of experience and breath of skills required for small rural clinical teams is increasingly difficult, plus maintenance of those skills, and the lack of affordable housing only adds to the issue.	2. Recruitment campaign: *Where Compassion Meets Adventure*.
	HR, SAER, incidents, complaints and whistleblowing review recommendation(s) and subsequent action plan(s), are not being triangulated to identify themes nor are the identified areas for learning / improvement, which relate to workforce, being tracked until all actions are completed.	HR, SAER, incidents, complaints & whistleblowing review(s) - Triangulation of themes and tracking of learning recommendations and action plans until all actions are completed, a final report written, and recommendation outcomes presented to NHSO equivalent of a Care Governance committee being implemented.
3. Incomplete clinical leadership structure	3. Capacity is an issue due to leadership instability	3. Clinical Services Review work stream

4. Impact of reduced working week (RWW)	at the tier below the Executive Team. 4. The impact of the RWW has been significant in terms of reviewing rosters and working patterns, but additionally the impact on updating rosters has affected the roll out of eRostering and SafeCare as key enablers to the Act and Act compliance. Further changes to the rosters will further impact implementation and roll out of these systems to support the board demonstrate and monitor compliance, as well as have more qualitative data to consider impact and patient outcomes.	4. Monitor success of recruitment across services and teams to the RWW hours shortfall, impact on staff wellbeing and patient outcomes.

COMPLIANCE ASSURANCE LEVEL
Limited Assurance

Duty 12IC: Duty to have real-time staffing assessment in place.

Duty Summary	**(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the real-time assessment of its compliance with the duty imposed by section 12IA.** **(2) The arrangements under subsection (1) must, in particular, include—** (a) a procedure for the identification, by any member of staff, of any risks caused by staffing levels to— (i) the health, wellbeing, and safety of patients, (ii) the provision of safe and high-quality health care, or (iii) in so far as it affects either of those matters, the wellbeing of staff, (b) a procedure for the notification of any such risk to an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, (c) a procedure for the mitigation of any such risks, so far as possible, by such an individual, and a requirement for that individual to seek and have regard to appropriate clinical advice, as necessary, in carrying out such mitigation, (d) raising awareness among staff about the procedures described in paragraphs (a) (b) and (c), (e) encouraging and enabling staff to use the procedures described in paragraphs (a) and (b), (f) training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (e), and (g) ensuring that such individuals receive adequate time and resources to implement those arrangements.

Please provide information on the steps taken to comply with Duty 12IC.

1. The aggregated quarterly self-assessment responses (72%) reveal that while most teams (75%) have established processes for documentation of staffing decisions, and real-time risk escalation, the consistency and depth of implementation vary significantly. Smaller or specialist teams often struggle with formalising supervision and documentation due to limited staffing and high clinical demands. Common challenges include protecting time for clinical leaders, maintaining thorough documentation, and managing the impact of absences. However, many teams have adopted adaptive strategies such as using locum staff, shared calendars, and regular safety huddles, which have led to improved risk management and team cohesion where these processes are well embedded.

2. Standard Operating Procedure (SOP) Real Time Staffing and Risk Escalation for Clinical Leaders / Managers v1.3.

3. The eRostering Officer post was vacant for the first 6-months of the reporting year impacting on NHS Orkney's ability to access and utilise the data held within the SafeCare system. These limitations have affected data extraction, analysis and reporting. 4. Clinical Services Review: Following receipt of the final Clinical Services Review report, several pressing workforce challenges have been identified that require strategic attention, including workforce fragility and shortages in critical areas such as Nursing and Midwifery, driven by a limited pool of trained professionals. Persistent gaps in the locum medical workforce, where substantive recruitment has proven difficult, highlight the need for innovative, collaborative solutions across health systems.
Please provide Information on your methods of monitoring compliance with Duty 12IC
1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum. 2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72%).

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Path to green	1. All services with roles in scope of the legislation have access to SafeCare and will need to be completing and utilising the data on a consistent basis before NHS Orkney is able to progress to, as a minimum, reasonable assurance on this duty.	1. Operational People Group to secure commitment and support to enable clinical leaders to engage with SafeCare.

2. SafeCare roll out and monitoring 3. Pharmacy Services - Morning huddles / team discussions now routine; Escalation process defined, SOP in place	2. SafeCare implementation initially saw positive engagement from many teams / services 3. Acute Pharmacists, Primary Care Pharmacy, Pharmacy Technicians discuss staffing and prioritise workload according to clinical / service need and demand; issues or assurance passed to service lead; SafeCare utilised regularly to inform and add professional judgement.	2. Currently within Optima, time to lead is set up differently depending on the unit. A uniform approach across all units to standardise reporting is required. 3. Further improve addition of professional Judgement following roll-out out of SOP.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. Path to green 2. Double-keying 3. Incomplete clinical leadership structure 4. Current SafeCare configuration	1. Clinical leaders need to be encouraged to utilise SafeCare system to capture challenges with staffing in real-time. 2. Double-keying (SSTS, eRostering) continues to cause a significant burden on the Board, requiring dedicated administrative time, or clinical time, to ensure information is correct and up to date. 3. Capacity is an issue due to leadership instability at the tier below the Executive Team.	1. Continue to work with clinical leaders to utilise SafeCare. 2. This risk is being managed by the local eRostering programme Board, with escalation to agree governance routes. 3. Clinical Services Review work stream. 4. Engage with relevant working group(s).

does not support all elements of duty	4. Engage with SafeCare national configuration work and engage with relevant working group(s).	

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12ID: Duty to Have Risk Escalation Process in Place.

Duty Summary	**(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the escalation of any risk.** (a) identified during the real-time assessment of its staffing levels in accordance with arrangements put in place under section 12IC, and (b)which it has not been possible to mitigate in accordance with the arrangements put in place under that section. **(2) The arrangements under subsection (1) of this duty must include:** a) A procedure for the initial reporting of a risk as described in subsection (1), by an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, to a more senior decision-maker, b) A requirement for any such decision-maker to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it, c) A procedure for the onward reporting of the risk, as necessary, to a more senior decision-maker in turn, and a requirement for that decision-maker in turn to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it, d) A requirement for the arrangements put in place under paragraph (c) to escalate further in order to reach a final decision on the risk, including in appropriate cases by the reporting of the risk to the members of the Health Board. e) A procedure for the notification of every decision made following the initial report, and the reasons for it, to: (i)any individual who was involved in identifying the risk in accordance with the arrangements put in place under section 12IC(2)(a), (ii)any individual who was involved in attempting to mitigate the risk in accordance with the arrangements put in place under section 12IC(2)(c), (iii)any individual who was involved in reporting the risk in accordance with the arrangements put in place under paragraph (a), (c) or (d) of this subsection, and (iv)any individual who gave clinical advice in accordance with the arrangements put in place under section 12IC(2)(c), or under paragraph (b), (c) or (d) of this subsection, f) A procedure for those individuals to record any disagreement with any decision made following the initial report, g) A procedure for those individuals to be able to request a review of the final decision on a risk (other than a final decision made by the members of the Health Board or the Agency) made in accordance with the arrangements put in place under section 12IC(2)(c) or, as the case may be, paragraphs (b), (c) or (d) of this subsection,

	h) Raising awareness among staff about the procedures described in paragraphs (a) to (f), i) Training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of healthcare, and other senior decision-makers, in how to implement the arrangements put in place under paragraphs (a) to (h), and j) Ensuring that such individuals receive adequate time and resources to implement those arrangements.

Please provide information on the steps taken to comply with Duty 12ID.

1. Escalation of a risk is through operational lines of management or professional lines, depending on the service structure. Where it is not the case that escalation follows a 'professional' line of seniority, services should have in place governance processes whereby a risk is reviewed by an appropriate professional clinician to ensure clinical advice is provided.

2. Escalation, decisions made and by whom are not consistently being recorded by all roles in scope across the organisation. Analysis of severe and recurrent risk is therefore difficult due to a lack of auditable data overtime to support identification of themes and trends. In addition, the Daily Pressures report, SafeCare, safety huddle(s) and 4pm handover capacity and capability information are not aligned, e.g., number of open beds v surge capacity. Use of SafeCare as single source of organisational capability and capacity, issue escalation, mitigation and management of severe and recurrent risk. Currently multiple documents / reports detailing inconsistent information, for some but not all roles in scope, are in use.

   Being able to evidence awareness and compliance with this overarching duty, including feedback to those involved in identifying, reporting or mitigating the risk, feedback has been provided in all cases is impossible without the use of digital systems and technology to support these communications, especially if decision making and feedback span across different shift patterns. Staff should have access to feedback within SafeCare (provided it has been completed), similarly the Integrated Incident and Risk Management Reporting System has this inbuilt function (which is currently not enabled), however for all other staff or communications, this is reliant of informal verbal feedback which cannot be evidenced robustly at this time.

   The aggregated quarterly self-assessment responses (72% return) reveal that while most teams (75%) have established processes for documentation of staffing decisions, and real-time risk escalation, the consistency and depth of implementation vary. Common challenges include protecting time for clinical leaders, maintaining thorough documentation, and managing the impact of absences.

However, many teams have adopted adaptive strategies such as using locum staff, shared calendars, and regular safety huddles, which have led to improved risk management and team cohesion where these processes are well embedded. 3. SOP Real Time Staffing and Risk Escalation for Clinical Leaders / Managers v1.3. 4. The eRostering Officer post was vacant for the first 6-months of the reporting year impacting on NHS Orkney's ability to access and utilise the data held within the SafeCare system. These limitations have affected data extraction, analysis and reporting.
Please provide Information on your methods of monitoring compliance with Duty 12IC
1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum. 2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72%).

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. SafeCare roll out and monitoring 2. Path to green	1. Safe Care implementation initially saw positive engagement from many teams / services. 2. All services with roles in scope of the legislation have access to SafeCare and will require to demonstrate effective risk escalation as set out in the legislation before NHS Orkney is able to	1. Currently within Optima, time to lead is set up differently depending on the unit. A uniform approach across all units to standardise reporting is required. 2. Operational People Group to secure commitment and support to enable clinical leaders to engage with SafeCare, specifically risk escalation.

3. Pharmacy Services – Formalisation of processes	progress to, as a minimum, reasonable assurance on this duty. 3. SOP including escalation to professional lead process in place Team leads have direct access to escalate to professional lead Challenges raised, where necessary, as part of Organisational RAG meeting	3. Critical escalation outside of the service, except for the morning RAG meeting, would be to escalate via professional lead to responsible executive director. This process needs to be documented.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. Resource pressures	1. Time and resources to continue to embed these resources and support practice, as new learning emerges, increased activity with compliance monitoring and reporting.	1. Continue monitoring, adapting, and highlighting risks due to reduced resources now that Scottish Government (SG) funding is no longer available.
2. Lack of standardised approach	2. Variable processes. A clearer process is required to facilitate monitoring and reporting.	2. Explore development of Integrated Incident and Risk Management Reporting System and SafeCare to provide reporting, escalation and monitoring of staffing risks.
3. Pharmacy Services - As a small team often responding to undefined clinical demand / activity within other service areas it can be challenging to assess real time demand.	3. Activity and service demand will be dependent on: Emergency department patient numbers, numbers of admissions and discharges, patient acuity, procurement challenges and number of medicines shortages, activity levels within GP practices, challenges within Community Pharmacies etc.	3. Challenges are discussed and managed within teams and escalated throughout the day and in real time. Open door policy for team leads and professional lead facilitates this.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IE: Duty to have arrangements to address severe and recurrent risks.

Duty Summary	**Duty to have arrangements to address severe and recurrent risks.** **(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements to—** (a) collate information relating to every risk escalated to such level as the Health Board or the Agency (as the case may be) consider appropriate in accordance with the arrangements put in place under section 12ID (2), and (b) identify and address those risks which are considered to be either or both— (i) severe, (ii) liable to materialise frequently. **(2) The arrangements under subsection (1) must, in particular, include a procedure for—** (a) the recording of a risk as described in subsection (1)(b), (b) the reporting of any such risk, as necessary, to a more senior decision-maker, including in appropriate cases to the members of the Health Board or the Agency (as the case may be), (c) the mitigation of the risk, so far as possible, and a requirement for appropriate clinical advice to be sought and had regard to in carrying out such mitigation, and (d) the identification of actions to prevent the future materialisation of the risk, so far as possible.

Please provide information on the steps taken to comply with Duty 12IE.

1. NHS Orkney continues to further strengthen our approach to risk management, governance, and clinical engagement. Risk jotters have been introduced and made changes to the layout of our Corporate Risk Register to simplify the process.

   Escalation, decisions made and by whom are not consistently being recorded by all roles in scope across the organisation. Analysis of severe and recurrent risk is therefore difficult due to a lack of auditable data overtime to support identification of themes and trends. In addition, the Daily Pressures report, SafeCare, safety huddle(s) and 4pm handover capacity and capability information are not aligned, e.g., number of open beds v surge capacity.

   All risks raised on the Integrated Incident and Risk Management Reporting System are allocated a rating for impact (severity) and likelihood (anticipated likelihood of reoccurrence) which can be reviewed across functional groups for trends and occurrences

(currently unable to confirm this occurs). Risks recorded in the Integrated Incident and Risk Management Reporting System should be a subject matter for Operational Groups, e.g., Clinical Governance, Workforce and Risk Management. Actions should be decided at this level on mitigation requirements to prevent reoccurrence, including escalation if appropriate. Functional groups report all risks into the Risk Management Group, Operational People Group and/or the clinical governance committee when appropriate. Also, each service area can pull risks specific to their area to provide localised and operational pictures of risk.

SafeCare has the function to raise an alert where there is a risk to staffing. This is used to report risks that occur frequently but did not require escalation into Integrated Incident and Risk Management Reporting System. Together these systems will provide robust data on severe and recurrent risks when properly embedded within the organisation.

The aggregated responses (72%) reveal that 62.5% of respondents have established processes for staff training, documentation of staffing decisions, and real-time risk escalation, the consistency and depth of implementation vary significantly. However, many teams have adopted adaptive strategies such as using locum staff, shared calendars, and regular safety huddles, which have led to improved risk management, training compliance, and team cohesion where these processes are well embedded.

2. There is one current risk directly linked to the legislation on the corporate risk register, plus a further nine that are associated with workforce, five of which relate directly to the staffing concerns and the ability to undertake expected duties or training due to these staffing issues.

3. SOP Real Time Staffing and Risk Escalation for Clinical Leaders / Managers v1.3.

Please provide Information on your methods of monitoring compliance with Duty 12IE

1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum.

2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72%).

3. Corporate risks are reviewed by the Risk Management Group.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Pharmacy Services: Risks recorded daily via SafeCare and Daily RAG; risks proactively managed as part of decision making and prioritisation during morning meetings and throughout the day	1. For example: Challenges with discharge planning and short notice to facilitate an urgent discharge require flexibility within the team and real time workload prioritisation; recurrent risks highlighted during RAG and clinical governance meetings.	1. Improvement in discharge planning processes

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. Risk dashboard	1. Creation of a staffing related risks dashboard, updated monthly prior to the Operational People Group to be considered. This enables senior leaders to be confident and assured that risks are recorded, and plans are in place to mitigate and reduce the risks.	1. Operational People Group to consider implementation / the use of a staffing related risk dashboard
2. Risk oversight / Management	2. Risks to be discussed regularly by the Executive Management Team, and Senior Leadership Team and also at the Risk Management Group. Risks to be discussed at service governance meetings, and safety huddle(s).	2. Embed discussing risks at the groups listed.
3. Pharmacy Services - Island,		

Remote and rural location and small team numbers mean there is no pool of staff to call on (agency and substantive team members) when unplanned staff shortages occur. 4. Path to green	3. When team members are ill during periods of planned annual leave; can leave teams with very low staff numbers. Real time and dynamic risk assessments undertaken. Service demand prioritised and information disseminated to service users as key stakeholders. 4. Severe and recurrent risk definitions have been included in the draft risk escalation SOP. To have improved assurance for this duty, SafeCare utilisation, and data analysis is required by all services and professions. This will enable the scrutiny and up to date information required to be confident in the functioning of the system.	3. Risk is included in risk register. Consideration to use of agency staff where absence is likely to be long term. 4. The Operational People Group to review yellow grading and implement an action plan to transition from yellow > green.

COMPLIANCE ASSURANCE LEVEL
Limited Assurance

Duty 12IF: Duty to Seek Clinical Advice on Staffing.

Duty Summary	**Duty to Seek Clinical Advice on Staffing.** **(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for—** (a) seeking and having regard to appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing under sections 12IA to 12IE and 12IH to 12IL, (b) recording and explaining decisions which conflict with that advice. **(2) The arrangements under subsection (1) must, in particular, include—** (a) where a Health Board or the Agency (as the case may be) reaches a decision on a matter which conflicts with the clinical advice it has received— (i) a procedure for the identification of any risks caused by that decision, (ii) a procedure for the mitigation of any such risks, so far as possible, (iii) a procedure for the notification of any such decision, and the reasons for it, to any individual who gave clinical advice on the matter, (iv) a procedure for any such individual to record any disagreement with the decision made on the matter, (b)a procedure for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the Health Board or the Agency (as the case may be), on at least a quarterly basis, about the extent to which that individual considers that it is complying with the duties imposed by— (i) this section, and (ii) sections 12IA to 12IE and 12IH to 12IL, (c) a procedure for such individuals to— (i) enable and encourage other employees to give views on the operation of this section, and (ii) record such views in reports made in accordance with the arrangements put in place under paragraph (b), (d) raising awareness among individuals with lead clinical professional responsibility for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (c), and (e) ensuring that such individuals receive adequate time and resources to implement those arrangements. **(3) Every Health Board and the Agency must have regard to the reports received in accordance with the arrangements put in place under subsection (2)(b).**

Please provide information on the steps taken to comply with Duty 12IF.

1. The aggregated quarterly self-assessment responses (72% return) reveal that while most teams have established processes for documentation of staffing decisions, and real-time risk escalation, the consistency and depth of implementation vary significantly. Smaller or specialist teams often struggle with formalising supervision and documentation due to limited staffing and high clinical demands. Common challenges include protecting time for clinical leaders, maintaining thorough documentation, and managing the impact of absences. However, many teams have adopted adaptive strategies such as using locum staff, shared calendars, and regular safety huddles, which have led to improved risk management and team cohesion where these processes are well embedded.

2. Vacancy Panel (VP) systems and processes, including the savings tracker, do not sufficiently capture data needed for the board to show legislative compliance. A VP Improvement Workshop has taken place, with several actions identified including alignment with the Health and Care (Staffing) (Scotland) Act 2019. Y2 Q1 - Q3

    i. A total of 129 vacancies were reviewed, with 80 roles (62.01%) falling within the scope of the legislation. Three posts have been rejected, and one was halted mid-recruitment
    ii. Eight posts have been deferred to seek additional information to ensure posts are fully reviewed
    iii. Eight posts are currently withheld within the system with the aim of being actioned during January 2026

3. SOP Real Time Staffing and Risk Escalation for Clinical Leaders / Managers v1.3.

2. The eRostering Officer post was vacant for the first 6-months of the reporting year impacting on NHS Orkney's ability to access and utilise the data held within the SafeCare system. These limitations have affected data extraction, analysis and reporting.

3. Clinical Services Review: Following receipt of the final Clinical Services Review report, several pressing workforce challenges have been identified that require strategic attention, including workforce fragility and shortages in critical areas such as Nursing and Midwifery, driven by a limited pool of trained professionals. Persistent gaps in the locum medical workforce, where substantive recruitment has proven difficult, highlight the need for innovative, collaborative solutions across health systems.

Please provide Information on your methods of monitoring compliance with Duty 12IF

1. NHS Orkney is currently unable to demonstrate the evidence required to confirm compliance with this duty. Essential processes and documentation that would typically underpin assurance, such as systems for identifying and managing clinical advice, recording decisions that diverge from such advice, and implementing appropriate risk mitigation measures, are not yet in place. Furthermore, there are no established procedures for notifying clinical staff when decisions conflict with their advice, nor mechanisms for managing differing clinical opinions. 2. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum. 3. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72%).

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Path to green	1. All services with roles in scope of the legislation will need to have access to SafeCare and completing and utilising the data on a consistent basis, before NHS Orkney is able to progress to, as a minimum, reasonable assurance on this duty.	1. Operational People Group to secure commitment and support to enable clinical leaders to engage with SafeCare.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. Engagement with SafeCare	1. Challenges with services and professions to utilise SafeCare on a consistent basis, including recording of clinical advice given and by whom.	1. Operational People Group to secure commitment and support to enable clinical leaders to engage with SafeCare.

2. Incomplete clinical leadership structure 3. Vacancy Control Panel	2. Capacity is an issue due to incomplete clinical leadership structure, specifically at senior operational level. 3. Vacancy panel systems and processes, including the savings tracker, do not sufficiently capture data needed for the board to demonstrate legislative compliance.	2. An up to date organisational and professional structures organogram publication date is to be confirmed. 3. Carry out the actions outlined during the Improvement Workshop, such as drafting a SOP and ensuring alignment with the Health and Care (Staffing) (Scotland) Act 2019.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IH: Duty to ensure adequate time given to clinical leaders.

Duty Summary	**In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that all individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to discharge that responsibility and their other professional duties, including, in particular, time—** (a) to supervise the meeting of the clinical needs of the patients in their care, (b) to manage, and support the development of, the staff for whom they are responsible, and (c) to lead the delivery of safe, high-quality, and person-centred health care.
Please provide information on the steps taken to comply with Duty 12IH.	
1. NHS Orkney is transitioning to Optima Health Roster and SafeCare, which will highlight when clinical leaders work clinically to mitigate staffing risk. Work is in progress to ensure consistency of data capture as currently there is inconsistency within and between services /	

professional groups, e.g., TL, SCN, SCM etc are not routinely included in clinical rota; being moved into clinical rota to mitigate / as per job description, e.g., 80% time to lead: 20% clinical, or 60% time to lead: 40% clinical etc. Multi-disciplinary (MD) professional judgment staffing level tool will further support implementation and monitoring. The eRostering Officer position remained vacant during the initial two quarters; after successful recruitment, a reset process is currently underway.

2. SOP Adequate Time given to Clinical Leaders (Time to Lead) v0.5.

3. Most of the quarterly aggregated self-assessment responses (72%) indicate clinical leaders have dedicated leadership time, though some lack enough resources. The SafeCare reset will review if their allotted time is sufficient.

Please provide Information on your methods of monitoring compliance with Duty 12IH

1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum.

2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72%).

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Pharmacy Services: Team leads have in place scheduled team meetings; autonomy to arrange convenient times to undertake annual and interim reviews	1. Pharmacy Senior leadership team meet monthly to discuss service needs and improvements, staffing challenges and skill mix requirements; each member of senior leadership team (SLT) have their own team meetings to discuss and facilitate delivery of quality improvement work	1. Due to the variable nature of clinical service demand, it is challenging to ringfence time for leads to undertake this work. Time is taken when convenient at present.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. Policies, systems and processes in place	1. Robust Organisational policies, systems and processes are required to be in place for facilitating and monitoring of Clinical leader's time, e.g. SOP and SafeCare.	1. Develop an audit and compliance framework
2. Path to green	2. SafeCare is available across NHS Orkney. Clinical leaders need to be encouraged to utilise the system to capture challenges with adequate time to lead for clinical leaders.	2. Continue to work with clinical leaders to utilise SafeCare; develop and monitor systems and processes.
3. Small teams - during periods of absence, team leads are required to undertake clinical workload. This is included within	3. Real time and dynamic risk assessments undertaken. Service demand prioritised and information disseminated to service users as key	3. Continual challenge within small remote and rural healthcare systems. Teams need to be flexible daily and throughout the day.

roles and remits but may necessitate rescheduling of leadership duties.	stakeholders. Non-clinical workload re-prioritised.	

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12II: Duty to ensure appropriate staffing: training of staff.

Duty Summary	**In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that its employees receive—** (a) such training as it considers appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b), and (b) such time and resources as it considers adequate to undertake such training.
Please provide information on the steps taken to comply with Duty 12II.	

1. Induction: Since the induction refresh in April 2023, NHS Orkney has seen a marked improvement in new starter experience. Earlier baseline data showed that 40% of staff did not feel comfortable or supported on their first day; this has now risen to 98% agreeing or strongly agreeing. Feedback consistently highlights a welcoming environment, clear communication, accessible and relevant training, strong line-manager support, and improved role clarity.

   The induction survey, refreshed September 2025, continues to identify areas for further refinement, such as scheduling consistency, digital navigation, timely role-specific training, and clearer communication around session changes. Ongoing developments, including automatic induction booking and enhanced manager guidance on early setup tasks, demonstrate that the induction process is working well overall while still being actively reviewed and improved.

   In addition, a separate Internationally Recruited Staff Survey was completed in September 2025 to review the induction, supernumerary support and training experience. 32 staff members who were recruited into direct clinical, indirect clinical or non-clinical support roles were invited to participate. The response rate was 50%; direct clinical care 87.5%, non-clinical support 12.5%, indirect clinical 0%.

2. Protected Learning Time Workstreams

   a. Workstream 1 - National Statutory and Mandatory Transition
   The nine Core Statutory and Mandatory modules are scheduled to launch on 2 March 2026, replacing the current mix of local and national modules. NHS Orkney does not anticipate any reduction in overall compliance except as a new mandatory module, OfS Counter Fraud - will be introduced, which has a six-month grace period for completion.

   b. Workstream 2 – Profession and Role-Specific: Workstream 2 continues to make steady progress in establishing a clear NHS Orkney wide picture of Profession and Role-Specific learning requirements. Learning Aids are expected to be submitted by 26 February 2026, enabling the transition into the next phase of engagement with Subject Matter Experts (SMEs). This structured approach ensures departments remain actively involved and that future training expectations are transparent and well-supported.

      (i) The first phase focuses on gathering departmental Learning Aids, which provide the foundation for a consistent and proportionate training framework.
      (ii) Once received, SMEs will review the content alongside departments to confirm accuracy, update outdated elements, and ensure alignment with national standards, professional guidelines and local operational needs in collaboration with the department manager.

   This collaborative model supports relevance, avoids unnecessary training burden, and reflects real service requirements. In total, 155 departments and roles have been identified, with 51 completed to date (32.9%), demonstrating ongoing, measurable progress toward a comprehensive and sustainable training structure across NHS Orkney. It has been identified that the yearly budget allocation for Nursing, Midwifery and Allied Healthcare Professions training is insufficient to support the required essential role specific training. This funding shortfall presents a significant risk to workforce readiness, professional development, and the safe delivery of care, as staff may be unable to access the training necessary to meet clinical standards and statutory obligations. A risk jotter has been completed to formally document and escalate the concern.

Please provide Information on your methods of monitoring compliance with Duty 12II

1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum.

2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72% compliance).

3. Protected Learning Time Workstream: Approximately 155 departments and roles have been identified, with 51 completed to date (32.9%).

4. Statutory and mandatory training and appraisal are tracked with the People Summary Dashboard, which provides data for quarterly internal governance updates. Performance has improved throughout the year across all areas, due to efforts from NHS Orkney teams and greater Senior Leadership oversight. As of 31 March 2026:

    a. eLearning compliance has risen from 78.24% to 83.47%
    b. Resuscitation training (now tracked with new metrics) stands at 51.73%
    c. Manual Handling training improved from 54.7% to 71.64%
    d. Safety Intervention training increased from 66.07% to 75.36%
    e. Appraisal completion has increased from 39.86% to 45.60%

5. eLearning (Core Statutory and Mandatory Modules only): Compliance remains above 80% (83.47%) with trend holding consistently strong with only minimal variation from the previous quarter.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Path to green	1. Education Strategy in development, plus review of statutory / mandatory, and essential training underway.	1. Complete and publish Education Strategy, review of Statutory and Mandatory, and essential training. Monitor compliance via internal governance committees.
2. AHPs - Historic Training Needs		2. Training Matrix development is ongoing.

Analysis reviewed to identify priority training. Capacity to progress training requirements at the appropriate level within the organisation has been enabled by a Lead AHP (adult) being in post. 3. Improved induction and training of medical locums	2. Lead AHP will continue to liaise with AHP service leads around the professional training needs and any alterations to the Training Matrix. 3. Ensure locums, both internal and external, are appropriately trained, experienced, up to date and familiar with NHS Orkney's systems and processes. Specific induction material has been developed, and a checklist is now available to ensure a conversation on experience and training levels is had.	3. Ongoing monitoring of utilisation and feedback on opportunity for improvement.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. Path to green 2. Process to booking agreed	1. Processes and procedures are in places for some clinical groups of staff but it is unclear who is responsible and accountable for defining what is an essential training programme, assessing training needs and overseeing that the required training has been undertaken and where this is collated and monitored. 2. For example, one £30 course took 7 hours to	1. Confirm the process and procedures to be completed, including time frame, e.g., annually or 2 yearly etc, and who responsible & accountable for completing underpinned by a policy / SOP.

external courses time consuming and people are missing learning opportunities as a result. 3. Embedding protected learning time	book. 3. Work required to ensure staff received protected learning time to complete statutory / mandatory and role specific training / development.	2. Clear streamline board process of identifying training funding. 3. The Operational People Group to review yellow grading and implement an action plan to transition from yellow > green.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IJ: Duty to follow the common staffing method.

Duty Summary	**(1)In relation to health care of a type mentioned in section 12IK, a Health Board or the Agency (as the case may be) must, no less often than at the frequency specified in regulations by the Scottish Ministers, use the common staffing method set out in subsection (2).** **(2) The common staffing method means that a Health Board or the Agency (as the case may be)—** (a) uses the staffing level tool and the professional judgement tool as prescribed in regulations under subsection (3) and takes into account the results from those tools, (b) takes into account, in so far as relevant, any measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H (1) by the Scottish Ministers (including any measures developed as part of a national care assurance framework), (c) takes into account— (i) its current staffing levels and any vacancies, (ii) the different skills and levels of experience of its employees, (iii) the role and professional duties, in particular, of any individual with lead clinical professional responsibility for the particular type of health care, (iv) the effect that decisions about staffing and the use of resources taken for the particular type of health care may have on the provision of other types of health care including, in particular, those to which this section does not apply, (v) the local context in which it provides health care, (vi) patient needs, (vii) appropriate clinical advice, (viii) any assessment by HIS, and any relevant assessment by any other person, of the quality of health care which it provides, (ix) experience gained from using the real-time assessment arrangements under section 12IC (1) and the risk escalation processes under sections 12ID and 12IE, (x) comments by patients, and by individuals who have a personal interest in their health care (for example family members and carers within the meaning of section 1 of the Carers (Scotland) Act 2016), which relate to the duty imposed by section 12IA, and (xi) comments by its employees which relate to the duty imposed by section 12IA, (d) identifies and takes all reasonable steps to mitigate any risks, and

	(e) having followed the steps described in paragraphs (a) to (d), decides what changes (if any) are needed as a result to its staffing establishment, and to the way in which it provides health care.

Please provide information on the steps taken to comply with Duty 12IJ.

1. During Year 2, the Common Staffing Method (CSM) was followed at the required frequency by 17.39% of the six types of health care listed in duty 12IK applicable to NHS Orkney. This was for several reasons, including leadership capacity and incomplete structures.

2. Staffing Level Tools – The Common Staffing Method v0.6 2 Feb 25 SOP.

3. Quarterly Common Staffing Method compliance updates to Executive Director of Nursing, Midwifery and Allied Health Professions / Chief Officer Acute Services, Interim Deputy Director of Nursing and Nursing and Midwifery Advisory Committee

4. Locally developed resources have been created to support teams, e.g. Common Staffing Method Report template and staffing level tools aide memoir(s), which include the requirement for staff consultation/engagement in local staffing level tool runs (before, during and after), and training utilising the Health Improvement Scotland (HIS) Healthcare Staffing Programme (HSP) learning resource(s).

Please provide Information on your methods of monitoring compliance with Duty 12IJ

1. Board Level Clinician(s) Quarterly report to Staff Governance Committee and Area Partnership Forum.

2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 62.5% compliance).

3. Quarterly Common Staffing Method compliance updates to Executive Director of Nursing, Midwifery and Allied Health Professions / Chief Officer Acute Services, Interim Deputy Director of Nursing and Nursing and Midwifery Advisory Committee.

4. Staffing Level Tools – The Common Staffing Method v0.6 2 Feb 25 SOP was circulated to relevant professional group for comment via internal governance groups and published.

5. Training on the CSM and staffing level tools, which incorporates preparatory education sessions, engagement with services and feedback sessions for all staff involved in the CSM including role specific delivery is available as group (face to face or via Teams) and 1:1 session(s). Uptake to date has been limited. All familiarisation sessions include training specific to the CSM. A log is kept of all staffing level tool familiarisation, staffing level tool run dates and reports received.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Local Common Staffing Method report template 2. Staffing Level Tools – The Common Staffing Method v0.6 2 Feb 25 Standard Operating Procedure (SOP)	1. Section 5 of the locally produced CSM reporting template: Staff Engagement and Feedback - 'describe how results will be cascaded to all staff within your wards/teams. 2. SOP has been published.	1. Review how staff engagement and feedback is being collated and informing workforce planning. 2. Update SOP to include Staffing Level Tool run dates for 2026/27.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. The Common Staffing Method (CSM) compliance	1. The CSM was followed at the required frequency by 17.39% of the six types of health care listed in duty 12IK applicable to NHS Orkney. This was for	1. Need to understand the barriers to staff engaging with the CSM and staffing level tool(s) run(s) to progress and embed into business as usual.

	several reasons, including leadership capacity and incomplete structures. Certain staffing level tools fail to capture the complexities specific to remote, rural, and island boards, especially in wards where there are multiple specialties and staff roles. For example, categories like adult in-patient, maternity, and small wards overlook single-room layouts; additionally, the adult inpatient specialist staffing tool does not align its sub-specialties with multi-speciality wards. This misalignment leads to data being entered repeatedly across various sub-specialties, such as medical and surgical.	Review local CSM report template prompts to capture limitations of specialist staffing level recommended whole time equivalent (rWTE), and where suitable, propose an extra multiplier for single room situations[3].
2. Nursing and Midwifery Practice Education	2. Nursing and midwifery education currently have no direct contribution to the delivery of training / education of the CSM or staffing level tools.	2. Discuss with nursing and midwifery practice education.

COMPLIANCE ASSURANCE LEVEL
Limited Assurance

[3] For example, Shelford Staffing Tool add 0.075 rWTE per room.

Duty 12IL: Training and consultation of staff

Duty Summary	**In complying with the duty imposed by section 12IJ, every Health Board and the Agency must—** (a) encourage and support its employees to give views on its staffing arrangements for the types of health care described in section 12IK, (b) take into account and use any such views it receives to identify best practice, and areas for improvement, in relation to such staffing arrangements, (c) train employees (including, in particular, employees of a type mentioned in the third column of the table in section 12IK (1)) using the common staffing method on how to use it (d) ensure that those employees receive adequate time to use the common staffing method, and (e) provide information to employees engaged in the types of health care described in section 12IK about its use of the common staffing method, including about— (i) the results from using the staffing level tool and the professional judgement tool under paragraph (a) of section 12IJ (2), (ii) the steps taken under paragraphs (b), (c) and (d)] of that subsection, and (iii)the results of its decision under paragraph (e) of that subsection.

Please provide information on the steps taken to comply with Duty 12IL.

1. The completion of the locally produced reporting template follows each tool run, incorporating the CSM. The teams / services are encouraged to share the report with all staff following completion to allow for transparency, and for staff to be made aware of outcomes. This is a specific step within the preparation and education elements of the Staffing Level Tool run process. All clinical leaders with responsibility for the completion of the CSM are encouraged to hold face to face feedback sessions in keeping with line management role and responsibilities. Section 5 of the locally produced CSM reporting template: Staff Engagement and Feedback - 'describe how results will be cascaded to all staff within your wards/teams. This includes the Emergency Department staff running the Emergency Care Provision tool (nursing and medical staff). The HIS HSP quality assurance self-assessment template prompts team leaders/ managers to seek feedback from staff on the CSM and training. Staff involvement is also encouraged and evidenced via the locally produced CSM reporting template.

2. Although nursing and midwifery education currently have no direct face to face contribution to the delivery of training / education of the CSM or staffing level tools, appropriate levels have been identified on all training passports for all registered staff.

Please provide Information on your methods of monitoring compliance with Duty 12IL

1. A quarterly update is provided to the Executive Director of Nursing, Midwifery and AHPs / Chief Officer Acute and the Interim Deputy Director of Nursing / Lead Midwife on a quarterly basis highlighting areas of good practice and concern. This is incorporated into the quarterly Board Level Clinician(s) Internal Compliance report that goes to Staff Governance Committee. 2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 62.5% compliance). 3. The Executive and Senior Leadership Team has oversight of areas of compliance and non-compliance, highlighted through the quarterly Board Level Clinician(s) Internal Compliance report reports and any required escalation to the Board can happen through this route. 4. Agenda item on the Nursing and Midwifery Advisory Committee and Area Partnership Forum.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Path to compliance	1. Staff induction includes 'Introduction video: Knowledge and Skills Framework for Health and Care Staffing in Scotland'.	1. Embed informed, skilled, enhanced and expert level into role specific training.
2. Local Common Staffing Method report template	2. Section 5 of the locally produced CSM reporting template: Staff Engagement and Feedback - 'describe how results will be cascaded to all staff within your wards/teams.	2. Review how staff engagement and feedback is being collated and informing workforce planning.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. Engagement / ownership by clinical leaders	1. Issues with capacity were identified across all staff groups, plus lack of engagement by clinical leaders.	1. Understand the barriers preventing senior clinical leaders for taking responsibility for embedding duty 12IL into BAU.
2. Nursing and Midwifery Practice Education	2. Nursing and midwifery education currently have no direct contribution to the delivery of training / education of the CSM or staffing level tools.	2. Discuss with nursing and midwifery practice education.

COMPLIANCE ASSURANCE LEVEL
Limited Assurance

Duty Summary	**Guiding principles etc. in health care staffing and planning** (1) In carrying out the duty relating to staffing imposed by section 12IA of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to the guiding principles for health and care staffing. (2) In planning or securing the provision of health care from another person under a contract, agreement or arrangements made under or by virtue of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to— (a)the guiding principles for health and care staffing, and (b)the need for the person from whom the provision of health care is to be secured to have appropriate staffing arrangements in place.

Please provide information on the steps taken to comply with section 2(2) of this Duty.

1. Commencing end of January 2025 a short life working group was set up to oversee the governance of service level agreement (SLA), contract and memorandum of understanding (MoU). This group undertook a review of our systems and processes to incorporate the duty and requirements of the Act.

2. Three yearly Combined Practice Inspections of local NHS contracted dental practices.

Please provide Information on your methods of monitoring compliance when planning and securing services

1. All agreements are currently managed by the Procurement function, which routinely reviews them as new agreements are established and existing agreements are updated or renewed, e.g. dermatology is in development; ophthalmology, ENT, rheumatology, and orthopaedics are under review. Baseline details are being established and as SLA documents are developed, refreshed and formalised, the Act regulations are being integrated to ensure compliance and consistency.

2. Independent Sector SLAs: Updated wording is being added as documents are refreshed this year to align with Act standards and regulations.

3. Combined Practice Inspections framework to review local NHS contracted dental practice(s).

Planning and Securing Services

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Procurement engagement. Procurement colleagues are now engaged in the implementation of the Act. Continue to develop and monitor Awareness of this requirement within the Act	1. All contracts, tenders, SLA and MoU where services are secured from 3rd party providers NHS Orkney considers the guiding principles of the Act. As a board we are currently setting up a new SLA which will ensure that the agreement reflects the Act and the duties placed.	1. Continue To work with colleagues from Finance and Procurement Team to update any other agreements as they are refreshed and transitioning to business as usual into planning groups.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. Potential risk of Board being unable to secure a health care provider that meets the specification reflecting the requirements of the Act but can offer a minimum essential service.	1. Board will need to agree with the provider to deliver elements essential to maintain patient safety and service provision, noting that some aspects of the contract cannot reflect the original specification. The Board will need to be assured that the provider can provide appropriate staffing for the services within scope of the contract and	1. To monitor patient outcomes and impact of the gap between service specification and delivery. Continue to work with any provider in this situation to look at options to further strengthen the provision of healthcare through monitoring and due diligence processes.

	make explicit any compromise to the original specification.	Continue to build on or amend current processes to ensure compliance with this Duty.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

NHS Orkney

Item 13.4

Themes from Board Walkarounds between November 2025 - March 2026

Meeting	NHS Orkney Board
Meeting date	Thursday, 30 April 2026
Responsible Executive/Non-Executive	• James Goodyear, Interim Chief Executive • Davie Campbell, Interim Board Chair
Report Author(s)	• Hazel Aim, Senior Corporate Governance Officer
Purpose of report	• Decision
Contribution to Strategic ambition	• Corporate Strategy 2024-2028 - People • Operational Improvement Plan • Annual Delivery Plan • Local Policy • NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred
Key points for consideration	• 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 between November 2025 and March 2026 and provides an analysis of the key themes for the Board to consider. • Since the last update in October 2025, two walkarounds have taken place. • The Board is asked to discuss and consider the reflections from Board walkarounds and approve the draft schedule of Board Walkarounds May – October 2026/27.
Route to meeting	• Direct to Board 30 April 2026
Recommendation(s)	• Decision - Reaching a conclusion considering the options

NHS Orkney

Item 13.4

Themes from Board Walkarounds November 2025 - March 2026

Hazel Aim, Senior Corporate Governance Officer
19/04/2026

1. Situation

1.1 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 between November 2025 and March 2026 and provides an analysis of the key themes for the Board to consider.

2. Background

2.1 Board Walkarounds involve a blend of Executive Directors and a Non-Executive Board Member visiting different teams and departments across NHS Orkney and listening to how it feels working here.

Since the last update in October 2025, two walkarounds have taken place as follows:

- **Physiotherapy** (reflections/feedback not received) – Dr Anna Lamont (Medical Director) and Ryan McLaughlin (Employee Director)
- **Communications and Media** – Sam Thomas (Executive Director Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services – EDoNMAHP) and Issy Grieve (Non-Executive Board Member).

3. Assessment

3.1 Analysis - main themes from reflections of visits between November 2025 - March 2026

Below is a summary of the main feedback from the Board Walkaround with the Communications and Media team, noting feedback is outstanding from the physiotherapy visit.

What's working well:

- Strong trusting and highly collaborative working relationships
- Seamless division of responsibilities within team
- Built positive relationships with local media which did not exist previously
- Constructive relationships with Executive colleagues
- Pride in professionalism, accuracy and positive profile for NHS Orkney

Areas for improvement:

Decisions regarding the communications structure and role expectations were previously made without direct involvement from the team, resulting in the absence of Executive-level line management and subsequent inconsistencies in strategic direction. To address this, our communications team are now firmly embedded within our Corporate Governance Team, the Head of Corporate Governance has established a formal mechanism for team consultation on

communications matters. Moving forward, all significant decisions relating to structure and role expectations will be made collaboratively, ensuring the team's perspectives are actively sought and incorporated. Additionally, the Head of Corporate Governance meets on a weekly basis with the team to provide clear updates on how team input has influenced outcomes, thus reinforcing that staff voices are both heard and acted upon, and offering assurance of alignment with the Board's strategic objectives.

3.2 Board Walkaround Schedule 2026/27

Following a commitment from the Board to continue Board Walkarounds in 2026/27, a schedule for the next 6 months is offered for consideration in Appendix 1.

3.3 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	Board Walkarounds 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
People	Workforce	Yes	
Performance	Finance	No	No impact.
Potential	Risk Management	Yes	No impact.
	Digital	No	No impact.
Place	Equality and Diversity including health inequalities	No	No impact.
	Climate Change Sustainability	No	No impact.

4. Recommendations

4.1 Discussion - Consider the Implications of a matter

The Board is asked to

- **Discuss** and **consider** the reflections from Board walkarounds.
- **Approve** the draft schedule of Board Walkarounds May – September 2026/27.

5. List of Appendices

5.1 The following appendices are included with this report

i. **Appendix 1** – Draft schedule of Board Walkarounds 2026/27

Appendix 1 - Schedule of Board Walkarounds May – September 2026/27

Date	Time	Service	Location	Executive Director	Non-Executive Board Member
6 May 2026	13:45	Outpatients	Outpatients B	Director of People & Culture	Davie Campbell
18 May 2026	15:15	Speech and Language	The Balfour	Director of People & Culture	Joanna Kenny
21 May 2026	10:00	Improvement Team	The Balfour	Director of Public Health	Issy Grieve
18 June 2026	12:30	Occupational Therapy	Selbro	Medical Director	Jason Taylor
7 July 2026	14:30	Community Nurse West	Primary Care - Stromness Surgery	Interim Director of Finance	Ryan McLaughlin
23 July 2026	14:30	Community Nurse West	Primary Care - Dounby	Director of Public Health	Davie Campbell
4 August 2026	10:30-15:30	Primary Care - Flotta	Flotta Surgery	Director of People & Culture	Joanna Kenny
19 August 2026	10:30	Diabetes	The Balfour	Interim Director of Finance	Jean Stevenson
1 September 2026	14:30	Corporate Governance	The Balfour	Director of Public Health	Jean Stevenson
17 September 2026	13:30	Orkney Drugs & Alcohol Team	The Balfour	Interim Director of Finance	Ryan McLaughlin

NHS Orkney

Item 14.1

Healthcare Associated Infection Reporting Template (HAIRT) Report

Meeting	**NHS Orkney Board**
Meeting date	Thursday, 30 April 2026
Responsible Executive/Non-Executive	• Sam Thomas, Executive Director Nursing, Midwifery, AHP's, Chief Officer Acute Services
Report Author(s)	• Sarah Walker, Head of Infection Prevention
Purpose of report	• Assurance
Contribution to Strategic ambition	• Government policy/directive
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred
Key points for consideration	• Two of the three Local Delivery Standards for 2025-26 have been achieved with one out with parameters, however the LDP standard was set at zero. Quarter 4 is yet to be validated. • Hand hygiene for February and March has met the 95% target. • Domestic and Estates monitoring has achieved above the 90% target. Included in the national information for benchmarking.
Route to meeting	• Nil: this is a mandatory Board report
Recommendation(s)	• **Assurance - For members assurance only**

NHS Orkney

Item 14.1

Healthcare Associated Infection Reporting Template (HAIRT) Report

Sarah Walker, Head of Infection Prevention

07/04/2026

1. Situation

1.1 The Healthcare Associated Reporting Template (HAIRT) Report is presented to the Board for oversight, assurance and scrutiny

2. Background

2.1 This report provides an overview of the changes since the last report two months ago, and highlights areas that require mandatory reporting as well as local data capture.

3. Assessment

3.1 Analysis

The HAIRT report is attached as appendix one and reflects end of year Local Delivery Standards

3.2 Current Position

Mandatory National Surveillance:

- Quarter 4 case numbers are yet to validated with Antimicrobial Resistance and Healthcare Associated Infections Scotland

Staphylococcus aureus bacteraemia – four Healthcare Associated Infections – Local Delivery Standard was set at zero therefore standard has not been met, no cases were deemed to be preventable.

Clostridioides difficile Infection (CDI) – one Healthcare Associated Infection – Target was set at one therefore the Local Delivery Standard has been met

Escherichia Coli Bacteraemia (ECB) - Four Healthcare Associated Infection – Target was set at five cases; the Local Delivery Standard has been met.

Domestic and Estates target- have achieved the **90%** and above target

Work ongoing to reduce splash zone and reduce splash risk to patients.

3.3 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	Robust management of investigation is undertaken for *Staphylococcus aureus* and *E.Coli* bacteraemia's and CDI cases. In order to reduce environmental risk to patients from splash zones work is ongoing to reduce the number of clinical hand wash sinks within the immediate patient area.
People	Workforce	No	No impact.
Performance	Finance	No	No impact.
Potential	Risk Management	Yes	Effectively addressing some of the current IPC risks to patients
	Digital	No	No impact.
Place	Equality and Diversity including health inequalities	No	No impact.
	Climate Change Sustainability	Yes	Reduction in water usage will be achieved with a reduction in hand wash sinks.

4. Recommendations

4.1 The Board are asked to review and scrutinise the information shared and raise any questions or clarification required.

4.2 Assurance - For members assurance only

5. List of Appendices

5.1 The following appendices are included with this report

i. **Appendix 1,** HAIRT Report

Appendix 1 - Healthcare Associated Infection Reporting Template

Mandatory National Surveillance

Local Delivery Plan (LDP) Standard for quarter 4 is yet to validated with ARHAI but unlikely to change.

***Staphylococcus aureus* bacteraemia (SAB)**

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

- * Quarter 4 case numbers are yet to validated with Antimicrobial Resistance and Healthcare Associated Infections Scotland

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

***Clostridioides difficile* Infection (CDI)**

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

- * Quarter 4 case numbers are yet to validated with Antimicrobial Resistance and Healthcare Associated Infections Scotland

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

Escherichia Coli Bacteraemia (ECB)

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

- * Quarter 4 case numbers are yet to validated with Antimicrobial Resistance and Healthcare Associated Infections Scotland

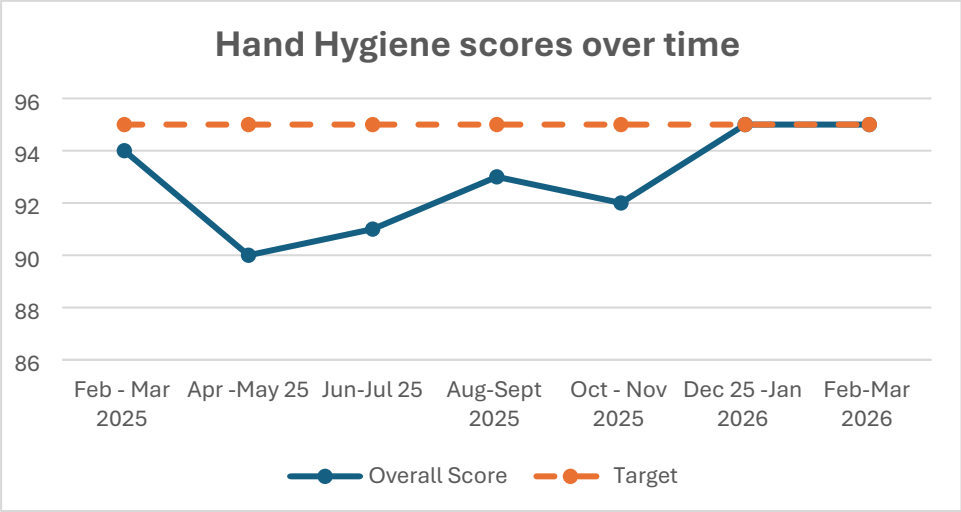
NHS Orkney are currently meeting the LDP standard which is set to no more than five Healthcare associated Infection (HCAI) cases.

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

There has been no national update to the clinical risk assessment

Hand Hygiene

The hand hygiene score for February to March 2026 is now **95%** which meets the national target.



Failed opportunities included wearing gloves inappropriately- not removing and cleaning hands in a timely manner, wearing nail varnish, and wristwatch/jackets.

Local Domestic and Estates Monitoring

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

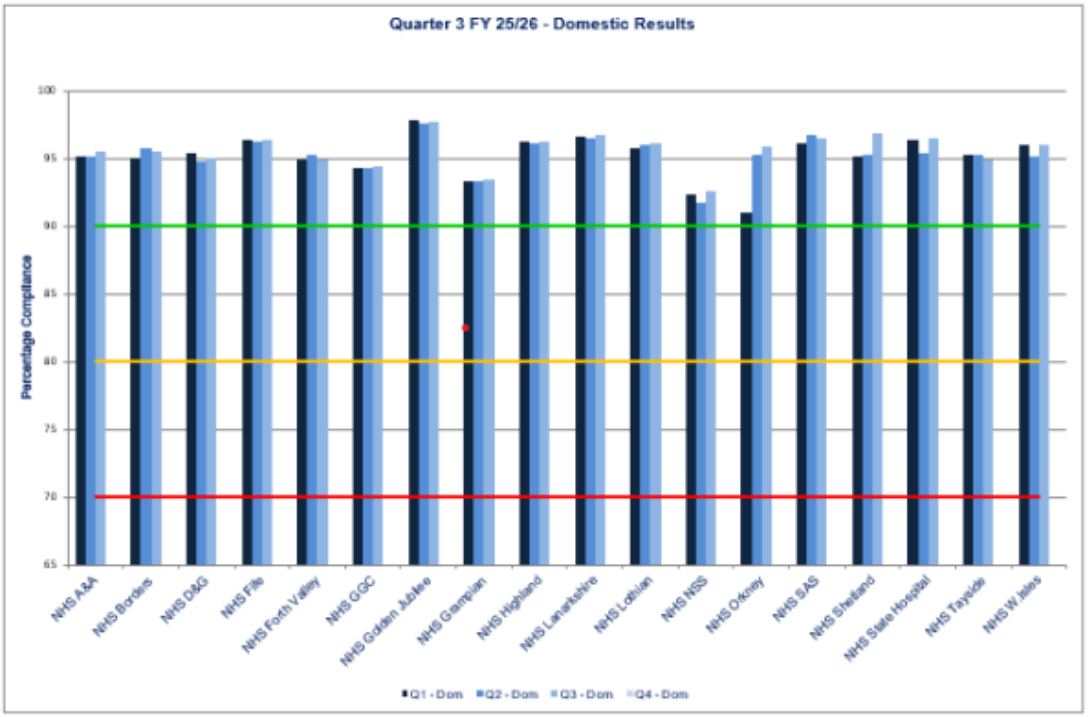
Annual Months	**Domestics % score**	**Estates % score**
Apr- 25	90%	100%
May-25	91%	100%
Jun-25	92%	100%
Jul-25	95%	100%
Aug-25	96%	100%
Sep-25	95%	100%
Oct-25	97%	100%
Nov-25	97%	100%
Dec- 25	95%	100%
Jan-26	96%	100%
Feb -26	97%	100%
Mar-26	94%	99%

National Domestic and Estates Monitoring for Benchmarking

Domestic services monitoring - NHS board performance

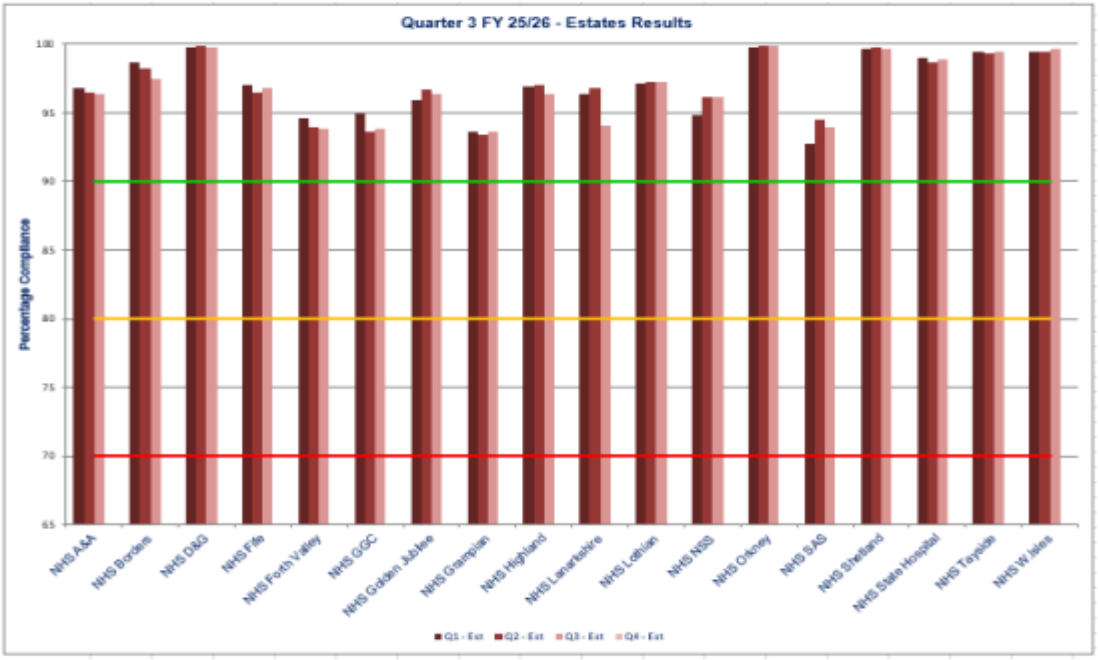
The following bar chart shows the quarterly domestic scores for each NHS board.

Figure 5.1 - Chart showing cumulative quarterly domestic scores by NHS board



Estates

Figure 7.1 - Chart showing cumulative quarterly estate scores for NHS boards



IPC Update

The Infection prevention team have been working through an improvement plan for reducing splash risk within the inpatient areas. Information released within the National Infection prevention and Control Manual Chapter 4 – Water highlights risk to patients from splashes of water and drains, therefore recommendation is that patients are located outside of a two metre “splash zone”. The Capital and Strategic planning group have approved plans to remove 19 clinical hand wash sinks. So, it is anticipated that work will begin within this calendar year. Currently this sits as a risk within the Acute risk register.

Community

Community GP infection prevention audits have commenced with the 1st audit completed on the 14th of April. These audits also include the Hyperbaric Chamber and a visit to the custody room within the Police station.

All audits are fed back at time and then formally followed up with areas of good practice and areas for improvement. An action plan is requested which is used for following up at the next visit.

Exception Reporting to ARHAI and Scottish Government.

No exception reporting

NHS Orkney

Item 14.2

Code of Corporate Governance 2026/27

Meeting	NHS Orkney Board
Meeting date	Thursday, 30 April 2026
Responsible Executive/Non-Executive	• James Goodyear, Interim Chief Executive • Davie Campbell, Interim Board Chair
Report Author(s)	• Debs Crohn, Head of Corporate Governance
Purpose of report	• Decision
Contribution to Strategic ambition	• Corporate Strategy 2024-2028 • NHS Board/Integration Joint Board Strategy/Direction • Annual Financial Plan • Financial Sustainability • Legal requirement
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred • Sustainability
Key points for consideration	• Following a review, the Corporate Code of Governance has been updated for 2026/27 (Version 20; see Appendix 1). • Standing Financial Instructions remain unchanged from Version 19 (2025/26). • Track changes highlight all revisions. • The Executive Management Team, Finance and Performance and Audit and Risk Committees have reviewed the updated Code and recommend its approval by the NHS Orkney Board.
Route to meeting	• Each Governance Committee of the Board has reviewed and recommended for approval the changes to the Terms of Reference relevant to the Committee. • Executive Management Team Monday 9 February 2026 • Finance and Performance Committee – 25 February 2026 • Audit and Risk Committee – 3 March 2026
Recommendation(s)	• **Decision - Reaching a conclusion considering the options**

NHS Orkney

Item 14.2

Code of Corporate Governance 2026/27

Debs Crohn, Head of Corporate Governance
19/01/2026

1. Situation

1.1 After reviewing the updated Corporate Code of Governance (Version 20) 2026/27 set out in Appendix 1, the Executive Management Team, Finance and Performance Committee and Audit and Risk Committee are recommending its approval by the NHS Orkney Board.

2. Background

2.1 In 2018, the Scottish Government recognised the need to ensure that the governance arrangements in NHS Scotland were fit for purpose and keeping pace with the changing policy and financial environment.

2.2 The Blueprint for Good Governance provides Health Boards with guidance on how to deliver and sustain good corporate governance. Outlined in the Blueprint is the requirement for NHS Orkney to have a Code of Corporate Governance (the Code) which sets out:

- How the business of the Orkney NHS Board and its Committees are organised
- Members' Code of Conduct
- Standard of Business Conduct for NHS staff
- Fraud Standards
- Reservation of powers and delegation of authority
- Standing Financial Instructions

2.3 The Code of Corporate Governance is reviewed on an annual basis to take account of changes in legislation and outcomes from the review of Governance Committee and Board key documentation.

2.4 The Code was last reviewed in March 2025 and approved by the Board at its April 2025 meeting.

3. Assessment

3.1 Analysis

Following the launch of our 5-year Corporate Strategy in April 2024, the Code is well aligned to our 5 Strategic Priorities. The main changes to the Code following the latest review are highlighted with track changes and include:

- Amendments to the Governance Committee Terms of Reference following individual Committee reviews.
- Minor changes to job titles, email addresses and links to reflect current arrangements. Noting this will need to be updated when the new Interim Director of Finance joins the organisation in March 2026.

Following Board approval, the Code will be widely distributed to staff with a covering email highlighting the amendments as noted above. This is in acknowledgment of the size of the document and will enable staff to note where changes have been made.

All budget holders will be required to confirm they have received and will adhere by the Code.

The Code will also be published on The Blog, NHS Orkney Policies and Procedures Teams Channel and the NHS Orkney website.

3.2 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	The Code plays a vital role in ensuring that governance arrangements support the delivery of high-quality patient care and maintain patient safety and experience. By keeping the Code up-to-date and ensuring staff compliance, NHS Orkney can continue to provide effective and person-centred healthcare services
People	Workforce	Yes	The Code applies to all staff, especially the Standards of Business Conduct for NHS Staff, which provides information to ensure that all staff are aware of their duties in situations where there may be conflict between their private interests and their NHS duties.
Performance	Finance	Yes	There is no direct financial impact of the amendments as proposed. The Standing Financial Instructions explain how staff will control the financial affairs of NHS Orkney and ensure proper standards of financial conduct.
Potential	Risk Management	Yes	The Code of Corporate Governance is reviewed annually to ensure any amendments in legislation are incorporated and that NHS Orkney is compliant with these.
	Digital	No	No impact.
Place	Equality and Diversity including health inequalities	No	The Code applies to all staff, especially the Standards of Business Conduct for NHS Staff, which provides information to ensure all staff are aware of their duties in situations where there may be a conflict between their private interests and their NHS duties While there is no direct impact, the Code emphasis staff awareness and compliance in relation to the principles of equality and diversity by ensuring all staff understand their responsibilities and adhere to high standards of conduct, creating an inclusive and

			fair working environment, which is crucial for delivering equitable healthcare services.
	Climate Change Sustainability	No	No impact.

4. Recommendations

4.1 Decision - Reaching a conclusion considering options

Members are asked to:

- Approve the updated NHS Orkney Code of Corporate Governance (Version 20) 2026/27

5. List of Appendices

5.1 The following appendices are included with this report

i. **Appendix 1** - NHS Orkney Code of Corporate Governance (Version 20) 2026/27.

Code of Corporate Governance

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Policy Author:	Head of Corporate Governance
Policy Owner (for updates):	Head of Corporate Governance
Engagement and Consultation Groups:	Audit and Risk Committee / Board members
Approval Record	**Date**
Audit and Risk Committee	~~6 March 2025~~3 March 2026
Board	~~24 April 2025~~
Equality and Diversity Rapid Impact Assessment	Not applicable
Finance and Performance Committee	25 February 2026~~27 March 2025~~
Version Control	
Version Number	20~~19~~
Date of Original Document	February 2004
Last Change and Approval Date	
Last Review Date	~~February 2025~~January 2026
Next Formal Review Date	~~February 2026~~January 2027
Location and Access to Documents	
Location of master document	Corporate Services folder – G:Drive
Location of backup document	Meetings folder – G:Drive
Location of E&D assessment	n/a
Access to document for staff	Blog and website
Access to document for public	Website
Post holder(s) names at last review	
Interim Head of Corporate Governance	Debbie Crohn
Senior Corporate Governance Officer	~~Rachel Ratter~~ Hazel Aim

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Email: ork.corporategovernance @nhs.scot

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Introduction

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1 Code of Corporate Governance

The Code of Corporate Governance includes the following sections:

Section A How Business is organised
Section B Members' Code of Conduct
Section C Standards of Business Conduct for NHS staff
Section D Fraud Standards
Section E Reservation of Powers and Delegation of Authority
Section F Standing Financial Instructions

It uses best practice in Corporate Governance, and guidance issued by the Scottish Government Health and Social Care Directorates and the Blueprint for good governance.

The Board reviews and approves the Code of Corporate Governance each year. Sections A to E are Orkney NHS Board's Standing Orders. The Standing Orders are made in accordance with The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

Statutory provision, legal requirement, regulation, or direction by Scottish Ministers take precedence over the Code of Corporate Governance if there are any conflicts.

2 Orkney NHS Board

Orkney NHS Board, The Board', means Orkney Health Board which is the legal name. It is a strategic body, accountable to the Scottish Government Health and Social Care Directorate and to Scottish Ministers for the functions and performance of NHS Orkney.

The Board will not concern itself with day-to-day operational matters, except where they have an impact on the overall performance of the system.

The Board consists of the Chair, Non-Executive and Executive Members appointed by Scottish Ministers to constitute Orkney Health Board. (National Health Services (Scotland) Act 1978, as amended).

Remuneration will be paid as determined by Scottish Ministers to the Chair and other Non-Executive Board Members. Any member of the Board may, on reasonable cause shown, be suspended, or removed, or disqualified from

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membership of the Board in accordance with the Regulations identified in Section 1 above.

A member of the Board may resign office at any time by giving notice in writing to Scottish Ministers to that effect.

2.1 Overall Purpose

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

2.2 Priority Areas

Our Corporate Strategy 2024-2028 is underpinned by our commitment to delivering excellent care and services to our community. We will do this by connecting with our community and ensuring our values are at the heart of everything we do to deliver our promise of looking after our community and providing excellent care.

Our values, aligned to those of NHS Scotland, are: Openness, honesty, respect and kindness.

We have 5 Strategic Objectives:

1. Place - By 2028 we will: be a key partner in leading the delivery of place-based care which improves health outcomes and reduces health inequalities for our community
2. People - By 2028 we will: ensure NHS Orkney is a great place to work
3. Patient safety, quality and experience - By 2028 we will: consistently deliver safe and high-quality care to our community
4. Performance - By 2028 we will: within our budget, ensure our patients receive timely and equitable access to care and services and use our resources effectively
5. Potential - By 2028 we will: ensure innovation, transformation, education and learning are at the forefront of our continuous improvement

~~1. Place - By 2028 we will: be a key partner in leading the delivery of place-based care which improves health outcomes and reduces health inequalities for our community~~

2.3 Function

The Second edition of the NHS Scotland Blueprint for Good Governance (issued through DL 2022 38) describes the functions of the Board as:

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- Setting the direction, including clarifying priorities and defining change and transformational expectations.
- Holding the Executive Leadership Team to account by seeking assurance that the organisation is being effectively managed and change is being successfully delivered.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with key stakeholders, as and when appropriate
- Influencing the Board's and the wider organisational culture.

2.4 Members of Orkney NHS Board

There are 10 Non-Executive Members, which include the Chair of the Board and 3 stakeholder members representing the following:

- Area Clinical Forum
- Orkney Islands Council
- Staff Side Employee Director

There are 5 Executive Members:

- Chief Executive
- Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services
- Director of Finance
- Director of Public Health
- Medical Director

In total, there are 15 members of Orkney NHS Board.

In attendance there will also be:

- Director of People and Culture
- Chief Officer, Integration Joint Board
- Head of Corporate Governance
- Director of Performance and Transformation, Deputy CEO

2.5 Co-option/Attendance of Non-Board Members at Meetings of the Board

The Board shall extend invitations to non-Board Members to participate in specific agenda items (with no voting rights) and to strengthen its governance arrangements regarding joint working.

2.6 Responsibilities of Members of the Board

Membership of Orkney NHS Board carries with it a collective responsibility for the discharge of the functions outlined in section 2.3.

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All members are expected to bring an impartial judgement to bear on issues of strategy, performance management, key appointments, and accountability, upwards to Scottish Ministers and outwards to the local community.

The Orkney NHS Board is a strategic body, accountable to the Scottish Government Health and Social Care Directorate and to Scottish Ministers for the designated functions of the NHS Board and performance of the NHS Orkney system. All members of Orkney NHS Board share collective responsibility for the overall performance of the NHS Orkney system.

2.7 Corporate Governance

The UK Corporate Governance Code (2018) defines Corporate governance as "The system by which organisation are directed and controlled". It expands on that statement by adding that "Governance is about what the board does and how it sets the values of the organisation and is to be distinguished from executive director led day-to-day operational management" A good governance system helps individuals avoid the tension and conflict that can arise in an organisation where the boundaries between roles are not clear.

The Orkney NHS Board's Ccorporate Governance function is essential for ensuring it operates ethically, transparently, and in the best interests of all its stakeholders. This includes:

1. **Ownership of the Board's Assurance Framework**: Which sets up the rules, practices, and processes by which the Orkney NHS Board is directed and controlled

2. **Board Oversight**: Setting the direction, clarifying priorities, defining expectations and influencing organisational culture.

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3. **Accountability and Transparency**: Ensuring the Orkney NHS Board's operations are transparent, holding the Executive Team to account and seeking assurance that the organisation is being effectively managed.

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4. **Risk Management**: Managing risks to the quality, delivery and sustainability of services.

5. **Ethical Conduct**: Promoting ethical behaviour and compliance with laws and regulations

.

6. **Community Engagement**: Balancing the interests of stakeholders, including shareholders, employees, customers, and the community

7. **Valuing Diversity –** ensuring we have different experience and points of view on the Board, encouraging applications from people with protected characteristics who are currently under-represented on the NHS Orkney Board, for example disabled people, people from the LGBTI+ community, people from minority ethnic communities, and those aged under 50.

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Effective corporate governance helps build trust, reduces risks, and enhances our reputation with our staff, patients, community and stakeholders.

Orkney NHS Board is responsible for:

- Giving leadership and strategic direction
- Putting in place controls to safeguard public resources
- Supervising the overall management of its activities; and
- Reporting on management and performance

The Senior Leadership Team (SLT) is responsible for the operational delivery of services supporting health protection and improvement.

2.8 Conduct, Accountability, and Openness

Members of Orkney NHS Board (Executive and Non-Executive) are required to comply with the Members' Code of Conduct and the Standards of Business Conduct for NHS staff.

Board Members and staff are expected to promote and support the Principles of Public Life In Scotland and be bound by the Members' Code of Conduct which are as follows:

The Principles of Public Life in Scotland	
Duty You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. You have a duty to act in the interests of the public body of which you are a member and in accordance with the core tasks of that body.	**Openness** You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.
Selflessness You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.	**Honesty** You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.
Integrity You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.	**Leadership** You have a duty to promote and support these principles by leadership and example, to maintain and strengthen the public's trust

	and confidence in the integrity of the public body and its members in conducting public business
Objectivity You must make decisions solely on merit when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.	**Respect** You must respect fellow members of your public body and employees of the body and the role they play, treating them with courtesy at all times. Similarly you must respect members of the public when performing duties as a member of your public body
Accountability and Stewardship You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that the public body uses its resources prudently and in accordance with the law.	

2.9 Understanding our responsibilities arising from the Code of Corporate Governance

It is the duty of the Chair and the Chief Executive to ensure Board Members and staff understand their responsibilities. Board Members and Managers will receive copies of the Code of Corporate Governance, and the Head of Corporate Governance will maintain a list of individuals to whom the Code of Corporate Governance has been issued. Managers are responsible for ensuring their staff understand their own responsibilities.

The Code of Corporate Governance is available on the Board's website, the intranet (The Blog) and on the Corporate Governance Teams channel.

2.10 Orkney Health Board Endowment Fund

The principles of this Code of Corporate Governance apply equally to Members of Orkney NHS Board who have distinct legal responsibilities as Corporate Trustees of the Board's Endowment Fund.

2.11 Advisory and Other Committees

The principles of this Code of Corporate Governance apply equally to all of NHS Orkney's Advisory Committee and all Committees and groups which report directly to an Orkney NHS Board Committee.

2.12 Review

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The Board will keep the Code of Corporate Governance under review and undertake a comprehensive annual ~~review.~~review. The Board may, on its own or if directed by the Scottish Ministers, vary and revoke Standing Orders for the regulation of the procedure and business of the Board and of any Committee. The Audit and Risk Committee is responsible for advising the Board on these matters.

2.13 Feedback

NHS Orkney wishes to improve continuously and reviews the Code of Corporate Governance regularly. To ensure this Code remains relevant, we would be happy to hear from you ~~with regard to~~about new operational procedures, changes to legislation, confusion regarding the interpretation of statements or any other matter concerning the Code. Comments and suggestions for improvement are welcomed and should be sent to:

Head of Corporate Governance
NHS Orkney
The Balfour
Foreland Road
Kirkwall
KW15 1NZ

(01856) 888910

ork.corporategovernance@nhs.scot

2.14 Definitions

Any expression to which a meaning is given in the Health Service Acts, or in the Regulations or Orders made under the Acts, shall have the same meaning in this interpretation and in addition:

Definition	Meaning
The Accountable Officer	Is the Chief Executive of NHS Orkney, who is personally answerable to the Scottish Parliament (in accordance with section 15 of the Public Finance and Accountability (Scotland) Act 2000, Annex 2: Memorandum to Accountable Officers for other Public Bodies) for the propriety and regularity of the public finances for NHS Orkney, ensuring they are used economical, efficiently and effectively. The Chief Executive of NHS Orkney is also accountable to the Board for clinical, staff and financial governance, including controls assurance and risk management. This is a legal appointment made by the Principal Accountable Officer of the Scottish Government.
The Act	The National Health Service (Scotland) Act 1978, as amended

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Definition	Meaning
The 1960 Act	The Public Bodies (Admission to Meetings) Act 1960, as amended
The 2016 Regulations	The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016
Board Executive Member	Or 'Executive' means the Chief Executive, the Director of Finance, the Director of Nursing, Midwifery, Allied Health Professionals and Acute, the Director of Public Health, and the Medical Director. All other Members are Non-Executive Members
Budget	Means Money proposed by the Board for the purpose of carrying out, for a specific period, any, or all of the functions of the Board
Chair	The person appointed by the Scottish Ministers to lead the Board and to ensure that it successfully discharges its overall responsibility for the Board as a whole. The expression "the Chair of the Board" is deemed to include the Vice-Chair of the Board if the Chair is absent from the meeting or is otherwise unavailable. The Chair of a Committee is responsible for fulfilling the duties of a Chair in relation to that Committee only
Chief Executive	Means the Chief Officer of Orkney NHS Board
Committee	Means a Committee established by the Board, and includes 'Sub-Committee'
Committee Members	Are people formally appointed or co-opted by the Board to sit on or to chair specific committees. All references to members of a committee are as 'committee member' and when the reference is to a member of the Board it is 'Board Member'
Contract	Includes any arrangement including an NHS contract
Co-opted Member	Is an individual, not being a Member of the Board, who is invited to attend Board meetings or appointed to serve on a committee of the Board
Head of Corporate Governance	A senior administrative officer in a public organisation with a role like that of Company Secretary, who is responsible for ensuring procedures are followed in accordance with good governance

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Definition	Meaning
Director of Nursing and Acute	Means the Director of Nursing, Midwifery, Allied Health Professionals and Acute
Director of Finance	The Chief Finance Officer of the Board
Directors	Means all direct reports to the Chief Executive
Meeting	Means a meeting of the Board or of any Committee
Member	A person appointed as a Member of the Board by Scottish Ministers, and who is not disqualified from membership. This definition includes the Chair and other Executive and Non-Executive Members. (Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016)
Motion	Means a proposal
Nominated Officer	Means an officer charged with the responsibility for discharging specific tasks within the Code of Corporate Governance
Non-Executive Member	Any Member appointed to the Board in terms of the Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 and who is not listed under the definition of Executive Member above
Responsible Officer	Subject to the below regulations, every designated body must nominate or appoint a responsible officer The Medical Profession (Responsible Officers) Regulations 2010 (legislation.gov.uk)
Officer	An employee of NHS Orkney
SFIs	Standing Financial Instructions
Sos	Standing Orders
The Code	Code of Corporate Governance
Vice-Chair	The Non-Executive Member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason
Working day	Any day between Monday and Friday inclusive, but not including, public holidays

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2.15 The Seven Principles of Public Life

The Seven Principles of Public Life (also known as the Nolan Principles) apply to anyone who works as a public officeholder. All public officeholders are both servants of the public and stewards of public resources. You have a duty to uphold the law and act in accordance with the law and public trust placed in you.

The Seven Principles of Public Life - GOV.UK (www.gov.uk)

1 Selflessness
Holders of public office should act solely in terms of the public interest

2 Integrity
Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships

3 Objectivity
Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias

4 Accountability
Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this

5 Openness
Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing

6 Honesty
Holders of public office should be truthful

7 Leadership
Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs

SECTION

A

How Business is Organised

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This section is for Members of Orkney NHS Board and details how they should conduct themselves in undertaking their duties.

1 How Board and Committee Meetings must be oOrganised

This section regulates how the meetings and proceedings of the Board and its Committees will be conducted and are referred to as 'Standing Orders'.

These Standing Orders for regulation of the conduct and proceedings of Orkney NHS Board, the common name for Orkney Health Board, and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

1 Calling and Notice of Meetings

1.1 The Chair may call a meeting of the Board at any ~~time~~time, ~~and~~ the Chair of a Committee may call a meeting of that Committee at any time or when required to do so by the Board.

1.2 Ordinary meetings of the Board or Committees shall be held in accordance with the timetable approved by the Board. The Board shall meet at least six times in the year and will annually approve a forward schedule of meeting dates.

1.3 Meetings of the Board and its Committees may be conducted in any way in which each member is enabled to ~~participate~~participate, such as video conferencing, ~~-~~and hybrid meeting arrangements.

1.4 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition

1.5 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least three clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point

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1.6 Notification of the time and place of Board meetings shall be placed on NHS Orkney's website,

1.7 Lack of service of the notice on any Member shall not affect the validity of a meeting.

1.8 Special meetings of Committees shall be held on the dates ~~and~~and at times that the Chairs of those Committees determine.

1.9 It is within the discretion of the Chair of any Committee to cancel, advance or postpone an ordinary meeting if there is a good reason for doing so.

1.10 Four or more members of any Committee may, by notice in writing, request a special meeting to be called to consider the business specified in the notice. Such a meeting shall be held within fourteen days of receipt of the notice by the Head of Corporate Governance or Lead Executive Officer.

1.11 In the case of the Audit and Risk Committee a special meeting may be called by the Audit and Risk Committee Chair, the Chief Executive, and the Director of Finance.

2 Appointment of Chair of Orkney NHS Board

2.1 The Scottish Ministers shall appoint the Chair of the Board.

The Scottish Ministers shall also appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension and disqualification of members in line with the above regulations. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

3 Appointment of Vice-Chair of Orkney NHS Board

3.1 The Chair shall nominate a candidate or candidates for vice-chair to the Cabinet Secretary. The candidate(s) must be a non-executive member of the Board. A member who is an employee of a Board is disqualified from being Vice-Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position.

Following the decision, the Board shall appoint the member as Vice-Chair. Any ~~person so~~person appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice-Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice-Chair is the process described at paragraph 3.1.

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3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained ~~period of time~~period to perform his or her duties due to illness, absence from Scotland or for any other reason, then the Board's Head of Corporate Governance should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair.

Where the Chair is absent for a short period due to leave (for whatever reason),~~.~~ the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to either the interim chair or the Vice-Chair. If the Vice-Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

4 Duties of the Chair and Vice-Chair

4.1 At every meeting of the Board the Chair shall preside. If the Chair is absent the Vice-Chair shall preside. If the Chair and Vice-Chair are both absent, the Members present shall elect a Non-Executive Member to act as Chair for that meeting. This cannot be an NHS Orkney employee.

4.2 If both the Chair and Vice-Chair (if any) of a Committee are absent from a meeting a member of the Committee chosen at the meeting by the other members shall act as Chair for that meeting.

4.3 It shall be the duty of the Chair:

- To ensure that Standing Orders are observed and to facilitate a culture of transparency, consensus, and compromise
- To preserve order and ensure that any member wishing to speak is given due opportunity to do so and a fair hearing
- To call members to speak according to the order in which they caught their eye
- To decide all matters of order, competence, and relevance.

4.4 The Chief Executive or Head of Corporate Governance shall draw the attention of the Chair to any apparent breach of the terms of these Standing Orders.

4.5 The decision of the Chair on all matters referred to in this Standing Order shall be final and shall not be open to question or discussion in any meeting of the Board.

4.6 Deference shall always be paid to the authority of the Chair. When the Chair commences speaking, they shall be heard without interruption.

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5 Membership

5.1 Non-Executive Membership

Each Committee will have a minimum number of Non-Executive Members which includes those Non-Executive Members who are members due to the office they hold:

Audit and Risk Committee	Four
Finance and Performance Committee	Four
Joint Clinical and Care Governance Committee	Three
Remuneration Committee	Five
Staff Governance Committee	Four

6 Quorum

6.1 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for committees will be set out in their terms of reference, however it can never be less than two Board members.

6.2 The quorum for Committees shall be as follows: -

One third of whole number of members including:

	Quorum
Audit and Risk Committee	Three Non-Executive Members, one of whom must be chair or vice-chair
Finance and Performance Committee	Three members including two Non-Executive Members, one of whom must be chair or vice-chair, and one executive member
Joint Clinical and Care Governance Committee	Three members including two Non-Executive Members, one of whom must be chair or vice-chair and two Orkney Islands Council voting

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	members of the Integration Joint Board.
Staff Governance Committee	Four members including two Non-Executive Members, one of whom must be chair or vice-chair, one executive member and one lay representative from Union or Professional body
Remuneration Committee	Three Non-Executive Members, one of whom must be Chair or Vice-Chair

6.3 If a quorum is not present ten minutes after the time specified for the start of a meeting of the Board or Committees, the Chair will seek agreement to adjourn the meeting or reschedule.

6.4 If, during any meeting of the Board or of its Committees, a Member or Members are called away and the Chair finds that the meeting is no longer quorate, the meeting shall be suspended. If a quorum is not present at the end of ten minutes, the Chair will seek agreement to adjourn the meeting or reschedule.

7 Human Rights

7.1 If the Business before the Board or its Committees involves the determination of a person's individual civil rights and obligations, no members shall participate in the taking of a decision on an item of business unless they have been present during consideration of the whole item, including where the item of business was discussed at a previous meeting. (Article 6 of the European Convention of Human Rights)

8 Order of Business

8.1 For an ordinary meeting of the Board, the business will proceed in the order shown on the agenda, the Chair may change the running order if there are reasons to do so. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

9 Order of Debate

9.1 **Informal Committee Rules**

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9.1.1 The Board or any Committee will routinely conduct its business under 'Informal Committee Rules' on the understanding that any one Board or Committee member may at any time, without giving due reason, request that the Board or Committee move to the formal order of debate of motions as set out below (Formal Committee Rules 9.2).

9.1.2 All speakers will address the Chair and observe order. The Chair will have discretion to conduct the meeting, that is, limit the number of contributions any speaker makes, the amount of time for which they speak or to ask a speaker to sum up their contribution. At the conclusion of the discussions, the Chair will summarise the decisions of the Board or Committee. Orderly debate in the public domain is essential to project a professional approach to business.

9.1.3 If any point arises which is not provided for in the Board's Standing Orders, the Chair shall give a ruling on the ~~point~~point, and their decision will be final.

9.1.4 The Chair will seek to establish a consensus. If a consensus is not emerging, the Chair will follow the procedure set out in Section 14 – Voting.

9.1.5 The Chair will have a casting vote in the event of an equality of votes.

9.2 **Formal Committee Rules**

9.2.1 Any Board or Committee Member wishing to speak shall indicate this by raised hand and, when called upon, shall address the Chair, and restrict their remarks to the matter being discussed by:

- Moving, seconding, or leading a motion or amendment
- Moving or seconding a procedural motion
- Asking a question
- Making a point of clarification; or
- Raising a point of order

9.2.2 There shall be no discussion on any motion or amendment except by the mover until such motion or amendment is seconded.

9.2.3 No Member shall speak more than once in a debate on any one motion and amendment unless raising a point of order, making a clarification, moving, or seconding a procedural motion. However, the mover of the substantive motion (or an amendment which has become the substantive motion) in any debate shall have a right of reply but shall not introduce any new matter.

9.2.4 After the mover of the substantive motion has commenced their reply, no Member shall speak except when raising a point of order or moving or seconding a procedural motion.

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9.2.5 Any Member wishing to raise a point of order may do so by stating that they are raising a point of order immediately after it has arisen. Any Member then speaking will cease and the Chair shall call upon the Member raising the point or order to state its substance. No other Member shall be entitled to speak to the point or order except with the consent of the Chair. The Chair shall give a ruling on the point of order, either immediately, or after such adjournment as they consider necessary. After this the Member who was previously speaking shall resume their speech, provided the ruling permits.

9.2.6 Any Member wishing to ask a question relating to the matter under consideration may do so at any time before the formal debate begins.

10 Motions and Amendments

10.1 When called to speak, the mover of any motion or amendment shall immediately state the exact terms of the motion or amendment before proceeding to speak in support of it. The mover shall also provide the terms in writing at the request of the Chair to the Head of Corporate Governance before any vote is taken, except in the case of: -

- Motions or amendments to approve or disapprove without further qualification
- Motions or amendments to remit for further consideration; or
- Motions or amendments, the terms of which have been fully set out in a minute of a Committee or report by an Executive Member or other officer

10.2 Every amendment must be relevant to the motion to which it is moved. The Chair shall decide as to the ~~relevancy~~relevance and shall have the power, with the consent of the meeting, to conjoin motions or amendments which are consistent with each other.

10.3 All additions to, omissions from, or variations upon a motion shall be considered amendments to the motion and shall be disposed of accordingly.

10.4 A motion or amendment once moved and seconded shall not be withdrawn without the consent of the mover and seconder.

10.5 Where an amendment to a motion has been moved and seconded, no further amendment may be moved until the result of the vote arising from the first amendment has been announced.

10.6 If an amendment is rejected, a further amendment to the original motion may be moved. If an amendment is carried, it shall take the place of the original motion, and any further amendment shall be moved against it.

10.7 A motion for the approval of a minute or a report of a Committee shall be

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considered as an original motion and any proposal involving alterations to or rejection of such minute shall be dealt with as an amendment.

10.8 The Chair of a Committee shall have the prior right to move the approval of the Minute of that Committee.

10.9 A motion or amendment moved but not seconded, or which has been ruled by the Chair to be incompetent, shall not be put to the meeting nor shall it be recorded in the minute, unless the mover immediately gives notice to the Head of Corporate Governance requesting that it be so recorded.

10.10 A Member may request their dissent to be recorded in the minute in respect of a decision which they disagree and on which no vote has taken place.

11 Notice of Motions to be placed on an Agenda

11.1 Notice of motions must be given in writing to the Head of Corporate Governance no later than noon fourteen days before the meeting and must be signed by the proposing member and at least one other member.

11.2 A member may propose a motion which does not directly relate to an item of business under consideration at the meeting.

11.3 The terms of motions of which notice have been given shall appear as items of business for consideration at the next meeting.

11.4 If a member who has given notice of a motion is absent from the meeting when the motion is considered or, if present, fails to move it, any other member shall be entitled to move it, failing which the motion shall fall.

12 Questions

12.1 A Board or Committee Member may put a question to the Chair relating to the functions of that Committee, irrespective of whether the subject matter of the question relates to the business which would otherwise fall to be discussed at that meeting, if notice has been given to the Head of Corporate Governance ten working days prior to the meeting.

12.2 The original questioner may ask a supplementary question, limited to seeking clarity on any answer given.

12.3 Questions of which notice has been given in terms of 10.1 above, and the answers thereto, shall be recorded in the minute of the meeting only if the questioner so requests, but any supplementary questions and answers shall not be recorded.

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13 Time Allowed for Speaking during Formal Debate

13.1 The Chair is entitled to decide the time that members may be allowed to speak on any one issue.

13.2 As a guide, a member who is moving any motion or amendment shall not normally speak for more than five minutes. Other members shall not normally speak for more than three minutes, and the mover in exercising a right of reply shall not normally speak for more than three minutes.

14 Closure of Debate

14.1 A motion that the debate be adjourned, or that a question be put, or that the meeting now pass to the next business may be made at any stage of the debate and such motion, if seconded, shall be the subject of a vote without further debate.

14.2 No motion in terms of 11.1 above may be made during a speech.

15 Voting

15.1 The Board may reach consensus on an item of business without taking a formal vote, and this will be normally what happens where consensus has been reached

Where the Chair concludes that there is not a consensus on the Board's position on the item and/ or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on

15.2 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines

15.3 The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines

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16 Voting in the case of Vacancies and Appointments

16.1 In filling vacancies in the membership of any Committee and making appointments of Board Members to any other body, where more than one candidate has been nominated and seconded, members shall be entitled to vote for up to as many candidates as there are places to be filled. Candidates shall be appointed in the order of number of votes received until all vacant places have been filled.

16.2 In the event of two or more candidates tying with the lowest number of votes to fill the last vacant place, a further vote shall be taken between or among those candidates. Each member shall have one vote.

16.3 In the event of a further tie, the appointment shall be determined by lot.

17 Adjournment and Duration of Meetings

17.1 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to another day, time, and place. A meeting of the Board, or of a committee of the Board, may be adjourned by the Chair until such day, time and place as the Chair may specify.

17.2 A motion for adjournment has precedence over all other motions and if moved and seconded, shall be put to the meeting without discussion or amendment.

17.3 If carried, the meeting shall be adjourned until the time and place specified in the motion. Unless the time and place are specified, the adjournment shall be until the next ordinary meeting of the Board or Committee.

17.4 Where a meeting is adjourned without a time for its resumption having been fixed, it shall be resumed at a time fixed by the Chair.

17.5 When an adjourned meeting is resumed, the proceedings shall be commenced at the point at which they were interrupted by the adjournment.

17.6 In case of disorder the Chair may adjourn the meeting to a time fixed then or decided afterwards. Vacating the Chair shall indicate that the meeting is adjourned.

17.7 Every meeting of the Board or its Committees shall last no longer than four hours.

17.8 It shall, however, be competent, before the expiry of the time limit, for any Member to move that the meeting be continued for such further period as is deemed appropriate.

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18 Conflict of Interest

18.1 If a Board or Committee Member, or associate of theirs, has any interest, direct or indirect, in any contract or proposed contract or other matter, they shall disclose the fact, and shall not take part in the consideration and discussion of the contract, proposed contract, or other matter or vote on any question with respect to it.

18.2 The Scottish Ministers may, subject to such conditions as they may think fit to impose, remove any disability imposed by the 2016 Amendment Regulations in any case in which it appears to them in the interests of the health service that the disability should be removed.

18.3 Remuneration, compensation, or allowances payable to a Chair or other member shall not be treated as an interest by the 2016 Amendment Regulations. (Paragraphs 4, 5 or 14 of Schedule 1 of the Act).

18.4 A member or associate of theirs shall not be treated as having an interest in any contract, proposed contract or other matter if the interest is so remote or insignificant that they cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

18.5 The 2016 Amendment Regulations apply to a Committee as they apply to the Board and apply to any member of any such Committee (whether or not they are also a Member of the Board) as they apply to a Member of the Board.

18.6 For the purposes of the 2016 Amendment Regulations, the word 'associate' has the meaning given by Section 229 of the Bankruptcy (Scotland) Act 2016.

18.7 A ~~Member must~~Member must consider whether they have an interest to declare in relation to any matter which is to be considered as soon as possible. ~~Members should~~Members should consider whether agendas for meetings raise any issue of interest. Declarations should be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed, you must declare the interest as soon as you realise it is necessary.

18.8 The oral declaration of interest should identify the item of business to which it relates. The declaration should begin with the words "I declare an interest". The declaration must be sufficiently informative to enable those at the meeting to understand the nature of the interest but need not give a detailed description of the interest.

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19 Reception of Deputations

19.1 Every application for the reception of a deputation must be in writing or e-mailed to the Head of Corporate Governance or Committee Support Officer at least three clear working days prior to the date of the meeting at which the deputation wished to be received. The application must state the subject and the action which it proposes the Board or Committee should take.

19.2 The deputation shall consist of not more than ten people.

19.3 No more than two members of any deputation shall be permitted to address the meeting, and they may speak in total for no more than ten minutes.

19.4 Any member may put any relevant question to the deputation but shall not express any opinion on the subject matter until the deputation has withdrawn. If the subject matter relates to an item of business on the agenda, no debate or decision shall take place until the relevant minute or other item is considered in the order of business.

20 Receipt of Petitions

20.1 Every petition shall be delivered to the Head of Corporate Governance or Committee Lead Officer at least three clear working days before the meeting at which the subject matter may be considered. The Chair will be advised and will decide whether the contents of the petition should be discussed at the meeting or not.

21 Submission of Reports

21.1 Reports shall be submitted by the Executive Members or other Senior Officers when requested or when, in the professional opinion of such an officer, a report is required to enable compliance with any statute, regulation or Ministerial Direction, or other rule of law, or where the demands of the service under their control require.

21.2 Any report to be submitted shall be provided to the Corporate Governance Team in the standard format no later than the deadline set out within the agreed timetable for the Board and Committee meetings (nine days prior to the meeting). The Director of Finance and Senior Leadership Team should be consulted on all proposals with significant financial implications. No paper with significant financial implications should be presented at a meeting when this has not been done. Any observations by those officers on matters within their professional remit shall be incorporated into the report.

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21.3 Only those reports which require a decision to be taken by the Board or Committee to discharge its business or exercise its monitoring ~~role,~~role will normally be included on the agenda. It shall be delegated to the Head of Corporate Governance or Committee lead in conjunction with the Chair of the Committee to make the final determination on whether or not an item of business should be included on an agenda.

21.4 All reports requiring decisions will be submitted in writing. Verbal reports will only be accepted in exceptional circumstances, and with the prior approval of the Chair of the Board or Committee.

22 Right to Attend Meetings and / or place Items on an Agenda

22.1 Any Board or Committee Member shall be entitled to attend any meeting of any Committee, and shall, with the consent of the Committee, be entitled to speak but not to propose or second any motion or to vote. Executive Members cannot attend the Remuneration Committee when matters pertaining to their terms and conditions of service are being discussed and the Audit and Risk Committee when deemed necessary by the Chair of that Committee.

22.2 A Board Member, who is not a member of a particular Committee and wishes that Committee to consider an item of business which is within its remit, shall inform in writing the Lead Officer no later than the deadline set out within the agreed timetable for the Committee prior to the meeting of the issue to be discussed. The Lead Officer shall arrange for it to be placed on the agenda of the Committee. The Member shall be entitled to attend the meeting and speak in relation to the item but shall not be entitled to propose or second any motion or to vote.

22.3 Board or Committee Members who wish to raise any item of business which is within its remit shall inform in writing the Committee Lead Officer not later than the deadline set out within the agreed timetable for that Committee prior to the meeting the issue to be discussed. The Committee Lead Officer shall arrange for it to be placed on the agenda of the Committee.

22.4 The Chief Internal Auditor and External Auditor have a right of attendance at all Committees. The Chief Internal Auditor and External Auditor shall have the right of direct access to the Chairs of the Board and all Committees.

22.6 Those in attendance at public sessions of Board meetings including co-opted members, will not routinely attend sessions held in private. Those in attendance of private sessions will normally be:

- The Head of Corporate Governance or any member of the Corporate Governance Team who has been assigned to take a formal minute of the proceedings

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- Named officers who have been closely involved in any items under consideration, where agreed by the Board Chair and Chief Executive

23 Alteration of Revocation of Previous Decision

23.1 Subject to 23.2 below, a decision shall not be altered or revoked within a period of six months from the date of such decision being taken.

23.2 Where the Chair rules that a material change of circumstances has occurred to such extent that it is appropriate for the issue to be reconsidered, a decision may be altered or revoked within six months by a subsequent decision arising from:

- A recommendation to that effect, by an Executive Member or other officer in a formal report; or
- A motion to that effect of which prior notice has been given in terms of 9.1

23.3 This does not apply to the progression of an issue on which a decision is required.

24 Suspension of Standing Orders

24.1 So far as it is consistent with any statutory provisions, any one or more of the Standing Orders may be suspended at any meeting, but only as regards the business at such meeting, provided that two-thirds of the members present and voting so decide.

25 Admission of Public and Press

25.1 Board meetings shall be held in public. Public notice of the time and place of the meeting shall be provided at least three clear days before the meeting is held. The notice and the meeting papers shall also be placed on the Board's website.

The meeting papers will include the minutes of committee meetings which the relevant committee has approved. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. Chairs Assurance Reports will inform the Board of Governance Committee business which has been discussed in committee meetings for which the final minutes are not yet available.

For items of business which the Board will consider in private session, only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them

25.2 The Board may exclude the public and press while considering any matter that is confidential. Exemptions included under: Freedom of Information

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(Scotland) Act 2002 (the Act) and Environmental Information (Scotland) Regulations 2004 (the Regulations)

A summary of the exemptions specified in the Act is contained at the end of this section at Paragraph 27 but should not be relied upon as a comprehensive application of the exemptions in restricting access to information.

For guidance on application of the Act and Regulations, please contact the Freedom of Information Officer (ORK.FOIrequests@nhs.scot).

More information can be found on NHS Orkney's website: http://www.ohb.scot.nhs.uk/about-us/freedom-information

25.3 The terms of any such resolution specifying the part of the proceedings to which it relates, and the categories of exempt information involved shall be specified in the minutes.

25.4 Members of the press admitted to meetings shall be permitted to make use of recording apparatus and use extracts from these recordings for reporting purposes.

25.5 Members of the public and press should leave when the meeting moves into reserved business (In Committee). It is at the discretion of the Chair of that meeting if NHS Orkney staff or co-opted members can remain.

26 Members' Code of Conduct

26.1 All those who are appointed or co-opted as members of the Board must comply with the Members' Code of Conduct of Devolved Public Bodies Revised Edition 2022 as incorporated into the Code of Corporate Governance and approved by the Scottish Ministers. This also applies equally to all members of Committees whether they are employed by NHS Orkney or not when undertaking Committee business.

26.2 For the purposes of monitoring compliance with the Members' Code of Conduct, the Head of Corporate Governance has been appointed as the designated monitoring officer.

26.3 Board and Committee Members having any doubts about the relevance of a particular interest should discuss the matter with the Head of Corporate Governance.

26.4 Board and Committee Members should declare on appointment any material or relevant interest and such interests should be recorded in the Board and Committee minutes. Any changes should be declared and recorded when they occur. Interests will also be entered into a register that is available to the public, details of which will be disclosed in the Board's Annual Report. The Register will be published on the Board's website.

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27 Suspension of Members from Meetings

27.1 If any Board or Committee Member disregards the authority of the Chairperson, obstructs the meeting or, in the opinion of the Chair, acts in an offensive manner at a meeting, the Chair may move that such Member be suspended for the remainder of the meeting. If seconded, such a motion shall be put to the vote immediately without discussion.

27.2 If such a motion is carried, the suspended Member shall leave the meeting room immediately. If the member fails to comply, the Chair may order the suspended member to be removed from the meeting.

27.3 A member who has been suspended in terms of this Standing Order shall not re-enter the meeting room except with the consent of the meeting.

27.4 In the event of a motion for suspension of a Member being defeated, the Chair may, if they think it appropriate to do so, adjourn the meeting as if a state of disorder had arisen.

27.5 The Scottish Ministers may by determination suspend a member from taking part in the business (including meetings) of a Board.

28 Minutes, Agendas and Papers

28.1 The -Head of Corporate Governance is responsible for ensuring that minutes of the proceedings of a meeting of the Board or its Committees, including any decision or resolution made at that meeting, shall be drawn up. The minutes shall be submitted to the next meeting of the Board, or relevant Committee, for approval by Members as a record of the meeting subject to any amendments proposed by Members and shall be signed by the person presiding at that meeting.

28.2 The names of Members present at a meeting of the Board or of a Committee of the Board shall be recorded in the Minute, together with the apologies for absence from any Member. The names of other persons in attendance shall also be recorded.

28.3 The Freedom of Information (Scotland) Act 2002 gives the public a general right of access to all recorded information held. Therefore, when minutes of meetings are created, it should be assumed that what is recorded will be made available to the public.

28.4 The Minute of a meeting being held where authority or approval is being given by the committee and the Minutes are intended to act as a record of the business of the meeting, then the Minute should contain:

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- A summary of the Committee's discussions
- A clear and unambiguous statement of all decisions taken
- If no decision is taken, a clear and unambiguous statement of where the matter is being referred or why the decision has been deferred
- Where options are presented, a summary of why options were either accepted or rejected
- Reference to any supporting documents relied upon
- Any other relevant points which influenced the decision or recommendation; and
- Any recommendations which require approval by a higher authority

28.5 The contents of a Minute will depend upon the purpose of the meeting.

If the meeting agrees actions, they will be recorded in an action log:

- A description of the task, including any phases and reporting requirements
- The person accepting responsibility to undertake the task; and
- The time limits associated with the task, its phases and agreed reporting

28.6 The business for inclusion on the agenda will, when necessary, be divided into two sections~~: Open~~: Open Business, where there would be no issue about the release of information and 'In Committee', where access is restricted to Board or Committee members and where information would not be routinely released.

29 Guide to Exemptions Under the Freedom of Information (Scotland) Act 2002

29.1 All the exceptions operate in different ways, and when applying the individual exemptions, we may need to consider the following factors:

- The content of the information
- The effect that disclosure would have
- The source of the information; and
- The purpose for which the information was recorded

The Act also recognises that the disclosure of certain categories of information may, at the time of the request, be harmful to the wider public interest, for example:

- Where disclosure might be harmful to an important public interest, such as national security or international relations
- Where disclosure is prohibited by statute
- Where responding to the request might involve providing personal information; or

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- Where disclosure might breach a duty of confidentiality

Because the Act strikes a balance between different and important issues, a decision to withhold or release information will require careful consideration. Access to information legislation is about providing the framework within which decisions can be made on where the balance of public interest lies on the release or withholding of information on a case-by-case basis. The Act contains several exemptions to the general right of access. The exemptions ensure that decisions to release or withhold information are taken with the interest of the public firmly to the fore.

There are two types of exemptions under the Freedom of Information (Scotland) Act 2002:

Absolute Exemptions:

If an absolute exemption applied, there is no obligation under the Act to consider the request for information further

Qualified Exemptions:

Are subject to the public interest test. Qualified exemptions do not justify withholding information unless, following a proper assessment, the balance of the public interest comes down against disclosure.

For further guidance contact the Freedom of Information Officer (ORK.FOIrequests@nhs.scot)

http://www.ohb.scot.nhs.uk/about-us/freedom-information

30 Records Management

Under the Freedom of Information (Scotland) Act 2002, NHS Orkney must have comprehensive records management systems and process in place. Separate guidance has been produced for records management in the Section 61 Code of Practice. This can be found ~~on~~ 'on 'ORK NHS Orkney Policies' Teams channel.

- Information Governance Strategy
- Information Governance Policy
- Records Management Policy

The NHS Scotland Business classification scheme gives clear guidance on time limits for the retention of records and documents.

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2 Committees

1 Establishing Committees

1.1 The Board shall create such Committees as are required by statute, guidance, regulation, and Ministerial direction and as are necessary for the economical efficient and effective governance of its business.

1.2 The Board shall delegate to such Committees those matters it considers appropriate. The matters delegated shall be set out in the Purpose and Remit of those Committees detailed in Paragraph 8, Purpose and Remits.

1.3 The Board may by resolution of a simple majority of the whole number of Members of the Board, present and voting, vary the number, constitution and functions of Committees at any meeting of which due notice has been given specifying the proposed variation.

2 Membership

2.1 The Board shall appoint the membership of Committees. By virtue of their appointment the Chair of the Board is an ex officio member of all Committees except the Audit and Risk Committee.

2.2 Any Committee shall include at least one Non-Executive Member of the Board, and may include persons, who are co-opted, and may consist wholly or partly of Members of the Board.

2.3 In determining the membership of Committees, the Board shall have due regard to its purpose, role and remit, and accountability requirements. Certain members may not be appointed to serve on a particular Committee because of their positions. Specific exclusions are:

- Audit and Risk Committee – Chair of the Board together with any Executive Member or Officer
- Remuneration Committee – any Executive Member or Officer

2.4 The Board has the power to vary the membership of Committees at any time, provided that:

- In any case this is not contrary to statute, regulation, or Direction by Scottish Ministers
- Each Member of the Board is afforded proper opportunity to serve on Committees

2.5 The Board shall appoint Chairs and Vice-Chairs of Committees who shall hold office for two years. In the case of Members of the Board, this shall be dependent upon their continuing membership of the Board.

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2.6 The persons appointed as Chairs of Committees shall usually be Non-Executive Members of the Board and only in exceptional circumstances shall the Board appoint a Chair of a Committee who is not a Non-Executive Member for example a co-opted member. Such circumstances are to be recorded in the Minutes of the Board meeting making the appointment.

2.7 As a consequence of the personal development appraisal and review process, the Chair of the Board will decide, with the relevant Non-Executive Members, which of the Committees they will serve on as member of as Chair or Vice Chair.

2.8 Casual vacancies occurring in any Committee shall be filled as soon as may be by the Board after the vacancy takes place.

3 Functioning

3.1 An Executive Member or another specified Lead Officer shall be appointed to support the functioning of each Committee.

3.2 Committees may seek the approval of the Board to appoint Sub-Committees for such purposes as may be necessary.

3.3 Where the functions of the Board are being carried out by Committees, the membership, including those co-opted members who are not members of the Board, is deemed to be acting on behalf of the Board.

3.4 During intervals between meetings of the Board or its Committees, the Chair of the Board or a Committee or in their absence, the Vice-Chair shall, in conjunction with the Chief Executive and the Lead Officer concerned, have powers to deal with matters of urgency which fall within the terms of reference of the Committee and require a decision which would normally be taken by the Committee. All decisions so taken should be reported to the next full meeting of the relevant Committee. It shall be for the Chair of the Committee, in consultation with the Chief Executive and Lead Officer concerned, to determine whether a matter is urgent in terms of this Standing Order.

4 Minutes

4.1 The approved minute of each Committee of the Board shall be submitted as soon as is practicable to an ordinary meeting of the Board for information, and for the consideration of any recommendations having been made by the Committee concerned.

4.2 The Minute of each Committee shall also be submitted to the next meeting for approval as a correct record and signature by the Chair.

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4.3 Minutes of the proceedings at a meeting of a Special Committee shall be made but these proceedings may be reported to the Board or to any Committee of the Board either by the Minutes or in a report from the Special Committee as may be considered appropriate.

5 Frequency

5.1 The Committees of the Board shall meet no fewer than four times a year

6 Delegation

6.1 Each Committee shall have delegated authority to determine any matter within its purpose and remit, except for any specific restrictions contained in Section E, paragraph items 1.2.1 to items 1.2.20.

6.2 Committees shall conduct their business within their purpose and remit, and in exercising their authority, shall do so in accordance with the following provisions. However, in relation to any matter either not specifically referred to in the purpose and remit, or in this Standing Order, it shall be competent for the Committee, whose remit the matter most closely resembles, to consider such matter and to make any appropriate recommendations to the Board.

6.3 Committees must conduct all business in accordance with NHS Orkney policies and the Code of Corporate Governance.

6.4 The Board may deal with any matter falling within the purpose and remit of any Committee without the requirement of receiving a report or Minute of that Committee referring to that matter.

6.5 The Board may at any time vary, add to, restrict or recall any reference or delegation to any Committee. Specific direction by the Board in relation to the remit of a Committee shall take precedence over the terms of any provision in the purpose and remit.

6.6 If a matter is of common or joint interest to several Committees, and is a delegated matter, no action shall be taken until all Committees have considered the matter.

6.7 In the event of a disagreement between Committees in respect of any such proposal or recommendation which falls within the delegated authority of one Committee, the decision of that Committee shall prevail. If the matter is referred but not delegated to any Committee, a report summarising the views of the various Committees shall be prepared by the appropriate officer and shall appear as an item of business on the agenda of the next convenient meeting of the Board.

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7 Committees

A Audit and Risk Committee
B Joint Clinical and Care Governance Committee
C Finance and Performance Committee
D Remuneration Committee
E Staff Governance Committee
F Executive Management Team
~~**E**~~**G** Senior Leadership Team

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A Audit and Risk Committee

1 Purpose

Orkney NHS Board has established the Audit and Risk Committee as a Committee of the Board to support the Board in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge.

On behalf of NHS Orkney Board, The Audit and Risk Committee has a dual role of providing:

- **An Audit Function:** Assuring that the organisation operates effectively and meets statutory objectives.
- **A Risk Assurance Function:** Assuring that adequate structures are in place to undertake activities which underpin effective risk management.

2 Composition

The Audit and Risk Committee shall consist of four Non-Executive Members, including the Employee Director, but not the Chair of the Board.

The Chair and Vice-Chair of the Committee will be appointed by the NHS Board.

Ordinarily, the Audit and Risk Committee Chair cannot chair any other governance committee of the Board but can be a member of other governance committees.

Committee membership will be reviewed annually.

3 Attendance

In addition, there will be in attendance:

- Chief Executive
- Director of Finance
- Lead Executive (Medical Director)
- Head of Finance
- Head of Quality, Safety and Risk
- Senior Management Accountant

The Chief Executive (as Accountable Officer), the Director of Finance, and the Lead Executive (Medical Director) of NHS Orkney must attend

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meetings of the Committee, together with other Executive Directors and senior staff as required.

The External Auditor and the Chief Internal Auditor shall also receive a standing invitation to attend.

4 Quorum

The Committee will be quorate when there are three members present, one of whom must be the chair or Vice-Chair.

It will be expected that another non-executive Board Member will deputise for a member of the Committee at any meeting when required.

5 Meetings

The Audit and Risk Committee will meet at least four times per annum.

At least once a year and when deemed necessary by the Chairperson, meetings of the Committee shall be convened and attended exclusively by members of the Committee and/or the External Auditor or Internal Auditor.

Extraordinary meetings may be called by:

- Audit and Risk Committee Chairperson
- Chief Executive
- Director of Finance
- Lead Executive

The Audit and Risk Committee shall exclude all but members from extraordinary meetings of the Committee if it so decides.

6 Remit

The Audit and Risk Committee will advise the Board and Accountable Officer on:

- The strategic process for risk, control, and governance and the Governance Statement
- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, and management's letter of representation to the external auditors
- The planned activity and results of both internal and external audit
- The adequacy of management response to issues identified by audit activity, including external audit's management letter / report

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- The effectiveness of the internal control environment and risk management arrangements
- Assurances relating to the corporate governance requirements for the organisation
- Proposals for tendering for internal audit services
- Anti-fraud policies, whistle-blowing processes, and arrangements for special investigations, Vice Chair to lead on any whistle-blowing related items to mitigate any possible conflict of interest
- Assurance from the Finance and Performance Committee around Information Governance
- Links to Integration Joint Board Audit Committee around jointly commissioned audits, annual planning, etc.
- Oversight of the Board Assurance Framework
- To ensure robust arrangements are in place in relation to Business Continuity and Emergency Planning

The Audit and Risk Committee will also annually review its own effectiveness and report the results of that review to the Board.

7 Best Value

The Committee is responsible for promoting the economical, efficient and effective use of resources by the organisation, on those areas within its remit, in accordance with the principles of Best Value. These are set out in the Scottish Public Finance Manual, along with a statutory duty under the Public Finance and Accountability (Scotland) Act 2000. The Committee will provide assurance to the Chief Executive, as Accountable Officer, that NHS Orkney has systems and processes in place to secure best value in these delegated areas, and this assurance will be included as an explicit statement in the Committee's Annual Report.

8 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and in so doing, is authorised to seek any information it requires from any employee.

All Members and employees are directed to co-operate with any request consistent with the Terms of Reference made by the Committee.

To fulfill its remit, the Audit and Risk Committee may obtain whatever professional advice it requires and require Directors or other officers of NHS Orkney to attend meetings.

The External Auditor and Chief Internal Auditor shall have the right of direct access to the Chair of the Audit Committee.

The Audit and Risk Committee will require a statement from the Integration Joint Board on its governance and the preparedness of the Integration

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Joint Board accounts to allow NHS Orkney to prepare consolidated accounts.

9 Reporting Arrangements

The Audit and Risk Committee reports to Orkney NHS Board.

Following a meeting of the Audit and Risk Committee the Chair will present at the next Orkney NHS Board meeting an update from the meeting and any approved minutes.

The Audit and Risk Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Audit and Risk Committee.

The Audit and Risk Committee will produce an annual report for presentation to Orkney NHS Board. The Annual Report will describe the outcomes from the Committee during the year.

The Risk Management and Clinical Quality Forum reports to the Audit and Risk Committee.

B Joint Clinical and Care Governance Committee

1 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 is consistent with the Healthcare Quality Strategy for NHS Scotland of safe, effective, and person-centered care

- the function of providing assurance that all necessary systems and processes are in place that ensure staff engaging in population health-related activities incorporate the key components of population health governance.
- the function of providing assurance regarding participation, patient and service users' rights, experience and feedback
- 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

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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.

2 Composition

The Joint Clinical and Care Governance Committee shall consist of:

- Three Non-Executive Members of NHS Orkney, one of whom must be the Area Clinical Forum Chair and one of whom must be a voting member of the Integration Joint Board (IJB).
- Two Orkney Islands Council voting members of the Integration Joint Board, excluding the Chair of the IJB when this is an Orkney Islands Council appointment, in which case a substitute will be appointed.
- A public representative.
- A third sector representative.

All members shall have authority to make decisions on ~~recommendations~~recommendations, and all decisions must be reached by consensus. The committee will seek to reach consensus on matters under discussion on agenda, and will seek input from the NHSO Board, IJB and Orkney Islands Council (OIC), should the group be unable to agree a consensus position

Views and engagement from unpaid carers would be positively encouraged where appropriate, in acknowledgement that there was not currently a carer representative on the committee.

Committee membership will be reviewed annually.

3 Chair and Vice Chairs

The Chair and two Vice Chairs of the Committee will be jointly appointed by the NHS Board and the Integration Joint Board. The appointment of the Chair will be reviewed biennially in line with current legislation.

There will be two vice chairs, one from NHS Orkney and one Orkney Islands Council voting member of the Integration Joint Board.

In the absence of the Chair, either Vice Chair may Chair the meeting.

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For items relating solely to non-delegated NHS functions, only the NHS Orkney Vice Chair may Chair that item.

4 Attendance

In addition, there will be in attendance:

- Director of Nursing, Midwifery, Allied Health Professions and Chief Officer Acute Services ~~(lead officer for Joint Clinical Care and Governance)~~
- Medical Director (lead officer for Clinical Governance)
- Director of Public Health
- ~~Chief Executive, NHS Orkney~~
- Chief Officer, Integration Joint Board (lead officer for Care Governance and Chair of the Orkney Alcohol and Drugs Partnership)
- Director of Pharmacy
- Chief Social Work Officer
- Head of Patient Safety, Quality and Risk
- ~~Associate and Interim Clinical Directors as indicated by the agenda~~
- Associate Director of Allied Health Professionals (AHP's)~~s~~
- Head of Primary Care
- Head of Community Care

The Committee shall invite others to attend, as required, for specific agenda items.

Where a core officer is unable to attend a particular meeting, a named representative shall attend in their place.

5 Quorum

Meetings of the Committee will be quorate when at least three 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 one Orkney Island Council voting member of the Integration Joint Board.

It will be expected that another Non-Executive Board Member or Integration Joint Board proxy Member will deputise for a member of the Committee at a meeting if required.

Meetings will not take place unless at least one Clinical Executive Director of NHS Orkney and the Chief Social Work Officer, or nominated depute, is present.

For the avoidance of doubt, advisors in attendance at the meeting, shall not count towards a quorum.

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6 Meetings

The Committee will meet at least quarterly.

The Chair may, at any time, convene additional meetings of the Committee.

A minimum of two development workshops/activities will be held each year. These may be attended by both members and advisors.

7 Conduct of Meetings

A calendar of Committee meetings, for each year, shall be approved by the members and distributed to members.

The agenda and supporting papers shall be sent to members at least seven days before the date of the meeting.

Notice of each meeting will confirm the venue, time and date together with an agenda and shall be made available to each member of the committee.

All JCCGC meetings shall be minuted, including the names of all those present or absent. Administrative support shall be provided by NHS Orkney.

Draft minutes shall be circulated promptly to the Chair of the JCCGC, normally within 5 days. Chair's Assurance Report will be produced by the Chair and the Executive Lead directly after the meeting.

Attendance and delegates should normally be confirmed at least 5 working days prior to the meeting.

The approved minutes of the JCCGC will be made publicly available.

A rolling work plan will be developed and maintained which will be reviewed and approved annually. The approved work plan will be submitted to NHS Orkney's Audit and Risk Committee and the Performance and Audit Committee of the Integration Joint Board.

The JCCGC shall, at least once per year, review its own performance. This shall be by means of a Self-Evaluation Form which will be sent to all members in attendance at any meeting during the relevant year.

8 Remit

In Broad terms, the remit of JCCGC is to seek assurance that our Health and Social Care services across Orkney are person-centered, safe and effective and we take account of the population as a whole, in an integrated manner. The remit spans NHS Orkney, Orkney Island Council

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(Integration Joint Board-delegated), independent sector and third sector services.

Population Health

To provide assurance that all necessary systems and processes are in place that ensure staff engaging in population health-related activities incorporate the key components of population health governance, namely:

- Quality and clinical/professional effectiveness.
- Public information and involvement.
- Population health research.
- Risk management.
- Addressing and reducing health inequalities.

Person-Centered

To provide assurance regarding participation, patient and service users' rights, experience and feedback:

- There are effective systems and processes in place across NHS Orkney and in the functions delegated to the Integration Joint Board to support participation with patients, service users, carers and communities, to comply with participation standards and the Patient Rights (Scotland) Act 2011 generally and specifically within the context of service redesign.
- To monitor complaints response performance on behalf of the Board of NHS Orkney and the Integration Joint Board for functions delegated and promote positive complaints handling including learning from complaints and feedback.
- To provide assurance that there are effective system and governance processes in place across all areas of patient and service user's rights, wellbeing and feedback.
- To provide assurance that there are effective system and governance processes in place across Infection, Prevention and Control.

Safe (Clinical and Care Governance and Risk Management)

To provide assurance:

- Robust clinical and care control frameworks are in place for the effective management of clinical and care governance and risk management and that they are working effectively across the whole of NHS Orkney and the functions delegated to the Integration Joint Board.
- Public protection arrangements are in place in relation to the Integration Joint Board and NHS Orkney. To achieve this the Chief Officers Group will report annually on the work of the Public Protection Committee through the Public Protection Committee annual report on child protection and the associated Improvement/ Business Plan produced by the Public Protection Committee.

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- Progress on all joint public protection improvement plans are reported to each meeting of the Joint Clinical and Care Governance Committee including findings of learning reviews that have implications for health and social care delivery.
- Incident management and reporting is in place and lessons are learned from adverse events and near misses.
- Complaints are handled in accordance with national guidance and organisational procedures and lessons are learned from their investigation.
- Clinical and care standards and patient and service user safety are maintained and improved within the Board of NHS Orkney's and the Integration Joint Board annual plans and efficiency programmes.

Effective (Clinical and Care Performance and Public Health Performance and Evaluation)

To provide assurance that clinical and care effectiveness and quality improvement arrangements are in place:

- To ensure that recommendations from any inspections have appropriate action plans developed and are monitored and reported through an appropriate Committee.
- Where performance improvement is necessary within the non-delegated functions of NHS Orkney or the functions delegated to the Integration Joint Board, to seek assurance regarding the reliability of the improvement intervention.
- To ensure that clinical dashboards and other data and measurement systems underpin the delivery of care.
- To ensure that the healthcare and social care provided is informed by evidence based clinical and professional practice guidelines.
- To ensure that staff governance issues which impact on service delivery and quality of services are appropriately managed through clinical and care governance mechanisms

Social Work and Social Care

To provide assurance in respect of social work and social care governance by seeking assurance that there are adequate systems and processes in place to ensure:

- Promotion of values and standards of professional practice, including all relevant National Standards and Guidance, and ensure local adherence with the Codes of Practice issued by the Scottish Social Services Council (SSSC) for social services workers and employers.
- That all social service workers' practice is in line with the SSSC's Code of Practice and that all registered workers meet the requirements of their regulatory body.
- Maintenance and development of high standards of practice and supervision in line with relevant guidance.

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- Effective governance arrangements for the management of the complex balance of need, risk and civil liberties, in accordance with professional standards.
- The promotion of continuous improvement and the identification of areas for professional development, workforce planning and quality assurance of services.
- Consideration of requirements for significant case reviews and/or serious incident reviews to be undertaken into critical incidents either resulting in – or which may have resulted in – death or serious harm.
- That only registered social workers undertake those functions reserved in legislation or are accountable for those functions described in guidance.
- The application of evidence-informed good practice, including the development of person-centered services that are focused on the needs of people who use services and carers.
- Care Home and Care at Home reporting.

9 Best Value

The Committee is responsible for reviewing those aspects of Best Value delegated to it from Orkney NHS Board and Orkney Islands Council in line with Local Government in Scotland Act 2003 Best Value: Revised Statutory Guidance 2020. The key themes are:

- Vision and leadership.
- Governance and accountability.
- Effective use of resources.
- Partnerships and collaborative working.
- Working with communities.
- Sustainability.
- Fairness.
- Equality.

The Committee will put in place arrangements which will provide assurance to the Chief Executives (of NHS Orkney and of Orkney Islands Council), as accountable officers, that NHS Orkney and the Integration Joint Board have systems and processes in place to secure best value in these delegated areas. The assurance to the Chief Executives should be included as an explicit statement in the Committee's Annual Report.

10 Authority

The Committee is authorised by the Board of NHS Orkney and the Integration Joint Board to investigate any activity within its Terms of Reference and in doing so, is authorised to seek any information it requires from any employee through appropriate staff governance standards / policies held by NHS Orkney and Orkney Island Council.

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The Committee may obtain whatever professional advice it requires, and require Directors or other officers of NHS Orkney, the Chief Officer of the Integration Joint Board or officers of Orkney Islands Council (in terms of the functions that are delegated by Orkney Islands Council to the Integration Joint Board) to attend whole or part of any meetings.

The External Auditors and Chief Internal Auditors shall have the right of direct access to the Chair of the Committee for audit purposes.

Authority to require information to be provided sufficient to satisfy the functions of assurance as set out above.

11 Reporting Arrangements

The Joint Clinical and Care Governance Committee reports to Orkney NHS Board and the Integration Joint Board within their defined functions.

The Chair of each meeting will be responsible for producing a Chair's Report, to be presented, along with the approved minute, to the next Board meeting of NHS Orkney and the next meeting of the Integration Joint Board immediately following the JCCGC. The Chair of the JCCGC will be appointed as a voting member of the Integration Joint Board by the Health Board.

The Joint Clinical and Care Governance Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Joint Clinical and Care Governance Committee. This will be used to set agendas and monitored throughout the year.

The Joint Clinical and Care Governance Committee will produce an annual report for presentation to Orkney NHS Board and the Integration Joint Board. The Annual Report will describe the outcomes from the committee during the year and provide assurance to the Audit and Risk Committee of Orkney NHS Board and the Performance and Audit Committee of the Integration Joint Board that the Committee has met its remit during the year.

The Committee will prepare an action log which will be monitored and updated at each meeting.

The Committee will review the Terms of Reference annually.

Groups that report to the committee are:

1.Infection Prevention Committee

3. Risk Management Forum
4. Social Work and Social Care Governance Board
5. Area Drugs and Therapeutics Committee

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Improving Together Programme Board – Clinical Services Review

C Finance and Performance Committee

1 Purpose

The purpose of the Finance and Performance Committee is to review the financial and non-financial performance of the Board, to ensure that appropriate arrangements are in place to deliver against organisational performance measures, to secure economy, efficiency, and effectiveness in the use of all resources, and provide assurance that the arrangements are working effectively.

The committee will provide cross committee assurance to the Integration Joint Board in relation to performance on delegated functions.

2 Composition

The membership of the Committee shall consist of:

- Non-Executive Board Member Chairperson
- Local Authority Nominated Non-Executive Board Member
- Two other Non-Executive Board Members

Where possible, at least one non-executive Board Member should have a qualification or demonstrable experience in the fields of finance or performance management.

3 Attendance

In addition, there will be in attendance:

- NHS Orkney Chief Executive
- NHS Orkney Director of Finance – Executive Lead
- Medical Director
- Director of Nursing, Midwifery, Allied Health Professions and Chief Officer Acute Services (lead officer Head of Finance
- Chief Finance Officer, IJB
- Chief Officer, IJB
- Head of Planning, Performance and Information

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- Head of Improvement
- Head of Improvement
- Head of Estates
- Head of Finance
- Head of Facilities and NPD
- Director of Public Health
- Director of Performance and Transformation

Deputies should attend as appropriate, to ensure that business is progressed in absence of one of the above attendees.

The Committee shall invite others to attend, as required, for specific agenda items.

4 Quorum

Members of the Committee shall be quorate when there are three members present including at least two non-executive Board Members, one of whom must be Chair or Vice-Chair, and one Executive Member.

It will be expected that another Non-Executive Board Member will deputise for a member of the Committee at any meeting when required.

5 Meetings

The Committee will meet at least bi-monthly.

Extraordinary meetings may be called by:

- The Finance and Performance Committee Chairperson
- NHS Orkney Chief Executive
- NHS Orkney Director of Finance
- NHS Orkney Board Chair

6 Remit

The Committee shall have accountability to the Board for ensuring that the financial position of the Board is soundly based, having regard to:

- Oversight of Strategic Estates
- Oversight of strategy delivery of sustainability and net-zero
- Such financial and performance monitoring and reporting arrangements as may be specified
- Compliance with statutory financial requirements and achievement of financial targets
- The impact of planned, known, or foreseeable future developments on the financial and non-financial performance of the Board and wider health planning agenda

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- Oversight and monitoring of NHS Orkney's response to de-escalation
- To oversee and monitor the Board's performance against the prevailing NHS Scotland and others performance measurement regime and other local and national targets as required
- To ensure robust arrangements are in place in relation to digital transformation and cyber security providing assurance to the Board in this regard

The Committee has responsibility for:

- The development of the Board's 1–3-year Financial Plan in support of the Strategic and Operational Plans
- Recommending to the Board annual revenue and capital budgets, and financial plans consistent with statutory financial responsibilities
- The oversight of the Board's Capital Programme and the review of the Property Strategy (including the acquisition and disposal of property)
- Putting in place and scrutinising arrangements which will provide assurance to the Chief Executive as Accountable Officer that NHS Orkney has systems and processes in place to secure best value, ensuring that this assurance is included as an explicit statement in the Committee's Annual Report
- To scrutinise the Board's financial and non-financial performance and ensure that corrective actions are taken in collaboration with other Governance Committees where appropriate
- To ensure better understanding between service provision and financial impact and to allow the Board to demonstrate that it provides value for money.
- To ensure adequate risk management is employed in all areas within the remit of the Committee
- Review performance, effectiveness, and Terms of Reference of the Committee on an annual basis
- To develop an annual cycle of business
- To have oversight of Climate Change and Sustainability Governance, including the transition to a net-zero emissions service and delivery of targets against and monitor delivery of the Scottish Government targets
- To receive Digital Cyber and Information Governance Assurance –
- To progress and process documentation for budget setting and forecasting
- To review progress regarding the Improvement Programme
- Oversight of the NPD contract and any other major procurement
- Review of Standing Orders and Standard Financial Instructions
- Oversight and assurance around integrated planning

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7 Best Value

The Committee is responsible for promoting the economical, efficient and effective use of resources by the organisation, on those areas within its remit, in accordance with the principles of Best Value. These are set out in the Scottish Public Finance Manual, along with a statutory duty under the Public Finance and Accountability (Scotland) Act 2000. The Committee will provide assurance to the Chief Executive, as Accountable Officer, that NHS Orkney has systems and processes in place to secure best value in these delegated areas, and this assurance will be included as an explicit statement in the Committee's Annual Report.

8 Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference and in doing so, is authorised to seek any information it requires from any employee.

The Committee may obtain whatever professional advice it requires and require Directors or other officers of NHS Orkney to attend whole or part of any meetings.

9 Reporting Arrangements

The Finance and Performance Committee reports to Orkney NHS Board.

Following a meeting of the Finance and Performance Committee the Chair will present at the next Orkney NHS Board meeting an update from the meeting and any approved minutes.

The Finance and Performance Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Committee.

The Chair of the Committee should raise any issues requiring cross committee input or assurance through the agreed reporting process.

The Finance and Performance Committee will produce an annual report for presentation to Orkney NHS Board. The Annual Report will describe the outcomes from the Committee during the year and provide assurance to the Board that the Committee has met its remit during the year.

The groups who report to the committee are:

- Improving Together Programme Board
- Digital and Information Operations Group (DIOG)
- Planned Care Programme Board
- Strategic Estates Group
- Environmental Sustainability Group

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D Remuneration Committee

1 Purpose

NHS Orkney is required to have a Remuneration Committee (herein referred to as the Committee) whose main function is to review the objectives and performance of executives and senior management cohorts, ensuring the application and implementation of fair and equitable pay systems on behalf of the Board as determined by Ministers and the Scottish Government.

In this regard, the Committee is a standing committee of the Board and will act with full authority in relation to the matters set out in its Role and Remit (detailed below). It will be required to provide assurance to the Board and Staff Governance Committee (see separate constitution) that systems and procedures are in place to do so, enabling the overarching staff governance responsibilities to be effectively discharged.

2 Composition

The Remuneration Committee shall consist of:

- The Chair of the Board
- Three other Non-Executive Members two of whom should, in normal circumstances, be the Employee Director and Chair of the Staff Governance Committee

Non-Executive Members cannot be members of this Committee if they are independent primary care contractors.

3 Attendance

~~In addition, there will be in attendance:~~

- ~~Chief Executive~~
- ~~Director of People and Culture~~

The Chief Executive and Director of People and Culture (Executive Lead) will be in attendance throughout to provide support and advice (apart from during their own reviews). A senior member of the People and Culture Team will deputise for the Director of People and Culture in their absence as

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appropriate, to ensure specialist Human Resource advice is always available to the Committee.

At the request of the Committee, other Senior Officers also may be invited to attend.

All members of the Remuneration Committee will require to be appropriately trained to carry out their role on the Committee.

No employee of the Board shall be present when any issue relating to their employment is being discussed.

The Chief Executive and Director of People will leave the meeting when their own remuneration and terms and conditions are to be discussed and at other times, at the discretion of the Chair.

4 Quorum

Meeting of the Remuneration Committee will be quorate when three non-executive members are present, one of whom must be the chair or vice-chair. Director of People and Culture to be present for quoracy.

Any non-executive Board member, except if they are independent primary care contractors, with the agreement of the Chair may deputise for a member of the Committee at any meeting.

5 Meetings

The Committee will normally meet at least 4 times a year, with such other meetings as necessary to conduct the business of the Committee.

Remuneration issues may arise between meetings and will be brought to the attention of the Chair of the Remuneration Committee by the Chief Executive or the Director of People and Culture. The Chair may call a special meeting of the Remuneration Committee to address the issue, or these may be considered virtually if appropriate.

6 Remit

The Remuneration Committee will oversee the remuneration arrangements for Executive Directors and others under the Executive Cohort and Senior Management Pay Systems of the Board and also to discharge specific responsibilities on behalf of the Board as an employing organisation.

Ensure that arrangements are in place to comply with NHS Orkney Performance Assessment Agreement with Scottish Government direction

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and guidance for determining the employment, remuneration, terms, and conditions of employment for Executive Directors, in particular:

- Approving, developing, coaching and monitoring the personal objectives and development plans of all Executive Directors in the context of NHS Orkney's Annual Operational Plan, Corporate Objectives, and other local, regional, and national policy. This includes monitoring progress of annual objectives as part of the mid-year review process.
- Receiving formal reports on the operation of remuneration arrangements and the outcomes of the annual assessment of performance and remuneration for each of the Executive Directors
- Review and approve Executive Directors Job Descriptions prior to advertisement

Undertake reviews of aspects of remuneration and employment policy for Executive Directors (for example Relocation Policy) and, where necessary, other senior managers, for example special remuneration, when requested by NHS Orkney.

To have regular oversight of the personal objectives and development plans of the deputies to the Executive Directors to ensure alignment with the Corporate Strategy and objectives.

When appropriate, in accordance with procedures, consider any redundancy, early retiral or termination arrangement, including Employment Tribunal Settlements (approved by Scottish Government) in respect of all NHS Orkney Employees and, after due scrutiny, obtain a separate individual direction to make the actual payment. Other challenging cases, not involving Executive Directors, may be discussed by the Committee, with the approval of the Chair.

The Remuneration Committee will act as the Discretionary Points Committee to determine which applicants should receive discretionary points each year in line with NHS Circular PCS(DD)1995/6 (Appendix I) as amended by the SEHD in its letter dated 12 January 2000 (Appendix II)~~To oversee the arrangements for the payment of "Discretionary Points" (via a dedicated session as the Discretionary Points Committee) to locally employed consultant staff,~~ This will inclu~~deding~~ making final decisions on awards and subsequent payment in individual cases based upon professional advice and in accordance with current guidance issued by the Scottish Government. The outcomes of the Discretionary Points Committee should be in the form of a paper brought to a Remuneration Committee meeting for assurance and final approval providing evidence that fair and equitable decisions have been made and to enable final approval to be given for the remuneration award. The Remuneration Committee should consider equality monitoring of the awarding of discretionary points to ensure equity.

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7 Best Value

The Committee is responsible for promoting the economical, efficient and effective use of resources by the organisation, on those areas within its remit, in accordance with the principles of Best Value. These are set out in the Scottish Public Finance Manual, along with a statutory duty under the Public Finance and Accountability (Scotland) Act 2000. The Committee will provide assurance to the Chief Executive, as Accountable Officer, that NHS Orkney has systems and processes in place to secure best value in these delegated areas, and this assurance will be included as an explicit statement in the Committee's Annual Report.

8 Confidentiality and Committee Decisions

Decisions reached by the Committee will be by agreement and with all members agreeing to abide by such decisions (to the extent that they are in accordance with the constitution of the Committee). All Members will treat the business of the Committee as confidential. The Committee may in certain circumstances decide a voting approach is required with the Chair having a casting vote.

9 Minutes and Reports

The minutes will record a clear summary of the discussions, demonstrating challenge where relevant, and decisions reached by the Committee. The full minutes will be circulated to Committee members and an Annual Report on Committee business will be submitted to the Staff Governance Committee.~~Board.~~

Cross Committee assurance will be provided/sought if required, through the Chair. This will **not** include the detail of confidential employment issues: these can only be considered by Non-Executive Board Members.

10 Authority

The Remuneration Committee is authorised by the Board to investigate any activity within its terms of reference, and in doing so, is authorised to seek any information it requires about any employee.

To fulfil its remit, the Remuneration Committee may seek additional professional advice, and it may require Directors or other officers of NHS Scotland to attend meetings, as necessary.

11 Reporting Arrangements

The Remuneration Committee is required to provide assurance that systems and procedures are in place to manage the responsibilities contained within its remit.

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It will do this by providing an annual report of its work to the Board and Staff Governance Committee describing the outcomes from Remuneration Committee during the year and providing an annual assurance that systems and procedures are in place to manage the appraisal and pay arrangements for all Executive Directors and others as deemed appropriate so that overarching Staff Governance responsibilities can be discharged.

The Annual Report will be prepared as close as possible to the end of the financial year but in enough time to allow it to be considered by the Board. This is to ensure that the Board is in a position in its Annual Report to provide the annual assurance that systems and procedures are in place to manage the pay arrangements for all staff employed in NHS Orkney.

The annual report will also be provided to the Staff Governance Committee for assurance that that systems and ~~process~~processes are in place to manage the issues set out in MEL(1993)114 and subsequent amendments.

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E Staff Governance Committee

1 Purpose

The role of this committee is to support and maintain a culture within the health system where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the system and is built upon partnership and collaboration. It will ensure that robust arrangements to implement the Staff Governance Standard are in place and monitored.

The NHS Reform (Scotland) Act 2004 requires the Board to put, and keep, in place arrangements for the purpose of:

(a) Improving the management of the officers employed by it
(b) Monitoring such management; and
(c) Workforce planning

It further requires all NHS Scotland employers to ensure the fair and effective management of staff.

The Health and Care (Staffing) (Scotland) Act 2019, which received Royal Assent on 6 June 2019 and came into force on 1 April 2024, places a statutory duty on NHS and care service providers to ensure appropriate staffing levels that support safe, high-quality care. It requires the use of evidence-based workforce planning tools and mandates that staff are engaged in decisions about staffing and workload. The Act reinforces the importance of professional judgment, transparency, and continuous improvement in staffing practices, aligning with the overarching aim of promoting the health, wellbeing, and safety of both service users and staff

The Committee will ensure alignment with the NHS Scotland national workforce strategy, the Fair Work Framework, and the ambitions set out in Everyone Matters: 2020 Workforce Vision. It will also provide oversight of the Board's workforce-related strategic risks, ensuring that appropriate mitigations and assurances are in place and reported to the Board

NHS Scotland recognises the importance of Staff Governance as a feature of high performance which ensures that all staff have a positive employment experience. Standards have been agreed and set down for NHS organisations which state that staff should be:

- Well informed
- Appropriately trained and developed
- Involved in decisions which affect them

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- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued and
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community

The role of the Staff Governance Committee is to scrutinise and advise the Board on these responsibilities by:

- Ensuring scrutiny of performance against the individual elements of the Staff Governance Standards
- Ensuring compliance with national and legislative requirements in relation to workforce and people
- Ensuring compliance with the Annual Review requirements
- Ensuring effective workforce planning arrangements are in place
- Reviewing and signing off data collected during annual Staff Governance monitoring
- Reviewing and monitoring Staff Experience Engagement Index Data and improvement plans.
- Seeking assurance from data and information provided in reports to the Committee.
- Having oversight of the Staff Experience Programme (including culture change and Equality, Diversity and Inclusion)
- Overseeing the development and implementation of an Integrated Education Strategy
- Having oversight and monitoring the delivery of the People priorities in the Corporate Strategy

2 Composition

Four Non-Executive Members, including the Employee Director and Whistleblowing Champion, plus two lay representatives from Trade Unions and professional organisations nominated by the Area Partnership Forum.

3 Attendance

In addition, there will be in attendance:

- Chief Executive
- Director of People and Culture – Executive Lead for Committee
- Director of Nursing, Midwifery, A**llied** H**ealth** P**rofessions** and Chief Officer Acute Services (lead officer)
- Health and Safety Lead
- Head of People and Culture
- Director of Medical Education
- Joint Local Negotiation committee (JLNC) Chair
- Clinical Lead - Workforce~~Health Care Staffing Lead~~

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- Practice Education Leador

Others will also be invited to attend for specific agenda items as required.

4 Quorum

Meetings of the Committee will be quorate when two non-executive Board members, and one lay representative from union and/or professional body or deputy are present.

Meetings will not take place unless at least one Executive Director of NHS Orkney is present. For the avoidance of doubt, advisors in attendance at the meeting, shall not count towards a quorum.

It will be expected that another non-executive Board Member or lay representative will deputise for a member of the Committee at any meeting when required.

5 Meetings

The Committee will meet at least quarterly.

Extraordinary meetings may be called by:

- The Staff Governance Committee Chairperson
- NHS Orkney Chief Executive

6 Remit

The Staff Governance Committee shall have accountability to the Board for:

Governance and Assurance

- Seek assurance on the timely submission of all Staff Governance information required for providing national monitoring arrangements.
- Provide Staff Governance information for the governance statement through the Staff Governance Committee Annual Report
- Overseeing the structures and processes which ensure that delivery against the Standard is being achieved and taking assurance around implementation
- Seek assurance that the Whistle Blowing Standards have a supported infrastructure, monitoring and reporting framework is in place to ensure that staff can safely raise concerns. Ensure that the Board is complying with the legislation included in the Public Services Reform (the Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020 (SSI 2220/5)

Policy and Planning

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- Monitoring and evaluating strategies and implementation plans relating to people management.
- Support policy amendment, funding bids, or resource submissions to achieve the Staff Governance Standards
- Note or approve workforce policies following consultation through the Joint Staff Negotiating Committee and Area Partnership Forum
- Review and approve workforce plans and workforce projections ensuring that appropriate processes have been followed.
- Receive regular updates and seek assurance on implementation of the Health and Care (Staffing) (Scotland) Act 2019, including receiving an annual report.

Performance

- Monitor the progress of the Area Partnership Forum through joint Chair reports to each Committee and an annual Report to the Board
- Review corporate risks relating to staff and workforce issues; and seek assurance that risks are minimised/mitigated.
- Review performance, effectiveness, and Terms of Reference of the Committee on an annual basis.
- Receive assurance with regards to volunteer programmes for directly and indirectly engaged volunteers.
- To ~~monitor~~ seek assurance on all aspects of staff induction and development and received assurance that these are being appropriately managed and progressed.
- To consider significant and/or strategic matters in relation to Occupational Health, Safety and Wellbeing
- Equality and Diversity (relevant updates)
-

7 Best Value

The Committee is responsible for promoting the economical, efficient and effective use of resources by the organisation, on those areas within its remit, in accordance with the principles of Best Value. These are set out in the Scottish Public Finance Manual, along with a statutory duty under the Public Finance and Accountability (Scotland) Act 2000. The Committee will provide assurance to the Chief Executive, as Accountable Officer, that NHS Orkney has systems and processes in place to secure best value in these delegated areas, and this assurance will be included as an explicit statement in the Committee's Annual Report.

8 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and in so doing, is authorised to seek any management information it requires across all departments across the

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organisation ~~from any employee.~~in relation to the Staff Governance Standards.

~~In order to~~To fulfill its remit, the Staff Governance Committee may obtain whatever professional advice it requires and require Directors or other officers of NHS Orkney to attend meetings.

The External Auditor and Chief Internal Auditor shall have the right of direct access to the Chair of the Staff Governance Committee.

9 Reporting Arrangements

The Staff Governance Committee reports to Orkney NHS Board. Following a meeting of the Staff Governance Committee the Chair will present at the next Orkney NHS Board meeting an update from the meeting and any approved minutes.

The Staff Governance Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Staff Committee.

The Staff Governance Committee will produce an annual report for presentation to the Audit and Risk Committee and Orkney NHS Board. The Annual Report will describe the outcomes from the Committee during the year and provide an assurance to the Audit and Risk Committee that the committee has met its remit during the year.

The Staff Governance Committee will submit the Self-Assessment Monitoring Return to the Scottish Government by the required deadline.

The Chair of the Committee should raise any issues requiring cross committee input or assurance through the agreed reporting process.

The Staff Governance Committee will receive the Remuneration Committee Annual Report for assurance to enable the Committee to provide overall assurance that systems and procedures are in place to manage the issues set out in MEL (1993)114.

Groups reporting to the Staff Governance Committee are:

- Medical Education
- ~~Area Partnership Forum~~
- Joint Local Negotiating Committee
- Occupational Health, Safety and Wellbeing Committee
- Operational People ~~Workforce~~ Group

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F Executive Management Team

NHS Orkney Executive Management Team Terms of Reference

1 Purpose

The Executive Management Team (EMT) provides strategic and operational Management to ensure the delivery of high-quality, safe, and effective health and care services.

It supports the Chief Executive Officer (CEO) in fulfilling their accountability to the NHS Orkney Health Board and Scottish Government as set out in Appendix 1.

The EMT supports the achievement and delivery of the Board's strategic objectives with responsibility for:

- Strategic planning and implementation
- Performance management and assurance
- Financial stewardship
- Workforce and organisational development
- Risk management and governance
- Stakeholder engagement and partnership working

The EMT has overall responsibility for the delivery of the strategic objectives set out in the Board's Corporate Strategy which are as follows:

1. Place
2. Patient Safety and Experience
3. People
4. Performance
5. Potential

2 Composition

Membership of EMT consists of:

- CEO – Chair
- Director of Performance and Transformation/Deputy CEO – Vice Chair
- Medical Director
- Executive Director Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services
- Director of People and Culture
- Director of Finance
- Chief Officer – Integration Joint Board
- Director of Public Health
- Head of Corporate Governance

In the absence of the Chair, the Vice-Chair will Chair the meeting.

In attendance (as required)

- Clinical Leads
- Members of Senior Management Team

3 Attendance

The Chair and Executive Assistant to the CEO and Board Chair should be informed in advance of a delegate attending as a deputy other than those from the membership list above.

Apologies should be sent to the Executive Assistant to the CEO and Board Chair at least 2 days before the meeting. Where necessary delegates should be briefed to present reports on behalf of members

Wider colleagues will be invited by the Chair to attend and contribute as required.

All EMT members will be expected to contribute to the workplan of the EMT, so the agenda is owned collectively by EMT.

4 Quorum

Minimum of 50% of members, including the CEO or the Director of Performance and Transformation/Deputy CEO.

5 Meetings

EMT will meet weekly; with meetings no longer than 2 hours.

Papers will be issued 2 days before the meeting. Members who have individual accessibility requirements are encouraged to discuss these with the Chair so appropriate accommodation can be arranged. By default, materials will be accessed via Teams.

Members are expected to attend at least 75% of meetings in a 12-month period.

Members unable to attend should notify the Executive Assistant CEO and Board Chair 2 days in advance of the meeting where possible and should identify a substitute to attend, who is appropriately briefed to present any necessary reports and participate in the meeting if appropriate.

Extraordinary meetings may also be called if urgent business arises as determined by the Chair (CEO).

The model meetings paper should be used for all EMT papers and submitted to the Executive Assistant CEO and Board Chair no later than 2 days prior to the meeting. No papers will be accepted (unless agreed with the Chair) if they are late or are without ca over paper.

The EMT operates on a consensus basis. Where consensus is not reached, the CEO has final decision authority as the Accountable Officer for the Board.

6 Role and Responsibilities

The EMT is responsible for

- **Strategic Management:** Developing and implementing the Board's strategic objectives, delivery and improvement plans where remedial steps are required to improve performance (spanning quality, safety and experience, people and workforce, digital, financial and operational performance).
- **Performance Oversight**: The Board's performance against key targets via the Integrated Performance Report, plans and other corporate objectives, delegating and co-ordinating action where appropriate with a specific focus on quality of care, patient safety and patient experience.
- **Financial Governance**: Ensuring financial plans are robust and resources are used efficiently. Approval of Business Cases up to £100,000 as per the Scheme of Delegation and the capital programme prior to Finance and Performance Committee and Board approval.
- **Quality and Safety**: Promoting a culture of continuous improvement and patient safety and approving policies following engagement at key operational groups/Committees and ahead of providing onward assurance to Board Committees regarding policy compliance
- **Workforce Planning**: Delivery of the workforce and staff governance standards plans, including plans to further improve staff engagement, experience and wellbeing and ensure that staff are kept up to date on organisation and community-wide issues.
- **Risk Management:** Identifying and mitigating strategic and operational risks to enable the Audit and Risk Committee and the Board to gain assurance that adequate structures are in place to undertake activities which underpin effective risk management.
- **Collaboration**: Fostering collaborative integrated working across Orkney's health and social care system

In addition, EMT will:

- Approve key reports prior to submission to the Board and Governance Committees to ensure their accuracy and quality.
- Remain fully sighted of key regional and national returns to Scottish Government to ensure NHS Orkney submissions and position statements are understood and owned.

7 Reporting Arrangements

The EMT supports and advises the CEO who chairs the EMT and is the accountable officer for the Board.

The CEO reports directly to the NHS Board, which includes non-executive and executive members and is responsible for governance, strategic direction, delivery and oversight.

Governance and Assurance

The EMT provides reports, updates, and recommendations to the NHS Board and Committees as follows:

- NHS Orkney Board
- Joint Clinical Care Governance Committee
- Finance and Performance Committee
- Staff Governance Committee
- Remuneration Committee
- Audit and Risk Committee
- Area Partnership Forum
- Area Clinical Forum

External Reporting

Through the CEO, the EMT contributes to reports submitted to:

- Scottish Government Health and Social Care Directorate
- Healthcare Improvement Scotland
- Integration Joint Board (IJBs)
- Public Health Scotland

G Senior Leadership Team

1 Purpose

The Senior Leadership Team (SLT) is a Committee of the NHS Orkney Board, and is delegated by the Executive Team to act on and investigate any activity within its Terms o Reference.

The SLT will act as the “think tank” for the organisation contributing to the development and delivery of the day-to-day management of an effective system of integrated governance, risk management and internal control across the whole organisation’s activities, both clinical and non-clinical, which supports the achievement and delivery of the organisation’s strategic objectives in line with the Board’s Code of Corporate Governance

The SLT consists of the Organisation's senior leaders and collectively handles issue resolution.

2 Composition

Membership of SLT shall consist of:

- Chief Executive – Chair
- Executive Team
  - Medical Director
  - Director of Nursing, Midwifery, AHPs and Chief Officer Acute
  - Director of Public Health
  - Director of Finance
  - Chief Officer (Integration Joint Board)
  - Director of People and Culture
- Director of Pharmacy
- Director of Performance and Transformation
- Associate Director of AHPs
- Head of Planning, Performance and Information
- Head of Quality, Safety and Risk
- Interim Deputy Director of Nursing and Midwifery
- Head of People and Culture
- Head of Community Health and Community Care
- Head of Corporate Governance
- Head of Procurement
- Senior Financial Accountant
- Health and Safety Lead
- Head of Primary Care
- Employee Director
- Head of Estates and Property
- Head of Facilities and NPD
- Head of Information Technology
- Head of Children, Families and Justice Services and Chief Social Work Officer
- Radiology/Audiology Manager
- Laboratory Manager

In the absence of the Chair, the Chair will nominate a member of SLT to Chair the meeting.

Members of SLT are encouraged to invite their teams to shadow and attend SLT as part of their personal development.

3 Attendance

The Chair and Corporate Governance team should be informed in advance of a delegate attending as a deputy other than those from the membership list.

Where necessary delegates should be briefed to present reports on behalf of members. Members unable to attend should notify the Head of Corporate Governance 3 days in advance of the meeting where possible and should identify a substitute to attend, who is appropriately briefed to present any necessary reports and participate in the meeting if appropriate.

Wider colleagues will be invited to attend and contribute as required to meet the work programme of the SLT.
Any member of Team Orkney is invited to attend an SLT meeting by emailing the Corporate Governance team - ork.corporategovernance@nhs.scot

All SLT members are expected to contribute to the workplan of SLT so that this agenda is owned collectively by SLT.

All members are expected to brief their line reports on the key decisions and discussion points from SLT (as detailed in the Chair's Assurance Report) within 5 days of the meeting.

4 Quorum

Quoracy of the meeting will include a minimum of 3 Executive Directors or 2 Executive Directors and the Chief Executive 1 of which one must be clinical and 8 wider attendees, 3 of which must be clinical

5 Meetings

SLT will meet monthly,with meetings no longer than 2 hours.

The Chair's Assurance Report will be issued for comments and approval within 2 days of the meeting and submitted to the Executive Management Team for assurance.

Members are expected to attend at least 75% of meetings in a 12-month period.

Extraordinary meetings may also be called if urgent business arises as determined by the Chair (CEO).

Before each meeting the agenda and papers shall be accessible to every member by electronic means via On Board, at least five working days before the date of the meeting. Unless there are individual accessibility requirements which should be discussed with the Chair so these can be addressed and accommodated, we will only access papers via On Board

The model meetings paper (appendix 1) should be used for all SLT papers and submitted to the Corporate Governance Team no later than 5 days prior to the meeting. No papers will be accepted (unless agreed with the Chair) if they are late or are without a cover paper.

6 Remit

SLT provides collective leadership for NHS Orkney on behalf of the Executive Team, this includes

- Providing advice on hospital and community-wide issues of current concern, ensuring co-ordination between teams and services and timely resolution of cross cutting issues.

- Supporting the development and delivery of annual planning and change management priorities, including delivery of Corporate and Clinical Strategies and other agreed programmes of work.
- Contributing to the development and delivery of the organisational improvement programme (Improving Together)
- Supporting the development and delivery of workforce and people plans, including actions to improve staff engagement, experience and culture.
- Being sighted on key regional and national requirements and returns, ensuring NHS Orkney submissions and position statements are understood, owned and delivered.
- Ensure staff within their teams are appropriately briefed on key organisational issues and decisions arising from SLT.

The agenda for SLT will be timed and will focus on items requiring decision or action. Items for noting only will be clearly marked on the agenda.

8 Authority

The Senior Leadership Team is authorised by the Executive Team to investigate any activity within its Terms of Reference and in doing so, is authorised to seek any information it requires within the scope of organisational data protection and Caldicott guidance.

9 Reporting Arrangements

SLT reports to the NHS Orkney Executive Team via a Chair's Assurance Report as set out in Appendix 1.

Following a meeting of SLT the approved Chair's Assurance Report will be submitted to the Executive Team for awareness.

SLT will escalate and report on any areas of concern to the Executive Team as appropriate principally via the Chair's Assurance Report as needed.

Ver

SECTION

B

Members Code of Conduct

Version 20

This section is for Members of Orkney NHS Board and details how they should conduct themselves in undertaking their duties.

1 Introduction to the Code of Conduct

The Scottish public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. You must meet those expectations by ensuring that your conduct is above reproach.

The Ethical Standards in Public Life etc. (Scotland) Act 2000, "the Act", provides for Codes of Conduct for local authority councilors and members of relevant public bodies; imposes on councils and relevant public bodies a duty to help their members to comply with the relevant code; and establishes a Standards Commission for Scotland, "The Standards Commission" to oversee the new framework and deal with alleged breaches of the codes.

The Act requires the Scottish Ministers to lay before Parliament a Code of Conduct for Councilors and a Model Code for Members of Devolved Public Bodies. The Model Code for members was first introduced in 2002 and has now been revised in June 20223 following consultation and the approval of the Scottish Parliament. These revisions consider the changes which, where appropriate, are consistent with the revised Councilors' Code which ~~and~~ highlights the need for board members to take personal responsibility for their behaviour.

As a member of Orkney NHS Board "the Board", it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct which has now been made by the Board.

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1 Appointments to the Boards of Public Bodies

1.1 The Chair may call a meeting of the Board at any ~~time~~time, and the Chair of a Committee may call a meeting of that Committee at any time or when required to do so by the Board.

1.2 Public bodies in Scotland are required to deliver effective services to meet the needs of an increasingly diverse population. In addition, the Scottish Government's equality outcome on public appointments is to

ensure that Ministerial appointments are more diverse than at present. To meet both aims, a board should ideally be drawn from varied backgrounds with a wide spectrum of characteristics, knowledge and experience. It is crucial to the success of public bodies ~~that they~~that attract the best people for the job and therefore it is essential that a board's appointments process should encourage as many suitable people to apply for positions and be free from unnecessary barriers. You should therefore be aware of the varied roles and functions of the Board on which you serve and of wider diversity and equality issues. You should also take steps to familiarise yourself with the appointment process that

Orkney NHS Board will have agreed with the Scottish Government's Public Appointment Centre of Expertise.

1.3 You should also familiarise yourself with how the board's policy operates in relation to succession planning, which should ensure public bodies have a strategy to make sure they have the staff in place with the skills, knowledge and experience necessary to fulfil their role economically, efficiently and effectively.

3 Guidance on the Code of Conduct

3.1 You must observe the rules of conduct contained in this Code. It is your personal responsibility to comply with these and review regularly, and at least annually, your personal circumstances with this in mind, particularly when your circumstances change. You must not at any time advocate or encourage any action contrary to the Code of Conduct.

3.2 The Code has been developed in line with the key principles listed in Section 2 and provides additional information on how the principles should be interpreted and applied in practice. The Standards Commission may also issue guidance. No Code can provide for all circumstances and if you are uncertain about how the rules apply, you should seek advice from Orkney NHS Board. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

3.3 You should familiarise yourself with the Scottish Government publication "On Board: a guide for members of statutory boards - gov.scot (www.gov.scot)This publication will provide you with information to help you in your role as a member of a public body in Scotland and can be viewed on the Scottish Government website.

4 Enforcement

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4.1 Part 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 sets out the provisions for dealing with alleged breaches of this Code of Conduct and where appropriate the sanctions that will be applied if the Standards Commission finds that there has been a breach of the Code. Those sanctions are outlined in **Annex 1**.

2 Key Principles of the Code of Conduct

The general principles upon which this Code is based should be used for guidance and interpretation only.

These general principles are:

1 Duty

1.1 You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. You have a duty to act in the interests of Orkney NHS Board of which you are a member and in accordance with the core functions and duties of the board.

2 Selflessness

2.1 You have a duty to take decisions solely in terms of public interest. You must not act to gain financial or other material benefit for yourself, family, or friends.

3 Integrity

3.1 You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

4 Objectivity

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4.1 You must make decisions solely on merit and in a way that is consistent with the functions of Orkney NHS Board when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

5 Accountability and Stewardship

5.1 You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that Orkney NHS Board uses its resources prudently and in accordance with the law.

6 Openness

6.1 You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.

7 Honesty

7.1 You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

8 Leadership

8.1 You have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of Orkney NHS Board and its members in conducting public business.

9 Respect

9.1 You must respect fellow members of the Board and employees of Orkney NHS Board and the role they play, treating them with courtesy always. Similarly, you must respect members of the public when performing duties as a member of Orkney NHS Board.

9.2 You should apply the principles of this Code to your dealings with fellow members of Orkney NHS Board, its employees, and other stakeholders. Similarly, you should also observe the principles of this Code in dealings with the public when performing duties as a member of Orkney NHS Board.

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3 General Conduct

The rules of good conduct in this section must be observed in all situations where you act as a member of Orkney NHS Board.

1 Conduct at Meetings

1.1 You must respect the Chair, your colleagues, and employees of Orkney NHS Board in meetings. You must comply with rulings from the Chair in the conduct of the business of these meetings.

2 Relationship with Board Members and Employees of the Public Body (including those employed by contractors providing services)

2.1 You will treat everyone with courtesy and respect. This includes in person, in writing, at meetings, when online and when using social media

It is expected that fellow board members and employees will show you the same consideration in return. It is good practice for employers to provide examples of what is unacceptable behaviour in their organisation. Public bodies should promote a safe, healthy, and fair working environment for all. As a board member you should be familiar with the policies of Orkney NHS Board in relation to bullying and harassment in the workplace and also lead by exemplar behavior.

3 Remuneration, Allowances and Expenses

3.1 You must comply with any rules of Orkney NHS Board regarding remuneration, allowances, and expenses.

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4 Gifts and Hospitality

4.1 You must not accept any offer by way of gift or hospitality which could give rise to real or substantive personal gain or a reasonable suspicion of influence on your part to show favour, or disadvantage, to any individual or organisation. You should also consider whether there may be any reasonable perception that any gift received by your spouse or cohabitee or by any company in which you have a controlling interest, or by a partnership of which you are a partner, can or would influence your judgement. The term "gift" includes benefits such as relief from indebtedness, loan concessions or provision of services at a cost below that generally charged to members of the public.

4.2 You must never ask for or seek any gifts or hospitality.

4.3 You are personally responsible for all decisions connected with the offer or acceptance of gifts or hospitality offered to you and for avoiding the risk of damage to public confidence in Orkney NHS Board. As a general guide, it is usually appropriate to refuse offers except:

(a) Isolated gifts of a trivial character, the value of which must not exceed £50
(b) Normal hospitality associated with your duties, and which would reasonably be regarded as appropriate; or
(c) Gifts received on behalf of Orkney NHS Board

4.4 You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision Orkney NHS Board may be involved in determining, or who is seeking to do business with the Board, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit in your capacity as a member of Orkney NHS Board then, as a general rule, you should ensure that the Board pays for the cost of the visit.

4.5 You must not accept repeated hospitality or repeated gifts from the same source.

4.6 Members of Orkney NHS Board should familiarise themselves with the terms of the Bribery Act 2010 which provides for offences of bribing another person and offences relating to being bribed.

5 Confidentiality Requirements

5.1 There may be times when you will be required to treat discussions, documents or other information relating to the work of Orkney NHS Board in a confidential manner. You will often receive information of a private nature which is not yet public, or which perhaps would not be

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intended to be public. You must always respect the confidential nature of such information and comply with the requirement to keep such information private.

5.2 It is unacceptable to disclose any information to which you have privileged access, for example derived from a confidential document, either orally or in writing. In the case of other documents and information, you are requested to exercise your judgement as to what should or should not be made available to outside bodies or individuals. In any event, such information should never be used for the purposes of personal or financial gain or for political purposes or used in such a way as to bring Orkney NHS Board into disrepute.

6 Use of Public Body Facilities

6.1 Members of Orkney NHS Board must not misuse facilities, equipment, stationery, telephony, computer, information technology equipment and services, or use them for party political or campaigning activities. Use of such equipment and services, etc. must be in accordance with the Board's policy and rules on their usage. Care must also be exercised when using social media networks not to compromise your position as a member of Orkney NHS Board.

7 Appointment to Partner Organisations

7.1 You may be appointed, or nominated by Orkney NHS Board, as a member of another body or organisation. If so, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body.

7.2 Members who become director or trustee (or equivalent) of a company or a charity, will be responsible for identifying, and taking advice on, any conflicts of interest that may arise between the company or charity and my public body.

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4 Registration of Interests

The following paragraphs set out the kinds of interests, financial and otherwise which you must register. These are called 'Registerable Interests'. You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in the Orkney NHS Board Register. It is your duty to ensure any changes in circumstances are reported within one month of them changing.

The Regulations[1] as amended describe the detail and timescale for registering interests. It is your personal responsibility to comply with these regulations and you should review regularly and at least once a year your personal circumstances. **Annex 2** contains key definitions and explanatory notes to help you decide what is required when registering your interests under any category. The interests which require to be registered are those set out in the following paragraphs and relate to you. It is not necessary to register the interests of your spouse or cohabite.

1 Category One: Remuneration

1.1 You have a Registerable Interest where you receive, or expect to receive, remuneration by virtue of being:

- Employed
- Self-employed
- The holder of an office
- A director of an undertaking
- A partner in a firm
- Appointed or nominated by my public body to another body; or

[1] SSI - The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003 Number 135, as amended.

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- engage in a trade, profession or vocation or any other work.

1.2 In relation to 1.1 above, the amount of remuneration does not require to be registered, and remuneration received as a board member of NHS Orkney does not have to be registered.

1.3 If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two, 'Other Roles'.

1.4 If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

1.5 When registering employment as an employee you must give the full name of the employer, the nature of its business, and the nature of the post held in the organisation.

1.6 When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a partnership, you must give the name of the partnership and the nature of its business.

1.7 Where you undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if you write for a newspaper, you must give the name of the publication, and the frequency of articles for which you are paid.

1.8 When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and the nature of its business.

1.9 Registration of a pension is not required as this falls outside the scope of the category.

2 Category Two: Other Roles

2.1 You must register any unremunerated directorships where the body in question is a subsidiary or parent of an undertaking in which you hold a remunerated directorship.

2.2 You must register the name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

2.3 The situations to which the above paragraphs apply are as follows:

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- You are a director of a board of an undertaking and receive remuneration declared under category one – and
- You are a director of a parent or subsidiary undertaking but do not received remuneration in that capacity.

3 Category Three: Contracts

3.1 You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in paragraph 5.1 below) have made a contract with Orkney NHS Board of which you are a member:

(a) Under which goods or services are to be provided, or works are to be executed; and
(b) Which has not been fully discharged

3.2 You must register a description of the contract, including its duration, but excluding the value.

4 Category Four: Election Expenses

4.1 If you have been elected to a public body, you will register a description of, and statement of, any assistance towards election expenses relating to election to a public body.

5 Category Five: Houses, Land and Buildings

5.1 You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of Orkney NHS Board.

5.2 The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to Orkney NHS Board and to the public, or could influence your actions, speeches or decision-making.

6 Category Six~~: Interest~~: Interest in Shares and Securities:

6.1 You have a registerable interest where:

(i) you own or have an interest in more than 1% of the issued share capital of the company or other body; or

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(ii) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that you own or have an interest in is greater than £25,000

7 Category Seven~~: Gifts~~: Gifts and Hospitality:

7.1 I understand the requirements regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

8 Category Eight: Non–Financial Interests

8.1 I may also have other interests, and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its committees and memberships of other organisations to which I have been appointed or nominated by my public body).

9 Category Nine: Close Family Members

9.1 I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

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5 Declaration of Interests

1 General

1.1 The key principles of the Code, especially those in relation to integrity, honesty, and openness, are given further practical effect by the requirement for you to declare certain interests in proceedings of Orkney NHS Board. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions.

1.2 Public bodies inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in Orkney NHS Board and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.

1.3 In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must, however, always comply with the **objective test** ("the objective test") which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your discussion or decision making in your role as a member of Orkney NHS Board.

1.4 If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to proceedings to require a declaration, and you are advised to err on the side of caution. If a board member is unsure as to whether a conflict of interest exits, they should seek advice from the Board chair.

1.5 As a member of Orkney NHS Board, you might serve on other bodies. In relation to service on the boards and management committees of limited liability companies, public bodies, societies and other organisations, you must decide, in the circumstances surrounding any matter, whether to declare an interest. Only if you believe that, in the circumstances, the nature of the interest is so remote or without significance, should it not be declared. You must always remember the public interest points towards transparency and a possible divergence of interest between Orkney NHS Board and another body. Keep particularly in mind the advice in paragraph 3.15 of this Code about your legal responsibilities to any limited company of which you are a director.

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2 Interests which Require Declaration

2.1 Interests which require to be declared if known to you may be financial or non-financial. They may or may not cover interests which are registerable under the terms of this Code. Most of the interests to be declared will be your personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration. The paragraphs which follow deal with (a) your financial interests (b) your non-financial interests and (c) the interests, financial and non-financial, of other persons.

2.2 You will also have other private and personal interests and may serve, or be associated with, bodies, societies and organisations because of your private and personal interests and not because of your role as a member of Orkney NHS Board. In the context of any matter, you will need to decide whether to declare an interest. You should declare an interest unless you believe that, in the circumstances, the interest is too remote or without significance. In reaching a view on whether the objective test applies to the interest, you should consider whether your interest (whether taking the form of association or the holding of office) would be seen by a member of the public acting reasonably in a different light because it is the interest of a person who is a member of Orkney NHS Board as opposed to the interest of an ordinary member of the public.

3 Your Financial Interests

3.1 You must declare, if it is known to you, any financial interest (including any financial interest which is registerable under any of the categories prescribed in Section 4 of this Code). If, under category one (or category seven in respect of non-financial interests) of section 4 of this Code, you have registered an interest:

a) As an employee of the Board; or
b) As a Councillor or a Member of another Devolved Public Body where the council or other devolved public body has nominated or appointed you as a Member of the Board

You are not required, for that reason alone, to declare that interest.

3.2 There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

3.3 You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

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4 Your Non-Financial Interests

4.1 You must declare, if it is known to you, any non-financial interest if:

(a) That interest has been registered under category seven (Non-Financial Interests) of Section 4 of the Code; or
(b) That interest would fall within the terms of the objective test.

4.2 There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

4.3 You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

5 The Financial Interests of Other Persons

5.1 You must declare if it is known to you any financial interest of:

(a) a spouse, a civil partner, or a cohabitee
(b) a close relative, close friend, or close associate
(c) an employer or a partner in a firm
(d) a body (or subsidiary or parent of a body) of which you are a remunerated member or director
(e) a person from whom you have received a registerable gift or registerable hospitality
(f) a person from whom you have received registerable expenses.

5.2 There is no need to declare an interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

5.3 You must withdraw from the meeting room until discussion of and voting on the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

5.4 This Code does not attempt the task of defining “relative” or “friend” or “associate”. Not only is such a task fraught with difficulty but is also unlikely that such definitions would reflect the intention of this part of the Code. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of Orkney NHS Board and, as such, would be covered by the objective test.

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6 The Non-Financial Interests of Other Persons

6.1 You must declare if it is known to you any non-financial interest of:

a) a spouse, a civil partner, or a cohabitee
b) a close relative, close friend, or close associate
c) an employer or a partner in a firm
d) a body (or subsidiary or parent of a body) of which you are a remunerated member or director
e) a person from whom you have received a registerable gift or registerable hospitality
f) a person from whom you have received registerable election expenses.

6.2 There is no need to declare the interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

6.3 There is only a need to withdraw from the meeting if the interest is clear and substantial.

7 Making a Declaration

7.1 You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether agendas for meetings raise any issue of declaration of interest. Your declaration of interest must be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed, you must declare the interest as soon as you realise it is necessary.

7.2 The oral statement of declaration of interest should identify the item or items of business to which it relates. The statement should begin with the words “I declare an interest”. The statement must be sufficiently informative to enable those at the meeting to understand the nature of your interest but need not give a detailed description of the interest.

8 Frequent Declarations of Interest

8.1 Public confidence in a public body is damaged by perception that decisions taken by that body are substantially influenced by factors other than the public interest. If you would have to declare interests frequently at meetings in respect of your role as a board member you should not accept a role or appointment with that attendant consequence. If members are frequently declaring interests at meetings, then they should consider whether they can carry out their role effectively and discuss with their chair. Similarly, if any appointment or nomination to another body

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would give rise to objective concern because of your existing personal involvement or affiliations, you should not accept the appointment or nomination.

9 Dispensations

9.1 In some very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and non-financial interests which would otherwise prohibit you from taking part and voting on matters coming before Orkney NHS Board and its committees.

9.2 Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

6 Lobbying and Access to Members of Public Bodies

1 Introduction

1.1 For Orkney NHS Board to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which Orkney NHS Board conducts its business.

1.2 You will need to be able to consider evidence and arguments advanced by a wide range of organisations and individuals to perform your duties effectively. Some of these organisations and individuals will make their views known directly to individual members. The rules in this Code set out how you should conduct yourself in your contacts with those who would seek to influence you. They are designed to encourage proper interaction between members of public bodies, those they represent and interest groups.

2 Rules and Guidance

2.1 You must not, in relation to contact with any person or organisation who lobbies, do anything which contravenes this Code or any other relevant rule of Orkney NHS Board or any statutory provision.

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2.2 You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon Orkney NHS Board.

2.3 The public must be assured that no person or organisation will gain better access to or treatment by you because of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a fee basis on behalf of clients be given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of Orkney NHS Board.

2.4 Before taking any action as a result of being lobbied, you should seek to satisfy yourself about the identity of the person or organisation who is lobbying and the motive for lobbying. You may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that you know the basis on which you are being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code and the Lobbying (Scotland) Act 2016.

2.5 You should not accept any paid work:

a) Which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation
b) To provide services as a strategist, adviser, or consultant, for example, advising on how to influence Orkney NHS Board and its members. This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of Orkney NHS Board, such as journalism, or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

2.6 If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of Orkney NHS Board.

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Annex A

Sanctions Available to The Standards Commission for Breach of The Code:

The sanctions that can be imposed following a finding of a breach of the Code are as follows:

- **Censure**: A censure is a formal record of the Standards Commission's severe and public disapproval of the member concerned.

- **Suspension**: This can be a full or partial suspension (for up to one year). A full suspension means that the member is suspended from attending all meetings of the public body. Partial suspension means that the member is suspended from attending some of the meetings of the public body. The Commission can direct that any remuneration or allowance the member receives as a result of their membership of the public body be reduced or not paid during a period of suspension.

- **Disqualification**: Disqualification means that the member is removed from membership of the body and disqualified (for a period not exceeding five years), from membership of the body. Where a member is also a member of another devolved public body (as defined in the Act), the Commission may also remove or disqualify that person in respect of that membership. Full details of the sanctions are set out in section 19 of the Act.

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Annex B

Definitions

A full list of definitions used in the code can be found at Annex B
Model Code of Conduct | The Standards Commission for Scotland (standardscommissionscotland.org.uk)

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Annex C

Bribery Act 2010 – NHS Orkney's Aims and Objectives

The Bribery Act 2010 ("The Act") has brought further obligations on NHS Orkney, its Non-Executive Members of the Board, and its staff.

NHS Orkney does not tolerate any form of bribery, whether direct or indirect, by, or of, its staff, agents or external consultants or any persons or entities acting for it or on its behalf. This includes Non-Executive Members of the Board, and any other co-opted members of committees or sub-committees of the Board.

The Board is committed to implementing and enforcing effective systems throughout NHS Orkney to prevent, monitor and eliminate bribery within NHS Orkney, in accordance with the Bribery Act 2010, and to the rigorous investigation of any such cases.

NHS Orkney will not conduct business with service providers, agents or representatives that do not support its anti-bribery statement and it reserves the right to terminate its contractual arrangements with any third parties acting for, or on behalf of, NHS Orkney with immediate effect where there is evidence that they have committed acts of bribery.

The success of NHS Orkney's anti-bribery measures depends on all employees, Non-Executive Members of the Board and those acting for NHS Orkney, playing their part in helping to detect and eradicate bribery. Therefore, all employees, Non-Executive Members of the Board and others acting for or on behalf of NHS Orkney are encouraged to report any suspected bribery in accordance with bribery in accordance with The Fraud Standards, Section D, of the Code of Corporate Governance.

Bribery Act 2010 (legislation.gov.uk)

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SECTION

C

Standards of Business Conduct for NHS Staff

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This section is for all staff to ensure they are aware of their duties in situations where there may be conflict between their private interests and their NHS duties.

1 Standards of Business Conduct for NHS Staff

1 Introduction

1.1 This section of NHS Orkney's Code of Corporate Governance provides instructions on those issues or matters which staff are most likely to encounter in carrying out their day-to-day duties. This is not exhaustive and is supplementary to (and therefore should be read in conjunction with) the Standards of Business Conduct for NHS Staff (NHS Circular MEL (1994) 48) and A Common Understanding 2012: Working Together for Patients.

1.2 The Standards of Business Conduct for NHS Staff will be incorporated into the contract of employment for each member of staff.

1.3 Guidance regarding accepted practice in NHS Orkney is detailed in these Standards; however, professionally registered staff should also ensure that they do not breach the requirements in respect of their Professional Codes of Conduct.

2 The Bribery Act 2010 - NHS Orkney's Aims and Objectives

2.1 The Bribery Act 2010 ("The Act") has brought further obligations on NHS Orkney, its Non-Executive Members and its staff.

2.2 NHS Orkney does not tolerate any form of bribery, whether direct or indirect, by, or of, its staff, agents or external consultants or any persons or entities acting for it or on its behalf. This includes Non-Executive Members, and any other co-opted members of committees or sub-committees of the Board.

2.3 The Board is committed to implementing and enforcing effective systems throughout NHS Orkney to prevent, monitor and eliminate bribery within NHS Orkney, in accordance with the Bribery Act 2010, and to the rigorous investigation of any such cases.

2.4 NHS Orkney will not conduct business with service providers, agents or representatives that do not support its anti-bribery statement and it reserves the right to terminate its contractual arrangements with any third parties acting for, or on behalf of, NHS Orkney with immediate effect where there is evidence that they have committed acts of bribery.

2.5 The success of NHS Orkney's anti-bribery measures depends on all employees, Non-Executive Members and those acting for NHS Orkney, playing their part in helping to detect and eradicate bribery. Therefore, all

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employees, Non-Executive Members and others acting for or on behalf of NHS Orkney are encouraged to report any suspected bribery in accordance with bribery in accordance with The Fraud Standards, Section D, of the Code of Corporate Governance.

3 The Bribery Act 2010 – Key Points

3.1 The Bribery Act 2010 is one a strict piece of legislation and makes it a criminal offence for any individual (employee, contractor, agent) associated with NHS Orkney, to give, promise or offer a bribe, and to request, agree to receive or accept a bribe (sections 1, 2 and 6 offences). This can be punishable by imprisonment of up to ten years.

3.2 In addition, the Act introduces a corporate offence (Section 7 offence) which means that NHS Orkney can be exposed to criminal liability, punishable by an unlimited fee, if it fails to prevent bribery by not having adequate preventative procedures in place that are robust, up-to-date and effective. The corporate offence is not a stand-alone offence and will follow from a bribery/corruption offence committed by an individual associated with NHS Orkney, in the course of their work. NHS Orkney takes its legal responsibilities very seriously.

3.3 If a bribery offence is proved to have been committed by an outside body corporate with the consent or connivance of a Director or Senior Officer of NHS Orkney, under the Act, the Director or Senior Officer would be guilty of an offence (section 14 offences) as well as the body corporate which paid the bribe.

3.4 Whilst the exact definition of bribery and corruption is a statutory matter, the following working definitions are given together with some examples:

Bribery is an inducement or reward offered, promised or provided in order to gain any commercial, contractual, regulatory or personal advantage.

Corruption relates to a lack of integrity or honesty, including the misuse of trust for dishonest gain. It can be broadly defined as the offering or acceptance of inducements, gifts, favours, payments or benefits in kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly; however, they may be unreasonably using their position to give some advantage to another.

Examples of bribery:

Offering a Bribe

A bribe would occur if:

- A payment was made to influence an individual who was responsible

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for making decision on whether NHS Orkney should be selected as the preferred bidder for the provision of services in a procurement process.

- A member of staff conducted private meetings, other than on NHS premises, with a public contractor hoping to tender an NHS Orkney contract, each time accepting hospitality far in excess of that deemed appropriate within the Standards of Business Conduct for NHS Orkney and without guidance being sought in advance from the line manager or Head of Corporate Services or subsequently being declared.

Receiving a Bribe

A bribe would occur if:

- A patient offered a member of NHS Orkney staff a payment (or other incentive) to speed up, beyond usual timeframe, the provision of a particular aspect of their care.

- A pharmaceutical company offered a member of NHS Orkney staff a payment (or other incentive such as a generous gift or lavish hospitality) in order to influence their decision making in the selection of a pharmaceutical product to appear on NHS Orkney's drug formulary.

3.5 The success of NHS Orkney's anti-bribery measures depends on all employees, and those acting for NHS Orkney, playing their part in helping to detect and eradicate bribery. Therefore, all employees and others acting for or on behalf of NHS Orkney are encouraged to report any suspected bribery in accordance with following The Fraud Standards, Section D, of the Code of Corporate Governance.

4 Responsibilities of Staff

4.1 NHS Orkney is committed to maintaining strict ethical standards and integrity in the conduct of its business activities. All NHS Orkney staff and individuals acting on NHS Orkney's behalf, are responsible for conducting NHS Orkney's business professionally, with honesty, integrity and maintaining the organisation's reputation and free from bribery.

4.2 Staff must ensure that they do not place themselves in a position which risks, or appears to risk, conflict between their private interests and their NHS duties such as, for example, abusing their present position to obtain preferential rates for personal gain or to benefit family members or associates.

This primary responsibility applies to **all NHS staff** but is of particular relevance to those who commit NHS resources directly (e.g. by the

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ordering of goods) or those who do so indirectly (e.g. by the prescribing of medicines).

4.3 The NHS must be impartial and honest in the conduct of its business and its employees should remain beyond suspicion.

4.4 Staff need to be aware that a breach of the provisions of the Bribery Act renders them liable to prosecution and may lead to potential disciplinary action and the loss of their employment and superannuation rights.

4.5 This Code reflects the minimum Standards of Business Conduct expected from all NHS staff. Any breaches of the Code may lead to disciplinary action.

N.B: If you are in any doubt at all as to what you can or cannot do, you should seek advice from your Line manager / Head of Department / Director of Finance or Head of Corporate Governance.

5 Key Principles of Business Conduct

5.1 The Standards of Business Conduct for NHS Staff [MEL (1994) 48] provide instructions to staff in maintaining strict ethical standards in the conduct of NHS business. All staff are therefore required to adhere to the Standards of Business Conduct for NHS Staff.

5.2 Public Service values must be at the heart of the NHS Board's activities. High standards of corporate and personal conduct, based on the recognition that patients come first, are mandatory. The NHS Board is a publicly funded body, accountable to Scottish Ministers and through them to the Scottish Parliament for the services and for the economical, efficient, and effective use of resources placed at the Board's disposal.

5.3 By staff following these principles, the Board should be able to demonstrate that it adheres to the three essential public sector values.

Accountability:

Everything done by those who work in the organisation must be able to stand these tests of parliamentary scrutiny, public judgements on propriety, and meet professional codes of conduct.

Probity:

Absolute honesty and integrity should be exercised in dealing with NHS patients, staff, assets, suppliers and customers.

Openness:

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The organisation's activities should be sufficiently public and transparent to promote confidence between the organisation and its patients, staff and public.

6 Acceptance of Gifts, Hospitality and Prizes

6.1 Gifts

6.1.1 The Standards of Business Conduct state that any money, gift or consideration received by an employee in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary.

6.1.2 Staff should therefore be very cautious if faced with the offer of a gift. Casual gifts offered by contractors or others excluding patients, relatives, or carers (for example, at the festive season) may not be in any way connected with the performance of duties to constitute an offence. Such gifts should nevertheless be declined. Items of low intrinsic value e.g. boxes of biscuits, chocolates or flowers from patients, relatives, or carers can be accepted. Any gifts of money should be handled in accordance with the Endowment Fund Charter.

Where an unsolicited or inappropriate gift is received and the individual is unable to return it or the donor refuses to accept its return, they should report the circumstances to the Head of Corporate Governance who will determine if the gift can be accepted, and this should be recorded in the Register of Gifts.

Financial donations to a department fund, which are to be used for the purposes of NHS Orkney must be administered through Orkney Health Board Endowment Fund and handled in accordance with the Endowment Fund Charter.

The Head of Corporate Governance should maintain a register to record gifts reported by staff. It is the responsibility of the recipients of such gifts to report all such items received to the Head of Corporate Governance for recording who will provide the registration form. This register will be published on the NHS Orkney website.

6.2 Hospitality

6.2.1 Standards of Business Conduct state that hospitality may be acceptable provided it is normal and reasonable in the circumstances e.g. lunches during a working visit. Any hospitality accepted should be similar in scale to that which the NHS as an employer would be likely to offer and must not exceed £25. All other offers of hospitality should be declined.

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6.2.2 Staff should seek guidance from their Line Manager prior to accepting any such hospitality. In cases of doubt, advice should be sought from the Head of Corporate Governance.

6.2.3 It may not always be clear whether an individual is being invited to an event involving the provision of hospitality (e.g. formal dinner) in a personal/private capacity or because of the position which they hold in NHS Orkney.

I If the invitation is the result of the individual's position with NHS Orkney, only hospitality which is modest and normal and reasonable in the circumstances should be accepted. If the nature of the event dictates a level of hospitality which exceeds this, then the individual should ensure that his/her Head of Department/Director is fully aware of the circumstances. An example of such an event might be an awards ceremony involving a formal dinner. If the Head of Department/Director grants approval to attend, the individual should declare his/her attendance for registration in the Register of Hospitality held by the Head of Corporate Governance.

II If the individual is invited to an event in a private capacity (e.g. as result of his/her qualification or membership of a professional body), they are at liberty to accept or decline the invitation without referring to his/her Line Manager. The following matters should however be considered before an invitation to an individual in a private capacity is accepted.

- The individual should not do or say anything at the event that could be construed as representing the views and/or policies of NHS Orkney
- If the body issuing the invitation has (or is likely to have or is seeking to have) commercial or other financial dealings with NHS Orkney, then it could be difficult for an individual to demonstrate that his/her attendance was in a private and not an official capacity. Attendance could create a perception that the individual's independence had been compromised, especially where the scale of hospitality is lavish. Individuals should therefore exercise caution before accepting invitations from such bodies and must seek approval from their Line Manager.

III Where suppliers of clinical products offer hospitality, it should only be accepted if it complies with the guidance in the Sponsorship Policy.

IV The Head of Corporate Governance should maintain a register to record hospitality reported by staff. It is the responsibility of the recipients of such hospitality to report all such items received to the Head of Corporate Governance for recording in NHS Orkney's

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Register of Hospitality. The form in Annex 2 should be used for this purpose. This register will be published on the NHS Orkney website.

6.3 Competitions / Prizes

Individuals should not enter competitions including free draws organised by bodies who have or are seeking to have financial dealings with NHS Orkney. Potential suppliers may use this as a means of giving money or gifts to individuals with NHS Orkney to influence the outcome of business decisions. If in doubt, contact the Head of Corporate Governance.

7 Register of Staff Interests

7.1 To avoid conflicts of interest and to maintain openness and accountability, employees are required to register all interests that may have any relevance to their duties/responsibilities. These include any financial interest in a business or any other activity or pursuit that may compete for an NHS contract to supply either goods or services to the NHS or in any other way could be perceived to conflict with the interests of NHS Orkney. The test to be applied when considering appropriateness of registration of an interest is to ask whether a member of the public acting reasonably might consider the interest could potentially affect the individual's responsibilities to the organisation and/or influence their actions. If in doubt the individual should register the interest or seek further guidance from the Head of Corporate Governance.

7.2 Interests that it may be appropriate to register, include:

(i) Other employments including self-employment.
(ii) Directorships including Non-Executive Directorships held in private companies or public limited companies (whether remunerated or not)
(iii) Ownership of, or an interest in, private companies, partnerships, businesses, or consultancies
(iv) Shareholdings in organisations likely or possibly seeking to do business with the NHS (the value of the shareholdings need not be declared)
(v) Ownership of or interest in land or buildings which may be significant to, of relevance to, or bear upon the work of NHS Orkney.
(vi) Any position of authority held in another public body, trade union, charity or voluntary body.
(vii) Any connection with a voluntary or other body contracting for NHS services.
(viii) Any involvement in joint working arrangements with Clinical (or other) Suppliers.

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This list is not exhaustive and should not preclude the registration of other forms of interest where these may give rise to a potential conflict of interest upon the work of NHS Orkney. Any interests of spouses, partner or civil partner, close relative or associate, or persons living with the individual as part of a family unit, will also require registration if a conflict of interests exists.

7.3 The completed register of interests' form should be returned to the Board. Secretary. The Register of Staff Interests will be retained for a period of five years.

7.4 It is the responsibility of everyone to declare any relevant interest to the Chair of any Committee/decision making group of which they are a member so that the Chair is aware of any conflict which may arise.

8 Purchase of Goods and Services

8.1 NHS Orkney has a procurement function under the direction of the Director of Finance to purchase the goods and services required for the functioning of NHS Orkney. Except for staff who have delegated authority to purchase goods and services, no other member of staff is authorised to make a commitment to a third party for the purchase of goods or services. The Procurement Officer should be contacted for advice on all aspects of the purchase of goods and services.

8.2 All staff who are in contact with suppliers and contractors (including external consultants), and particularly those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services are expected to adhere to Section 13 of NHS Orkney's Standing Financial Instructions (SFIs).

8.3 Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of SFIs and of EC Directives on Public Purchasing for Works and Supplies. This means that:

- No private or public company, firm or voluntary organisation which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors whether there is a relationship between them and the NHS employer, such as a long-running series of previous contracts
- Each new contract should be awarded solely on merit in accordance with the SFIs

8.4 SFIs describe the process to be followed to purchase goods and services. Key points to note are:

(i) SFIs define the limits above which competitive quotations and competitive tenders must be obtained and describe the process which

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should be followed to achieve fair and open competition.

(ii) No organisation should be given unfair advantage in the competitive process, e.g. by receiving advance notice of NHS Orkney's requirements.

8.5 No special favour should be shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or managerial capacity.

8.6 Contracts must be won in fair competition against other tenders and scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

8.7 All invitations to potential contractors to tender for NHS business should. include a notice warning the tenderer of the consequences of engaging in any corrupt practices involving NHS Orkney's employees and that facilitation payments are prohibited in line with the Bribery Act 2010.

9 Purchase, Sale and Lease of Property

9.1 Scottish Government have issued a strict set of rules governing all types of property transactions and these rules require that, each year, all NHS Orkney's property transactions are subject to scrutiny by the Audit Committee. The results of this scrutiny are reported to Scottish Government. Failure to comply with the rules governing property transactions could be viewed as a serious disciplinary matter.

9.2 Where it is necessary to acquire, dispose of or lease property land and/or buildings, the proposed transaction should be referred to the Head of Finance in the first instance, who is responsible for property matters, including the conduct of all property transactions.

9.3 Authority to sign off property transactions is limited to officers to whom authority has been formally and specifically delegated by Scottish Ministers. These officers are:

- Chief Executive
- Director of Finance

9.4 No other member of staff is authorised to make any commitment in respect of the acquisition or disposal of property or interest in property, e.g. leases.

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10 Benefits Accruing from Official Expenditure

10.1 The underlying principle is to obtain best value from public expenditure and decisions should not be determined by private/personal benefit.

10.2 Staff should not use their official position for personal gain or to benefit their family and friends.

10.3 Employees should not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had or may have official dealings on behalf of NHS Orkney. This does not apply to concessionary agreements negotiated on behalf of NHS staff.

11 Free Samples

11.1 Free samples should not be accepted.

12 Outside Interests and Secondary Employment

12.1 Outside interests include directorships, ownership, part-ownership or material shareholdings in companies, business, or consultancies likely to seek to do business with the NHS. These should be declared to the individual's line manager, as should the interests of a spouse/partner or close relative.

12.2 In principle, staff can accept additional employment out with NHS Orkney in their own time. It is also possible that a conflict of interest may arise because of an employee accepting an outside post that is with a company that does business, or is in competition with, the NHS. Where there is any doubt, the employee must seek advice from their manager before accepting any outside post. Additional employment must have no adverse effect on the work of NHS Orkney or their own performance. The resources of NHS Orkney cannot be used in external employment.

13 Acceptances of Fees

13.1 Where staff are offered fees by outside agencies, including a clinical supplier, for undertaking work or engagements (e.g. radio or TV interviews, lectures, consultancy advice, membership of an advisory board, etc.) within their normal working hours, or draw on his/her official experience, the employee's Line Manager must be informed and his/her written approval obtained before any commitment is given by the employee. Directors must obtain written approval from the Chief Executive and the Chief Executive must obtain written approval from the Chair of NHS Orkney before committing to such work.

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An assurance will be required that:

(i) The individual concerned is not making use of his/her NHS employment to further his/her private interests.
(ii) Any outside work does not interfere with the performance of his/her NHS duties.
(iii) Any outside work will not damage NHS Orkney's reputation.

13.2 If the work carried out is part of the employee's normal duties, or could reasonably be regarded as falling within the normal duties of the post, then any fee due is the property of NHS Orkney and it should be NHS Orkney (and not the individual) that issues any invoice required to obtain payment. The individual must not issue requests for payment in his/her own name. The individual must pass the relevant details to the Director of Finance.

13.3 Employees should not commit to any work which attracts a fee until they have obtained the required written approval as described in paragraph 12.1. It is possible that an individual may undertake work and not expect a fee but then receive an unsolicited payment after the work in question has been completed. The principle set out in paragraph 12.2 applies where an unsolicited payment is received.

13.4 It is also possible that an individual may be offered payment in kind, e.g. book tokens. The principle is that these should be refused.

13.5 A gift offered in respect of work undertaken as part of the individual's normal duties should be declined.

14 Contact with the Media

14.1 To achieve consistency and appropriateness of sometimes sensitive public messages, only authorised staff may speak to the media. Should you be contacted by the press you should refer to the office of the Chief Executive.

14.2 Staff must not invite journalists, photographers or camera crews onto any NHS Orkney's premises without the prior agreement of the Chief Executive.

14.3 Where an individual exercises the right in a private capacity to publish an article, give an interview or otherwise participate in a media event or debate in a public forum (including the internet), they should make it clear that they are acting in a private capacity and any opinions expressed are not those of NHS Orkney. This should be agreed in principle with your line manager.

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15 Conduct During Elections

15.1 General Principles

Scottish Government issue regular guidance to health bodies about their roles and conduct during election campaigns. The following general principals are set out:

(i) There should be even-handedness in meeting information requests from candidates from different political parties. Such requests should be handled in accordance with the principals laid down in the election guidance and the Freedom of Information (Scotland) Act 2002

(ii) Care should be taken over the timing of announcements of decisions made by NHS Orkney to avoid accusations of political controversy or partisanship. In some cases, it may be better to defer an announcement until after the election, but this would have to be balanced against any implication that the deferral itself could influence the outcome of the election. Each case should be considered on its merits, and any cases of doubt should be referred to Scottish Government for advice

(iii) Existing advertising campaigns should be closed and there should be a general presumption against undertaking new campaigns unless agreement has been reached in advance with Scottish Government

(iv) In carrying out day to day work and corporate activities, care should be taken to do nothing which could be construed as politically motivated or as taking a political stance.

Public resources must not be used for party political purposes.

15.2 Freedom of Information (Scotland) Act 2002

The Freedom of Information (Scotland) Act 2002, (FOISA) remains in full force during the election period. FOISA requests should continue to be dealt with in accordance with normal procedures. Scottish Government should be consulted in advance or responding to requests which are thought likely to impact on the election campaign in any way.

16 Intellectual Property Rights

If an employee invents a new technology, for instance, a device or diagnostic, or otherwise creates intellectual property (IP) as part of the normal duties of their employment, the patent rights in the invention belong to the employer (Patents Act 1977). Although legally the employee is not automatically entitled to any royalty or reward derived from such an invention, they would expect to be acknowledged as the inventor in any

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patent application. The Director of Finance should see that this effected. Full guidance is available in circulars MEL (1998) 23 and MEL (2004) 9.

17 Sponsorship

17.1 Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable but only where the employee seeks permission in advance from the relevant Director, and the employer is satisfied that the acceptance will not compromise purchasing decisions in any way.

17.2 On occasions when NHS employers consider it necessary for staff advising on the purchasing of equipment to expect to see such equipment in operation in other parts of the country (or exceptionally overseas) the employer will meet the cost to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

17.3 Companies may offer to sponsor wholly or partially a post. The employer will not enter such an arrangement unless it is made abundantly clear to the company concerned that sponsorship would have no effect on the purchasing decision within NHS Orkney. Where the sponsorship is accepted, the Director of Finance will be fully involved and will establish monitoring arrangements to ensure that purchasing decisions are not being influenced by the sponsorship agreement.

17.4 Under no circumstances should any employee agree to deals where sponsorship is linked to the purchase of a particular product or to supply from sources.

18 Remedies

18.1 Managers or staff who fail to comply with the guidance detailed in this code could be subject, following full investigation, to disciplinary action up to and including dismissal. If through their actions or omissions managers or staff are found to be in contravention of either this guidance or their legal responsibilities then NHS Orkney reserves the right to take legal action, if necessary. Where staff suspect, or are aware of non-compliance with this code, they should report any such instances to their line manager or the Director of Finance.

19 Communications

19.1 This code is applicable to every NHS Orkney employee and therefore it is imperative that all staff are informed of its contents. Each manager within NHS Orkney will receive a copy of the code and will confirm their receipt and understanding of the code in writing as well as confirming that they have a permanent record of formally informing their staff.

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20 Contact for further Guidance.

20.1 The Head of Corporate Governance will provide advice and guidance on the Standards of Business Conduct for NHS staff and its interpretation.

21 Review Process

The Standards of Business Conduct for NHS Staff will be reviewed annually.

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SECTION

D

The Fraud Standards

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This section explains how staff must deal with suspected fraud / bribery / corruption or theft and NHS Orkney's intended response to a reported suspicion of fraud / bribery / corruption or theft.

1 Fraud Policy

1 Introduction

1.1 NHS Orkney is committed to maintaining strict ethical standards and integrity in the conduct of its business activities. All NHS Orkney staff and individuals acting on NHS Orkney's behalf are responsible for conducting NHS Orkney's business professionally, with honesty, integrity and maintaining the organisation's reputation and free from bribery.

1.2 One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk of and the means of enforcing the rules against fraud/theft and other illegal acts involving corruption, dishonesty or damage to property.

2 The Bribery Act 2010 – Key Points

2.1 The Bribery Act 2010 ("The Act") came into effect on 1 July 2011, aiming to tackle bribery and corruption in both the private and public sectors.

2.2 The Act is one of the strictest pieces of legislation on bribery and makes it a criminal offence for any individual (employee, contractor, agent) associated with NHS Orkney, to give, promise or offer a bribe, and to request, agree to receive or accept a bribe (sections 1, 2 and 6 offences), and this can be punishable for an individual by imprisonment of up to ten years.

2.3 In addition, the Act introduces a corporate offence (section 7 offence) which means that NHS Orkney can be exposed to criminal liability, punishable by an unlimited fee, if it fails to prevent bribery by not having adequate preventative procedures in place that are robust, up to date and effective. The corporate offence is not a stand-alone offence and will follow from a bribery/corruption offence committed by an individual associated with NHS Orkney, in the recourse of their work. NHS Orkney therefore takes its legal responsibilities very seriously.

2.4 If a bribery offence is proved to have been committed by an outside body corporate with the consent or connivance of a director or senior officer of NHS Orkney, under the Act, the director or senior officer would be guilty of an offence (section 14 offence) as well as the body corporate which paid the bribe.

3 The Bribery Act 2010 – NHS Orkney's Aims and Objective's

3.1 NHS Orkney welcomes the Act and is keen to ensure compliance with the Act's standards.

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3.2 NHS Orkney does not tolerate any form of bribery, whether direct or indirect, by its staff, agents or external consultants or any persons or entities acting for it or on its behalf.

3.3 NHS Orkney will not conduct business with service providers, agents or representatives that do not support its anti-bribery statement and it reserves the right to terminate its contractual arrangements with any third parties acting for or on behalf of NHS Orkney with immediate effect, where there is evidence that they have committed acts of bribery.

3.4 The success of NHS Orkney's anti-bribery measures depends on all employees, and those acting for NHS Orkney, playing their part in helping to detect and eradicate bribery. Therefore, all employees and others acting for or on behalf of NHS Orkney are encouraged to report any suspected bribery for following the guidance below.

4 National Fraud Initiative

4.1 NHS Orkney is required by law to protect the public funds it administers. It may share information provided to it with other bodies responsible for auditing or administering public funds, in order to prevent and detect fraud.

5 Guidance to Staff on Fraud / Bribery / Corruption / Theft

5.1 This guidance is not intended solely for staff. It is also intended for anyone acting on the Board's behalf including Non-Executive Directors of the Board (see section B, Members Code of Conduct, paragraph 1.7) contractors, agents etc. Reference to 'staff' in this section will also mean all of these.

5.2 The Fraud Policy relates to all forms of fraud, bribery, corruption, or theft and is intended to provide guidance to employees on the action, which should be taken when any of these are suspected. Such occurrences may involve employees of NHS Orkney, suppliers/contractors or any third party. This document sets out the Board's policy and response plan for detected or suspected fraud, bribery, corruption, or theft. It is not the purpose of this document to provide direction on the prevention of fraud.

5.3 Whilst the exact definition of fraud, bribery, corruption, or theft is a statutory matter, the following working definitions are given for guidance:

- Fraud broadly covers deliberate material misstatement, falsifying records, making, or accepting improper payments or acting in a manner not in the best interest of the Board for the purposes of personal gain
- Bribery is an inducement or reward offered, promised, or provided to gain any commercial, contractual, regulatory or personal advantage

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- Corruption relates to a lack of integrity or honesty, including the use of trust for dishonest gain. It can be broadly defined as the offering or acceptance of inducements, gifts, favours, and payments or benefits in kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly; however, they may be unreasonably using their position to give some advantage to another
- Theft is removing property belonging to NHS Orkney, its staff or patients with the intention of permanently depriving the owner of its use, without their consent

For simplicity, this document will refer to all such offences as "fraud", except where the context indicates otherwise.

5.4 NHS Orkney already has procedures in place, which reduce the likelihood of fraud occurring. These are included within the Code of Corporate Governance (i.e. Standards of Business Conduct, Standing Orders, Standing Financial Instructions), accounting procedures, systems of internal control and a system of risk assessment. The Board has a payment verification system which concentrates on Family Health Service expenditure.

5.5 It is the responsibility of NHS Orkney and its management to maintain adequate and effective internal controls, which deter and facilitate detection of any fraud. The role of Internal Audit is to evaluate these systems of control. It is not the responsibility of Internal Audit to detect fraud, but rather to identify weaknesses in systems that could potentially give rise to error or fraud.

6 Collaborating to Combat Fraud

6.1 NHS Orkney will work closely with other organisations, including Counter Fraud Services, the Central Legal Office, Audit Scotland, the Cabinet Office, Department for Work and Pensions, the Home Office, Councils, the Police and the Procurator Fiscal/Crown Office to combat fraud.

6.2 NHS Orkney will agree formal partnership agreements with other investigative bodies e.g. Counter Fraud Services and, where appropriate, engage in joint investigations and prosecutions.

6.3 The Cabinet Office on behalf of Audit Scotland assists appointed auditors by conducting a National Fraud Initiative which is a data matching exercise. Data matching involves comparing computer records held by one body against other computer records held by the same or another body. This is usually personal information. Computerised data matching allows potentially fraudulent claims and payments to be identified. Where a match is found it indicates that there may be an inconsistency which requires further investigation. No assumption can be made as to whether there is

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fraud, error or other explanation until an investigation is carried out. The exercise can also help bodies to ensure that their records are up to date.

6.4 Audit Scotland currently requires NHS Orkney to participate in a statutory data matching exercise under its powers in Part 2A of the Public Finance and Accountability (Scotland) Act 2000 to assist in the prevention and detection of fraud. We are required to provide sets of data to the Cabinet Office on behalf of Audit Scotland for matching for each exercise, and these are set out in Audit Scotland's instructions for Participants. It does not require the consent of the individuals concerned under the Data Protection Act 1998.

6.5 Data matching in Scotland is subject to a Code of Data Matching Practice, and information on Audit Scotland's legal powers and the reasons why it matches information, is provided in the full text Privacy Notice.

7 Public service values

7.1 The expectation of high standards of corporate and personal conduct, based on the recognition that patients come first, has been a requirement throughout the NHS since its inception. MEL (1994) 80, "Corporate Governance in the NHS", issued in August 1994, sets out the following public service values:

Accountability: Everything done by those who work in the organisation must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity: Absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers, and customers.

Openness: The organisation's activities should be sufficiently public and transparent to promote confidence between the organisation and its patients, staff, and the public.

7.2 All those who work in the organisation should be aware of, and act in accordance with, the above values. In addition, NHS Orkney will expect and encourage a culture of openness between NHS bodies and the sharing of information in relation to any fraud.

8 NHS Orkney policy and public interest disclosure act

8.1 NHS Orkney is committed to maintaining an honest, open and well- intentioned atmosphere within the service. It is committed to the deterrence, detection, and investigation of any fraud within NHS Orkney.

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8.2 NHS Orkney encourages anyone having reasonable suspicion of fraud to report the incident. It is NHS Orkney's policy that no staff member will suffer in any way because of reporting any reasonably held suspicions. For these purposes "reasonably held suspicions" shall mean any suspicions other than those which are groundless and/or raised maliciously.

8.3 In addition, the Public Interest Disclosure Act protects workers who legitimately report wrongdoing by employers or colleagues. The disclosure must be made in good faith and workers must have reasonable grounds to believe that criminal offences such as fraud or theft have occurred or are likely to occur. The disclosure must not be made for personal gain.

9 Instructions to staff

9.1 Staff who suspect improper practices or criminal offences are occurring relating to fraud, theft, bribery or corruption, should normally report these to the Fraud Liaison Officer (FLO) via their line manager, but may report directly where the line manager or Head of Department is unavailable or where this would delay reporting. If the suspected improper practice involves the Head of Department, the report should be made to a more senior officer or the nominated officer as described in 10.4 below. Managers receiving notice of such offences must report them to the nominated officer.

9.2 It should be noted that staff who wish to raise concerns about unprofessional behaviour or decisions, where fraud, theft, bribery or corruption are not suspected, should do so by following the guidance contained in the NHS Orkney 'Whistleblowing' policy. Following investigation of the complaint if improper practices or criminal offences are suspected, the matter should be referred by the investigating officer, to the Fraud Liaison Officer. Any further action taken will follow the guidance contained within 'The Fraud Standards'.

9.3 Confidentiality must be maintained relating to the source of such reports.

9.4 Further choices for staff are:

You may use the Counter Fraud Service (CFS) Fraud Hot Line which is 0800 151628 or report your suspicions (anonymously, if desired) through the CFS Website on www.cfs.scot.nhs.uk

9.5 It should be added that under no circumstances should a member of staff speak or write to representatives of the press, TV, radio~~, other~~, or other third parties or use blogs or twitter to publicise details about a suspected fraud/theft. Care needs to be taken that nothing is done which could give rise to an action for slander or libel.

9.6 Please be aware that time may be of the utmost importance to ensure that NHS Orkney does not continue to suffer a loss.

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10 Roles and responsibilities

10.1 Responsibility for receiving information relating to suspected frauds and for co-ordinating NHS Orkney's response to the National Fraud Initiative has been delegated to the Fraud Liaison Officer (FLO). This individual is responsible for informing third parties such as Counter Fraud Services, the Cabinet Office on behalf of Audit Scotland, Internal and External Audit or the Police when appropriate. The FLO, shall inform and consult the Chief Executive, the Chair of the Board and the Audit and Risk Committee Chair in cases where the loss may be above the delegated limit or where the incident may lead to adverse publicity. The contact name and address of the FLO, is as follows:

~~Keren Somerville~~Suzanne Grey
~~Head of Finance~~:Senior Financial Accountant
The Balfour
Foreland Road
Kirkwall
KW15 1NZ
Email: ~~keren.somerville~~suzanne.grey@nhs.scot

10.2 Where fraud is suspected within the service, including the Family Health Services, i.e. independent contractors providing Medical, Dental, Ophthalmic or Pharmaceutical Services, the FLO will make an initial assessment and, where appropriate, advise Counter Fraud Services (CFS) at NHS National Services Scotland.

10.3 The Head of People and Culture ~~Manager~~, or nominated deputy, shall advise those.
involved in the investigation on matters of employment law and other.
procedural matters, such as disciplinary and complaints procedures.

10.4 Where the incident is thought to be subject to either local or national controversy and publicity then the Board and the Scottish Government Health Directorates should be notified before the information is subjected to publicity.

10.5 It is the responsibility of NHS Orkney's senior officers to ensure that their staff are aware of the above requirements and that appropriate reporting.
arrangements are implemented.

10.6 It is the responsibility of all staff to protect the assets of NHS Orkney. Assets include information and goodwill as well as property.

10.7 It shall be necessary to categorise the irregularity prior to determining the appropriate course of action. Two main categories exist:

- Theft, burglary, and isolated opportunist offences; and

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- Fraud, bribery, corruption, and other financial irregularities

The former will be dealt with directly by the Police whilst the latter may require disclosure under the SGHD NHS Circular No. HDL (2002)23 – Financial Control: Procedure where Criminal Offences are suspected.

10.8 Responsibility for ensuring that recommendations from Counter Fraud Services investigation reports and from data matching exercises conducted under the National Fraud Initiative have been implemented and steps taken to ensure full ~~compliance,~~compliance has been delegated to the Counter Fraud Champion (CFC).

The contact name and address of the CFC, is as follows:

Melanie Barnes
Interim Director of Finance
The Balfour
Foreland Road
Kirkwall
KW15 1NZ
Email: melanie.barnes@nhs.scot

11 Contact points

Relevant contact points are as follows:

Interim Director of Finance and Deputy Fraud Liaison Officer
Melanie Barnes
The Balfour
Foreland Road
Kirkwall
KW15 1NZ
Email: melanie.barnes @nhs.scot

Accountable Officer for Controlled Drugs:
Wendy Lycett
Interim Director of Pharmacy
The Balfour
Foreland Road
Kirkwall
KW15 1NZ
Email: wendy.lycett2@nhs.scot

Chief Audit Executive:
David Eardley
Azets
Exchange Place 3
Semple Street
Edinburgh

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EH3 8BL
Email: david.eardley@azets.co.uk

Counter Fraud Services: www.cfs.scot.nhs.uk

National Fraud Initiative: The National Fraud Initiative in Scotland 2022 | Audit Scotland (audit-scotland.gov.uk)

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2 Response Plan

1 Introduction

1.1 The following sections describe NHS Orkney's intended response to a reported suspicion of fraud / bribery / corruption or theft. It is intended to provide procedures, which allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal or civil action. Each situation is different; therefore, the guidance will need to be considered carefully in relation to the actual circumstances of each case before action is taken.

2 Reporting Fraud

2.1 A "nominated officer" will be appointed as the main point of contact for the reporting of any suspicion of fraud, corruption, bribery, or theft. For NHS Orkney, this officer is the FLO (see 11.1). In the absence of the FLO, the Deputy will deal with the issue. For incidents involving any Executive Directors, the nominated officer shall be the Board's Chair, contacted through the FLO.

2.2 The Fraud Liaison Officer shall be trained in the handling of concerns raised by staff. Any requests for anonymity shall be accepted and should not prejudice the investigation of any allegations. Confidentiality should always be observed.

2.3 All reported suspicions must be investigated as a matter of priority to prevent any further potential loss to NHS Orkney.

2.4 The Fraud Liaison Officer shall maintain a log of any reported suspicions. The log will document with ~~reasons~~reasons for the decision to take further action or to take no further action. The log will also record any actions taken and conclusions reached. This log will be maintained and will be made available for review by Internal Audit.

2.5 The Fraud Liaison Officer should consider the need to inform the Orkney. NHS Board, the Chief Internal Auditor, External Audit, the Police and Counter Fraud Services, of the reported incident. In doing so, he/she should take cognisance of the following guidance:

- Inform and consult the Director of Finance and the Chief Executive at the first opportunity, in all cases where the loss may exceed the delegated limit (or such lower limit as NHS Orkney may determine) or where the incident may lead to adverse publicity
- It is the duty of the Director of Finance to notify the Chief Executive and Chair immediately of all losses where fraud/theft is suspected.

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- Counter Fraud Services should normally be informed immediately in all but the most trivial cases
- If fraud, bribery, or corruption is suspected, it is essential that there is the earliest possible consultation with Counter Fraud Services. In any event, Counter Fraud Services should be contacted before any overt action is taken which may alert suspects and precipitate the destruction or removal of evidence. This includes taking action to stop a loss or tighten controls
- If a criminal act of fraud, bribery or corruption is suspected, it is essential that there is the earliest possible consultation with the Police. In any event the Police should be contacted before any overt action is taken which may alert suspects and precipitate the destruction or removal of evidence. This includes taking action to stop a loss or tighten controls
- At the stage of contacting the Police, the Fraud Liaison Officer should contact the Head of People and Culture to consider whether/when to initiate suspension of the employee pending an enquiry.

2.6 All such contact should be formally recorded in the Log.

3 Managing the investigation

3.1 The Director of Finance will appoint a manager to oversee the investigation. Normally, the manager will be an employee from Counter Fraud Services. The circumstances of each case will dictate who will be involved and when.

3.2 The manager overseeing the investigation (referred to hereafter as the "investigation manager") should initially:

- Initiate a Diary of Events to record the progress of the investigation
- If possible, determine the nature of the investigation i.e. whether fraud or another criminal offence. In practice it may not be obvious if a criminal event is believed to have occurred. If this is established the Police, External Audit and the Chief Executive should be informed if this has not already been done.

3.3 If after initial Counter Fraud Services (CFS) enquiries it is determined that there are to be no criminal proceedings, then a NHS Orkney internal investigation may be more appropriate. In this instance, all information/evidence gathered by CFS will be passed to NHS Orkney. The internal investigation will then be taken forward in line with Employment law, PIN guidelines and relevant Workforce policies such as the Management of Employee Conduct, as appropriate.

3.4 The formal internal investigation to determine and report upon the facts, should establish:

- The extent and scope of any potential loss
- If any disciplinary action is needed

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- The criminal or non-criminal nature of the offence, if not yet established
- What can be done to recover losses; and
- What may need to be done to improve internal controls to prevent recurrence

3.5 This report will normally take the form of an Internal Audit Report to NHS Orkney's Audit and Risk Committee.

3.6 Where the report confirms a criminal act and notification to the Police has not yet been made, it should now be made.

3.7 Where recovery of a loss to NHS Orkney is likely to require a civil action, arising from any act (criminal or non-criminal), it will be necessary to seek legal advice through the Central Legal Office, which provides legal advice and services to NHS Scotland.

3.8 This report should form the basis of any internal disciplinary action taken. The conduct of internal disciplinary action will be assigned to the Head of People and Culture or delegated officer within the Directorate, who shall gather such evidence, as necessary.

4 Disciplinary/dismissal procedures

4.1 Consideration should be made in conjunction with CFS/CFC/FLO on whether/when to suspend the employee(s) who are subject to any investigation, pending the results of the investigation. This should be carried out in line with NHS Orkney's Employee Conduct Policy.

4.2 The disciplinary procedures of NHS Orkney must be followed in any disciplinary action taken by NHS Orkney toward an employee (including dismissal). This may involve the investigation manager recommending a disciplinary hearing to consider the facts, consideration of the results of the investigation and making further recommendations on appropriate action to the employee's line manager.

Where the fraud involves a Family Health Services Practitioner, the Board should pass the matter over to the relevant professional body for action.

5 Gathering evidence

5.1 This policy cannot cover all the complexities of gathering evidence. Each case must be treated according to the circumstances of the case taking professional advice, as necessary.

5.2 If a witness to the event is prepared to give a written statement, it is best practice for an experienced member of staff, preferably from the People and Culture Department, to take a chronological record using the witness's own

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words. The witness should sign the statement only if satisfied that it is a true record of his or her own words.

5.3 At all stages of the investigation, any discussions or interviews should be documented and where feasible agreed with the interviewee.

5.4 Physical evidence should be identified and gathered (impounded) in a secure place at the earliest opportunity. An inventory should be drawn up by the investigating officer and held with the evidence. Wherever possible, replacement or new document etc. should be put into use to prevent access to the evidence. If evidence consists of several items, for example several documents, each one should be tagged with a reference number corresponding to the written record.

6 Interview procedures

6.1 Interviews with suspects should be avoided until the formal disciplinary hearing. The investigating officer should, wherever possible, gather documentary and third-party evidence for the purposes of his report. If, however, an employee insists on making a statement it must be signed and dated and should include the following:

"I make this statement of my own free will; I understand that I need not say anything unless I wish to do so and that what I say may be given in evidence".

6.2 Informal contact with the Police should be made at an early stage in the investigation to ensure that no actions are taken which could prejudice any future criminal case through the admissibility of evidence, etc.

7 Disclosure of loss from fraud

7.1 Guidance on the referring of losses and special payments is provided in CEL44 (2008). A copy of the Fraud report, in an appropriate format, must be submitted to the Scottish Government Health Directorates. External Audit should be notified of any loss as part of their statutory duties. Scottish Financial Return (SFR) 18.0 on Losses and Compensation Payments, is submitted annually to the Audit Committee and will include all losses with appropriate description within the standard categories specified by the Scottish Government Health Directorates.

7.2 Management must take account of the permitted limits on writing off losses for "Category 3 Boards", as outlined in circular CEL44 (2008).

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8 Police Involvement

8.1 It shall normally be the policy of NHS Orkney that, wherever a criminal act is suspected, the matter will be notified to the Police, as follows:

- During normal working hours, it will be the decision of the Director of Finance as to the stage that the Police are contacted. If the Director of Finance is unavailable, this decision will be delegated to the Fraud Liaison Officer
- Out with normal working hours, the manager on duty in the area where a criminal act is suspected, may contact the Police and is duty bound to report the matter to the Director of Finance at the earliest possible time

8.2 The Fraud Liaison Officer and investigating manager should informally notify the Police of potential criminal acts, to seek advice on the handling of each investigation at an early stage in the investigation.

8.3 Formal notification of a suspected criminal act will normally follow completion of the investigating manager's report and formal disciplinary action. It is important that the internal report is carried out in a timely manner to avoid delaying the Police investigation.

9 Press Release

9.1 To avoid potentially damaging publicity to the NHS and/or the suspect, NHS Orkney should prepare at an early stage, a Press release, giving the facts of any suspected occurrence and any actions taken to date, e.g. suspension. The Central Legal Office and the Police should agree the release where applicable.

10 Resourcing the investigation

10.1 The Director of Finance will determine the type and level of resource to be used in investigating suspected fraud. The choices available will include:

- Internal staff from within NHS Orkney
- People and Culture
- Internal Audit
- External Audit
- Counter Fraud Services (CFS)
- Specialist Consultant
- Police

10.2 In deciding, the Director of Finance, should consider independence, knowledge of the organisation, cost, availability and the need for a speedy investigation. Any decision must be shown in the Log held by the Fraud Liaison Officer. A decision to take "No action" will not normally be an acceptable option unless exceptional circumstances apply.

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10.3 In any case involving a suspected criminal act, it is anticipated that Counter Fraud Services involvement will be in addition to NHS Orkney resources. In any case involving other suspected criminal acts, it is anticipated that Police involvement will be in addition to NHS Orkney resources.

11 The law and its remedies

11.1 Criminal Law

The Board shall refer all incidences of suspected fraud/criminal acts to Counter Fraud Services or the Police for decision by the Procurator Fiscal as to any prosecution.

11.2 Civil Law

The Board shall refer all incidences of loss through proven fraud/criminal act to the Central Legal Office for opinion, as to potential recovery of loss via Civil Law action.

Annex 1 to this policy gives guidance to staff on the action which should be taken in all cases where misappropriation of medicines is suspected.

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ANNEX 1

Misappropriation of Medicines

1 Background and purpose

1.1 Probity is one of the three public service values, which underpin the work of the NHS. There is a requirement for absolute honesty when dealing with the assets of the NHS. Medicines are one such asset.

Medicines are widely used throughout the NHS in the treatment of patients. Healthcare staff, who have access to medicines, are given access for the purpose of patient care in accordance with their individual professional role. Most healthcare staff discharge this responsibility without incident.

However, the opportunity to abuse this privilege is omnipresent and experience confirms that individual staff have removed medicines that belong to the NHS, or to patients, for their own personal use. While not a common occurrence, the increasing problem of drug misuse and dependence within the wider ~~population,~~population increases the risk of this occurring.

1.2 The purpose of this annex is to ensure that all healthcare staff understand the implications associated with the misappropriation of medicines for personal use, or for other purposes.

2 Scope

2.1 All staff including all Healthcare Practitioners employed by NHS Orkney (includes doctors, nurses, pharmacists, other healthcare staff and all support staff).

2.2 Includes all medicines:

- medicines stored in pharmacy departments
- medicines stored in wards and departments
- medicines belonging to patients
- medicines being processed for destruction

The fraudulent use of prescriptions and other controlled stationery is also covered.

2.3 While the policy does not directly apply to staff employed within the independent contracted services, the principles associated with the high level of honesty required by ~~staff, who~~staff who have access to medicines, and other NHS resources, are equally applicable.

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3 Policy statement

3.1 Medicines belong to the NHS or named patients and misappropriation, for personal or other purposes, is theft.

3.2 Theft of medicines constitutes gross misconduct and will be managed according to the employee conduct policy of NHS Orkney.

3.3 Where misappropriation of medicines is proven the police and the relevant professional organisation will be informed.

3.4 Theft of medicines is a serious criminal offence under the Medicine Act 1968, the Misuse of Drugs Act 1971 and other legislation.

4 Responsibilities

4.1 The Accountable Officer for Controlled Drugs (CDs) is responsible for ensuring the safe management and use of CDs, including the assessment and investigation of concerns. The UK Health Act 2006 and the Controlled Drugs (Supervision of Management and Use) Regulations 2013 set out Accountable Officers responsibilities. In NHS Orkney, the Director of Pharmacy has been appointed as the Accountable Officer for CDs.

4.2 The Director of Pharmacy is responsible for ensuring that systems are in place to ensure the security of medicines across NHS Orkney.

4.3 The local Pharmacy Lead is responsible for ensuring the security of medicines within a designated pharmacy department.

4.4 The Appointed Nurse in Charge is responsible for ensuring that the systems in place to ensure the security of medicines within a ward / department are followed. The Appointed Nurse in Charge may decide to delegate some of the duties, but the responsibility always remains with the Appointed Nurse in Charge.

Where there is no nurse in the area, the recognised manager will take responsibility.

4.5 The Fraud Liaison Officer (FLO) is responsible for developing links with NHS Scotland Counter Fraud Services. Working with the Director of Pharmacy, the FLO will support and review the development of systems to minimise the likelihood of fraud associated with medicines.

5 Guidance regarding misappropriation of medicines

5.1 Medicines most vulnerable to misappropriation are those with addictive properties or those with a street value.

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5.2 Misappropriation is most frequently associated with opiate containing analgesics and sedatives that are not subject to the full controls defined within the Misuse of Drugs Act 1971 for example benzodiazepines

5.3 The increased security of medicines subject to the Misuse of Drugs Act 1971, (register requirements, more secure storage, and daily stock reconciliation) make the misappropriation of fully controlled drugs difficult, but not impossible.

6 Where misappropriation of medicines is suspected

6.1 Where staff suspect that medicines are being misappropriated, they should raise the matter, in confidence, with the responsible officer in their area. The responsible officer should seek advice from their senior pharmacist.

6.2 Where staff suspect the responsible officer may be involved, they should report any concerns to a more senior officer.

6.3 The Senior Pharmacist must report all cases of suspected misappropriation of controlled drugs (Schedule 1 – 5) to the Accountable Officer. The Head of Pharmacy should be notified about suspected misappropriation of all other medicines.

6.4 Where there is no dedicated senior pharmacist or where the pharmacist may be involved, staff should report concerns directly to the Accountable Officer for Controlled Drugs or Head of Pharmacy.

6.5 The Accountable Officer for Controlled Drugs/Head of Pharmacy will liaise with the FLO and agree a course of action commensurate with the circumstances presented, which may include referring the matter to Counter Fraud Services.

6.6 The Accountable Officer or Head of Pharmacy will advise other officers of the NHS Board, as appropriate.

7 Incident Review

7.1 The Accountable Officer for Controlled Drugs/Head of Pharmacy and FLO will agree a course of action, which may include the setting up of an incident review panel.

7.2 Incident review panels will be small and normally comprise of a Senior Pharmacist, the Responsible Officer and a more Senior Manager in the area under consideration. Where appropriate the panel will include a nomination from People and Culture. The People and Culture representative will advise regarding staff governance and ensure that all employee conduct policies are applied fairly and equitably.

7.3 The outcome of the review panel will be documented.

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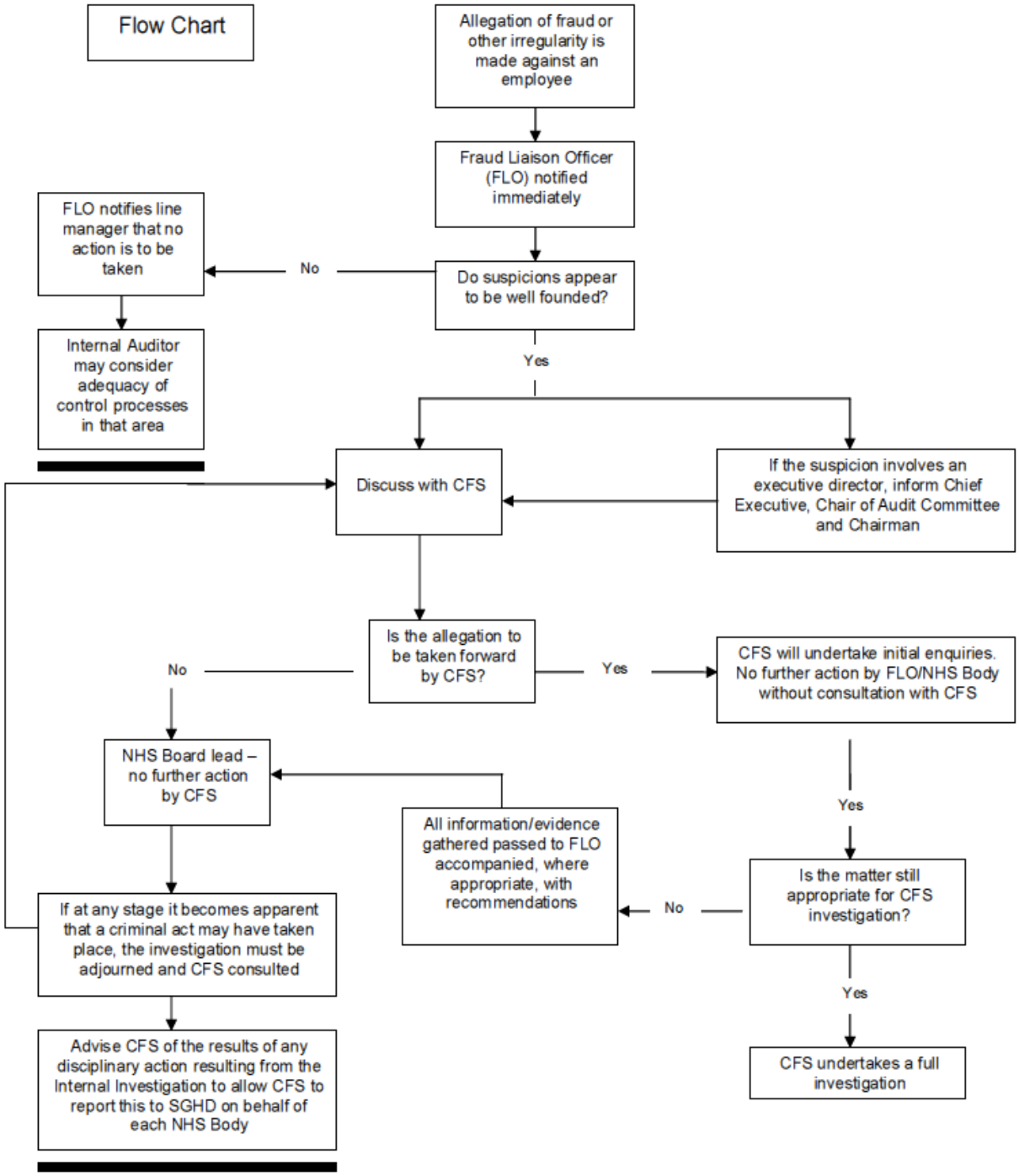
ANNEX 2

Procedures for Dealing with Allegations of Fraud/Bribery/Corruption/Other Irregularities



SECTION

E

Reservation of Powers and Delegation of Authority

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This section gives details and levels of delegation across all areas of our business.

1 Schedule of Matters Reserved for Board Agreement

1 Background

1.1 Under the proposals contained in the NHS Circular HDL (2003) 11 'Working Towards Single System Working', Orkney NHS Board will retain its focus as a board of governance, delivering a corporate approach to collective decision making based on the principles of partnership working and devolution of powers. Local leadership will be supported by delegating financial and management responsibility as far as is possible consistent with the Board's own responsibility for governance.

Orkney NHS Board has a corporate responsibility for ensuring that arrangements are in place for the conduct of its affairs, including compliance with applicable guidance and legislation, and ensuring that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively. The Board has an ongoing responsibility to ensure that it monitors the adequacy and effectiveness of these arrangements in practice.

The Board is required to ensure that it conducts a review of its systems of internal control, including in particular its arrangements for risk management, at least annually, and to report publicly on its compliance with the principles of corporate governance codes.

2 Matters Reserved for Board Agreement

2.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at an NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

The following matters shall be reserved for agreement by the Board: -

a) Standing Orders
b) The establishment and terms of reference of all its committees, and appointment of committee members
c) Organisational Values
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Annual Operational Plan for submission to the Scottish Government for its approval(Note: The Board should consider the draft for submission in private session. Once the Scottish

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Government has approved the Annual Operational Plan, the Board should receive it at a public Board meeting.)

f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Standing Financial Instructions and a Scheme of Delegation.
j) Annual accounts and report. (Note: Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly the Board cannot publish the report of the external auditors of their annual accounts in this period.)
k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment.)

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2 Schedule of Matters Delegated to Board Executive Directors

1 Interpretation

1.1 Any reference to a statutory or other provision shall be interpreted as a reference as amended from time to time by any subsequent legislation.

Any power delegated to a Chief Officer in terms of this scheme may be exercised by such officer or officers as the ~~chief officer~~Chief Officer may authorise.

2 Chief Executive

2.1 General Provisions

In the context of the Board's principal role to protect and improve the health of Orkney residents, the Chief Executive, as Accountable Officer, shall have delegated authority and responsibility to secure the economical, efficient and effective operation and management of NHS Orkney and to safeguard its assets in accordance with:

- The statutory requirements and responsibilities laid upon the Chief Executive as Accountable Officer for NHS Orkney
- Direction from the Scottish Government Health and Social Care Directorates
- Current policies and decisions made by the Board
- Within the limits of the resources available, subject to the approval of the Board; and
- The Code of Corporate Governance

The Chief Executive is authorised to take such measures as may be required in emergency situations, subject to consulting, where possible, with the Chair and Vice-Chair of NHS Orkney and the relevant Committee Chair. Such measures that might normally be out-with the scope of the authority delegated by the Board or its Committees shall be reported to the Board or appropriate Committee as soon as possible thereafter.

The Chief Executive is authorised to give a direction in special circumstances that any official shall not exercise a delegated function subject to reporting on the terms of the direction to the next meeting of the appropriate Committee.

2.2 Finance

Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Chief Executive, after taking

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account of the advice of the Director of Finance. The Chief Executive acting together with the Director of Finance has delegated authority to approve the transfer of funds between budget heads, including transfers from reserves and balances, up to the limit set out in the scheme of delegation. The Chief Executive shall report to the Finance and Performance Committee for formal inclusion in the minutes those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest.

The Chief Executive may, acting together with the Director of Finance, and having taken all reasonable action to pursue recovery, approve the writing-off of losses, subject to the limits laid down from time to time by the Scottish Government Health and Social Care Directorate.

2.3 **Legal Matters**

The Chief Executive is authorised to institute, defend or appear in any legal proceedings or any inquiry, including proceedings before any statutory tribunal, board or authority, and following consideration of the advice of the Central Legal Office, to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests.

In circumstances where a claim against the Board is settled by a decision of a Court, and the decision is not subject to appeal, the Chief Executive shall implement the decision of the relevant Court on behalf of the Board.

In circumstances where the advice of the Central Legal Office is to reach an out-of court settlement, the Chief Executive may, acting together with the Director of Finance, settle claims against the Board, subject to a report thereafter being submitted to the Finance and Performance Committee.

The Chief Executive, acting together with the Director of Finance, may make ex-gratia payments, subject to the limits laid down from time to time by the Scottish Government Health Directorate.

The arrangements for signing of documents in respect of matters covered by the Property Transactions Manual shall be in accordance with the direction of Scottish Ministers. The Chief Executive and the Director of Finance are currently authorised to sign such documentation on behalf of the Board and Scottish Ministers.

The Chief Executive shall have responsibility for the ~~safe keeping~~safety of the Board's Seal, and together with the Director of Finance and the Chair or other nominated non-executive member of the Board, shall have responsibility for the application of the Seal on behalf of the Board.

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2.4 Procurement

The Chief Executive shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders.

Where ~~post tender~~post-tender negotiations are required, the Chief Executive shall nominate in writing, officers and/or agents to act on behalf of the Board.

The Chief Executive, acting together with the Director of Finance, has authority to approve on behalf of the Board the acceptance of tenders, submitted in accordance with the Board's Standing Orders, in accordance with the Board's scheme of delegation.

The Director of Finance shall maintain a listing, including specimen signatures, of those officers or agents to whom the Chief Executive has given delegated authority to sign official orders on behalf of the Board.

2.5 People and Culture

The Chief Executive may appoint staff in accordance with the Board's Scheme of Delegation for the Appointment of Staff as detailed in the Code of Corporate Governance Section E 3.

The Chief Executive may, after consultation and agreement with the Director of People and Culture, and the relevant Director, amend staffing establishments in respect of the number and grading of posts. In so doing, the Director of Finance must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit approved by the Board for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to human resource planning, approved by the Board or Staff Governance Committee.

The Chief Executive may attend and may authorise any member of staff to attend, within the United Kingdom, conferences, courses or meetings of relevant professional bodies and associations, provided that: -

- Attendance is relevant to the duties or professional development of such member of staff; and
- Appropriate allowance has been made within approved budgets; or
- External reimbursement of costs is to be made to the Board.

The Chief Executive may, in accordance with the Board's agreed Disciplinary Procedures, take disciplinary action, in respect of members of staff, including dismissal where appropriate.

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The Chief Executive shall have overall responsibility for ensuring that the Board complies with Health and Safety legislation, and for ensuring the effective implementation of the Board policies.

2.6 Patients' property

The Chief Executive has overall responsibility for ensuring that the Board complies with legislation in respect of ~~patient's~~patients' property. The term 'property' means all assets other than land and buildings (for example furniture, pictures, jewellery, bank accounts, shares, cash).

3 Director of Finance

3.1 General Provision

Authority is delegated to the Director of Finance to take the necessary measures as undernoted, to assist the Board and the Chief Executive in fulfilling their corporate responsibilities.

3.2 Accountable Officer

The Director of Finance has a general duty to assist the Chief Executive in fulfilling their responsibilities as the Accountable Officer of Orkney NHS Board.

3.3 Financial Statements

The Director of Finance is empowered to take all steps necessary to assist the Board to:

- Act within the law and ensure the regularity of transactions by putting in place systems of internal control to ensure that financial transactions are in accordance with the appropriate authority
- Maintain proper accounting records; and
- Prepare and submit for audit timeous financial statements which give a true and fair view of the financial position of the Board and its income and expenditure for the period in question

3.4 Corporate Governance and Management

The Director of Finance is authorised to put in place proper arrangements to ensure that the financial position of the Board is soundly based by ensuring that the Board, its committees, and supporting management groups receive appropriate, accurate and timely information and advice with regard to:

- The development of financial plans, budgets, and projections

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- Compliance with statutory financial requirements and achievement of financial targets; and
- The impact of planned future policies and known or foreseeable developments on the Board's financial position

The Director of Finance is empowered to take steps to ensure that proper arrangements are in place for:

- Developing, promoting, and monitoring compliance with the Code of Corporate Governance
- Developing and implementing systems of internal control, including systems of financial, operational and compliance controls and risk management
- Developing and implementing strategies for the prevention and detection of fraud and irregularity; and
- Internal Audit

3.5 **Performance Management**

The Director of Finance is authorised to assist the Chief Executive to ensure that suitable arrangements are in place to secure economy, efficiency, and effectiveness in the use of resources and that they are working effectively. These arrangements include procedures:

- For planning, appraisal, authorisation and control, accountability, and evaluation of the use of resources; and
- To ensure that performance targets and required outcomes are met

3.6 **Banking**

The Director of Finance is authorised to oversee the Board's arrangements in respect of accounts held in the name of the Board with the Paymaster General's Office and the commercial bankers appointed by the Board.

The Director of Finance will maintain a panel of authorised signatories.

The Director of Finance will be responsible for ensuring that the Paymaster General's Office and the commercial bankers are advised in writing of amendments to the panel of authorised signatories.

3.7 **Patients' Property**

The Director of Finance has delegated authority to ensure that detailed operating procedures in relation to the management of the property of patients (including the opening of bank accounts where appropriate) are compiled for use by staff involved in the management of patients' property and financial affairs.

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4 Provisions Applicable to other Executive Directors of the Board

4.1 General Provisions

The other Executive Directors of the Board are:

- Medical Director
- Director of Nursing, Midwifery, Allied Health Professions and Acute
- Director of Public Health

Executive Directors have delegated authority and responsibility with the Chief Executive for securing the economical, efficient, and effective operation and management of their own Directorates or Departments and for safeguarding the assets of the Board.

Executive Directors are authorised to take such measures as may be required in emergency situations, subject to consulting, where possible, the Chief Executive, the Chair and Vice-Chair of the Board or relevant Committee Chair as appropriate. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Committees to the relevant Executive Director, shall be reported to the Board or appropriate Committee as soon as possible thereafter.

4.2 People and Culture

Executive Directors may appoint staff within the delegated authority and budgetary responsibility in accordance with Standing Financial Instructions.

Executive Directors may, after consultation and agreement with the Director of People and Culture, amend staffing establishments in respect of the number and grading of posts. In so doing, the Director of Finance must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit approved by the Board for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to human resource planning, approved by the Staff Governance Committee.

Executive Directors may attend and may authorise any member of staff to attend within the United Kingdom, conferences, courses or meetings of relevant professional bodies and associations, provided that:

- Attendance is relevant to the duties or professional development of such member of staff
- Appropriate allowance must also be contained within approved budgets; or
- External reimbursement of costs is to be made to the Board

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Executive Directors have overall responsibility within their Directorates/Departments for ensuring compliance with Health and Safety legislation, and for ensuring the effective implementation of the Board's policies.

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3 Delegation of Powers for Appointment of Staff

1 Use of Powers

1.1 The powers delegated are to be exercised in accordance with procedures or guidance issued by the Scottish Government Health and Social Care Directorates or approved by the Board.

1.2 Procedures governing the appointment of Consultants and other medical and dental grades are contained in Statutory Instruments issued by Scottish Ministers.

1.3 Appointments will be made within the delegated authority and budgetary responsibility in accordance with Standing Financial Instructions. Schemes of delegation for appointment of staff will specify appointing officers and, where necessary, the composition of appointment panels.

2 Appointment of Staff

2.1 Canvassing of Appointing Officers or Members of the Appointment Panel directly or indirectly for any appointment shall disqualify the candidate for such appointment.

2.2 A Member of the Board shall not solicit for any person any appointment under the Board or recommend any person for appointment. This, however, shall not preclude any Member from giving a written testimonial of a candidate's suitability, experience, or character for submission to the Board.

2.3 Every Member of the Board shall disclose to the Board any known relationship to a candidate for an appointment with the Board. It shall be the duty of the Chief Executive to report to the Board any such disclosures made.

2.4 It shall be the duty of the Appointing Officer to disclose to their Line Manager any known relationship to a candidate for an appointment for which he or she is responsible.

2.5 Where a relationship of a candidate for appointment to a Member of the Board is disclosed, that Member must play no part in the appointment process.

2.6 Two people shall be deemed to be related if they are husband and wife, or partners or if either of the two, or the spouse or partner of either of them is the son or grandson, daughter or granddaughter, or brother or

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sister, or nephew or niece, of the other, or of the spouse or partner of the other.

3 Authority to Appoint

Chief Executive	Board following confirmation that Ministers are content with report from the Appointment Panel.
Posts at Director level (other than Director of Public Health / Medical Director)	The appropriate Board Appointments Committee
Director of Public Health, Medical Director Consultants	The Board on the recommendation of an Advisory Appointments Committee
Other Staff	Appointment Panel or Officer specified in the Scheme of Delegation

4 Composition of Appointment Panel / Committees

The Board shall determine the individual membership of the relevant appointment committees at the beginning of the appointment process.

4.1 Chief Executive

The Board Appointments Panel shall consist of:

- Chair of the Board (and Chair of the panel)
- One non-executive member
- Chair or other member of National Performance Management Committee
- One additional Chair of another Health Board
- The Director General / Chief Executive of the NHS in Scotland

4.2 Posts at Director Level (other than Medical)

The Board Appointments Committee shall consist of:

- Chair of the Board or their nominee
- Chief Executive
- Up to two Non-Executive Members of the Board; and
- Up to two External Assessors, one of whom shall be a representative of the Scottish Government Health and Social Care Directorates or his/her nominee, the other a representative of another NHS or local authority partner organisation

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4.3 **Director of Public Health, Medical Director and Consultant Posts**

The appointment is made by a Board Committee on the recommendation of an Advisory Appointments Committee, constituted in accordance with the National Health Service (Appointment of Consultants) (Scotland) Regulations 2009.

4.4 **Responsible Officer**

Each designated body must provide the responsible officer nominated or appointed for that body with sufficient funds and other resources necessary to enable the officer to discharge their responsibilities for that body under regulations The Medical Profession (Responsible Officers) Regulations 2010 (legislation.gov.uk)

4.5 **Other staff**

Appointment of other staff will be in accordance with the scheme of delegation.

5 Disciplinary Procedures

5.1 The Disciplinary Procedures regarding the Board staff are contained in the Employee Conduct Policy and Procedure. In the case of Executive Members and other Directors, such procedures shall be a matter for the full Board.

It is delegated to Chief Executive to apply the terms of the Board's disciplinary procedures.

Version 2

SECTION

F

Standing Financial Instructions

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This section explains how staff will control the financial affairs of NHS Orkney and ensure proper standards of financial control.

1 Introduction

Made in Terms of Regulation 4 Of The National Health Service (Financial Provisions) (Scotland) Regulations, 1974

1 Background

1.1 These Standing Financial Instructions (SFIs) are issued in accordance with financial directions issued by the Scottish Government Health and Social Care Directorates (Scottish Government) under National Health Service statutes and circulars. The SFIs are in accordance with the Scottish Public Finance Manual. Their purpose is to secure adequate measures of control of all NHS Orkney's financial transactions. They have effect as if incorporated in the Standing Orders of Orkney NHS Board (the Board). The SFIs should be used along with the Scheme of Delegation.

1.2 The purpose of such a scheme of control is:

- To ensure that NHS Orkney acts within the law and that financial transactions are in accordance with the appropriate authority
- To ensure that financial statements, give a true and fair view of the financial position of NHS Orkney expenditure and income, and are prepared in a timely manner
- To protect NHS Orkney against the risk of fraud and irregularity
- To safeguard NHS Orkney's assets
- To ensure proper standards of financial conduct
- To ensure that NHS Orkney seeks Best Value from its resources, by making arrangements to pursue continuous improvement, economy, efficiency and effectiveness in its operations
- To ensure that delegation of responsibility is accompanied by clear lines of control accountability, and reporting arrangements.

2 Compliance

2.1 All employees, individually and collectively, are responsible for the security of the Board's property, avoiding loss and for the efficiency in the use of resources. All employees must comply with the requirements of Standing Orders, Standing Financial Instructions and other financial procedures which the Director of Finance may issue

2.2 The Chief Executive is accountable to the Board, and as Accountable Officer, to the Scottish Minister, for ensuring that the Board meets its obligation to perform within the available financial resources and in line with Best Value. The Chief Executive has executive responsibility to the Chair and Board for NHS Orkney activities, the system of internal control, and ensuring that financial obligations and targets are met.

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2.3 The Chief Executive shall be responsible for the implementation of the Board's financial policies and for coordinating any corrective action necessary to further these policies, taking account of advice given by the Director of Finance on all such matters. The Director of Finance shall be accountable to the Board of Directors for this advice

2.4 Director of Finance will assist the Chief Executive to ensure that SFIs are in place, up to date and observed in NHS Orkney. The responsibilities of the Director of Finance may also be carried out by the Head of Finance.

2.5 Members, officials, and agents of NHS Orkney, including, but not limited to, local authority employees working in joint health and social care projects, must comply with these SFIs. Executive Directors will ensure that the SFIs are made issued within the services for which they are responsible and ensure that they are adhered to. All employees must protect themselves and the Board from allegations of impropriety by seeking advice from their line manager, whenever there is doubt as to the interpretation of the Standing Orders, Scheme of Delegation, and SFIs. If there are any difficulties in interpretation or application of these documents, the advice of the Director of Finance should be sought.

2.6 All members of the Board and staff have a duty to disclose noncompliance with SFI's to the Director of Finance as soon as possible. Breaches will be reported as part of the Board's Incident Reporting process. Minor, isolated and unintentional noncompliance will be reviewed by the Director of Finance. For significant breaches, full details, and a justification will be reported to the Audit and Risk Committee. Failure to comply with SFIs may result in disciplinary action.

2.7 Where these SFIs place a duty upon any person, this may be delegated to another person, as documented in the Scheme of Delegation, and approved by the Director of Finance.

2.8 Employees must not:

- Abuse their official position for the personal gain or to the benefit of their family or friends
- Undertake outside employment that could compromise NHS duties
- Advantage or further their private business or interest in the course of their official duties.

2.9 Nothing in these SFIs shall override any legal requirement or Ministerial Direction placed upon NHS Orkney, its members, or officers.

3.0 Administration of Standing Financial Instructions

3.1 A register shall record the control and issue of these instructions and future amendments

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3.2 SFIs should be issued to all employees whose duties fall within scope of the regulations contained within them

3.3 Wherever the title Chief Executive, Director of Finance or other nominated Officer is used in these instructions, it should be deemed to include such other Officers who have been duly authorised to represent them.

3.4 Where appropriate terms used in these instructions shall have the same meaning as ascribed in the National Health Service (Scotland) Act 1978 and the National Health Service and Community Care Act 1990.

4.0 Terminology

4.1 “Board” and “Health Board” means NHS Orkney Health Board

4.2 “Budget” means a resource expressed in financial terms proposed by the Board for the purpose of carrying out, for a specific period, any or all functions of NHS Orkney.

4.3 “Budget Holder” means the director or officer with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.

4.4 “Chief Executive” means the Chief Executive Officer of NHS Orkney

4.5 “Director of Finance” means the executive financial officer of NHS Orkney

4.6 “Executive Team” means the committee of executive officers of NHS Orkney appointed by the Board to act in accordance with its remit.

4.7 Officer” means an employee of NHS Orkney or any other person holding a paid appointment officer within NHS Orkney

4.8 “SCHSCD” means the Scottish Government Health and Social Care Directorate

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2 Responsibilities of The Board

1.0 The Board

1.1 The Board are accountable to the Cabinet Secretary for Health & Wellbeing through Scottish Government Health & Social Care Directorate (SGHSCD)

1.2 The key functions that the Board are accountable for are:

- To set the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer-term objectives and agree plans to achieve them
- To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken where necessary
- To ensure effective financial stewardship through value for money, financial control and financial planning and strategy
- To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation
- To ensure there is effective dialogue between the organisation and the community on its plans and performance and that these are responsive to the community's needs
- To appoint, appraise and remunerate senior executives

1.3 In fulfilling these functions, the Board should:

- Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure that the Board can fully undertake its responsibilities
- Be clear what decisions and information are appropriate to the Board and draw up standing orders, a schedule of decisions reserved to the Board and standing financial instructions to reflect this
- Establish performance and quality targets that maintain the effective use of resources and provide value for money
- Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programme of action and for performance
- Establish audit and remuneration committees based on formally agreed terms of reference that conforms with extant Scottish Government instructions and other guidance on good practice
- Act within statutory financial and other constraints

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2.0 The Chair

2.1 The Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the organisation as a whole. It is the Chair's role to:

- Provide leadership to the Board
- Enable all directors to make a full contribution to the Board's affairs and ensure that the Board act as a team
- Ensure that key and appropriate issues are discussed by the Board in a timely manner
- Ensure that the Board has adequate support and is provided efficiently will all the necessary data on which to base informed decisions
- Lead Non-Executive Directors through a formally appointed remuneration committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive, other executive directors and other senior officials
- Appoint Non-Executive Directors to sub committees of the main Board

3.0 Non-Executive Directors

3.1 Non-Executive Directors are appointed by and on behalf of the Cabinet Secretary for Health & Wellbeing to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the NHS Scottish Government Health and Social Care Directorate to Ministers and the Community.

3.2 They are not involved in the operational management of NHS Orkney

3.3 Non-Executive Directors will be able to contribute to Board business from a wide experience and critical detachment. They have a key role in working with the Chair in the appointment of the Chief Executive and other Board Members

3.4 Along with the Chair, nominated Non-Executive Directors comprise the remuneration committee responsible for the appraisal and remuneration decision affective executive Board members

3.5 A major role of the Non-Executive Members will be in monitoring internal control as a member of the Audit Committee

3.6 In addition, they support the Chief Executive and Executive Directors on specific functions agreed by the Board including oversight of staff relations with the general public and the media, clinical governance, participation in professional conduct and competency enquiries and staff disciplinary appeals and grievances

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3 Responsibilities of Chief Executive as Accountable Officer

Under Sections 14 and 15 of the Public Finance and Accountability (Scotland) Act 2000 (the PFA Act), the Principal Accountable Officer for the Scottish Government has designated the Chief Executive of the Board as Accountable Officer.

Accountable Officers must comply with the terms of the Memorandum to Accountable Officers for Other Public Bodies, and any updates issued to them by the Principal Accountable Officer for the Scottish Government. The Memorandum was updated in March 2019.

1 General Responsibilities

1.1 The Accountable Officer is personally answerable to the Scottish Parliament for the propriety and regularity of the public finances of NHS Orkney, ensuring that resources are used economically, efficiently, and effectively. The Accountable Officer must ensure that the Board takes account of all relevant financial considerations, including any issues of propriety, regularity or value for money, in considering policy proposals relating to expenditure, or income.

1.2 It is incumbent upon the Accountable Officer to combine their duty as Accountable Officer with their duty to the Board to whom they are responsible, and from whom they derive their authority. The Board is in turn responsible to the Scottish Parliament in respect of its policies, actions and conduct.

1.3 The Accountable Officer has a personal duty to sign the Annual Accounts of the Board. Consequently, they may also have the further duty of being a witness before the Audit and Risk Committee of the Scottish Parliament, and be expected to deal with questions arising from the Accounts, or, more commonly, from reports made to Parliament by the Auditor General for Scotland.

1.4 The Accountable Officer must ensure that arrangements for delegation promote good management, and that they are supported by the necessary staff with an appropriate balance of skills. This requires careful selection and development of staff and the sufficient provision of special skills and services. They must ensure that staff are as conscientious in their approach to costs not borne directly by their component organisation (such as costs incurred by other public bodies) as they would be were such costs directly borne.

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2 Specific Responsibilities

2.1 The Accountable Officer must:

- Ensure that proper financial systems are in place and applied, and that procedures and controls are reviewed from time to time to ensure their continuing relevance and reliability, especially at times of major changes

- Sign the Accounts and the associated governance statement, and in doing so accept personal responsibility for ensuring that they are prepared under the principles and in the format directed by Scottish Ministers

- Ensure that proper financial procedures are followed incorporating the principles of separation of duties and internal check and that accounting records are maintained in a form suited to the requirements of the relevant Accounting Manual, as well as in the form prescribed for published Accounts

- Ensure that the public funds for which they are responsible are properly managed and safeguarded, with independent and effective checks of cash balances in the hands of any official

- Ensure that the assets for which they are responsible, such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate

- Ensure that, in the consideration of policy proposals relating to expenditure, or income, for which they have responsibilities as Accountable Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and where necessary brought to the attention of the Board

- Ensure that any delegation of authority is accompanied by clear lines of control and accountability, together with reporting arrangements

- Ensure that procurement activity is conducted in accordance with the requirements in the Procurement section of the Scottish Public Finance Manual

- Ensure that effective management systems appropriate for the achievement of the Board's objectives, including financial monitoring and control systems have been put in place

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- Ensure that risks, whether to achievement of business objectives, regularity, propriety, or value for money, are identified, that their significance is assessed and that systems appropriate to the risks are in place in all areas to manage them

- Ensure that arrangements have been made to secure Best Value from resources as set out in the Scottish Public Finance Manual, by making proper arrangements to pursue continuous improvement by having regard to economy, efficiency and effectiveness and in a manner which encourages the observance of equal opportunity requirements

- Ensure that managers at all levels have a clear view of their objectives, and the means to assess and measure outputs, outcomes or performance in relation to those objectives

- Ensure managers at all levels are assigned well-defined responsibilities for making the best use of resources (both those assumed by their own commands and any made available to organisations or individuals outside NHS Orkney) including a critical scrutiny of output, outcomes and value for money

- Ensure that managers at all levels have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

3 Regularity and Propriety of Expenditure

3.1 The Accountable Officer must ensure that the Board achieves high standards of regularity and propriety in the consumption of resources. Regularity involves compliance with relevant legislation, relevant guidance issued by Scottish Ministers (in particular the Scottish Public Finance Manual) and the framework document defining the key roles and responsibilities which underpin the relationship between the body and the Scottish Government. Propriety involves respecting the Parliament's intentions and conventions and adhering to values and behaviours appropriate to the public sector.

3.2 Accountable Officers have a particular responsibility for ensuring compliance with parliamentary requirements in the control of expenditure. A fundamental requirement is that funds should be expended only to the extent and for the purpose authorised by the Parliament in Budget Acts (or otherwise authorised by Section 65 of the Scotland Act 1998). Parliament's attention must be drawn to losses of special payments by appropriate notation of the Board's Accounts.

3.3 All actions must be able to stand the test of parliamentary scrutiny, public judgement on propriety and professional codes of conduct. Care must be

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taken not to misuse an official position to further private interests, and to avoid actual, potential, or perceived conflicts of interest.

4 Advice to the Orkney NHS Board

4.1 In accordance with **section 15(8)** of the PFA Act the Accountable Officer has particular responsibility to ensure that, where they consider that any action that they are required to take is inconsistent with the proper performance of their duties as Accountable Officer, they obtain written authority from the Board and send a copy of this as soon as possible to the Auditor General. A copy of such written authority should also be sent to the Clerk to the Public Audit Committee. The Accountable Officer should ensure that appropriate advice is tendered to the Board on all matters of financial propriety and regularity and on the economic, efficient and effective use of resources. They will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to their own duty as Accountable Officer to seek written authority and notify the Auditor General and the Public Audit Committee.

4.2 The Accountable Officer has a duty to ensure that appropriate advice is tendered to the Board, the Executive Team and other decision-making bodies on all matters of financial propriety and regularity, and more broadly, as to all considerations of prudent and economical administration, efficiency, and effectiveness.

4.3 If the Accountable Officer considers that, despite their advice to the contrary, the Board is contemplating a course of action which they consider would infringe the requirements of financial regularity or propriety, or that they could not defend as representing value for money within a framework of Best Value, they should set out in writing the objection to the proposal and the reasons for this objection. If the body decides to proceed, they should seek written authority to take the action in question. In the case of a body sponsored by the Scottish Government, the sponsor unit should be made aware of any such request in order that, where considered appropriate, it can inform the relevant Portfolio Accountable Officer and Cabinet Secretary / Minister. Having received written authority, they must comply with it, but should then, without undue delay, pass copies of the request for the written authority and the written authority itself to the Auditor General and the Clerk to the Public Audit Committee.

4.4 The Accountable Officer must ensure that their responsibilities as Accountable Officer do not conflict with those as a Board member. They should vote against any action that they cannot endorse as Accountable Officer, and in the absence of a vote, ensure that their opposition as a Board member, as well as Accountable Officer is clearly recorded. It will

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not be sufficient to protect their position as a Board member merely by abstaining from a decision which cannot be supported.

5 Appearance before the Public Audit and Risk Committee

5.1 Under **section 23 of the PFA Act** the Auditor General may initiate examinations into the economy, efficiency and effectiveness with which relevant bodies have used their resources in discharging their functions. The Accountable Officer may expect to be called upon to appear before the Public Audit Committee to give evidence on reports arising from any such examinations involving the Board. They will also be expected to answer the questions of the Committee concerning resources and accounts for which they are Accountable Officer and on related activities. They may be supported by other officials who may, if necessary, join in giving evidence or the Committee may agree to hear evidence from other officials in their absence.

5.2 They will be expected to furnish the Committee with explanations of any indications of weakness in the matters covered by paragraphs 2.7.1 above, to which their attention has been drawn by the Auditor General or about which they may wish to question them.

5.3 In practice, they will have delegated authority widely but cannot on that account disclaim responsibility. Nor, by convention, should they decline to answer questions where the events took place before their designation.

5.4 They must make sure that any written evidence or evidence given when called as a witness before the Public Audit and Risk Committee is accurate. They should also ensure that they are adequately and accurately briefed on matters that are likely to arise at the hearing. They may ask the Committee for leave to supply information not within their immediate knowledge by means of a later note. Should it be discovered subsequently that the evidence provided to the Committee has contained errors, they should let this be made known to the Committee at the earliest possible moment.

5.5 In a case where they were overruled by the Board on a matter of propriety or regularity, their advice would be disclosed to the Committee. In a case where they were overruled by the Board on the economic, efficient and effective use of resources they should be ready to discuss the costs, benefits and risks of options considered and explain the reasoning for the decision taken. They may also be called upon to satisfy the Committee that all relevant financial considerations were brought to the Board's attention before the decision was taken.

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6 Absence of Accountable Officer

6.1 The Accountable Officer should ensure that they are generally available for consultation and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, a senior officer is identified to act on their behalf if required.

6.2 In the event that the Accountable Officer would be unable to discharge their responsibilities for a period of four weeks or more, NHS Orkney will notify the Principal Accountable Officer of the Scottish Government, in order that an Accountable Officer can be appointed pending their return.

6.3 Where an Accountable Officer is unable by reason of incapacity or absence to sign the Accounts in time for them to be submitted to the Auditor General, the Board may submit unsigned copies, pending the return of the Accountable Officer.

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4 Responsibilities of the Director of Finance

1.0 The Director of Finance shall be responsible for:

- The provision of financial advice to the Board and its Officers
- The implementation of the Board's financial policies
- The design, implementation and supervision of systems of financial control, including the adoption of Standing Financial Instructions
- The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Board may require for the purpose of carrying out its statutory duties
- The financial management of the Board's resources to ensure that the Board meets its financial targets. This will be carried out by means of budgetary planning and control, financial reporting and treasury management amongst other things
- Ensuring the Board discharges its responsibilities in respect of public accountability and stewardship of funds. Included in this remit is the production of statutory accounts and the provision of a sound control environment
- The detailed preparation and submission to the Scottish Government of accurate and timely financial proforma, monitoring returns, annual accounts and other information which the Scottish Government determines it requires to discharge its monitoring responsibilities
- The consideration of the bases and assumptions used in the preparation of each budget, statement, forecast or report provided to the Board as to whether any such basis or assumption is reasonable and the monitoring of delegated budgets in order that where an unfavourable variance is shown, corrective actions may be instigated on a timely basis

1.1 The Director of Finance shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal checks to supplement these instructions

1.2 The Director of Finance shall be responsible for the establishment and provision of an internal audit service which meets the audit requirements as set out in the NHS in Scotland Audit Manual

1.3 The Director of Finance shall ensure that the Board is achieving overall value for money in its operations

1.4 The Director of Finance shall require, in relation to any officer who carries out a financial function, that the form in which the officer discharges his duties shall be to the Director's satisfaction.

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5 Financial Strategy and Planning

1 Responsibilities

1.1 The Board is required by statutory provisions made under Section 85 of the National Health Services (Scotland) Act 1978, as amended by the Health Services Act 1980 to perform its functions within the total funds allocated by the Cabinet Secretary for Health & Wellbeing plus income generated from other sources, and all plans, financial approval systems and budgets shall be designed to meet these obligations.

The Scottish Government has set the following financial targets for all Health Boards:

- To operate within the revenue resource limit
- To operate within the capital resource limit
- To operate within the cash requirement

The Chief Executive is responsible for leading an inclusive process, involving staff and partner organisations, to compile and secure approval of the Annual Delivery Plan (ADP) for NHS Orkney by the Board. The ADP will include:

- The significant assumptions on which the plan is based
- Details of major changes in workload, delivery of services or resources required to achieve the plan
- Action points from the community planning partnership
- Health care plans covering primary and secondary services provided by NHS Orkney
- Regional dimension of healthcare and scope for sharing resources with partners.

1.2 By concisely describing the health and healthcare issues facing Orkney, setting out succinctly how these will be tackled and by whom, and by setting priorities, milestones, quantified improvements and targets, the ADP will help to secure understanding of health issues, a shared approach to taking action, and commitment to achieving results.

1.3 The Director of Finance is responsible for the annual preparation of a 3-5-year Financial Plan. In addition, the ADP and Financial Plan will be informed by and supported by a Workforce Plan. Before inclusion in the plan, all service developments must be supported by a business case typically approved by the Senior Leadership Team.

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1.4 The Financial Plan will comprise both revenue and capital components and will be compiled in accordance with Scottish Government guidelines and aligned to available resources as determined by the Revenue Resource Limit and Capital Resource Limit as notified or indicated by Scottish Government, and forecast for future years.

1.5 The ADP and the Financial Plan will be submitted to the Senior Leadership Team for detailed scrutiny and risk assessment, following which the Finance and Performance Committee will consider and recommend approval by the Board.

1.6 The Financial Plan will include the financial planning returns which the Director of Finance will prepare and submit to the Scottish Government.

2 Budget Setting

2.1 The Director of Finance shall, on behalf of the Chief Executive, and in advance of the financial year to which they refer, prepare and submit budgets within the forecast limits of available resources and planning policies to the Board of Directors for approval.

2.2 Executive Directors and Officers will provide the Director of Finance with all financial, statistical and other relevant information as necessary for the compilation of such business plans, estimates and forecasts.

2.3 These budgets will:

- Be in accordance with the aims and objectives set out in the Annual Delivery Plan
- Accord with workload and workforce aims
- Be produced following discussion with appropriate budget holders
- Be prepared within the limits of available funds
- Identify potential risks

3.0 Control

3.1 The Director of Finance will ensure that adequate financial and statistical systems are in place to monitor and control income and expenditure, and to prepare financial plans, estimates and investigations as required.

3.2 The Director of Finance will devise and maintain a system of budgetary control. These will include:

- Monthly financial reports to the Board in a form approved by the Board
- The issue of timely accurate and comprehensible advice and financial reports to each Budget Holder, covering the areas for which they are responsible

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- Investigation and reporting of variance from financial and workforce budgets
- Monitoring of management action to correct variances
- Arrangements for authorisation of budget transfer

3.3 The Board and Senior Leadership Team will empower officers to engage staff, incur expenditure and collect income. All officers who are empowered will comply with the requirements of those systems of budgetary control.

4 Budgetary Delegation

4.1 The Board shall delegate management of the Financial Plan to the Chief Executive who may in turn, within limits approved by the Board, delegate authority for a budget or a part of a budget to an individual or group of officers to permit the performance of defined activities. The terms of delegation confers individual and group responsibilities for control of expenditure, virement of budgets, achievement of planned levels of service and regular reporting on the discharge of delegated functions to the Chief Executive. Responsibility for overall budgetary control remains with the Chief Executive.

4.2 Except where approved by the Chief Executive (taking account of advice of the Director of Finance) budgets will only be used for the purpose for which they were provided. Any budgeted funds not required for their designated purpose will revert to the control of the Chief Executive, unless covered by delegated powers of virement. The Director of Finance will issue procedural guidance on powers of virement.

4.3 Expenditure for which no provision has been made in an approved budget can only be incurred after authorisation by the Chief Executive or Director of Finance, subject to their delegated limit. Delegated authority to approve individual items of expenditure, is undernoted, provided that approval remains within Revenue and Capital Budgets:

- The Finance and Performance Committee can approve individual items up to £1,000,000 in any one instance
- The Chief Executive, can approve individual items up to £500k in any one instance
- The Director of Finance can approve individual items up to £250k in any one instance.

This includes virement between budgets, including from reserves.

4.4 The Director of Finance will keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards, and other events and trends affecting budgets, and will advise on the financial and economic aspects of future plans and projects.

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4.5 There is a duty for the Chief Executive, and all employees not to exceed approved budgetary limits.

4.6 The Chief Executive will negotiate funding for the provision of services in accordance with the ADP and establish arrangements for cross boundary treatment of patients. The Chief Executive will take advice from the Director of Finance regarding:

- Costing and pricing of services
- Payment terms and conditions
- Arrangements for funding in respect of patients from out-with Orkney, and for the funding of the treatment of Orkney residents other than by NHS Orkney.

4.7 The Chief Executive is responsible for negotiating agreements for the provision of support services to/from other NHS bodies.

5 Reporting and Monitoring

5.1 The Chief Executive will report on material variances arising from inability to action, or delay in implementation of projects approved by the Board and will advise the Finance and Performance Committee on the use of such funds. The Committee will report as appropriate to the Board.

5.2 The Director of Finance will compile a monthly Financial Report for the Senior Leadership Team.

5.3 The Director of Finance will produce a regular Financial Report for the Finance and Performance Committee and the Board. This report will highlight significant variances from the Financial Plan, and the forecast outturn position, and will recommend proposed corrective action.

5.4 The Director of Finance has right of access to all budget holders on budgetary and financial performance matters.

5.5 Each Budget Holder is responsible for ensuring that:

- Any likely overspending or reduction of income is not incurred without the prior consent of the Director of Finance
- The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised
- No permanent of temporary employees are appointed without the approval of the Director of People and Culture, and then only those provided for within budget establishment as approved by the Board

5.6 Budget Holders are responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Financial Plan and a balanced budget

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5.7 The Director of Finance is responsible for ensuring that the appropriate monitoring forms are submitted to Scottish Government within the prescribed timescale. It is the responsibility of the Director of Finance to ensure that the financial information presented to the Scottish Government is consistent with financial information presented to the Board.

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6 Commissioning and Provision of Healthcare Services

1 Commissioning and Provisioning of Services

1.1 The Chief Executive, in conjunction with the Director of Finance, will be responsible for ensuring that:

- Services required or provided are covered by Service Level Agreements (SLAs)
- Adequate funds are retained to cover the cost for services obtained without SLAs in alignment with the approved Annual Delivery Plan (ADP) and Financial Plan
- Overall service framework is affordable within the Financial Plan, and Revenue and Capital Resource Limits set by Scottish Government Health Directorates.

2 Service Agreements

2.1 The Chief Executive will ensure that service agreements are placed with due regard to the need to achieve Best Value. The Chief Executive, Director of Finance, Medical Director or Executive Director of Nursing, Midwifery, Allied Health Professionals & Chief Officer Acute Services will authorise SLAs for health care services.

2.2 The Director of Finance shall be accountable for approving the financial elements of SLAs endorsed by the board.

2.3 The Chief Executive will be accountable for establishing robust financial arrangements, in accordance with guidance from the Scottish Government Health Directorates, for treatment of Orkney residents by other NHS bodies, or the private sector.

2.4 The Director of Finance shall be responsible for maintaining a system for the rendering and payment of SLA invoices in accordance with the agreed terms, or otherwise in accordance with national guidance.

2.5 All SLAs should support the agreed priorities within the ADP. The Chief Executive should take into account:

- Standards of service quality expected, including patient experience
- Relevant national service framework (if any);
- Provision of reliable information on cost and volume of services, and
- SLAs are based on integrated care pathways.

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3 Data Protection

3.1 The Caldicott Guardian for NHS Orkney will be responsible for ensuring that all systems operate in a way to maintain confidentiality of patient information as set out in the in the Data Protection Act 2018 and the UK General Data Protection Regulation.

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7 Annual Report and Accounts

1 Requirement

1.1 NHS Orkney is required under Section 86(3) of the National Health Service (Scotland) Act 1978 to prepare and submit Annual Accounts to Scottish Ministers.

1.2 Scottish Ministers have issued Accounts Directions in exercise of the powers conferred by Section 86(1) of the National Health Service (Scotland) Act 1978.

1.3 Under the Public Finance and Accountability (Scotland) Act 2000, Annual Accounts must not be made public until they have been formally laid before the Scottish Parliament.

2 Preparation of Annual Accounts

2.1 The Director of Finance shall ensure that proper records are maintained to support the preparation of Annual Accounts.

2.2 Annual Accounts will be prepared:

- In accordance with the Government Reporting Manual (FReM) issued by HM Treasury;
- In accordance with the Accounts Direction and Accounts Manual issued by Scottish Government
- In compliance with all relevant accounting standards and disclosure requirements.

2.3 The Director of Finance shall prepare, certify and submit Annual Accounts to the Chief Executive and the Scottish Government Health and Social Care Directorates, in accordance with agreed timetable.

2.4 The External Auditor, appointed by the Auditor General for Scotland shall conduct the statutory audit and provide and audit opinion on the Annual Accounts.

2.5 The Director of Finance will agree with the External Auditor a timetable for the production, audit, adoption by the Board and submission of Accounts to the Auditor General for Scotland and Scottish Government.

2.6 The Chief Executive will prepare a Governance Statement, seeking appropriate assurances, including that of the Chief Internal Auditor, regarding the adequacy of internal control throughout NHS Orkney.

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2.7 The Audit and Risk Committee shall review the Annual Accounts and recommend adoption to the board.

2.8 Once approved the board, the Annual Accounts shall be signed on its behalf and submitted to the External Auditor for certification and onward submission to the Auditor General for Scotland and the Scottish Government.

3 Annual Report

3.1 The Chief Executive will arrange for the production and circulation of an Annual Report in the form determined by the Scottish Government.

3.2 The Annual Report shall provide an account of NHS Orkney's performance, governance and stewardship of public funds during the financial year.

3.3 The Director of Finance shall prepare a Financial Statement for inclusion in the Annual Report, in accordance with relevant guidance.

3.4 The Annual Report shall be considered by the Audit and Risk Committee and approved by the Board.

3.5 The Annual Report will be published no later than two months after the Annual Review and discussed at a public meeting, fulfilling the requirement under the NHS (Scotland) Act 1978 to present the Accounts publicly.

3.6 NHS Orkney shall ensure the Annual Report and Accounts are made accessible to the public, including through its website and other appropriate channels, once formally laid before Parliament.

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8 Banking Arrangements

1 All arrangements with NHS Orkney's bankers and the Government Banking Service will be made under arrangements approved by the Director of Finance who is authorised to operate bank accounts, as necessary. The Director of Finance will report to the Board on the details of all accounts, including conditions on which they are operating.

2 All funds will be held in accounts in the name of NHS Orkney, or the Endowment Fund. The Director of Finance will advise the bankers in writing of the conditions under which each account will operate, including prompt notification of the cancellation of authorisation to draw on NHS Orkney accounts.

3 The Director of Finance will nominate, for each bank account, the officers authorised to release monies from each account. The Director of Finance will notify the bank promptly of any changes to the authorised signatories.

4 All cheques will be crossed with "Not Negotiable - Account Payee Only" and must be treated as controlled stationery in the charge of a designated officer controlling their issue. Two signatures are required on cheques.

5 All cheques, postal orders, cash, etc. will be banked promptly, to the main account (or, if appropriate, endowment fund deposit account - see Section 16). Disbursements must not be made from cash.

6 The Director of Finance will make arrangements for:

- Receipt and payment of monies using the Clearing Houses Automated Payment System (CHAPS) and the Bankers Automated Clearing Services (BACS)
- Payments to be made by Standing Order or Direct Debit
- The use of credit cards
- Payments to be made to foreign bank accounts.

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9 Security

1 Security of Cash and Negotiable Instruments

1.1 All receipt books, tickets, agreement forms, or other means of officially acknowledging or recording amounts received or receivable will be in a form approved by the Director of Finance. Such stationery will be ordered and controlled using the same procedures as applied to cash.

1.2 All officers, whose duty it is to collect or hold cash, will be provided with a safe or a lockable cash box (which in turn must be deposited in a locked cupboard). The loss of a key must be reported immediately to the Fraud Liaison Officer. The Director of Finance will, on receipt of a satisfactory explanation, authorise release of a duplicate key. The Director of Finance will arrange for all new keys to be dispatched directly to them from the manufacturers and will maintain a register of authorised holders of safe keys.

1.3 The safe key-holder must not accept unofficial funds for depositing in the safe unless in sealed envelopes or locked containers. NHS Orkney is not liable for any loss and written indemnity must be obtained from the organisation or individual absolving NHS Orkney from responsibility.

1.4 During the absence of the holder of a safe or cash box key, the officer who acts in their place will be subject to the same controls. Transfer of responsibilities for the safe and/or cash box contents will be written and a signed copy of the document must be retained.

1.5 Cash, cheques, postal orders and other forms of payment will be counted each week by a finance officer, and will be entered in the cash collection sheet, which must then be signed. The remittance will be passed to the Cashier and signed for.

1.6 The opening of coin-operated machines and the counting and recording of the takings in the register must be undertaken by two officers and the coin-box keys will be held by a nominated officer. Takings will be passed to the Cashier and a signature will be obtained.

1.7 The Director of Finance will prescribe the system for transporting of cash and uncrossed pre-signed cheques.

1.8 All unused cheques, receipts and all other orders will be subject to the same security as applied to cash: bulk stocks of cheques will be retained by the banker and released only against authorised requisitions.

1.9 All Prescription Pads in Primary Care will be subject to the same security and controls as cash.

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1.10 In all cases where officers receive cash, cheques, credit or debit card payments, empty vending or other machine coin boxes, etc. personal identity cards must be displayed prominently. Staff will be informed in writing on appointment, by their line manager, of their responsibilities and duties for the collection, and handling of cash and cheques.

1.11 Any loss or shortfall of cash, cheques, etc. must be reported immediately in accordance with the agreed procedure for reporting losses. (Section 15).

1.12 Under no circumstances should funds managed by NHS Orkney be used to cash private cheques or make loans of a personal nature.

2 Security of Physical Assets

2.1 The Chief Executive is responsible for the overall control of fixed assets. All employees have a duty of care over property of NHS Orkney. Senior staff will apply appropriate routine security practices. Persistent breach of agreed security practices must be reported to the Chief Executive.

2.2 Where practical, items of equipment will be indelibly marked as NHS Orkney property.

2.3 The Finance Department will maintain an up-to-date capital asset register. The Director of Finance will set out the approved form of asset register and method of updating (Section 22).

2.4 Items on the register will be checked at least annually, and all discrepancies will be notified in writing to the Director of Finance, who may also undertake other independent checks as necessary.

2.5 Damage to premises, vehicles and equipment, or loss of equipment or supplies must be reported (Section 15).

2.6 On the closure of any facility, a check must be carried out and the responsible officer will certify a list of items held including eventual location. The disposal of fixed assets (including donated assets) will be in accordance with Section 22.

2.7 On the closure of any facility a check must be carried out and a responsible officer will certify that all patient and other personally identifiable and commercially sensitive information has been removed from the facility under the NHS Orkney policy for Records Management.

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10 Income

1 The Director of Finance will design and maintain systems for the proper recording, invoicing, and collection of money due.

2 All officers must inform the Director of Finance of money due from transactions they initiate, including contracts, leases, tenancy agreements and any other transactions. The Director of Finance will approve Service Level Agreements or contracts with financial implications in excess of £10,000. Responsibility for agreeing the level of rental for newly acquired property and for the regular review of rental and other charges rests with the Director of Finance who may take into account independent professional advice on matters of valuation.

3 The Director of Finance will take appropriate recovery action of debts and will establish procedures for the write-off of debts after all reasonable steps have been taken to secure payment. (Section 15.)

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11 Payment of Accounts

1 The Director of Finance will maintain and approve a list of approved signatories, including specimen signatures and approved financial limits to authority. This will set out the officers authorised to certify invoices, non-invoice payments, and payroll schedules. Electronic authorisation must be achieved through effective access control permissions approved by the Director of Finance.

2 The Director of Finance will pay accounts, invoices and contract claims in accordance with contractual terms and/or the CBI Prompt Payment Code and the Scottish Government payment target. Payment systems will be designed to avoid payments of interest arising from non-compliance with the Late Payment of Commercial Debts (Interest) Act 1998.

3 All officers must inform the Director of Finance promptly of all monies payable arising from transactions which they initiate, including contracts, leases, tenancy agreements and other transactions. To assist financial control, a register of regular payments will be maintained.

4 The Director of Finance will operate a system for verification, recording and payment of all amounts payable. The system must ensure that:

- Goods have been duly received, examined, are in accordance with specification and order, are satisfactory and prices are correct
- Work done or services rendered have been satisfactorily carried out in accordance with the order
- Materials were of the requisite standard and charges are correct
- For contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, rates of labour are in accordance with the order, materials have been checked as regards quantity, quality and price, and charges for the use of vehicles, plant and machinery have been examined
- All necessary authorisations have been obtained
- The account is arithmetically correct
- The account is in order for payment
- Clinical services to patients have been carried out satisfactorily in accordance with Service Level Agreements and Unplanned Activity arrangements
- Provision is made for early submission of accounts subject to cash discounts or requiring early payment
- Appropriate segregation of duties
- VAT is recovered as appropriate

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- Payment for goods and services is only made once the goods and services are received other than under the terms of a specific contractual arrangement.

5 The PECOS purchasing system must be used to raise orders to all suppliers, unless an exemption has been agreed by Finance and Procurement in advance of the commitment to spend. Purchase Orders must be raised and approved before any commitment of spend with a supplier. Purchase Order numbers must be stated on the invoice otherwise payment will not be made. Purchase Orders must not be raised retrospectively. Procurement will be responsible for reporting on retrospective purchase orders to the Director of Finance.

6 Where an electronic payment system has been approved the system must ensure that payment is made only for goods matched against an authorised purchase order, and goods received note.

7 Authorised signatories will ensure, before an order for goods or services is placed, that the purchase has been properly considered and forms part of the department's agreed service plans and is within known and specific funds available to the department.

8 Any grants or similar payments to local authorities and voluntary organisations or other bodies must comply with procedures laid down by the Director of Finance.

9 Authorised signatories must ensure that there is effective separation of duties between:

- The person placing the order
- The person certifying receipt of goods and services, and
- The person authorising the spend/invoices

In no circumstances should one person undertake all three functions.

10 In the case of contracts for building or engineering works which require payment to be made on account during progress of the works, the Director of Finance will make payment on receipt of a certificate from the technical consultant or officer. Without prejudice to the responsibility of any consultant or works officer appointed to a particular building or engineering contract, where necessary, a contractor's account will be subject to financial examination and general examination by a works officer, before the person responsible for the contract issues the final certificate. To assist financial control, a contracts register will be maintained by procurement.

11 Officers responsible for commissioning self-employed contractors must ensure that, before any assignment is agreed, evidence is obtained from the contractor which confirms their employment status. This will

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ensure that NHS Orkney is not held liable for Income Tax and National Insurance by HMRC. This evidence must be submitted to the Director of Finance and Procurement.

12 Advance payment for supplies, equipment or services will not normally be permitted other than in exceptional circumstances, advanced booking of courses, subscriptions and goods supplied on pro forma invoices. Should other exceptional circumstances arise, a proposal should be submitted to the Director of Finance at the earliest opportunity. The Director of Finance will take appropriate advice in determining a course of action.

13 Authorised signatories are responsible for ensuring that all items due under a payment in advance contract are received and must inform the Director of Finance or Chief Executive immediately if problems are encountered.

14 Advance payments to general medical practitioners and community pharmacists shall be processed through NHS National Services Scotland.

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12 Construction Industry Scheme

1 The scheme will be administered in line with guidance supplied by HMRC in booklet CIS340. Registration under the Construction Industry Scheme (CIS) is necessary where construction expenditure exceeds £1m per annum in any three-year period. Before the threshold is likely to be breached, the Director of Finance should apply for registration from HMRC.

2 The Estates Department will ensure that certificates and/or vouchers are obtained from contractors/subcontractors and supplied to the Finance Department to support payment requests.

3 In the event of doubt, the Head of Finance will determine whether a payment should be made gross or net of deduction of tax and will consult with HMRC, as necessary.

4 The Director of Finance will remit to HMRC any tax deducted from payments made to sub-contractors, and must comply with the timetable set out in CIS340.

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13 Terms of Service and Payment to Board Members and Staff

1 The Remuneration Committee will:

- Agree terms and conditions of Executive Directors
- Approve changes to remuneration, allowances and conditions of service of Chief Executive and Executive Directors
- Ensure arrangements are in place for the assessment of performance of Executive and senior management staff
- Consider redundancy, early retiral or termination agreements in respect of Executive Directors
- Approve other terms and conditions of service not covered by direction or regulation, e.g. Discretionary Points for Medical Staff.

2 After approval by the Remuneration Committee, and sign off approval by the National Performance Monitoring Committee (NPMC) pay for executives under Executive Managers terms and conditions may be paid in line with the Government issued circulars

3 NHS Orkney will pay allowances to the Chair and non-executives in accordance with instructions issued by the Scottish Minister.

4 No member of staff shall be engaged, re-engaged, or regraded, nor shall agency staff be hired, unless authorised by the Chief Executive or as delegated by the Chief Executive, and within the limit of approved budgets and funded establishments. From time to time, the Chief Executive may add certain caveats to this delegation of authority (such as a requirement to take vacant posts to the Board Vacancy Panel).

5 The Director of People and Culture will be responsible for ensuring that each employee is issued with a contract which will comply with current employment legislation and in a form approved by NHS Orkney. The Director of People and Culture will ensure that variations to, and termination of contracts are properly processed.

6 All timesheets, staff returns, and other pay records and notifications will be in a form approved by the Director of Finance and must be certified and submitted in accordance with their instructions.

7 The Director of Finance will ensure payments and processes are supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

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8 Authorised managers have delegated responsibility for:

- Sending a signed copy of the engagement form and other documents necessary for the payment of staff to the Payroll Department immediately upon the employee commencing duty
- Submitting time records, and other notifications, in accordance with agreed timetable
- Completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by them
- Making any necessary changes in eESS immediately the effective date of any change in employment or personal circumstances is known
- Submitting via eESS termination of employment details as required, for payment purposes, immediately upon the effective date of an employee's resignation, retirement or termination being known
- Immediately advising the Payroll Department when an employee fails to report for duty in circumstances which suggest that they have left without notice.

9 The Director of People and Culture and the Director of Finance will be jointly responsible for ensuring that rates of pay and relevant conditions of service are in accordance with current agreements. The Chief Executive, or the board in appropriate circumstances, will be responsible for the final determination of pay, but subject to the statutory duty of the Director of Finance. The Director of Finance will issue instructions regarding:

- Verification of documentation or data
- Timetable for receipt and preparation of payroll data and the payment of staff
- Maintenance of records for Superannuation, Income Tax, National Insurance and other authorised deductions
- Security and confidentiality of payroll information in accordance with the Data Protection Act
- Checks to be applied to payroll before and after payment
- Authority to release payroll data under the provisions of the Data Protection Act
- Methods of payment available to staff
- Procedures for payment of cheques and bank credits to staff
- Procedures for unclaimed wages which should not be returned to salaries and wages staff
- Pay advances and their recovery
- A system for recovery from leavers of sums due by them
- A system to ensure recovery or write-off of payment of pay and allowances

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- Maintenance of regular and independent reconciliation of adequate control accounts.

10 The Director of Finance in conjunction with the payroll service provider will ensure salaries and wages are paid on the agreed dates but may vary these when necessary due to special circumstances (e.g. Christmas and other Bank Holidays). Payment to an individual will not be made in advance of normal pay, except as authorised by the Chief Executive or Director of Finance to meet special circumstances and limited to the net pay due at the time of payment.

11 All employees will be paid by bank credit transfer monthly unless otherwise agreed by the Director of Finance.

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14 Travel, Subsistence and Other Allowances

1 The Director of Finance will ensure that all expense claims by employees or outside parties are reimbursed in line with relevant national agreement, and that all such claims will be supported by receipts wherever possible. Removal expenses will be limited to the amount specified by HMRC as being tax free and in accordance with NHS Orkney's Relocation Policy.

2 The Director of Finance will issue guidance on submission of expense claims, specifying documentation to be used, timescales to be adhered to and required level of authorisation. All claims will be submitted to the Payroll Department duly certified in an approved form and made up to a specified day of each month. The approved list of signatories as maintained by the Director of Finance will include names of officers authorised to sign claims and will be submitted to the payroll service provider.

3 No officer can approve their own expenses. Expenses should only be approved where the approving officer is satisfied that all journeys have been authorised in accordance with the board's vacancy panel procedures, the expenses are properly and necessarily incurred and evidenced, and that the allowances are properly payable.

4 The Chairperson will authorise all expense claims from the Chief Executive. The Chief Executive will authorise all claims from Executive Members of the Board. The Chairperson will authorise all claims from Non-Executives. In the absence of the Chairperson, this will be undertaken by the Chief Executive or Director of Finance.

5 Claims submitted more than three months after the expenses were incurred will be paid only if approved by the Director of Finance, who will only authorise payment where there is an appropriate justification for the delay and it is an isolated occurrence.

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15 Non-pay Expenditure – Procurement

1 Introduction

1.1 The purpose of this SFI is to set clear rules for the proper management of expenditure for the procurement of goods, works and services. The rules should ensure that NHS Orkney is fair, transparent and accountable in dealings with contractors and suppliers.

1.2 This SFI:

- Sets out thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained
- Incorporates the thresholds in the Scheme of Delegation
- Provides procedural instructions and guidance incorporating the thresholds on the obtaining of goods, works and services.

2 Procurement Legislation

2.1 NHS Orkney is required to comply with public procurement legislation to ensure a fair and transparent process is followed. In addition, NHS Orkney is required to comply with the Procurement Reform (Scotland) Act 2014, where any Public Contract of £50,000 or greater and any public works contract over £2m for works.

2.2 To ensure that we meet the requirements of the legislation, Budget Holders and other key stakeholders must involve the Procurement Department as early in the process as possible.

3 Procurement Process

3.1 The Procurement team will support budget holders to complete the appropriate procurement process depending on the level of purchase.

3.2 In the first instance, Procurement will support Budget Holders to utilize an existing framework agreement. This is where a procurement has been undertaken by or on behalf of other public sector bodies to achieve best value.

3.3 Where a suitable contract doesn't exist, the first stage in the process is ensuring that we advertise all opportunities appropriately through the

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Public Contracts Scotland (PCS) Portal. The Procurement team will lead on all requirements for the portal on behalf of NHS Orkney.

3.4 The procurement route to Market is based on the anticipated value of the cost over the expected whole life of the contract. The routes an values are as detailed below:

Purchase/Contract Value	Process
Goods and Services: £3,000 to £49,999 Works: £3,000 to £2,000,000	Minimum 3 quotations to be obtained (via Quick Quote)
Goods and Services: £50,000 to GPA Threshold Works: £2,000,000 to GPA Threshold	Appropriate Advertising and competitive tender through Public Contract Scotland (PCS) Portal
Goods and Services: Over GPA Threshold Works: Over GPA Threshold	

Note: The Government Procurement Agreement (GPA) thresholds are ~~set a~~nd reviewed every two years.

3.5 Where it is decided that competitive tendering is not applicable and should be waived, an SFI waiver must be completed, detailing the reasons and submitted to the Procurement Team for review, with final approval and sign off required by the Director of Finance or Chief Executive.

3.6 Equipment and assets over £5,000 (including VAT) are funded by the Capital Resource Funding and must be approved by the Capital and Strategic Estates Group.

4 Tendering

4.1 All invites to tender on a formal competitive basis must state that no tender will be considered for acceptance unless submitted electronically through Public Contracts Scotland (PCS) Portal

4.2 .For audit purposes all Q&A responses must be directed through the Public Contracts Scotland (PCS) Portal to ensure fairness and transparency. This includes any post-tender clarifications and negotiations.

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4.3 The evaluation process will be led by Procurement and all panel members must adhere to the code of governance regarding declaration of potential conflicts and interests and are required to sign a declaration of interest form.

4.4 All tender outcomes must be awarded through the Public Contracts Scotland (PCS) Portal with notification and feedback letters being issued to the non-successful bidders.

5 Contracts

5.1 NHS Orkney may only enter into contracts within their statutory powers and must comply with:

- SFIs
- National Directives and other statutory provisions
- Any relevant directions including the SCIM and guidance on the use of Management Consultants
- NHS standard contract conditions as are applicable.

5.2 Where specific contract conditions are considered necessary by the lead officer appointed by the Chief Executive or Director of Finance, advice shall be sought from suitably qualified persons. Where this advice is deemed to be legal advice, this must be sought from the Central Legal Office.

5.3 Contracts will be in the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

5.4 In all contracts, members and officials will seek to obtain Best Value. The Chief Executive or Director of Finance will nominate an officer to oversee and manage each contract.

5.5 All contracts will contain standard clauses allowing NHS Orkney to:

- Cancel the contract and recover all losses in full where a company or their representative has offered, given or agreed to give, any inducement to members or officials
- Recover losses or enforce specific performance where goods or services are not delivered in line with contract terms
- Ensure that suitable terms are included to cover arrangements should dispute arise.

5.6 Members and officials must seek authority from the Chief Executive or the Director of Finance in advance of making any commitment to contracts, leases, tenancy agreements, property transactions and other commitments for which a financial liability may result but without secured funding or budget provision.

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5.7 Procurement will maintain a contract's register. All contracts awarded over £50,000 will be published on the Public Contracts Scotland Portal, Contracts register. All contracts must be advised to procurement for inclusion in the contracts register.

5.8 The Director of Finance will ensure that the arrangements for financial control comply with the guidance contained within SCIM and Property Transaction Handbook. The technical audit of these contracts is the responsibility of the Chief Executive.

6 Appointment of Management Consultants

6.1 The bespoke nature of many consultancy services and the degree of interest in the amount of public money spent on this area means that additional procedures are needed for procuring consultancy services to ensure they are used sparingly, effectively and only where their use is unavoidable to deliver business objectives. Scottish Government guidance "Use of Consultancy Procedures (Professional Services)" should be followed when seeking to use consultancy services.

6.2 If it is still not clear, advice should be sought from the procurement or finance department.

6.3 A business case, establishing the need for consultancy services should be completed at the outset and sent to the Director of Finance for consideration. Business cases up to £5,000 (excluding VAT) over the life of the consultancy agreement can be approved by the relevant Executive Director. Business cases in excess of £5,000 (excluding VAT) require Senior Leadership Team approval.

6.4 Appointment of Consultants should in the first instance use National Contracts and, where this is not possible, by competitive tender. The reasons and approval for waiving the requirement to tender should be clearly documented and submitted to the Director of Finance. Procurement SFI Waiver Form

6.5 Successive assignments beyond the scope and terms of an appointment made by competitive tender should also be subject to tender arrangements. If it is expected that there may be follow-on assignments, it would be more appropriate for the tendering exercise to appoint one or more Consultants under a call-off arrangement.

6.6 Professional advisers are defined as having two characteristics. Firstly, they are engaged ~~on~~in work that is an extended arm of the work done in-house and secondly, they provide an independent check. Examples include professional advice on the treatment of VAT and work carried out in relation to ratings revaluations and appeals. Professional advisers' fees may also relate to capital projects such as architects, surveyors, and engineers. Such fees are not exempt from normal tendering arrangements.

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6.7 The Property Transactions Manual states that all external professional advisers, including property advisers, independent valuers and other valuers or consultants, should be appointed by competitive tender unless there are convincing and justifiable reasons to the contrary.

7 Purchase Orders

7.1 Goods, services, or works may only be ordered on an official order. NHS Orkney operates a No PO No Payment policy and suppliers will be notified that they must not accept orders without an official order number.

7.2 In most case purchase orders must be raised using PECOS (the eProcurement system provided by Scottish Government). The Director of Finance will grant approval for no purchase order to be raised where the raising of a purchase order does not add to the control environment. Items currently covered by such approval are:

- Utilities
- Patient and Staff Flights
- Exceptional circumstances which are approved by the Director of Finance or Chief Executive

7.3 Electronic ordering systems shall contain controls to ensure proper segregation of duties in the ordering process. Budget Holders are responsible for the following:

- Ensuring that they advise the appropriate system administrators in the event of staff changes
- Ensuring that they have adequate budget for all items ordered
- Ensuring that purchase orders are appropriately receipted on a timely basis to pay supplier invoices within the Scottish Government target time (currently 10 days)

8 Trials and Lending

8.1 Goods, e.g. medical equipment, must not be taken on trial or loan in circumstances that could commit NHS Orkney to a future uncompetitive purchase. Any requests must come through the Procurement Department for review with an indemnity agreement signed by the Director of Finance.

9 Agencies/Locums

9.1 On the procuring of agency and locum staff, the Head of Services has the autonomy to negotiate a rate of pay within an agreed limit set by the Director of People and Culture and Director of Finance. The Head

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of Services needs to keep within their overall delegated resource limit unless prior approval has been provided from the Director of Finance or Chief Executive Officer.

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16 Stores

1 Stores, defined in terms of controlled stores and departmental stores (for immediate use), should be

- kept to a minimum;
- subject to annual stocktake; and
- valued at the lower of cost and net realisable value.

2 The Chief Executive shall delegate the responsibility for the control of stores to officers throughout the Health Board. For pharmaceutical stocks, the delegation of responsibility must legally always sit with the Director of Pharmacy.

3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

4 The Director of Finance shall approve procedures for stocktaking, and there shall be a physical check covering all items in stock at least once a year

5 Responsibility for security arrangements and the custody of keys for all store's locations will be defined in writing by the designated officer. Wherever practicable stocks shall be marked as NHS property.

6 Where a complete system of stores control is not justified, alternative arrangements will require the approval of the Director of Finance

7 All goods received will be checked as regards quantity and/or weight and inspected as to quality and specifications. A delivery note should, if possible, be obtained from the supplier at the time of delivery and will be signed by the person receiving the goods. Instructions will be issued to staff covering the procedure to be adopted in cases where a delivery note is not available. Details of goods received will be entered on a goods received record or input to the computer system on the day of receipt. Where goods received are unsatisfactory or short on delivery they will be accepted only on authority of the designated officer and the supplier will be notified immediately.

8 The issue of stores will be supported by an authorised requisition. Where a "topping-up" system is used, a record will be maintained in a form approved by the Director of Finance (such a form may be electronic in place of paper). Comparisons will be made of the quantities issued, and explanations recorded of significant variations.

9 Breakages and other losses of goods in stores will be recorded as they occur, and a summary will be approved by the Director of Finance at regular intervals. Tolerance limits will be established for all stores

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subject to unavoidable loss, e.g. shrinkage in the case of certain foodstuffs and natural deterioration of certain goods.

10 Stocktaking arrangements and the basis for valuation will be agreed with the Director of Finance and there will be a physical check covering all items in store at least once a year. The Director of Finance will have the right to attend or be represented. Any surplus or deficiency revealed on stocktaking will be reported immediately to the Director of Finance, and he may investigate as necessary.

11 The designated officer will be responsible for a system approved by the Director of Finance for a review of slow-moving and obsolete items for condemnation, disposal, and replacement of all unserviceable articles. The designated officer will report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice.

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17 Losses and Special Payments

1 Any officer discovering or suspecting a loss of any kind must inform their head of department, who must immediately inform the Fraud Liaison Officer. Where a criminal offence is suspected, the Fraud Policy must be applied. Any case of suspected fraud must be reported to the Counter Fraud Service.

2 The Director of Finance will maintain a losses register in which details of all losses will be recorded as they are known. Write-off action will be recorded against each entry in the register.

3 Losses are classified according to the Annual Accounts Manual.

4 The Chief Executive, acting together with the Director of Finance, or any nominated deputy, can approve the writing off of losses within limits delegated by Scottish Government in SPFM.

5 The exercise of powers of delegation in respect of losses and special payments will be regularly reported to the Audit and Risk Committee.

6 The Board will approve any losses and special payments when adopting the Annual Accounts.

7 Special payments exceeding the delegated limits laid down must have prior approval of the Scottish Government.

8 The Director of Finance is authorised to take any necessary steps to safeguard the interests of NHS Orkney in bankruptcies and company liquidations.

9 All articles surplus to requirements or unserviceable will be condemned or otherwise disposed of by an officer authorised by the Director of Finance. The condemning officer will satisfy themself as to whether there is evidence of negligence and will report any evidence to the Chief Executive, who will take the appropriate action.

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18 Endowment Funds

These SFIs apply equally to the Endowment Fund of NHS Orkney with the additional control that expenditure from Endowment Funds is restricted to the purposes of the Fund and made only with the approval of the Trustees. Guidance for Endowments administration and expenditure of funds will be issued separately as the Endowments Charter. A Treasurer will be appointed to the fund.

1 Trustees

1.1 All Members of Orkney NHS Board, appointed by Scottish Ministers, are ***"ex officiis"*** Trustees of the Endowment Fund. The Trustees have specific responsibilities including those described in Section 66 of the Charities and Trustee Investment (Scotland) Act 2005 (the 2005 Charities Act):

- To seek, in good faith, to ensure that the charity acts in a manner which is consistent with its purpose
- To act in the interests of the charity above all other things, including their own interests and the interests of the Board or any other organisation
- To act with the care and diligence that it is reasonable to expect of a person who is managing the affairs of another person.

Transactions entered into by Trustees, which although legal but outwith the charity's objectives and thus deemed to be 'ultra vires', could lead to the trustees being personally liable for any loss incurred by the Endowment Fund.

1.2 Under the 2005 Charities Act, the Trustees have a responsibility to:

- Control and manage the finances of the Endowment Fund, ensuring proper accounts are kept as required by statute, regulations and reported in a form prescribed as best practice in the Statement of Recommended Practice (SORP)
- Approve the annual statement of accounts and authorise one of their members to sign the accounts
- Provide on request an up to date annual report and set of accounts in a form consistent with requirements of the Act
- Control the investment policy and monitor the performance of the investments within that policy on a regular basis
- Submit annual returns to the Office of the Scottish Charity Regulator (OSCR).

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2 Endowments Sub-committee

2.1 Trustees may appoint an Endowment Fund sub-committee to provide advice to Trustees in the exercise of their responsibilities.

3 Accounting

3.1 The Treasurer will ensure that annual accounts are:

- Prepared as soon as possible after the year end
- In accordance with the SORP
- Based on records as are necessary to record and protect all transactions on behalf of the Trustees
- Subject to audit by a properly appointed External Auditor.

3.2 All gifts, donations and proceeds of fund-raising activities which are intended for Endowment Funds must be handed immediately to the Cashier, to be banked directly into the Endowment Fund.

4 Sources of New Funds

4.1 All gifts accepted will be received and held in the name of Trustees and administered in accordance with the Endowments Charter, subject to the terms of specific Funds. NHS Orkney can accept gifts only for purposes relating to the advancement of health and staff wellbeing. Officers should, in cases of doubt, consult the Director of Finance before accepting a gift.

4.2 In respect of donations, the Director of Finance will:

- Provide guidance to officers as to how to proceed when offered funds, including clarification of the donor's intentions and, where possible, the avoidance of new complex restrictions that cannot sensibly be met (in particular for specific items of equipment, brands or suppliers)
- Provide a notification of donation process which will ensure that funds have been accepted directly into the Endowment Fund and that the donor's intentions have been noted and accepted.

4.3 The Director of Finance should be kept informed of all enquiries regarding legacies and will keep an appropriate record. After the death of a testator all correspondence concerning a legacy will be dealt with by the Director of Finance. The Director of Finance will:

- Provide guidance regarding the wording of wills, and the receipt of funds/other assets from executors
- Obtain Confirmation of Estate, where the Board is the beneficiary

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- Negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty
- Take legal advice, as necessary.

4.4 In respect of Fund-raising, the Director of Finance will:

- Advise the Trustees on the financial implications of any proposal for fund raising activities based on the guidance contained in MEL (2000)13
- Give approval for fund-raising based on direction of the Trustees
- Be responsible, after taking legal advice as necessary, for alerting the Trustees to any irregularities regarding the use of the Board's name or its registration numbers.

4.5 In respect of investment income, the Director of Finance will be responsible for the appropriate treatment of all dividends, interest, and other receipts from this source.

5 Investment Management

5.1 Investment policy will be determined by the Trustees, considering advice received from the Director of Finance and the investment advisers. Where the Board has delegated authority to its investment advisers to manage funds on its behalf they will be bound by any conditions imposed by the Board or its officers with regard to investment policy. All share and stock certificates and property deeds will be deposited with the investment managers.

6 Expenditure

6.1 The over-riding objective of the Endowment Fund is to support the advancement of health. All expenditure from the fund must conform to this objective. The fund must not be used to subsidise the normal running expenses of NHS Orkney or for expenditure otherwise not admissible under these SFIs.

Subject to the foregoing, expenditure is governed by the Orkney Health Board Endowment Charter.

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19 Primary Care Contractors

1 The Practitioner Services Division (PSD) of the NHS National Services Scotland (NSS) is the payment agency for all Family Health Service (FHS) contractor payments:

- General Medical Services
- Prescribing/dispensing
- FHS Non-cash Limited.

2 The Head of Primary Care Services will:

- Ensure that systems are in place to deal with applications, resignations, and inspection of premises, within the appropriate contractor's terms and conditions of service
- Approve additions to, and deletions from, approved lists of contractors, considering the health needs of the local population, and the access to existing services
- Deal with all applications and resignations equitably, within time limits laid down in the contractors' terms and conditions
- Ensure that lists of all contractors, for which NHS Orkney is responsible, are maintained and kept up to date.

3 The Director of Finance will monitor the Service Level Agreement with PSD covering validation, payment, monitoring and reporting and the provision of an audit service by the NSS internal auditors. Through this process, the Director of Finance will seek evidence that NSS systems provide assurance that:

- Only contractors who are included on the Board's approved lists receive payments
- All valid contractors' claims are paid correctly, and are supported by the appropriate documentation and authorisation
- Regular independent post payment verification of claims is undertaken to confirm that:
  - rules have been correctly and consistently applied
  - overpayments are prevented wherever possible
  - if overpayments are detected, recovery measures are initiated
  - fraud is detected and instances of actual and potential fraud are followed up as per the Fraud Policy.
- Exceptionally high/low payments are brought to their attention
- Payments made on behalf of the Board by the NSS are pre-authorised.

4 The Director of Finance will ensure that:

- Payments made by NSS are reconciled with the cash draw-down reported by the Scottish Government to Health Boards.

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5 Payments made to all Primary Care independent contractors and community pharmacists will comply with their appropriate contractor regulations.

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20 Health and Social Care Integration

1 Integration

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 established the framework for the integration of community adult health and social care services in Scotland. A single Integration Joint Board (IJB) has been established in Orkney. The approved Integration Scheme sets out the detail of the integration arrangement, including those functions delegated by NHS Orkney to the IJB.

1.2 Each partner will agree the formal budget setting timelines and reporting periods as defined in the Orkney Integration Scheme and supporting Financial Regulations:

- An initial schedule of payments will be agreed within the first 40 working days of each new financial year and may be updated.
- The format and frequency of reports will be agreed by the Chief Officer, Chief Finance Officer of the IJB in conjunction with the NHS Orkney Director of Finance and Orkney Islands Council (OIC) Section 95 Officer.

1.3 Annually, the NHS Board will evaluate the case for the integrated budget against its other priorities and will agree its contributions accordingly. The business case put forward by the IJB will be evidenced based and will detail assumptions made.

1.4 Following on from the budget process, the IJB Chief Officer and Chief Finance Officer will prepare a financial plan supporting the Strategic Plan and once approved by the IJB, will issue Directions with defined payment levels to NHS Orkney. 'Payment' does not mean an actual cash transaction but a representative allocation for the delivery of integrated functions in accordance with the Plan.

1.5 If at the outset NHS Orkney does not believe the Direction can be achieved for the payment being offered then it will notify the IJB that in line with s 28 (4) of the Public Bodies (Joint Working) (Scotland) Act 2014 additional funding is necessary to comply with the Direction.

1.6 Once the payments to be made by the IJB to NHS Orkney for the delegated functions have been agreed they will form the basis of annual budgets to be issued to budget holders. Payments for the set aside budgets will be issued to the relevant NHS budget holder

1.7 Where the Chief Officer is the budget holder they will comply with these SFIs. In further delegating budgetary authority to managers in their

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structure the Chief Officer is responsible for ensuring all transactions processed by the NHS comply with these SFIs and any further detailed procedural guidance relevant to the transaction.

1.8 The Chief Officer may have a structure including joint management posts with responsibility for both health and council expenditure.

1.9 Where a manager has delegated authority for both health and council expenditure they must ensure the VAT treatment is in line with Integrated Resource Advisory Group and HMRC guidance. If in doubt they should seek advice from the Director of Finance for any expenditure from NHS budgets.

1.10 A council employee who has been given delegated authority for NHS budgets will sign a declaration that they have received and will comply with these SFIs. This should also be signed by the Chief Officer, who will pursue any breaches of the SFIs through the council line management structure if required.

1.11 The IJB Financial Regulations state that the Chief Officer is not permitted to vire between the Integrated Budget and those budgets managed by the Chief Officer, but which are outside of the scope of the strategic plan, unless agreed by those bodies. Internal virements require approval: up to £100,000 by the Chief Officer and Chief Finance Officer; over £100,000 by the IJB. Further requirements for the virement of budgets within NHS Orkney are specified in detailed guidance issued by the Director of Finance.

1.12 Notwithstanding that a budget virement lies within the Chief Officer's level of authority it can only be executed if detailed consideration of the financial impact indicates that any risks associated with it are acceptable. If there is a difference of opinion between the Chief Officer and NHS Director of Finance as to the acceptability of the risk, the Chief Officer and Director of Finance will seek to reach an acceptable solution. Failing that the Chief Executive will consider the level of risk, involving the Senior Leadership Team if necessary. Should there still not be agreement the IJB would be invited to set out how it would mitigate the stated risk.

1.13 Where there is a projected overspend against an element of the Integrated Budget, the Chief Officer, the Chief Finance Officer of the IJB and the relevant finance officer and operational manager of NHS Orkney must agree a recovery plan to balance the overspend.

1.14 Underspends on the NHS element of the Integrated Budget should be returned to the IJB and carried forward through the reserves. This will require adjustments to the allocations from the IJB to NHS Orkney for the amount of the underspend.

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1.15 The Director of Finance is responsible for providing the Chief Officer (as with all budget holders) with regular financial information to allow them to manage their budgets. The Director of Finance is also responsible for providing the Chief Finance Officer of the IJB with the financial information required by the integration scheme and expanded by subsequent agreements, to meet the reporting requirement of the IJB. In advance of each year a timetable will be agreed with the IJB.

1.16 The IJB Chief Finance Officer will be responsible for the preparation of the annual financial statements as required by s39 of the Public Bodies (Joint Working) (Scotland) Act 2014 and the statutory annual accounts. Recording of financial information in respect of the IJB will be processed via the OIC ledger (though this will be reviewed in time). The Director of Finance will ensure information is supplied from the NHS as required to fulfil these obligations.

1.17 Year-end balances and transactions will be agreed timeously in order to allow completion of the Accounts in line with required timescales. This date will be agreed annually by the IJB, NHS Orkney and OIC.

1.18 Detailed Financial Regulations governing the Integration Joint Board are in place, agreed between OIC and NHS Orkney and approved by the IJB. The Director of Finance will be responsible for ensuring NHS obligations are fulfilled.

1.19 Although the Public Bodies (Joint Working) (Scotland) Act 2014 supersedes most of the previous joint working arrangements, it remains possible that there could be pooled or aligned budgets with community partners, such as for children's services, that fall outwith that. The previous standing financial instruction provisions relating to this have therefore been retained in case they should be required.

2 Aligned and Pooled Budgets

2.1 NHS Scotland organisations and Scottish Local Authorities have a statutory duty to co-operate to provide improved Community Care Services. The Community Care and Health (Scotland) Act 2002 and the Community Care (Joint Working etc.) Regulations 2002 increased the flexibility available to both organisations to improve outcomes for people using these services, together with their carers. Scottish Ministers also have power to direct NHS and LA organisations to enter into joint working arrangements, where existing performance is unsatisfactory. The Regulations specify the social care, health and housing functions covered by these enabling and intervention powers.

2.2 Part 2 of the Act enables payments to be made between NHS and LA organisations in connection with relevant functions, both Capital and Revenue, in order to move resources to deliver joint objectives. The Act provides a framework within which NHS and LA may delegate functions and pool budgets, where the host partner is best placed to manage the

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day-to-day operation of a joint service. The existing responsibility and accountability of each partner for the exercise of the function remains. A Local Partnership must develop a governance framework for any service and activity delegated. The host partner is required to account for the use of the pooled resources and service performance to both partners. Jointly managed services will be managed using either aligned or pooled budgets.

2.3 Aligned Budgets are where clearly identified financial resources are contributed by each partner into a joint "pot", but the funds remain held within each partner organisation in separate and distinct budgets. This enables each partner organisation to identify and account for their contribution to the joint "pot".

2.4 Pooled budgets are where each partner contributes agreed resources to a discrete fund, which is managed as a single budget, by a separate discrete body. This body is not a separate legal entity, and for legal reasons must be linked to one of the statutory authorities, which becomes the "host" partner. The partners must agree the purpose, scope and outcomes for services within the agreement, meeting their own statutory obligations and justifying their contribution to the fund.

2.5 Partnership arrangements entered into by NHS Orkney must comply with guidance issued by Scottish Government.

2.6 A Local Partnership Agreement must be drawn up between the partner organisations. This will specify the services to be managed jointly, joint arrangements for management structures, governance and accountability, budgetary control, financial reporting and monitoring. Each organisation's Chief Officer must approve the Local Partnership Agreement which must be ratified by both organisations.

2.7 Each partner will agree the level of its contribution in advance of each financial year. Levels of contribution will take account of inflation, new developments, service pressures, capital charges and savings targets.

2.8 The Joint Management Team, as defined in the Local Partnership Agreement will have delegated authority to develop jointly managed services, through the Local Partnership Agreement. Joint Service Manager posts will be employed by one or the partners, who will be responsible for the risks and liabilities associated with that.

2.9 Each Joint Services Manager will have delegated authority for the management of budgetary resources from each partner. There will be clearly defined roles and responsibilities for the achievement of financial and service performance targets. For the management of resources and activities associated with NHS Orkney's contribution, the NHS Orkney Code of Corporate Governance will be complied with. For the management of resources and activities associated with OIC's contribution to the jointly managed services, the OIC Financial

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Regulations and Contract Regulations will be complied with. Any instructions or guidance produced by the NHS Director of Finance and OIC Section 95 Officer will be complied with if it is to be applied to the appropriate budget/resources.

2.10 Where a separate body is created to manage pooled budgets, the lead officer of the partnership body will issue Financial Regulations and Standing Financial Instructions/Code of Corporate Governance, in accordance with directions issued by the Scottish Government, and agreed by the partner authorities. Such regulations and instructions will specify the arrangements for the provision of financial and service performance information to the partner authorities who remain responsible and accountable for their contribution.

2.11 The NHS Orkney Chief Executive and the OIC Section 95 Officer remain accountable to Scottish Government for the financial contribution made by their organisation.

2.12 Jointly managed services will be subject to both financial and value for money audit by both internal audit and the appointed auditors. Annual statements will be prepared for inclusion in both partners' Annual Accounts, complying with all appropriate accounting standards and Scottish Government requirements. Each partner's Director of Finance will be equally responsible for ensuring that all relevant financial information is made available to the other partner as appropriate.

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21 Patients' Property

1 Responsibility

1.1 NHS Orkney has a responsibility (NHS Circular 1976 (GEN) 68) to provide safe custody, for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. NHS Orkney will not exercise the power to manage patients' finances under the Adults with Incapacity Scotland Act 2000), this responsibility will lie with Social Services.

1.2 Patients or their guardians, as appropriate, will be informed before or at their admission that NHS Orkney will not accept responsibility or liability for patients' property unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt. This information will be provided through:

- Notices and booklets
- Admission documentation and property records
- Advice of staff responsible for admissions.

1.3 The Director of Finance will provide written instructions on the collection, custody, recording, safekeeping and disposal of patients' property (including instructions on the disposal of the property of deceased patients and patients transferred to other premises) for all staff whose duty it is to administer the property of the patients.

1.4 Bank accounts for patients' monies will be operated under arrangements agreed by the Director of Finance.

1.5 A patient's property record, in a form determined by the Director of Finance, will be completed by a member of staff in the presence of a second member of staff and the patient or personal representative where practicable. It will be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity, when it could be signed by the patient representative on their behalf. Any alterations will be validated by the same signatory process as required for the original entry.

1.6 The Director of Finance will prepare an abstract of receipts and payments of patients' private funds in the form laid down in the Manual for Accounts. The abstract will be audited independently and presented to the Audit and Risk Committee, together with a report from the auditor.

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1.7 Property which has been handed in for safe custody will be returned to the patient, as required, by the officer who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate, and witnessed by another member of staff.

1.8 The disposal of property of deceased patients is governed by GEN (1992) 33, which should be read as part of the SFIs.

1.9 All property including cash, watches, jewellery, clothing, bank books, insurance policies and all other documents which the patient had in their possession in the hospital, should, as soon as practicable after their death, be collected together, identified as being their belongings and kept in safe custody until disposal.

1.10 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

2 Patient Died Intestate and Without Next of Kin

2.1 If the patient was of Scottish domicile, died intestate and without next of kin, the estate will pass to the Crown and is dealt with by the Crown Office, Regent Road, Edinburgh. The particulars of each case should be notified separately and promptly to the Crown Office. The particulars should include the last known address of the patient.

2.2 The law governing the succession to the estate of patients dying intestate and without next of kin, who were not of Scottish domicile, varies according to the country. Details should be reported to the Crown Office for investigation. All property and documents should be retained until instructions are received from the Crown Office.

3 Patient Died Intestate but Next of Kin / Beneficiaries Identified

3.1 Those items of the estate in the possession of NHS Orkney should be handed over only to the executor or executors named in the document known as the “Confirmation of the Estate”. The document should be inspected before the items are handed over. The executor ***may*** be the next of kin but need not necessarily be so. Where the total amount of the deceased’s estate is not more than £25,000, there is provision for the Confirmation document to be obtained by an expedited procedure, but nevertheless a Confirmation should still be obtained. A Confirmation of Estate document can be obtained by the executor or the next of kin from any sheriff clerk for a small fee. A signed Receipt for all the items of estate delivered to the executor should be in the form shown as Appendix B to GEN (1992) 33.

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3.2 If the next of kin decides not to obtain a Confirmation, because for example, the value of the estate is too small, if possible all items of the estate should be handed over in exchange for a signed Receipt in the form shown as Appendix C of GEN (1992) 33. Staff ***must*** ensure that all the items handed over are listed on the receipt.

3.3 No payments should be made to anyone out of the estate funds other than the executor or the next of kin, as appropriate, but when handing over the items of estate, staff should provide them with known details of any sums owing and the names and addresses of creditors.

3.4 Where items are handed over to a beneficiary, the form of receipt should be as shown on Appendix D of GEN (1992) 33.

4 Cost of Burial or Cremation

4.1 NHS Orkney should not assume responsibility for arranging a burial or cremation. Section 50(i) of the National Assistance Act 1948 places a duty on Councils to arrange for the burial or cremation of the body of a deceased person where no suitable arrangements for the disposal of the body have been made or are being made. The local authority should be informed immediately, in writing, so that they can make the arrangements.

4.2 The local authority can seek to be reimbursed from the deceased's estate for the expenses incurred. Where the Crown Office has an interest, the local authority should be referred to them for payment.

4.3 Where NHS Orkney cannot trace the named executor, or any beneficiary, it may be convenient for NHS Orkney to hand over to the local authority as much of the patient's property in its possession as is sufficient to cover the burial or cremation expenses. NHS Orkney must not hand over property which is worth more than the expenses incurred, and must retain the balance for claiming by next of kin, beneficiary or named executor.

4.4 An itemised statement of the total expenses payable must be obtained from the local authority, and a receipt obtained in the form of Appendix E to GEN (1992)33.

4.5 In accordance with GEN (1992)33, NHS Orkney, to save parents the additional distress of arranging for the funeral of a baby still-born in hospital, or in the community, may offer to arrange and pay for the funeral on their behalf.

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22 Audit

1 Audit and Risk Committee

1.1 The Board will establish an Audit and Risk Committee, with clearly defined terms of reference, which follows guidance contained in the Scottish Government Audit and Assurance Committee Handbook. The Audit and Risk Committee will consider:

- The strategic process for risk, control and governance and the Governance Statement
- The effectiveness of the internal control environment
- Assurances relating to the corporate governance requirements for NHS Orkney
- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors
- The planned activity and results of both internal and external audit
- The adequacy of management response to issues identified by audit activity, including external audit's management letter / report
- Proposals for tendering for internal audit services
- Anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

1.2 Where the Audit and Risk Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or other important matters that the Committee wish to raise, the Chair of the Audit and Risk Committee should refer the matter to a full meeting of the Board. Exceptionally, the matter may need to be referred to the Scottish Government.

1.3 It is the responsibility of the Audit and Risk Committee to regularly review the operational effectiveness of the internal audit service and to recommend approval of the appointment of outsourced internal auditors following the required procurement process following the required procurement process.

1.4 The Audit and Risk Committee provides a forum through which Non-Executive Board Members can secure an independent view of activity within the appointed auditor's remit. The Audit and Risk Committee has a responsibility to ensure that the Board receives a cost-effective service and that co-operation with senior managers and Internal Audit is appropriate.

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2 Director of Finance

2.1 The Director of Finance is responsible for ensuring that:

- There are arrangements to review, evaluate and report on the effectiveness of internal control including the establishment of an effective internal audit function
- Internal Audit is adequate and meets the NHS mandatory audit standards
- The Chief Internal Auditor prepares the following for approval by the Audit and Risk Committee:
  - Strategic audit plan
  - A detailed operational plan for the coming year.

The decision at what stage to involve the police in cases of fraud, misappropriation, and other irregularities has been delegated to the Fraud Liaison Officer.

2.2 The Director of Finance will ensure that an annual internal audit report is prepared by the Chief Internal Auditor, in accordance with the timetable laid down by the Audit and Risk Committee, for consideration by the Audit and Risk Committee. The report must cover:

- A clear statement on the effectiveness of internal control
- Major internal control weakness discovered
- Progress on the implementation of internal audit recommendations
- Progress against plan for the year.

2.3 The Director of Finance and designated auditors are entitled without necessarily giving prior notice to require and receive:

- Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature
- Access at all reasonable times to any land, premises or employee of each organisation
- The production of any cash, stores or other property under an employee's control
- Explanations concerning any matter under investigation.

3 Internal Audit

3.1 Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve NHS Orkney's operations. It helps NHS Orkney accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

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A professional, independent and objective internal audit service is one of the key elements of good governance, as recognised throughout the UK public sector. The Public Sector Internal Audit Standards (PSIAS) set out the framework for Internal Audit services. The Chief Internal Auditor will lead the Board's internal audit function.

The Chief Internal Auditor will ensure that the internal audit function operates in accordance with PSIAS, and will provide assurance, at least annually, to the Audit and Risk Committee that this is being achieved.

3.2 **Internal Audit Activity**

Internal Audit must assess and make appropriate recommendations for improving governance process in its accomplishment of the following objectives:

- Promoting appropriate ethics and values within the organisation
- Ensuring effective organisational performance management and accountability
- Communicating risk and control information to appropriate areas of the organisation
- Coordinating the activities of and communicating information among the board, external and internal auditors and management.

Internal audit must assess whether the information technology governance supports the organisation's strategies and objectives.

Internal audit must evaluate risk exposures relating to the organisation's governance, operations and information systems regarding the:

- Achievement of strategic objectives
- Reliability and integrity of financial and operational information
- Effectiveness and efficiency of operations and programmes
- Safeguarding of assets
- Compliance with laws, regulations, policies, procedures and contracts.

The Chief Internal Auditor will prepare a risk-based Strategic Internal Audit Plan and an Internal Audit Charter for consideration and approval by the Audit and Risk Committee before the start of the audit year.

The Chief Internal Auditor will issue a draft terms of reference for consideration by the lead executive (Audit Sponsor) and the relevant operational staff for the area under review (key contacts) before each audit. These will set out the scope, objectives, resources and timescales for the audit. The Chief Internal Auditor will give the sponsor and key contacts adequate time to consider and respond to the draft terms of reference before it is finalised. The Chief Internal Auditor will issue the final terms of reference before the start of the audit fieldwork.

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The Chief Internal Auditor will issue the draft report for an audit to the audit sponsor, and the audit sponsor will have two weeks to provide a response. The sponsor, or their or her representative, should respond either in writing or during a close-out meeting with Internal Audit.

Management are responsible for ensuring that appropriate internal control systems exist within their own area (or parts thereof), and for deciding whether or not to accept and implement internal audit findings and recommendations. Where internal audit recommendations are not accepted, the audit sponsor must provide a comprehensive explanation to the Audit and Risk Committee, normally as part of the management response within the associated internal audit report.

The Chief Internal Auditor will prepare an Annual Internal Audit Report, in line with PSIAS and any relevant Scottish Government directions, and present it to the Audit and Risk Committee to inform its review of the draft Governance Statement.

Internal audit activity must evaluate the potential for the occurrence of fraud and how the organisation manages fraud risk.

The Audit and Risk Committee will normally invite the Chief Internal Auditor to attend Audit and Risk Committee meetings. The Chief Internal Auditor will have direct access to all Audit and Risk Committee members, the Chairperson, the Board and the Chief Executive. The Chief Internal Auditor has the right to meet in private with any of these individuals.

3.3 While maintaining independence, the Chief Internal Auditor is accountable to the Director of Finance. Reporting and follow-up systems for internal audit will be agreed between the Director of Finance, the Audit and Risk Committee and the Chief Internal Auditor. The agreement will be in writing and will comply with guidance on reporting contained in the PSIAS. The reporting system will be reviewed at least every 3 years.

4 External Audit

4.1 The External Auditor is concerned with providing an independent assurance of NHS Orkney's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. Responsibility for securing the audit of NHS Orkney rests with Audit Scotland. The appointed External Auditor's statutory duties are contained in the PFA Act 2000.

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4.2 The External Auditor has a general duty to satisfy themself that:

- NHS Orkney's accounts have been properly prepared in accordance with directions given under the PFA Act 2000
- Proper accounting practices have been observed in the preparation of the accounts
- NHS Orkney has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources.

4.3 In addition to these responsibilities, Audit Scotland's Code of Audit Practice requires the External Auditor to provide an opinion on whether the statement of accounts presents a true and fair view of the financial position of the organisation, and on the regularity of transactions.

The External Auditor will also review and report on:

- Other information published with the financial statements.
- Corporate governance arrangements including arrangements in place for the prevention and detection of fraud and corruption
- The financial position
- Arrangements to achieve Best Value
- Arrangements to manage performance.

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23 Information and Management Technology

1 The Chief Executive as the Senior Information Responsible Officer (SIRO) is responsible for the accuracy and security of the financial data of NHS Orkney.

2 The Chief Executive will devise and implement procedures to protect the Board and individuals from inappropriate use or misuse of any financial or other information held on computer files for which he has responsibility and will take account of the provisions of the Data Protection Act 2018 (legislation.gov.uk) .

3 The Chief Executive will satisfy themself that computer audit checks and reviews are being carried out.

4 The Director of Finance will ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by an organisation out with NHS Orkney, assurances of adequacy will be obtained from them prior to implementation.

5 The Chief Executive will ensure that contracts or agreements for computer services for financial applications with NHS Boards or any other agency will clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing and storage. The contract or agreement will also ensure rights of access for audit purposes.

6 Where NHS Orkney or any other agency provides a computer service for financial applications, the Director of Finance will periodically seek assurances that adequate controls are in operation.

7 Where computer systems have an impact on corporate financial systems the Director of Finance will ensure that:

- Systems acquisition, development and maintenance are in line with corporate policies and strategies such as the IT/eHealth/ Digital Strategy
- Data produced for use with financial systems is adequate, accurate, complete and timely, and that an audit trail exists
- Finance staff have access to such data.

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24 Fixed Assets

1 The Chief Executive will ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal on the Financial Plan for NHS Orkney.

2 The Director of Finance will ensure that every capital expenditure proposal meets the following criteria:

- Potential benefits have been evaluated and compared with known costs
- Potential purchasing authorities should be able and (as far as can be ascertained) willing to meet cost consequences of the development as reflected in prices
- Complies with guidance in the Capital Investment Manual.

3 Consideration should be given to the use of Private Finance, Non-Profit Distribution or Leases where appropriate.

4 NHS Orkney will maintain a system for assessing how leases or Private Finance Initiative / Public Private Partnership / Non-Profit Distributing contracts should be accounted for as in accordance with relevant accounting standards and any other relevant guidance and advice received.

5 For large capital schemes a system will be established for managing the scheme and authorising necessary payments up to completion (Section 11-Payment of accounts). Provision will be made for regular reporting of actual expenditure against authorised capital budgets.

6 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to original documents and invoices (where appropriate). Where land and property is disposed of, the Property Transactions Handbook must be followed.

7 There is a requirement to achieve Best Value when disposing of assets. Competitive tendering should be undertaken in line with the tendering procedure (Section 15 – non-pay expenditure procurement).

8 Competitive tendering or quotation procedures will not apply to the disposal of:

- Any matter where a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or nominated officer
- Obsolete or condemned articles and stores, which may be disposed of in accordance with the losses policy
- Items with an estimated sale value of less than £1,000

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- Items arising from works of construction, demolition, or site clearance, which should be dealt with in accordance with the relevant contract
- Land or buildings concerning which Scottish Government guidance has been issued.

9 Managers must ensure that:

- The Director of Finance is consulted prior to disposal
- All assets are be disposed of in accordance with MEL(1996)7 'Sale of surplus and obsolete goods and equipment'
- All proceeds are notified to the Director of Finance.

10 The overall control of fixed assets is the responsibility of the Chief Executive.

11 NHS Orkney will maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by Scottish Government.

12 Registers will be maintained by the nominated officer for:

- Donated equipment
- Equipment on loan
- Leased Equipment
- Other leases
- Non-Profit Distributing contracts
- Contents of furnished lettings.

13 The Director of Finance will approve fixed asset control procedures. These procedures will make provision for:

- Recording managerial responsibility for each asset
- Identification of additions, disposals, and transfers between departments
- Identification of all repair and maintenance expenses
- Physical security of assets
- Periodic verification of the existence of, condition of, and title to assets recorded
- Identification and reporting of all costs associated with the retention of an asset.

14 Additions to fixed asset registers must be clearly attributed to an appropriate asset holder and be validated by reference to:

- Properly authorised and approved agreements, architect's certificates, suppliers' invoices, and other documentary evidence in respect of purchases from third parties

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- Stores requisitions for own materials and wages records for labour including appropriate overheads
- Lease agreements in respect of assets held under a lease and capitalised.

15 The Director of Finance will approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

16 All discrepancies revealed by verification of physical assets to the fixed asset register will be notified in writing to the Director of Finance.

17 The value of each asset will be indexed to current values in accordance with methods specified by Scottish Government.

18 The value of each asset will be depreciated using methods and rates as specified by Scottish Government.

19 Capital charges will be calculated as specified in the Capital Accounting Manual.

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25 Management, Retention and Disposal of Administration Records

1 NHS Orkney must comply with the national guidance on record keeping as outlined in:

- Public Records (Scotland) Act 2011
- Records management guidance set out in the Code of Practice on Records Management issued under Section 61(6) of the Freedom of Information (Scotland) Act 2002
- Scottish Government Records Management
- NHSS BCS Retention Schedule which incorporates NHS (2006) 28, and provides guidance on the retention and disposal of administrative records.

2 The Board has a Records Management Plan which is the overarching framework ensuring NHS Orkney records are managed and controlled effectively. This includes the Records Management Policy and supporting policies and procedures. This can be accessed on the website. https://www.ohb.scot.nhs.uk/public-records-scotland-act

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26 Risk Management and Insurance

1 The Medical Director will ensure that NHS Orkney has a programme of risk management which is approved and monitored by the Board and its committees.

The programme of risk management will include:

- A process for identifying and quantifying risks
- Engendering among all staff a positive attitude to the control of risk
- A programme of risk awareness training
- Management processes to ensure that all significant risks are addressed, including effective systems of internal control, and decisions on the acceptable level of retained risk
- All significant risks and action taken to manage the risks will be reported to the Board and its committees
- The maintenance of an organisation-wide risk register Contingency plans to offset the impact of adverse events
- Audit arrangements, including internal audit, clinical audit, health and safety review
- Arrangements to review the risk management programme.

2 The existence, integration and evaluation of the above elements will provide a basis for the Audit and Risk Committee to make a statement to the Board on the effectiveness of risk management in NHS Orkney.

3 In the case of Partnership Working with other agencies, the NHS Orkney risk management framework will be shared to identify and quantify the individual risks, particularly where responsibility cannot be assigned to an individual partner. Each partners' risk management and insurance arrangements will be taken into account when identifying and quantifying risks associated with the provision of jointly managed services and associated with the delegation of the management of a partner's financial resources. Where conflicts occur between these sets of arrangements each partner's Director of Finance will be required to agree a course of action to resolve the conflict.

4 The Director of Finance will ensure that insurance arrangements exist in accordance with the risk management programme.

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27 Financial Irregularities

This section should be read in conjunction with the NHS Orkney Fraud Policy contained within the Code of Corporate Governance.

1 Guidance

1.1 Guidance on the approach to various forms of financial irregularities is contained in https://www.sehd.scot.nhs.uk/mels/HDL2005_05.pdf, which draws a clear distinction between treatment of suspected (a) theft and (b) fraud, embezzlement, corruption, and other financial irregularities (hereafter referred to as “fraud, etc”). This procedure also applies to any non-public funds.

2 Theft, Fraud, Embezzlement, Corruption and Other Financial Irregularities

2.1 The Chief Executive will designate an officer within the Board with specific responsibility for co-ordinating action where there are reasonable grounds for believing that an item of property, including cash, has been stolen – the Fraud Liaison Officer.

2.2 It is the Fraud Liaison Officer’s responsibility to inform as they deem appropriate, the Police, the Counter Fraud Services (CFS), the appropriate Director, the External Auditor, and the Chief Internal Auditor that such an occurrence is suspected.

2.3 Where any officer of the Board has grounds to suspect that any of the above activities has occurred, their line manager should be notified without delay. Line managers should in turn immediately notify the Fraud Liaison Officer, who should ensure consultation with the CFS, and the Chief Internal Auditor. It is essential that preliminary enquiries are carried out in strict confidence and with as much speed as possible.

2.4 If, in exceptional circumstances, the Fraud Liaison Officer and the Chief Internal Auditor are unavailable, the line manager will report the circumstances to the Chief Executive who will be responsible for informing the CFS. As soon as possible thereafter, the Fraud Liaison Officer should be advised of the situation.

2.5 Where preliminary investigations suggest that *prima facie* grounds exist for believing that a criminal offence has been committed, the CFS will undertake the investigation, on behalf of, and in co-operation with NHS Orkney. At all stages, the Director of Finance and the Chief Internal Auditor will be kept informed of developments on such cases. All referrals to the CFS must also be copied to the External Auditor.

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2.6 Any additions and suspicions of fraud, including those dismissed, will be promptly reported to the Audit and Risk Committee on a regular basis.

3 Remedial Action

3.1 As with all categories of loss, once the circumstances of a case are known, the Director of Finance will require to take immediate steps to ensure that so far as possible these do not recur. However, no such action will be taken if it would prove prejudicial to the effective prosecution of the case. It will be necessary to identify any defects in the control systems, which may have enabled the initial loss to occur, and to decide on any measures to prevent recurrence.

4 Reporting to Scottish Government

4.1 While normally there is no requirement to report individual cases to the Scottish Government there may be occasions where the nature or scale of the alleged offence or the position of the person or persons involved, could give rise to national or local controversy and publicity.

4.2 Moreover, there may be cases where the alleged fraud appears to have been particularly ingenious or where it concerns an organisation with which other health sector bodies may also have dealings. In such cases, the Scottish Government must be notified of the main circumstances of the case at the same time as the CFS.

5 Responses to Press Enquiries

5.1 Where the publicity surrounding a particular case of alleged financial irregularity attracts enquiries from the press or other media, the Chief Executive should ensure that the relevant officials are fully aware of the importance of avoiding issuing any statements, which may be regarded as prejudicial to the outcome of criminal proceedings.

5.2 The Scottish Government should also be advised of any unusual or significant incidents involving patients or endowment funds.

6 List of Financial Crime Offences

6.1 There are numerous types of financial crime that can be perpetrated, and some examples are given below:

- **Dishonest action by staff to obtain a benefit** for example working whilst on sick leave, false expenses, false overtime, embezzlement of cash or goods and procurement fraud
- **Account fraud** for example fraudulent transfer to employee account, fraudulent account transfer to third party account and fraudulent account withdrawal

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- **Employment application fraud** for example false qualifications, false references or use of false identity
- **Unlawfully obtaining or disclosure of personal data** for example fraudulent use of customer/payroll data, modification of customer payment instructions and contravention of IT security policy with intent to facilitate the commission of a criminal offence
- **Unlawfully obtaining or disclosure of commercial data** for example contravention of IT security policy with intent to facilitate the commission of a criminal offence
- **Other irregularities** for example involving failure to declare gifts, breaches of NHS circulars or SFIs or other accounting irregularities.

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28 Bribery

This section should be read in conjunction with the Standards of Business Conduct contained within Section C of the Code of Corporate Governance and the Fraud and Corruption Policy contained within Section D of the Code of Corporate Governance

1 The Bribery Act 2010 has brought further obligations on NHS Orkney and its staff.

2 NHS Orkney operates a zero-tolerance approach to bribery, whether direct or indirect, by, or of, its staff, agents or external consultants or any persons or entities acting for it or on its behalf. The Board is committed to implementing and enforcing effective systems throughout NHS Orkney to prevent, monitor and eliminate bribery, in accordance with the Bribery Act 2010.

3 NHS Orkney will not conduct business with service providers, agents or representatives who do not support its anti-bribery statement. We reserve the right to terminate contractual arrangements with any third parties acting for, or on behalf of, NHS Orkney with immediate effect where there is evidence that they have committed acts of bribery.

4 The success of NHS Orkney's anti-bribery measures depends on all employees, and those acting for NHS Orkney, playing their part in helping to detect and eradicate bribery. Therefore all employees and others acting for, or on behalf of NHS Orkney are encouraged to report any suspected bribery in accordance with Section D of the Code of Corporate Governance – Fraud and Corruption Policy.

5 Where there are grounds to suspect that bribery has occurred a response shall be initiated as per the Fraud and Corruption Policy.

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Annex 1

Sponsorship Policy

1 Sources of Sponsorship

It is accepted that NHS Orkney may benefit from sponsorship opportunities. However, there are circumstances under which sponsorship should not be accepted:

- If a company's products have inherent health risks, i.e. manufacturers and suppliers of tobacco and alcohol products
- Where a company has a history of failing to meet legislative standards in respect of industrial relations and work conditions, human rights, animal rights or environmental issues.

2 Purpose of Sponsorship

It is NHS Orkney's duty to provide health services for its population and it is not appropriate to use sponsorship to meet the costs of what is perceived to be NHS Orkney's primary responsibilities. However, it could be used to fund what are seen as secondary activities such as:

- Materials for education, training, and health promotional events
- Educational grants
- Sponsorship for training courses
- Expenses for attendance at local or national conferences
- Research or clinical audit projects
- Printing and distribution of guidelines
- Facilitate access to research and development work elsewhere.

The principles upon which any sponsorship must be based are:

- Agreements must protect the interests of individual patients, e.g. guard against the use of any single product to the exclusion of other reputable brands on the market
- Agreements should not undermine or conflict with the ethical requirement of any health care professional including the duty of doctors to provide treatment they consider clinically appropriate
- Agreements must comply with requirements for data protection and information sharing
- Agreements must be reviewed by the Central Legal Office
- Agreements will be publicly available documents in line with NHS Orkney's accountability requirements.

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3 Control Framework

Sponsorship within the framework outlined above would allow some credit to be given to the sponsors, acknowledging the fact that they have provided the funding to allow the project or event to be run.

However, the following issues must be made clear:

- Credit for the work is due to the Board and not the sponsors
- The acceptance of sponsorship is not an endorsement of a specific product or drug
- Any mention of the sponsor will be to the Company and not to any of its products
- The sponsoring company may attend any sponsored event and display samples of its products at sponsored events, but it must be clear that the Board is not endorsing or promoting the company or its products.

Companies or suppliers offering sponsorship should be sent a copy of this policy and are required to confirm in writing that they have read it and will abide by its content.

Any offers of sponsorship should be submitted to the Director of Finance. A final decision on the appropriateness of an offer of sponsorship will rest with the Chief Executive.

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Annex 2

SCHEME OF DELEGATED AUTHORITY

Purchase of Goods and Services

Delegated Issue	Responsible Officer	Deputy(s)	Scope (Excl VAT)
Approval of Business Cases			
Capital Investment	Scottish Government		£3,000,000 and above (as per DEL (2019)5)
Capital Schemes – Individual Project Value	Capital and Strategic Estates Group		Up to £50,000
	Senior Leadership Team		From £50,000 to £250,000
	Board		£250,000 and above
Revenue Business Cases	Executive Director		Up to £5,000
	Senior Leadership Team		£5,000 to £100,000
	Board		£100,000 and above
Quotes and Tenders			
Process Quick Quotes	Procurement Team		£3k and above
Issuing Tenders	Director of Finance or Procurement Manager		£50,000 and above
Opening Tenders	Director of Finance or Procurement Manager		All
Post-tender negotiation	Procurement Manager		All
Approval of Tenders	Procurement Manager & Executive Director	Procurement Staff & Budget Holder	£50,000 to £100,000
	Director of Finance		Up to £500,000
	Chief Executive		Up to £1,000,000
	Board		£1,000,000 and above
Authorisation of PECOS Orders (Only those included on the approved signatories list will	Team Lead, Supervisor	All orders will be escalated upwards to the next approval level where the original approver	Up to £1,000

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be added to PECOS as an approver)		is not available to complete the approval	
	Functional Manager		Up to £5,000
	Head of Service		Up to £15,000
	Executive Director		Up to £50,000
	Director of Finance		Up to £500,000
	Chief Executive		£500,000 and above
PECOS (procurement review)	Procurement Staff	Procurement Manager	Up to £50,000
	Procurement Manager	Director of Finance	£50,000 and above
Other Expenditure			
Legal Claims	Patient Experience Officer		Up to £15,000
	Medical Director		From £15,000 to £50,000
	Chief Executive	Director of Finance	£50,000 and above
Ex Gratia Payments	Chief Executive		All
Losses & Write Offs	Chief Executive or Director of Finance		See Section 17
Staff Travel	Vacancy Panel		All
Endowments	EFSC Chair & Lead Executive Director		Up to £1,000
	Endowment Fund Sub Committee (EFSC)		£1,000 to £10,000
	Board of Trustees		£10,000 and above
Provision of Services			
Approval of NHSO services to others	Executive Directors		Up to £10,000
	Director of Finance		£10,000 and above
Funding Requests			
Grant applications	Director of Finance		All
Budgets			
Budget Virements	Director of Finance		All

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Other Delegated Matters

Delegated Action and Scope of Delegation	Responsible Officer	Delegated Officer(s)
Delegation of budgets and approval to spend within delegated Limits	Chief Executive	Director of Finance
Devise and maintain systems of budgetary control	Director of Finance	Head of Finance
Demonstrate best value for all services	Chief Executive	Director of Finance
Develop and monitor efficiency programmes	Director of Performance & Transformation (and Deputy CEO)	Head of Improvement
Procedures for the procurement, ordering and receipt of goods	Director of Finance	Procurement Manager
Control of Stocks	Director of Finance	Procurement Manager
Develop and implement financial policies ensuring detailed financial procedures and systems are prepared and documented	Director of Finance	Head of Finance
Operation of detailed financial matters including bank accounts and banking procedures	Director of Finance	Senior Financial Accountant
Insurance Arrangements	Director of Finance	Head of Finance
Liaison with Internal Audit Service	Director of Finance	Head of Finance
Review, appraise and report in accordance with NHS Internal Audit Manual and best practice	Chief Internal Auditor (Azets)	Head of Finance
IT systems Development	Chief Executive	Head of Improvement
IT Systems Control and Security	Chief Executive	Head of Improvement
Management of Land & Buildings	Chief Executive	Head of Estates
Preparation of Operational Plan and Performance Assessment Framework	Chief Executive	
Annual Reports and Accounts	Director of Finance	Senior Financial Accountant

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Investigate and suspected cases of fraud or other irregularity	Director of Finance	Fraud Liaison Officer
Standards of business conduct for staff	Chief Executive	Director of People & Culture
Develop and implement HR policies ensuring details HR procedures and systems are prepared and documented	Director of People & Culture	Head of People & Culture
Health and Safety Policy	Director of People & Culture	Health & Safety Lead
Health and Safety Management	Director of People & Culture	Health & Safety Lead
Caldicott Guardian	Medical Director	
Information Governance including freedom of information	Chief Executive	Head of Improvement
Complaints	Medical Director	Head of Patient Safety, Quality & Risk
Educational Quality Assurance	Executive Director of NMAHP	
Health Protection	Director or Public Health	Public Health Manager
Integrated Joint Board (Orkney Health & Care)	Chief Executive	Chief Officer of the Integrated Joint Board

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NHS Orkney

14.3

Annual Whistleblowing Report 2025/26

Meeting	**NHS Orkney Board**
Meeting date	Thursday, 30 April 2026
Responsible Executive/ Non-Executive	• Dr Anna Lamont, Medical Director
Report Author(s)	• Kat Jenkin, Head of Patient Safety, Quality and Risk
Purpose of report	• Decision
Contribution to Strategic ambition	• Government policy/directive • Legal requirement
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective
Key points for consideration	• No whistleblowing concerns were raised by NHS Orkney staff or independent contractors during 2025/26 under the National Whistleblowing Standards. • Staff and contractors continue to access a range of speaking up routes, with issues reviewed promptly and directed through established organisational processes. • Regular engagement between the Executive Lead for Whistleblowing, the Whistleblowing Champion, Confidential Contacts and the Head of Patient Safety, Quality and Risk continue.
Route to meeting	• This paper is presented to this meeting for approval • The annual report will be presented to the Staff Governance Committee in May 2026 for noting
Recommendation(s)	• **Decision - Reaching a conclusion considering the options**

Annual Whistleblowing Report 2025/26

Kat Jenkin, Head of Patient Safety, Quality and Risk
20/04/2026

1. Situation

1.1 In accordance with the National Whistleblowing Standards, NHS Orkney is required to produce an annual report detailing how it has met the requirements set out within the Standards. This report provides oversight of performance against the key performance indicators (KPIs) and includes more detailed information on any whistleblowing concerns raised during the reporting period.

1.2 As part of NHS Orkney's ongoing commitment to fostering a culture of openness and encouraging individuals to speak up, the report also includes information on concerns raised through the anonymous reporting form and via Confidential Contacts. Including these additional sources of feedback reinforces the organisation's dedication to transparency, accountability, and continuous improvement.

2. Background

2.1 The National Whistleblowing Standards, developed by the Independent National Whistleblowing Officer (INWO), provide a comprehensive framework for how all NHS service providers in Scotland must handle whistleblowing concerns. These Standards apply to anyone delivering NHS services, whether directly or indirectly, including employees, contractors, students, volunteers, and agency staff. The Standards are designed to ensure that concerns are addressed fairly, consistently, and transparently, and that individuals who raise concerns are supported throughout the process. They outline a clear, two-stage procedure for managing concerns, define what constitutes a whistleblowing issue, and set expectations for governance, reporting, and learning from concerns raised.

2.2 The Standards are underpinned by a set of core principles that promote openness, accountability, and continuous improvement. They also include specific guidance for NHS Boards, primary care providers, and other contracted services, ensuring that responsibilities are clearly defined across all sectors. NHS organisations are required to ensure that the Standards are accessible to all relevant individuals, and that appropriate training and support mechanisms are in place. The INWO monitors compliance and provides oversight to ensure that the Standards are implemented effectively and that learning from whistleblowing concerns contributes to safer, higher-quality care across the NHS in Scotland

3. Assessment

3.1 The Annual Whistleblowing Report for 2025/26 provides assurance that NHS Orkney's whistleblowing arrangements remain in place, operational and proportionate to the level of activity during the reporting year. No whistleblowing concerns were raised by NHS Orkney staff or independent contractors, and there were no upheld cases, action plans or matters requiring escalation under the National Whistleblowing Standards.

3.2 Assurance is not derived solely from activity levels, but from the strength of the systems, behaviours and governance in place to support speaking up. Evidence within the report demonstrates that staff and contractors continue to access a range of speaking up routes, with matters reviewed promptly and directed through established organisational processes.

3.3 Strong working relationships between the Executive Lead for Whistleblowing, the Whistleblowing Champion, Confidential Contacts and the Patient Safety, Quality and Risk Team have supported early advice seeking, consistent decision making and clear oversight. Routine engagement with Confidential Contacts and quarterly reporting from independent contractors provides further assurance that organisational culture and emerging themes are kept under review.

3.4 The report identifies ongoing actions to strengthen awareness and understanding, including planned inclusion of whistleblowing within the Managers' Programme, review of whistleblowing guidance, and continued work to expand and diversify the pool of Confidential Contacts.

3.5 The Board is asked to take assurance from the report while continuing to seek evidence of listening, learning and openness as part of its oversight of patient safety, staff wellbeing and organisational culture and approve the annual report.

3.6 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	For an organisation to achieve high performance and deliver quality care any opportunity for learning must be vigorously pursued. Learning from whistleblowing is essential to shape our services and uphold the NHS Orkney values of being open and honest, respectful and kind as well as ensuring patient safety.
People	Workforce	Yes	Anyone who delivers an NHS service should feel able and empowered to raise concerns about harm or wrongdoing. They should be trained so they are aware

			of the channels available to them for raising concerns, and what access to the Standards means. All staff have access to training through Turas Learn and information to support staff in raising or dealing with a concern is available on a dedicated Whistleblowing page on the Blog. This includes signposting to internal and external sources of information and support as well as relevant Standard Operating Procedures.
Performance	Finance	No	No impact.
Potential	Risk Management	Yes	The implementation of the National Whistleblowing Standards is a vital component of the organisation's risk management framework. By ensuring that all whistleblowing concerns are handled in a structured, transparent, and timely manner, the organisation is better equipped to identify and address risks that may impact patient safety, staff wellbeing, or service delivery. The Standards support early intervention and resolution, helping to prevent escalation of issues and promoting a culture of openness and accountability. This proactive approach not only strengthens organisational resilience but also reinforces NHS Orkney's commitment to delivering safe, high-quality care across all services.
	Digital	No	No impact.
Place	Equality and Diversity including health inequalities	Yes	The national Standards were subject to public consultation and equality and diversity impact assessment. Through the implementation of the standards, it is expected that a culture of openness and psychological safety where staff and those who provide services for the NHS feel able to speak up will be created, ensuring that every voice is heard.
	Climate Change Sustainability	No	No impact.

4. Recommendation(s)

4.1 It is asked that the Board approves the report for publication to the NHS Orkney internet site and for sending onward to INWO as per the whistleblowing standard expectations.

i **Decision** – Reaching a conclusion after the consideration of options.

5. List of appendices

5.1 The following appendices are included with this report:

5.2 **Appendix 1,** Annual whistleblowing report 2025/26

Item 15.2.1

Whistleblowing Standards

Annual Report 2025/26

Safety, Quality and Risk Team

Lead Executive for Whistleblowing: Dr Anna Lamont, Medical Director
Author: Kat Jenkin, Head of Patient Safety, Quality and Risk

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NHS Orkney Whistleblowing Standards

Annual Report 2025/26

1. Introduction

NHS Orkney recognises the importance of ensuring that staff and those delivering NHS services feel safe and supported to raise concerns in the public interest. Effective whistleblowing arrangements are a core part of the organisation's wider approach to patient safety, quality, staff wellbeing and organisational learning.

In line with the National Whistleblowing Standards, NHS Orkney monitors whistleblowing activity and reports performance against the national indicators. This includes concerns raised by NHS Orkney staff and information received from independent contractors who deliver NHS services on behalf of the Board. These arrangements are embedded as business as usual and form part of routine governance and assurance processes.

This annual report brings together whistleblowing activity and performance across the 2025/26 financial year, providing an overview of engagement, learning and assurance in relation to whistleblowing. It reflects NHS Orkney's ongoing commitment to openness, listening and continuous improvement.

2. Background

The National Whistleblowing Standards, established by the Independent National Whistleblowing Officer (INWO), provide a consistent framework for how NHS organisations in Scotland must support individuals to raise concerns and how those concerns should be received, assessed and managed. The Standards are designed to promote openness, protect individuals from detriment and ensure that concerns are addressed fairly, proportionately and with a focus on learning and improvement.

The Standards apply to all individuals involved in delivering NHS services, including directly employed staff, students, volunteers, agency workers, contractors, Third Sector organisations and those working within Health and Social Care Partnerships. NHS Boards are responsible for ensuring that these groups are aware of the Standards, understand how to raise concerns and know what support is available.

Within NHS Orkney, whistleblowing arrangements are embedded within the organisation's wider safety, quality and governance structures. Leadership at all levels plays an important role in creating the conditions for speaking up, supported by clear routes, confidential contacts and executive oversight.

3. Speaking Up

NHS Orkney provides a range of ways for staff and those delivering NHS services to raise concerns or seek advice. These include the formal whistleblowing process, an anonymous reporting form, Confidential Contacts, and the option to speak directly with senior leaders such as the Chief Executive, the Whistleblowing Champion or the Executive Lead for Whistleblowing. These routes are intended to support early advice seeking, proportionate handling of issues and confidence that concerns will be listened to.

Across the 2025/26 reporting year, a small number of matters were raised through speaking up routes. These included concerns raised anonymously, and issues discussed with senior leaders or Confidential Contacts. Where concerns did not meet the definition of whistleblowing under the National Whistleblowing Standards, they were reviewed promptly and directed to the most suitable organisational process, such as workforce, service management or support routes, with the aim of resolving issues early and effectively.

Examples from the quarterly reports include:

- An anonymous concern relating to service delivery and waiting times, which was acknowledged and used to inform wider service discussion and improvement activity within the relevant specialty.
- Anonymous and identifiable concerns relating to individual behaviour or workplace issues, which were addressed and resolved through normal line management and workforce processes.
- Requests for advice and support where individuals were seeking reassurance or guidance, rather than raising a formal whistleblowing concern.

During some quarters, no concerns were raised directly with the Chief Executive or the Executive Lead for Whistleblowing. In others, senior leaders were approached for advice or signposting rather than to initiate a formal whistleblowing process. This pattern reflects the use of multiple speaking up routes and supports early resolution and learning.

Overall, activity across the year demonstrates that speaking up routes are being used flexibly and proportionately. NHS Orkney continues to focus on ensuring that staff understand the available options, feel supported to seek advice, and are confident that concerns will be taken seriously and handled fairly.

4. Confidential Contacts

Confidential Contacts are a well established part of NHS Orkney's speaking up arrangements and provide a safe, informal route for individuals to seek advice, discuss concerns or explore options before deciding whether to raise a matter

formally. Confidential Contacts do not investigate concerns but offer support, signposting and reassurance.

Throughout the 2025/26 reporting year, Confidential Contacts received a small number of contacts. These varied in nature and included:

- Requests for advice relating to workplace or departmental issues, which were resolved locally through management routes.
- Concerns relating to organisational culture or governance processes, which were escalated for further consideration.
- Situations where individuals sought reassurance or guidance rather than raising a formal whistleblowing concern.

None of the contacts received during the year progressed to formal whistleblowing concerns under the National Whistleblowing Standards. This reflects the role of Confidential Contacts in supporting early conversations and helping individuals access the most suitable route for their issue.

A quarterly “touchpoint” meeting is held involving the Confidential Contacts, the Whistleblowing Champion, the Executive Lead for Whistleblowing and the Head of Patient Safety, Quality and Risk. These meetings provide an opportunity to:

- Share themes and learning, even where no formal concerns have been raised.
- Reflect on organisational culture and morale.
- Identify opportunities to promote speaking up and early advice seeking.
- Consider the visibility, accessibility and resilience of Confidential Contact arrangements.

During the year, these discussions included consideration of staff morale during periods of organisational change, and exploration of ways to strengthen the Confidential Contact role. This has included work to expand and diversify the pool of Confidential Contacts, including exploring alignment with existing Peer Support arrangements, to ensure that support remains accessible and trusted across the organisation.

In quarters where no contacts were received, this was considered alongside wider engagement and speaking up activity, rather than viewed in isolation. This approach recognises that assurance comes from understanding how concerns would be handled if raised, not solely from the volume of activity.

5. Outcomes and Performance Against the Whistleblowing Indicators

The National Whistleblowing Standards outline a series of key performance indicators (KPIs) against which each NHS Board is required to report. These indicators are designed to ensure transparency, accountability, and continuous improvement in the handling of whistleblowing concerns.

This report presents NHS Orkney's performance against these indicators and includes separate reporting for NHS Orkney and its independent contractors. The independent contractors are only required to report against KPI's four – nine. While the indicators are not presented in numerical order, they have been arranged to enhance clarity and readability. For ease of reference, the corresponding indicator number is included alongside each heading.

The indicators are as follows:

1. Learning from concerns raised
2. Experience for those raising concerns
3. Staff awareness and training
4. The total number of concerns received
5. Concerns closed at each stage in the process
6. Concerns upheld, partially upheld and not upheld
7. Average times
8. Number of concerns closed at each stage with the set timescales
9. Number of cases where extension was authorised

Staff Awareness and Training (indicator 3)

Count of Learning Status				2025/26			
Course Title	Completed all time	In Progress all time	Total	Completed Q1	Completed Q2	Completed Q3	Completed Q4
Whistleblowing: an overview	111	0	111	0	2	2	2
Whistleblowing: for managers & people who receive concerns	7	0	7	0	0	0	0
Whistleblowing: for senior managers	24	0	24	0	0	0	0

Whistleblowing e-learning is available to all staff through Turas and is promoted through topic specific pages and regular internal communications. While completion is not mandatory, it is highlighted for managers when they join the organisation and as part of ongoing development.

Uptake during 2025/26 remained low. This reflects the absence of active whistleblowing cases rather than a lack of organisational capability. NHS Orkney is exploring additional ways to support understanding and confidence around speaking up that are practical, meaningful and accessible, including planned inclusion within the Managers' Development Programme.

Concerns and Management of Concerns (indicators 4-9)

NHS Orkney

Indicator	Performance 2025/26			
	Q1	Q2	Q3	Q4
The total number of concerns raised	0	0	0	0
Concerns closed at each stage of the process	N/A	N/A	N/A	N/A
Concerns upheld, partially upheld, and not upheld	N/A	N/A	N/A	N/A
Average times (working days)	N/A	N/A	N/A	N/A
Number of concerns closed at each stage within the set timescales	N/A	N/A	N/A	N/A
Number of cases where extension was authorised	N/A	N/A	N/A	N/A

No whistleblowing concerns were raised by NHS Orkney staff during the 2025/26 reporting year.

Independent Contractors

Indicator	Performance 2025/65			
	Q1	Q2	Q3	Q4
The total number of concerns raised	0	0	0	0
Concerns closed at each stage of the process	N/A	N/A	N/A	N/A
Concerns upheld, partially upheld, and not upheld	N/A	N/A	N/A	N/A
Average times (working days)	N/A	N/A	N/A	N/A
Number of concerns closed at each stage within the set timescales	N/A	N/A	N/A	N/A
Number of cases where extension was authorised	N/A	N/A	N/A	N/A

No whistleblowing concerns were reported by independent contractors during the reporting year. Engagement with contractors is now embedded within routine quarterly processes, supporting consistent expectations and alignment with national standards.

Learning From Concerns Raised (indicator 1)

No whistleblowing concerns were raised during the 2025/26 reporting year. Engagement activity throughout the year focused on embedding updated guidance, strengthening awareness and supporting a culture where speaking up is encouraged and valued.

Learning from previously escalated concerns concluded in the prior year has been fully embedded, with actions completed and improvements sustained.

Experience For Those Raising Concerns (indicator 2)

As no whistleblowing concerns were raised during the reporting year, no direct feedback from whistleblowers was sought. NHS Orkney continues to consider how feedback can be gathered in future to inform improvement and strengthen the experience for individuals who speak up.

6. Action plans and Progress on Upheld Concerns

There were no whistleblowing concerns or outstanding action plans during the 2025/26 reporting year. All actions arising from previously escalated concerns were completed and closed following review and resolution.

7. Executive Assurance Summary

This annual report provides assurance that NHS Orkney's whistleblowing arrangements remain in place, operational and proportionate to the level of activity during the 2025/26 financial year. Throughout the year, no whistleblowing concerns were raised by NHS Orkney staff or independent contractors, and there were no upheld cases, action plans or outstanding matters requiring escalation under the National Whistleblowing Standards.

While the absence of formal whistleblowing concerns is noted, NHS Orkney recognises that assurance is not derived solely from activity levels. Instead, assurance is drawn from the effectiveness of the systems, relationships and behaviours in place to support speaking up, should concerns arise. Across the year, staff and contractors continued to access a range of speaking-up routes, including anonymous reporting, Confidential Contacts and senior leadership, with matters addressed promptly and proportionately through different organisational processes.

Effective working relationships between the Executive Lead for Whistleblowing, the Whistleblowing Champion, Confidential Contacts and the Head of Patient Safety, Quality and Risk have supported consistent decision making, early advice seeking and clarity around the routes for managing concerns. These arrangements help to reduce unnecessary escalation while ensuring that issues relating to safety, quality,

governance or integrity would be recognised and managed effectively in a timely manner.

Engagement with independent contractors delivering NHS services has continued throughout the year and is now embedded within routine quarterly reporting. This supports consistent expectations across organisational boundaries and strengthens system wide confidence in whistleblowing arrangements.

During 2025/26, NHS Orkney has also focused on strengthening awareness, accessibility and understanding of whistleblowing. This has included active promotion of guidance, reflective discussion through Confidential Contact meetings, and consideration of how training and learning can be supported in ways that are practical and meaningful. Planned inclusion of whistleblowing within the forthcoming Managers' Development Programme provides an opportunity to further reinforce roles, responsibilities and confidence in handling concerns.

Looking ahead, NHS Orkney will continue to focus on maintaining awareness of whistleblowing routes, strengthening relationships across the system and enhancing support mechanisms for those who speak up. Work to expand and diversify the pool of Confidential Contacts remains ongoing, alongside a review of whistleblowing guidance to improve clarity and address areas where further explanation has been requested through consultation.

Overall, the position at the end of the 2025/26 reporting year provides assurance that whistleblowing governance within NHS Orkney is functioning as intended, aligned with national standards and supported by effective leadership, collaborative working and a continued commitment to openness, learning, patient safety and staff wellbeing.

Whistleblowing Champion's Assurance Statement – 2025/26

Meeting	**NHS Orkney Board**
Meeting date	Thursday, 30 April 2026
Responsible Executive/ Non-Executive	• Dr Anna Lamont, Medical Director
Report Author(s)	• Jason Taylor, Non-Executive Director and Whistleblowing Champion • Kat Jenkin, Head of Patient Safety, Quality and Risk
Purpose of report	• Assurance
Contribution to Strategic ambition	• Government policy/directive • Legal Requirement
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality
Key points for consideration	• The Whistleblowing Champion provides assurance that NHS Orkney has arrangements in place to manage whistleblowing concerns in line with the National Whistleblowing Standards. • Strengthened whistleblowing processes and governance are in place, though these have not yet been fully tested due to low levels of whistleblowing activity. • While staff awareness of the Standards remains variable, staff demonstrate confidence in raising concerns, supported by Confidential Contacts and additional speaking up routes.
Route to meeting	• This is presented to the Board for assurance and will be presented to the Staff Governance Committee in May 2026.
Recommendation(s)	• **Assurance - For members assurance only**

Whistleblowing Champion's Assurance Statement – 2025/26

Jason Taylor, Non-Executive Director and Whistleblowing Champion
Kat Jenkin, Head of Patient Safety, Quality and Risk
21/04/2026

1. Situation

1.1 NHS Orkney is required, under the National Whistleblowing Standards, to obtain independent assurance that its whistleblowing arrangements are working as intended and that staff feel able to raise concerns safely. One of the key ways this assurance is provided is through an annual statement from the Whistleblowing Champion.

1.2 The attached assurance statement has been prepared to fulfil this requirement and to support the Board in meeting its responsibilities under the National Whistleblowing Standards. It provides an independent assessment of NHS Orkney's whistleblowing arrangements for 2025/26, including consideration of recent changes to leadership arrangements, improvements made following feedback from the Independent National Whistleblowing Officer (INWO), staff awareness and training, the availability of Confidential Contacts, and how the organisation would respond to recommendations arising from whistleblowing concerns.

1.3 The assurance statement is intended to give the Board, staff and members of the public confidence that whistleblowing arrangements are in place, understood and supported, while also highlighting areas where continued focus is needed to maintain compliance with the Standards and to sustain a culture where staff feel safe to speak up.

2. Background

2.1 The National Whistleblowing Standards were introduced to ensure that staff working in NHS services across Scotland can raise concerns about patient safety, quality of care or wrongdoing in a way that is safe, fair and transparent. The Standards place clear responsibilities on NHS Boards to ensure that whistleblowing arrangements are accessible, well governed and subject to independent oversight.

2.2 The role of the Whistleblowing Champion is a key part of this framework. The Champion provides independent oversight and assurance to the Board on how whistleblowing arrangements are operating and highlights any risks or areas of concern that could affect confidence in the process. Importantly, this assurance is not based solely on the number of whistleblowing concerns raised, but on whether the systems, leadership and culture needed to support speaking up are in place.

2.3 The annual assurance statement helps the Board to understand how well whistleblowing arrangements are embedded within the organisation, whether learning is acted upon, and whether there are any gaps that require further attention. This approach reflects the intent of the Standards, which emphasise prevention, openness and learning, rather than activity levels alone.

3. Assessment

3.1 The Whistleblowing Champion's assurance statement confirms that NHS Orkney has arrangements in place to record, manage, investigate and report whistleblowing concerns in line with the National Whistleblowing Standards. It recognises that leadership arrangements have been strengthened and that processes have been refreshed following feedback from the Independent National Whistleblowing Officer.

3.2 The statement also provides a balanced view of where further work is needed. Due to the low number of whistleblowing concerns raised during the year, some of the revised arrangements have not yet been fully tested in practice. It also highlights ongoing challenges in ensuring consistent staff awareness of the Whistleblowing Standards, particularly for staff working outwith the main hospital setting, and notes that completion of whistleblowing training remains low, although steps are being taken to strengthen expectations for managers and team leaders.

3.3 Positively, the statement notes that staff who were engaged as part of the assurance process were able to describe how they would raise concerns and expressed confidence in doing so. The availability of Confidential Contacts and the option for anonymous reporting are viewed as supporting a culture of openness and early issue identification, rather than undermining formal whistleblowing processes.

3.4 Overall, the assurance statement provides proportionate assurance that whistleblowing arrangements are in place and supported within NHS Orkney, while clearly identifying areas where continued attention is required to maintain public confidence, comply with the National Whistleblowing Standards, and support a safe and open organisational culture.

3.5 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	The aim of this report is to evidence and provide assurance of areas of excellence supporting quality and good patient care. The report will also highlight areas that are being reviewed and plans to improve the quality and standards of care.

People	Workforce	Yes	The report celebrates where our workforce is demonstrating good practice, supporting positive patient experiences, and also plans to support the teams in improving care where needed.
Performance	Finance	No	
Potential	Risk Management	Yes	Through the identification of themes and trends and review of incidents and complaints, the organisation is enabled to identify areas of increased risk and to formulate mitigating actions to address these.
	Digital	No	
Place	Equality and Diversity including health inequalities	No	
	Climate Change Sustainability	*No*	

4. Recommendation(s)

4.1 It is asked that the NHS Orkney Board receives and takes assurance from the Whistleblowing Champion's Assurance Statement.

i **Assurance** – For members assurance only.

5. List of appendices

5.1 The following appendices are included with this report:

i **Appendix 1,** Whistleblowing Champion's Assurance Statement – 2025/26.

NHS Orkney

Whistleblowing Assurance Assessment

Item 14.4.1

1. Introduction

The Whistleblowing Champion is predominantly an assurance role which helps NHS boards comply with their responsibilities in relation to Whistleblowing. The Whistleblowing Champion provides critical oversight to ensure the organisation is responding to Whistleblowing concerns appropriately, in accordance with the Standards.

The Whistleblowing Champion is also expected to raise any issues of concern with the board as appropriate, either in relation to the implementation and operation of the Standards, patterns in reporting of concerns or in relation to specific cases.

1. Assessment

Over the course of the year 2025/2026, executive leadership of Whistleblowing moved from the Chief Executive portfolio to the Medical Director, with day-to-day responsibility for the management of Whistleblowing continuing under the Head of Patient Safety, Quality and Risk.

Whilst systems are in place to record, manage, investigate and report on Whistleblowing concerns, weaknesses have previously been evident in the areas of organisational response and communication following the investigation of concerns.

In previous assurance statements, I highted the areas in which NHS Orkney could improve its response to any recommendations flowing from a concern being upheld, as delays in acting upon recommendations risk undermining confidence in the process.

In response, the previous Chief Executive committed to any future recommendations being progressed and actions minuted via both Corporate Leadership Team (Executive Team) and Senior Leadership Team meetings as required, with responsibility, accountability and agreed timeframes being allocated to relevant executives / senior managers as appropriate, including regular communications with the individual(s) who raised the concern. This system of response remains largely untested due to low numbers of concerns being raised.

Following on from a review undertaken by The Independent National Whistleblowing Office (INWO), which made a number of recommendations encompassing the areas highlighted above, a refreshed and strengthened process to record and manage Whistleblowng Concerns has been adopted. Again, due to low numbers of Whistleblowing concerns being raised, this system remains largely untested.

Staff training completion rates remain low. To date, completion of the Whistleblowing training modules has been voluntary. Whilst I continue to concur that for the majority of staff this remains appropriate, I welcome moves the

organisation is making to require managers / team leaders who potentially have to deal with concerns, to undertake the relevant training module, to ensure they have clarity around their role and responsibilities in respect of Whistleblowing.

Despite a regular tempo of communication to the organisation, knowledge of the Whistleblowing Standards remains mixed, and it is notable that it is higher among Balfour based NHS Orkney staff compared to those delivering NHS Services out with the main hospital setting. This awareness level gap remains an ongoing challenge.

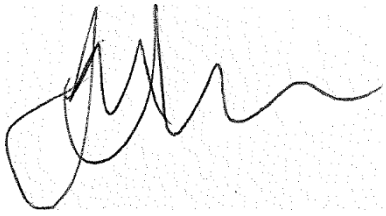
On a positive note, all of the staff I spoke to when testing awareness, were able to articulate knowledge of a process to raise concerns and intimated confidence to do so, even when they had limited knowledge of the Whistleblowing Standards themselves.

NHS Orkney currently has 3 confidential contacts. Work is currently underway to (potentially) integrate the newly formed cadre of peer supporters into the confidential contact space, which would significantly increase resilience in this critical area. In response to feedback indicating that an external organisation contact option would enhance the confidential contact offer, the Executive lead has undertaken to investigate if anything could be delivered in partnership with Orkney Islands Council, and to revisit the question with NHS Shetland.

As described in the annual report, staff continue to approach our confidential contacts for a variety of reasons, the vast majority of which do not result in a formal Whistleblowing concern being raised. The option to report issues anonymously, initially introduced in response to staff feedback, remains in place. Staff continue to use this method to highlight minor issues they were perhaps previously unwilling to raise but would not constitute a Whistleblowing concern. As such this method of raising issues appears to be complementing rather than undermining the Whistleblowing process.

2. Conclusion

I am satisfied that NHS Orkney has systems in place to record, manage, investigate and report Whistleblowing concerns.



Jason Taylor
Whistleblowing Champion

Date: 06 March 2026

NHS Orkney

Item 14.5

Clinical Services Review Older Persons and Frailty Workstream Deep Dive

Meeting	**NHS Orkney Board**
Meeting date	Thursday, 30 April 2026
Responsible Executive/ Non-Executive	• Stephen Brown, Chief Officer. • Sam Thomas, Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services.
Report Author(s)	• Stephen Brown, Chief Officer. • Sam Thomas, Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services.
Purpose of report	• Assurance
Contribution to Strategic ambition	• Annual Operational Plan • NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred • Sustainability
Key points for consideration	• A Deep Dive in relation to the Older Persons and Frailty Workstream has been undertaken. • Significant work to date has been undertaken in relation to Older Persons and Frailty. • Multi professional engagement in all elements of the workstream • An Intermediate Care Allied Health Professions Single Point of Contact pilot is due to launch on 5 May 2026 • Orkney has recently been accepted onto the Healthcare Improvement Scotland Focus on Frailty Programme with clear national outcome milestones for 2027.
Route to meeting	• Direct to Board 30 April 2026
Recommendation(s)	• Assurance - For members assurance only

Clinical Services Review Older Persons and Frailty Workstream Deep Dive

Stephen Brown, Chief Officer IJB, and Sam Thomas, Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services.

21/04/2026

1. Situation

1.1 This paper aims to provide members with an update on the work currently being done in relation to the Older Persons and Frailty Workstreams.

2. Background

2.1 The Chief Executive of NHS Orkney commissioned an external Clinical Services Review in early 2025. The review commenced in February 2025 and concluded in June 2025. The Board of NHS Orkney received a presentation on Clinical Services Review High-level Recommendations/Findings on 12 June 2025.

2.2 In July 2025, the Integration Joint Board received a report on Delayed Transfers of Care – System Pressures where the Integration Joint Board approved the establishment of a Short Life Working Group be established to review discharge processes, delayed transfers of care and options for working differently/creating system capacity and that a report would be taken to the Integration Joint Board on the outcome of its deliberation no later than December 2025.

2.3 On 28 August 2025 the Board of NHS Orkney received the Clinical Services Review Implementation Plan which included the final Clinical Services Review as well as the Clinical Services Implementation Plan (Horizon 1). One of the recommendations from this was to develop an elderly care strategic plan setting out the development of a HUB approach

2.4 Following a discussion between the Chief Officer and the Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services it was agreed to merge the two working groups.

3. Assessment

3.1 In January 2026, the Older Persons and Frailty workstreams were merged to better integrate acute, community and social care recognising strong interdependencies across services.

3.2 The workstream, which meets every three weeks, provides a system-wide framework to reduce variation, strengthen multi-disciplinary team (MDT) working, improve coordination and support independence while reducing avoidable admissions and delayed transfers of care.

3.3 An Older Person and frailty Workstream Deep Dive, attached as Appendix 1 to this report, was undertaken in Spring 2026.

3.4 The key highlights of the deep dive are:

I. Extensive analytical activity is underway to understand system pressures, patient pathways, MDT coordination, delayed transfers of care and unscheduled admissions. This includes

- Case study mapping of three patient journeys (frailty/falls, dementia and isles).
- MDT activity mapping to clarify current arrangements and improve organisation around the person.
- Guardianship and Power of Attorney deep dive to understand their role in delayed discharges.
- Admission and readmission deep dives for people aged 75+, including 30, 60, and 90 day reviews.

ii A GIRFE (Getting It Right For Everyone) toolkit pilot is underway, testing person-centred coordination tools ("My Plan" and "My Team") across wards, one GP practice and the Link Practitioner Service. This focuses on reduced duplication, better coordination and improved patient experience. The pilot runs to the end April with evaluation informing a phased rollout from May 2026.

iii An Intermediate Care Allied Health Professions Single Point of Contact pilot is due to launch on 5 May 2026 with the evaluation by the end of June. The aim of this is to establish a clear, consistent referral route and Duty Huddle for community Allied Health Professions services. It is also hoped that it will reduce duplication and delays and improve clarity for referrers and patients.

iv A review of dementia service pathways and processes are underway which includes reviewing pre-diagnosis, diagnosis, post-diagnostic support, workforce capacity and awareness of dementia risk factors. An initial Dementia Workshop was held in April 2026 with a further session scheduled in June 2026 to map pathways. An updated formal Dementia Strategy will be produced, aligned with Public Health priorities, and presented to the Integration Joint Board.

v Care at Home and Care Home services are a key strategic priority within the workstream and represent the most resource-intensive area of delivery. A Project Initiation Document (PID) has been developed and is due to be considered by the

Council's Corporate Leadership Team on 23 April 2026. This PID aims to look at workforce and models of care.

vi As mentioned above, progress on the recommendations in relation to Frailty have been incorporated to support a more integrated system-wide approach. The key areas of focus include the use of the Clinical Frailty Scale (CFS) and eFrailty index, clear protocols linked to frailty scores and Improved MDT working and care planning. Orkney has recently been accepted onto the Healthcare Improvement Scotland Focus on Frailty Programme with clear national outcome milestones for 2027.

vii In December 2025, Professor Stephen Friend held a session in Orkney on the use of dynamic frailty assessment tools which enable daily frailty monitoring and support earlier intervention as well as to allow more proactive care. The workstream are exploring expansion of telehealth, remote monitoring, apps and wearable technology to support independence.

3.5 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	While there are no patient, safety or quality implications directly arising as a result of this report, completing the actions of the Older Persons and Frailty Workstream will improve service delivery, increase multi-disciplinary working and improve the outcomes for individuals receiving services.
People	Workforce	No	While there are no immediate workforce implications, progressing the actions within the Older Persons and Frailty Workstream will improve MDT working and collaboration which will benefit the services.
Performance	Finance	No	There are no immediate financial implications directly arising as a result of this report, nevertheless, it is anticipated that improvements in service delivery will better ensure that people will more consistently receive the help they need when they need it This is likely to improve their outcomes and reduce the costs of crisis and acute care.
Potential	Risk Management	No	There are no risk implications directly arising from this report.
	Digital	No	There are no digital implications directly arising as a result of this report, although there is a recognition that further work and developments will be required to maximise digital solutions to some aspects of health care.
Place	Equality and Diversity including health inequalities	No	There are no equality or diversity implications directly arising as a result of this report.

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

4. Recommendation

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

5. List of appendices

5.1 The following appendices are included with this report:

i **Appendix 1**, Older Persons and Frailty Workstream Deep Dive.

ii **Appendix 2,** Older Persons and Frailty Workstream – Deliverables & Milestones

NHS Orkney

Item 14.5.1

Transformational Priorities Programme

Older Persons and Frailty Workstream Deep Dive

1. Introduction / Background

The Older Persons and Frailty Workstream was established following the Clinical Services Review (CSR). It focuses on improving care and outcomes for older people in Orkney, particularly those living with frailty, dementia, and complex needs. The workstream provides a coordinated, system-wide approach to supporting earlier intervention, improved multidisciplinary working, and more joined up care across services, aiming to reduce unwarranted variation, support people to maintain independence and live at home for longer, while improving patient experience and system flow.

The workstream brings together a range of interrelated improvement activities under a single framework, providing oversight and coordination across key areas of focus. Governance arrangements are in place to support delivery, with progress monitored through a dedicated Older Persons Working Group and escalated through established programme reporting routes.

This paper provides a deep-dive overview of the Older Persons and Frailty Workstream, outlining the key areas of activity and progress to date.

The agreed work strands are:

1. Analytical reviews
2. Getting It Right for Everyone (GIRFE) Team Around the Person
3. Intermediate Care Allied Health Professions (AHP) Single Point of Contact (SPoC)
4. Dementia services review
5. Care at Home and Care Home Services
6. Frailty development areas
7. Telehealth expansion

2. Work strands Overview

2.1 Analytical Reviews

A programme of time-limited analytical activity is underway to build a shared understanding of current pathways, decision-making, system pressures, and to inform where earlier intervention, improved coordination, or service redesign could improve patient outcomes and system flow.

Case study mapping exercise

Three patient journeys – one with frailty and falls, one with dementia, and one from the isles – are being mapped to understand system challenges, duplication, and missed opportunities for earlier intervention or prevention.

Three patients have been identified with information requests issued. Due to the resource-intensive nature of data collation, particularly where paper records are involved, cases are being progressed sequentially to support focused collation. Data will be consolidated into chronological timelines and reviewed by the Working Group, with learning captured through case studies.

Milestone: Completion of case study mapping, with learning identified and case studies produced by end June 2026.

Output: Evidence-based case studies that articulate system constraints and opportunities.

Outcome: A robust evidence base to agree and prioritise improvement actions that improve system flow, multidisciplinary working, and service experience for older people.

Multidisciplinary (MDT) Team activity mapping

MDT activity mapping is being undertaken to clarify existing MDT arrangements, including purpose, frequency, membership, and administrative support, in response to identified coordination challenges. An MDT mapping template has been developed to

support consistent data collection and identification of opportunities to better organise MDTs around the person, aligned with GIRFE.

Milestone: Completion of MDT activity mapping by end May 2026.

Output: Completed MDT mapping dataset and standardised template capturing current MDT arrangements.

Outcome: A shared understanding of current MDT arrangements and coordination challenges, providing a clear evidence base to improve MDT organisation and strengthen multidisciplinary working.

Guardianship deep-dive

Analysis is underway to assess the extent to which delayed discharges are linked to the absence of Power of Attorney (PoA) or guardianship arrangements. Findings will inform opportunities to strengthen capacity assessment processes and earlier intervention, including consideration of extended sign-off assessments and targeted public awareness to support earlier planning.

Admission deep-dives

An admission deep-dive for patients aged 75 and over, alongside a 30-60-90-day admission review, will examine reasons for presentation, admission, and readmission across defined time horizons. This analysis will identify demand patterns, early readmission trends, medium-term deterioration or system gaps, and opportunities for admission avoidance and earlier preventative intervention.

Support has been offered by the Scottish Government Rapid Improvement Team to assist with these analytical reviews. Milestones will be confirmed once scope and support arrangements are agreed.

Outputs (across above reviews): A suite of evidence-based analytical outputs covering delayed discharge drivers linked to absent POA

or guardianship arrangements, admission and readmission trends, and wider system pressures.

Outcomes (across above reviews): A clear evidence base to inform improvements to capacity assessment and earlier POA planning, and to prioritise high-impact improvement actions that improve system flow, outcomes, multidisciplinary working, and service experience for older people.

2.2 GIRFE Team Around the Person Pilot

The GIRFE Team Around the Person toolkit was codeveloped through national pathfinder areas, including Orkney Health and Social Care (OHAC) Partnership. Older people and frailty were a defined GIRFE pathfinder theme, with local engagement identifying priorities such as a single care coordinator, better connected support, reduced repetition, and access to services closer to home, including through virtual appointments. These priorities informed the development of the toolkit.

A pilot is underway to test the toolkit on the inpatient wards, with one GP practice and the Link Practitioner Service. The *My* Plan and *My* Team documents have been refined, alongside a patient leaflet and Patient Reported Experience Measure (PREM) based evaluation tools. These are being tested with a small cohort of older people to inform refinement ahead of wider rollout. The pilot runs until the end of April, supported by drop-in sessions to capture feedback and learning.

Following evaluation, a phased rollout to other services will be proposed through the Older Persons Working Group, with opportunities to remove duplicative documentation where appropriate.

Milestone: Completion of pilot and review of evaluation by end May 2026.

Output: GIRFE toolkit developed and tested with a pilot cohort, with evaluation findings informing refinement of the toolkit and approach.

Outcome: A refined GIRFE toolkit with clear recommendations for phased rollout and scope across services, strengthening person-centred, coordinated care and reducing duplication.

2.3 Intermediate Care AHP Single Point of Contact Pilot

A key recommendation from the CSR was to establish a Single Point of Contact (SPoC) for Intermediate Care AHP services to address unclear referral pathways, duplication, and inefficiencies arising from referrals entering services through multiple routes. The SPoC and duty model being established aims to improve coordination, efficiency, and patient experience.

Referral and triage documentation has been developed, with the referral form added to SCI gateway for GPs. A Duty Huddle is being established to coordinate community-based referrals for Physiotherapy, Occupational Therapy, and Intermediate Care services (Home First, Ageing Well, and ICT), with rota arrangements being finalised. A training plan, including *Good Conversations* training, will be delivered ahead of the pilot launch on 5 May 2026.

Milestone: Launch of pilot by 5 May 2026, with evaluation completed by end June 2026 to inform decisions on continuation or scale-up.

Output: A tested Single Point of Contact model, including agreed referral and triage processes, Duty Huddle arrangements, and supporting training.

Outcome: Improved coordination and oversight of community-based AHP referrals, reducing duplication and delays, clarifying referral pathways for referrers, and a more efficient, person-centred approach that improves patient experience and supports system flow.

2.4 Dementia services review

A review of dementia service pathways and processes is underway to assess effectiveness and identify opportunities for improvement and service redesign. Agreed areas of focus include pre-diagnosis and future arrangements for the GP with a Specialist Interest in Dementia role, expansion of the Admiral Nursing Service, redesign of post-diagnostic support, and increasing awareness of dementia risk factors.

A dementia development session has been held to map existing pathways, with a focus on pre-diagnosis and referral into dementia services. A second session is scheduled in June 2026 to consider acute and inpatient pathways. Findings from both sessions will inform service changes and improvements. Public Health has agreed to support increased awareness of dementia risk factors, aligned with a current focus on brain health, and the dementia strategy will be updated and formalised.

Milestone: Completion of development sessions, with agreed actionable plans for improvements and redesign by end July 2026.

Output: A mapped and evaluated overview of current dementia service pathways, and identified improvement priorities, informed by development sessions, and an updated dementia strategy.

Outcome: A clear agreed direction for dementia service improvement and redesign, enabling more coordinated pathways, strengthened post-diagnostic support, increased awareness of dementia risk factors, and a formalised dementia strategy that improves experience and outcomes for people living with dementia and their carers.

2.5 Care at Home and Care Home services

Care at Home and Care Home services are a key strategic priority within the workstream and represent a significant area of delivery. Work is underway to scope future service and workforce models across community and social care to ensure they are sustainable, flexible, and aligned to current and future needs.

This programme of work will support the development of more coordinated, nursing-enabling models of care, strengthening capacity across the system and supporting improved flow for older people.

Further detail on scope, milestones, and delivery arrangements will be developed as this work progresses, subject to appropriate governance and engagement.

2.6 Frailty development areas

Frailty recommendations arising from the CSR are being incorporated into the Older Persons and Frailty Workstream to support a more integrated, system-wide approach.

Key areas of focus include the introduction of Clinical Frailty Scale (CFS) scoring supported by eFrailty index use, development of clear protocols linked to frailty scores (including referral triggers and integration of advanced care planning), establishment of dedicated frailty assessment and triage processes, strengthened MDT working, expansion of responsive community services (including virtual ward monitoring for high-risk patients), and improved communication and handover across services. A regular complex frailty MDT meeting has already been established, led by the Consultant Geriatrician to support patients with moderate to severe frailty.

Before progressing these recommendations, the Older Persons Working Group agreed to undertake a frailty process-mapping exercise to identify system gaps, disconnections, and opportunities for improvement. This will inform prioritisation and phasing of subsequent improvements.

Milestone: Completion of frailty process-mapping workshop and agreement of prioritised improvement actions and phasing by end June 2026.

Additionally, NHS Orkney has been accepted onto the Healthcare Improvement Scotland (HIS) Focus on Frailty Programme, providing a structured national improvement framework.

Programme outcome-based milestones (HIS Focus on Frailty):

- By March 2027, at least 10% of people aged 65 and over will have a recorded Rockwood Clinical Frailty Scale assessment within the relevant clinical system, with improved information-sharing to reduce duplication and support joined-up working.

- By March 2027, 70% of people with a CFS score of 5 or above will have evidence of proactive, community-based support within the previous 12 months, supporting

earlier intervention, reduced deterioration, and improved outcomes for older people across Orkney.

2.7 Telehealth expansion

A key opportunity identified through the CSR is the expansion of telehealth, self-monitoring, and app-based support to help people maintain independence and live at home for longer.

In December 2025, engagement with Professor Stephen Friend explored the use of dynamic frailty assessment tools, including apps and wearable technologies, which enable daily frailty monitoring and support earlier intervention and more proactive care.

Further opportunities are being explored through a potential partnership with BT and Feebris to develop virtual care solutions for people living with frailty. As frailty pathway mapping progresses, these opportunities will be assessed to identify where digital solutions can most effectively support local improvement activity and emerging frailty pathways.

Milestone: Review of telehealth opportunities by end June 2026.

Output: An assessment of telehealth and virtual care opportunities for frailty including dynamic frailty assessment tools and remote monitoring solutions, with recommended priority use cases aligned to local frailty pathways.

Outcome: A clear basis for optimising digital solutions where they add most value, supporting earlier intervention, proactive management of frailty, and helping people maintain independence and live at home for longer.

4.0 Summary

The Older Persons and Frailty Workstream is a large, system-wide programme of improvement. Good progress has been made across all work strands, supported by strong governance. Key analytical reviews, pathway mapping, and pilot activity are underway or nearing completion, providing a growing evidence base to inform targeted improvement actions and service redesign.

Delivery is supported through clear governance arrangements, defined milestones, and alignment with national programmes, including GIRFE, the HIS Focus on Frailty Programme and support from the Scottish Government Rapid Improvement Team. An Older Persons Strategy will be produced as a key output of the workstream.

Given the scale and interdependency of the workstream, delivery will continue until 2028, particularly in high-impact areas such as Care at Home and Care Home services and frailty development. Continued dedicated project management is essential to maintain momentum, manage dependencies and coordination across strands, and ensure emerging learning is translated into sustainable improvements that reduce delays and improve experience and outcomes for older people in Orkney.

Appendix 2: Older Persons and Frailty Workstream – Deliverables & Milestones

Item 14.5.2

Work Package	Deliverable	Delivery Lead
Complex frailty MDT meetings	By April 2026, establish regular complex frailty MDT meetings and identify the mechanism to coordinate them to effectively support pre-emptive frailty care planning	Rita Mildner / Ruth Lea
GIRFE Team Around the Person	By May 2026, embed the Getting It Right for Everyone (GIRFE) Team Around the Person approach, starting with the inpatient areas and one GP practice	Ruth Lea / Gina McMahon
MDT mapping exercise	By May 2026, complete a mapping exercise of all Multidisciplinary Team (MDT) activity across acute, primary, and community care, detailing membership, function, remit, and how each MDT is embedded within the system. Agree and embed recommendations to support a consistent foundation for multidisciplinary forums	Stephen Brown / Harmony Bourn
Case study mapping exercise	By June 2026, complete chronologies and undertake a mapping exercise for three individual patients - one with frailty and falls, one with dementia, and one from the isles - each with multiple professional interventions and hospital admissions. Identify where issues could have been prevented or managed differently and produce three case studies to inform shared learning	Ruth Lea / Harmony Bourn
Intermediate Care AHP Single Point of Contact (SPoC)	By June 2026, establish a Single Point of Contact (SPoC) for referrals to Ageing Well, Home First, Intermediate Community Therapy, Community Physiotherapy, and Occupational Therapy services	Ruth Lea
Review dementia service	By July 2026, review the dementia service by undertaking dementia development sessions and agree a plan for required service changes, including future arrangements for the GP with a Specialist Interest in Dementia role and extending the Admiral Nursing service	Gillian Coghill
Review and redesign the model for post-diagnostic dementia support	By September 2026, review and redesign the model for post-diagnostic dementia support, with tendering and negotiation undertaken through Orkney Islands Council procurement	Lynda Bradford
Produce draft dementia strategy	By September 2026, produce a draft updated Dementia Strategy for Orkney and increase the awareness of risk factors for developing dementia	Gillian Coghill / Hannah Casey

Appendix 2: Older Persons and Frailty Workstream – Deliverables & Milestones

Work Package	Deliverable	Lead
Develop proposal to enhance innovative respite services	By September 2026, develop a proposal to enhance innovative respite services aligned with the Carers Strategy	Helen Sievewright
Expand telehealth provision	By March 2027, expand telehealth provision for older people by increasing access to self-monitoring and app-based support to enable more individuals to manage their health independently from home	Stephen Brown
Produce Older Persons Strategy	By March 2027, produce an Older Persons Strategy that outlines how the needs of older people will be met through a coordinated, multidisciplinary approach across acute, primary, community, and third-sector services	All

Appendix 2: Future work strands in scope (Milestones to be agreed)

Work Package	Deliverable	Lead
Integrate Intermediate Care AHP Workforce	Integrate the Intermediate Care Allied Health Professional (AHP) Workforce	Ruth Lea
Care home staffing model and Care at Home service	Review workforce models across Care Home and Care at Home services to ensure they are sustainable, flexible, and aligned to current and future needs. Review and implement a new staffing model for the three care homes, including rota redesign, introduction of residential nursing beds, and a review of the Care at Home service to maximise workforce capacity and ensure a sustainable, fit-for-purpose model	Helen Sievewright / Lynda Bradford

Item 15.1

Month 11 Financial Position

Meeting	**NHS Orkney Board**
Meeting date	Thursday, 30 April 2026
Responsible Executive/Non-Executive	• Melanie Barnes, Interim Director of Finance
Report Author(s)	• Melanie Barnes, Interim Director of Finance
Purpose of report	• Discussion
Contribution to Strategic ambition	• Corporate Strategy 2024/28 • Annual Operational Plan • Government policy/directive • Legal requirement
Alignment to NHS Scotland quality ambition(s)	• Effective • Quality • Sustainability
Key points for consideration	• Improvement in the YTD financial position and year end forecast due to unanticipated income and release of IJB reserves • As at Month 11 the reporting position is a deficit of £2.44m and a Year End Forecast of £2.6m. • Savings of £2.526m have been achieved as Month 11
Route to meeting	• Finance and Performance Committee 25 March 2026
Recommendation(s)	• Discussion - Consider the Implications of a matter

Month 11 Financial Position

Melanie Barnes, Interim Director of Finance

31/03/2026

1. Situation

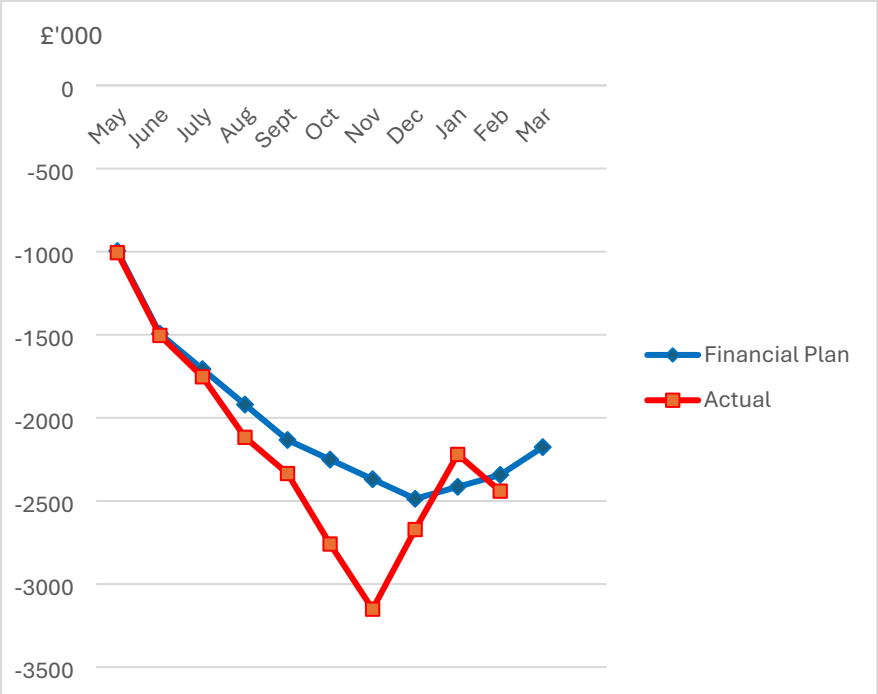
1.1 NHS Orkney remains escalated to stage 3 of the NHS Scotland Support and Intervention Framework for finance. The Board has an approved financial plan for 2025/26 which projects a full-year deficit of £2.176 million against its revenue resource limit. This is prior to the application of £2.9 million in Transitional Funding Support agreed with the Scottish Government.

1.2 At the end of Month 10, the reported financial position an overspend of **£2.441m**, which is £276k higher than the planned deficit of £2.176m but £98k higher than the planned trajectory at Month 11.

2. Background

2.1 At the end of Month 11, the reported financial position an overspend of **£2.441m**, which is £276k higher than the planned deficit of £2.176m but £98k higher than the planned trajectory at Month 11. The achieved savings at Month 10 is **£0.609m adverse** to the YTD target of £3.135m.

2.2 Whilst there has been a slight deterioration in the YTD position as at Month 11, the position has significantly improved since Month 9. This is predominantly due to the release of reserves by the IJB. This is a non-recurring benefit for 2025/26 only.



2.3 A revised year-end forecast was submitted to SG in Month 8, predicting a deficit of £4.2m at 31 March 2026. Due to the improvements in Month 9, a revised forecast of £3.6m was submitted. With the release of the IJB reserves, the forecast has been further reduced in Month 10 to £2.7m. Scottish Government have confirmed that the transitional funding of £2.9m will be provided, however any deficit position over £2.9m will be shown as an overspend in the annual accounts. The forecast year end position is likely to around £2.7m so the risk of a Section 22 Qualification should be mitigated for 2025/26.

3. Assessment

3.1 Analysis

Following submission of the revised year-end forecast in Month 8, SG made it clear that they are still expecting NHS Orkney to deliver as close to the approved financial plan as possible. The revised forecast of £2.6m at Month 10 is positive and work is continuing to review expenditure forecasts and savings schemes to identify opportunities for reducing the year end deficit to as much as possible.

The improvement in the position since Month 9 is due to:

- Agreement by the IJB to released untilised reserves of a YTD value of around £580k
- Unanticipated income of around £640k
- Additional unplanned expenditure in the first 10 months which was not included in the financial plan

- a reduction in funding from SG from what was originally anticipated
- YTD savings target underachieved by £.609m (excluding the unachieved IJB savings target).

3.2 Current Position

At Month 8 a detailed expenditure forecast was undertaken and outlined a range of potential outcomes. This showed that the likely year-end out-turn would be £4.2m. Due to the receipt of income and the release of IJB reserves, this has now been revised to show a likely year end income of £2.7m

3.3 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	Successful delivery of transformation ensures improved clinical outcomes and patient experience. Quality Impact Assessments are a pre-requisite of any identified efficiency/ transformation scheme to ensure the best outcomes for patients as part of any scheme pursued in the delivery of the financial plan.
People	Workforce	Yes	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	Several of the ongoing improvement/ savings schemes in place to deliver against the Board's financial plan incorporate schemes to reduce travel to and from Orkney with a number of additional schemes that look to reduce waste and overall the environmental impact

4. Recommendations

4.1 Discuss the Month 11 Financial Position

4.2 Discussion - Consider the Implications of a matter

5. List of Appendices

5.1 The following appendices are included with this report

i. **Appendix 1,** Month 11 Financial Position

Notes on use of the template

i. The first page is the cover page, the main body of your report should follow from page 2.

ii. Where a separate report is attached as the main report, complete the impact assessment and recommendations (sections 3 and 4)

iii. The markers <….> indicate what should be completed, do not include the <> markers.

iv. The numbering of each section is automatic, use tab, and shift tab to move ahead and back a numbering level.

v. Font is Arial 12pt for body text and is set by default

vi. Do not change the margins

NHS Orkney

Financial Position – Month 11 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 £2.9 million in Transitional Funding Support agreed with the Scottish Government.

At the end of Month 11, the reported financial position an overspend of **£2.441m**, which is £276k higher than the planned deficit of £2.176m and £98k higher than the planned trajectory at Month 11.

Year to Date Financial Position

After 11 months of the 2025/26 reporting period, the revenue position shows an **overspend of £2.441m**, which is **£0.276m higher** than the approved deficit in the financial plan of £2.176m and **£0.098m higher** than the planned year-to-date overspend of £2.343m.

The achieved savings at Month 11 is **£0.609m adverse** to the YTD target of £3.135m. The trajectory of savings was geared towards the final quarters of the financial year with 17.5% due to be delivered in the final month of the year. Following a full review of each of the workstreams, only £1.676m of cash-releasing savings will be delivered (44% of the total target of £3.8m).

A review of the expenditure forecast has also been carried out which shows the run-rate is in line with predictions and total expenditure will overspend by £2.66m at year-end following analysis on the reserve position for both the Board and the IJB.

Month 11 Year to Date Financial Position

The favourable YTD variance at Month 11 is due to several events:

- Agreement by the IJB to release unutilised reserves of a YTD value of around £580k
- Unanticipated income of around £640k

This is offset against:

- Additional unplanned expenditure in the first 11 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 £0.609m (excluding the unachieved IJB savings target).

Graph 1 illustrates the financial plan trajectory compared to the actual monthly results after 11 months of the 2025/26 financial year.

Graph 1: Year to Date Run Rate vs Planned Run Rate

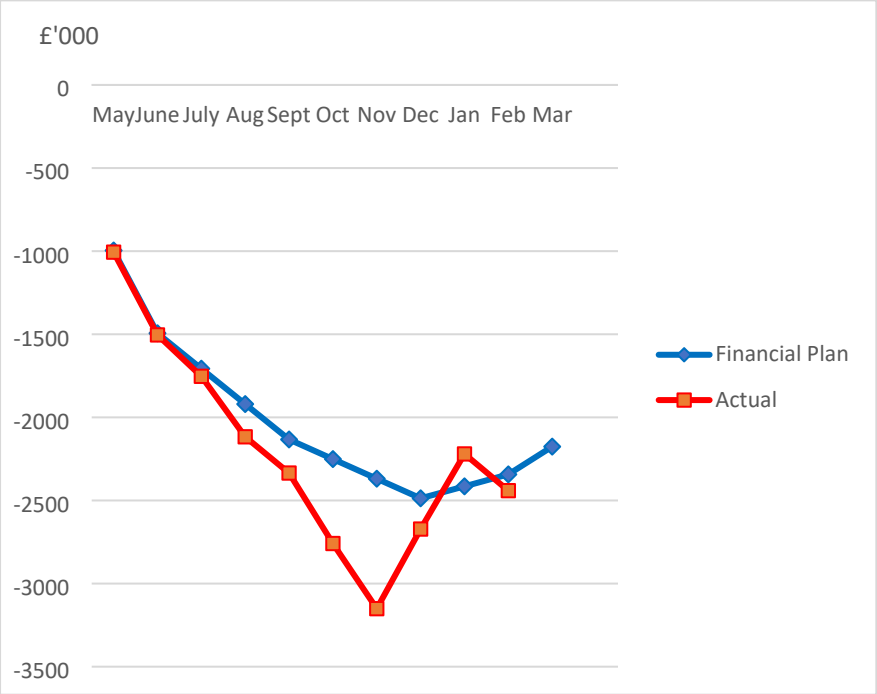


Table 1: Summary Month 11 Position

Level 4 Cost Category	Annual Budget	YTD Period Budget	YTD Actuals	Variance	Period Budget	Actuals	Period Variance
Income							
Health Board Income	-1,169	-1,020	-1,127	106	-172	-68	-104
Other	-491	-450	-1,131	682	-41	-80	39
Primary Care Patient Charges	-375	-393	-342	-51	-41	-36	-5
Total Income	**-2,035**	**-1,863**	**-2,600**	**737**	**-254**	**-184**	**-70**
Expenditure							
Pay							

Medical & Dental	9,268	8,495	11,440	-2,945	772	1,108	-335
Nursing & Midwifery	17,003	15,582	14,729	853	1,440	1,376	64
Other Staff Costs	28,181	25,799	21,053	4,746	2,498	2,008	490
Total Pay	**54,451**	**49,876**	**47,222**	**2,654**	**4,711**	**4,492**	**219**
Non-Pay							
Drugs - Primary Care	4,902	4,493	4,472	21	408	450	-42
Drugs - Secondary Care	3,698	3,389	3,008	381	308	287	21
General Dental Services	1,009	1,077	1,077	0	95	95	-0
General Medical Services	5,244	4,807	4,798	9	431	432	-1
General Ophthalmic Services	316	283	284	-0	23	23	0
Medical Supplies	1,594	1,461	1,703	-242	133	150	-17
Other Expenditure	9,994	9,049	14,843	-5,794	746	980	-235
Pharmaceutical Services	1,017	972	975	-3	89	80	9
Resource Transfer	2,334	2,140	2,134	6	195	194	1
SLA's & UNPACs	10,033	9,197	9,407	-210	836	943	-107
Total Non-Pay	**40,141**	**36,868**	**42,701**	**-5,833**	**3,264**	**3,634**	**-370**
Total Expenditure	4,902	4,493	4,472	21	408	450	-42
Total	**92,558**	**84,881**	**87,322**	**-2,441**	**7,721**	**7,942**	**-221**

Improvement Programme

NHS Orkney has an integrated improvement function which is responsible for driving savings delivery within the organisation. £3.800m of savings are required to be achieved during 2025/26 to deliver the £2.176m deficit plan (before Transitional Funding Support £2m).

The Board has achieved £2.526m after 11 months against a trajectory of £3.135m.

At M5 the Improvement Programme reported a forecast delivery of £3.326m with additional pipeline schemes being scoped and progressed to implementation stage. At Month 5 £1.95m had been highlighted as medium or high risk to deliver.

A further review of all schemes was undertaken during M6, and the savings forecast was updated to reflect progress made to date in the implementation of schemes. As 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 £1.676M** of which £1.634M are already in the forecast run rate.

Overview: Month 11 Financial Position (Core RRL)

The overview at Month 11 is summarised in Table 2, with further detail provided in Appendix 1. Estates, Facilities and IT were moved under the Finance Directorate in Month 7.

Table 2 – Core RRL by Area

Directorate		Annual Budget	YTD Period Budget	YTD Actuals	Variance	Period Budget	Actuals	Period Variance
Acute Services Directorate	Income	-235	-215	-308	93	-20	4	-24
	Pay	17,359	15,912	18,139	-2,227	1,468	1,587	-120
	Non Pay	2,188	2,006	1,988	18	182	183	-0
Acute Services Directorate	**Total**	**19,312**	**17,703**	**19,818**	**-2,116**	**1,630**	**1,774**	**-144**
Chief Executive Directorate	Income	0	0	-17	17	0	-1	1
	Pay	2,575	2,380	2,124	256	195	199	-4
	Non Pay	167	163	72	91	4	-52	56
Chief Executive Directorate	**Total**	**2,741**	**2,543**	**2,179**	**364**	**199**	**146**	**53**
Chief Officer Integration Board	Income	-681	-572	-600	27	-132	-52	-80
	Pay	17,291	15,794	14,502	1,292	1,611	1,374	236
	Non Pay	15,753	14,444	16,205	-1,760	1,309	1,464	-155
Chief Officer Integration Board	**Total**	**32,363**	**29,666**	**30,107**	**-441**	**2,788**	**2,786**	**2**
Directorate of Human Resources	Income	-43	-39	-79	40	-4	-4	1
	Pay	1,496	1,371	1,027	344	125	97	28
	Non Pay	333	305	229	77	28	34	-7
Directorate of Human Resources	**Total**	**1,786**	**1,637**	**1,177**	**460**	**149**	**127**	**22**
Finance Directorate	Income	-572	-525	-942	418	-48	-51	3
	Pay	9,385	8,603	5,889	2,714	782	615	167
	Non Pay	2,534	2,306	7,354	-5,047	113	418	-305

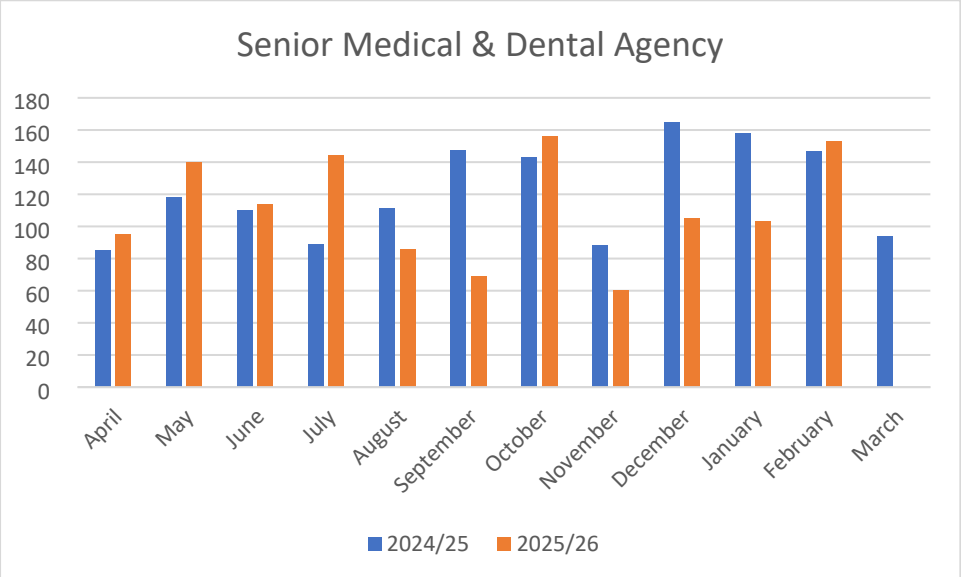
Finance Directorate	**Total**	**11,347**	**10,385**	**12,301**	**-1,916**	**847**	**982**	**-135**
Medical Directorate	Income	-196	-181	-290	110	-16	-41	26
	Pay	3,457	3,170	3,074	96	287	389	-102
	Non Pay	16,737	15,233	14,521	712	1,413	1,385	28
Medical Directorate	**Total**	**19,997**	**18,222**	**17,305**	**918**	**1,684**	**1,733**	**-49**
Performance And Transformation	Income	0	0	-12	12	0	-1	1
	Pay	1,768	1,617	1,462	155	151	141	10
	Non Pay	14	13	37	-24	1	-3	4
Performance And Transformation	**Total**	**1,782**	**1,630**	**1,487**	**143**	**152**	**136**	**16**
Public Health Directorate	Income	-66	-61	-81	20	-6	-7	2
	Pay	1,122	1,028	1,004	24	93	89	4
	Non Pay	183	168	66	102	15	7	8
Public Health Directorate	**Total**	**1,239**	**1,136**	**989**	**147**	**103**	**89**	**14**
	Total	**90,568**	**82,922**	**85,363**	**-2,441**	**7,553**	**7,774**	**-221**

Appendix 1 provides high level performance detail of each area.

Significant Areas of Concern

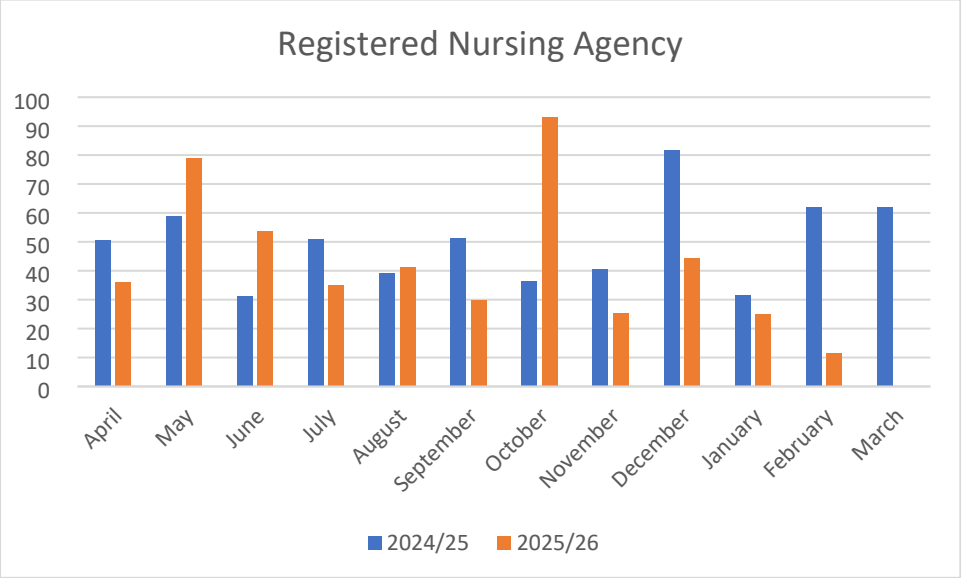
Medical Staffing Costs

During the first 11 months of the 2025/26 financial year, medical staffing costs have remained high, with costs £1.345m higher than 2024/25, thereby continuing to represent a significant area of financial pressure. This cost category is a key focus within the Board's grip and control measures, with targeted actions being implemented through the Improvement Programme to reduce expenditure over the remainder of the year. Review of locum and agency rates is being undertaken to reduce costs.



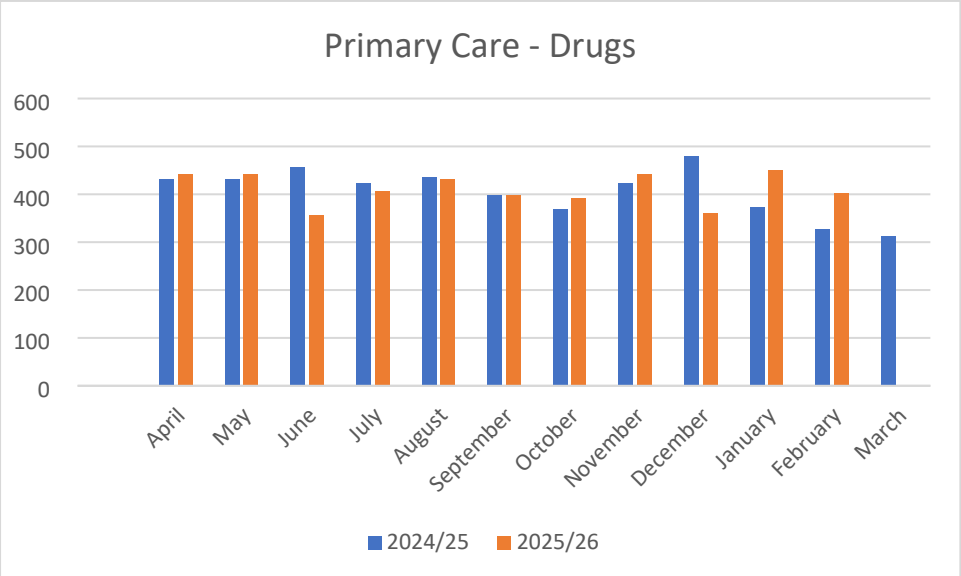
Agency Spend

Agency spend in nursing reduced in Q2 (compared to Q1) due to successful recruitment to vacant posts both within Acute and Community services however it rose again in Q3 (above Q1 levels) but has reduced again in Q4. Community nurse agency costs have remained above what was originally planned in the first 11 months of the financial year and rose in Q3 to cover vacancies. The agency costs are covering vacancies within community nursing teams and whilst controls are in place to ensure the overall spend does not exceed budget, the continued reliance on agency staffing must be reduced wherever possible.



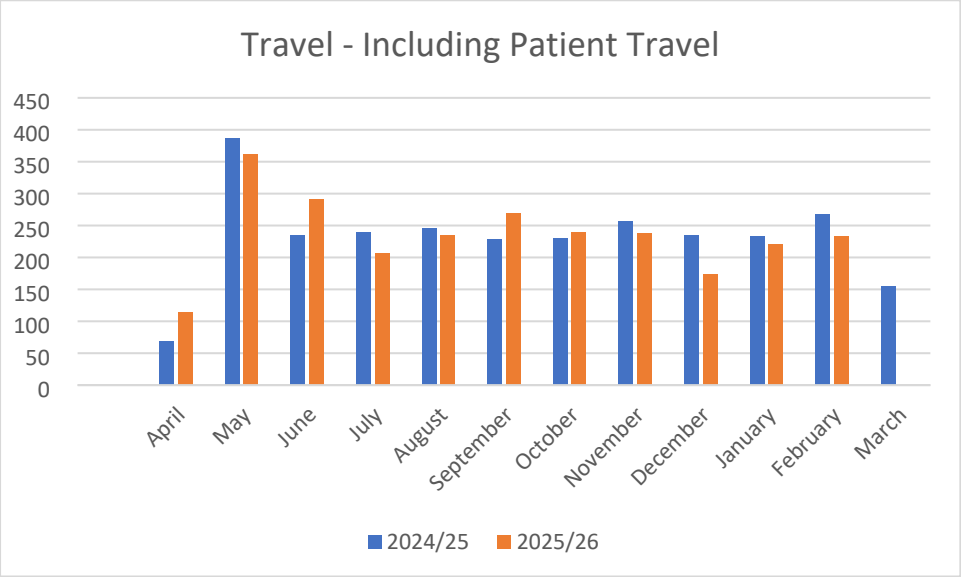
Primary Care Prescribing

Primary Care prescribing costs continue to be lower than those anticipated during the budget setting process, although we have seen a significant increase in Months 10 and 11. 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.



Travel

Travel (including patient and staff travel) saw decrease in the past 3 months which is probably a result of fewer patients and staff travelling over the Christmas period and due to weather disruption in January and February. Inflationary increases of 3.8% have been charged from 1 December on flights which will have an impact of the final 4 months of the year. The financial plan assumed a 2.2% increase in the cost of flights.



Year-End Forecast

In Month 8, we undertook a detailed expenditure forecast and outlined a range of potential outcomes. The forecast out-turn at that stage was estimated to be in the region of a £4.2m deficit. Several turn-around actions were implemented and in the past few months we have seen an increase in non-recurring income and a reduction in expenditure which has improved the forecasted position at year end.

Scottish Government has confirmed that we will receive our planned transitional funding and increased the value for 2025/26 to £2.9m.

Modelling of the likely year-end scenarios show that in the worst-case scenario the likely overspend is in the region of £3.0m. This is a reduction from previous forecasts due to the increase income and reduced expenditure. Any year-end position over a deficit of £2.9m will result in reporting an overspend position at year end.

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		**(2.270)**	**(2.058)**	**(1.700)**
Any New Funding		**(0.457)**	**(0.457)**	**(0.457)**
Reduction in Funding		**165**	**165**	**165**
Net Gap	**5,776**	**4.714**	**4.926**	**5.284**

CIPs – Recurring	**(2,800)**	**(1.521)**	**-1.268**	**(1.268)**
CIPs – Non Recurring	**(1,000)**	**(1.193)**	**-0.994**	**(0.994)**
Service Development Commitments	**200**	**0**	**0**	
25/26 Out-Turn	**2,176**	**2.000**	**2.664**	**3.022**
Transitional Funding	**(2,000)**	**(2.000)**	**(2.000)**	**(2.000)**
2025/26 Out-Turn	**176**	**0**	**0.664**	**1.022**

Capital

The Capital formula allocation for 2025/26 is £1.078m, there are several earmarked allocations anticipated in year for National Infrastructure Board (£202k), Decontamination (£282k), Solar Panels & Batteries (£109k) and Fleet Funding (£4k). Bids for unallocated capital budgets are reviewed and approved through the monthly Capital and Property Strategy Group. There is £613k of unallocated capital funding at the end of Month 6 and there is a plan to transfer £500k to Revenue as a result.

Currently there is no risk to any of the projects delivering. A final review of proposals for the unallocated capital funding will be undertaken during Month 7 and thereafter an action plan will be developed to utilise any unallocated budget.

Capital Projects		Total Approved Budget	YTD Actual	Forecast Remaining Expenditure	Variance	Notes
		£'000	£'000	£'000	£'000	
Formula Capital Projects		519	286	233	0	Approved Estates Projects 25/26
Earmarked Allocations	NIB Funding	202	109	93	0	Replacement of medical equipment 25/26
	Decontamination Funding	282		282	0	Replacement of CDU equipment 25/26
	Decontamination Funding	205		202	0	
	Digital Funding	56		56	0	
	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		559		0	559	£200k for survey works for demolition of the old Balfour

Transfer to Revenue		(500)			(500)	
Capital Receipts						
Total		1,436	395	982	59	

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.

Conclusion and Next Steps

The year-to-date financial position after the first 11 months of the 2025/26 financial year shows an adverse variance to plan, with a reported deficit of **£2.441m,** against the trajectory overspend of £2.343m, giving an overall adverse variance of **£0.098m** 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.

Appendix 1 –Performance summary

Acute Services - £2.116m overspend

- *Hospital Medical Staff, £2.532m 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, £0.239m overspend*

All services are overspending at the end of month 11. Theatres is overspent by £146k, OPD by £47k and Dialysis by £47k due to unfunded bank usage however Theatres is also overspent on surgical supplies.

- *Clinical Nurse Manager, £216k underspend*

Inpatients 1 (£216k overspend) and MacMIllan Specialist Nursing (£136k overspend) are both reporting overspends at month 11 which are being offset by underspends in HDU (£300k underspend), the Emergency Department (£163k underspend) and Macmillan Inpatient (£105k underspend). It was anticipated that the additional agency workers contracted in Q4 of 2024/25 would be removed in Q1 however, there continues to be some usage so far this year however plans are in place to remove all agency in Acute areas at the earliest opportunity.

- *Women's Health £155k underspend*

All services are underspending at the end of month 11. The main area of underspend is the Maternity Ward (£78k) and most of it can be attributed to vacancies.

- *Laboratories, £125k underspend*

Laboratories are reporting an underspend at month 11 due non-pay costs being down however the adverse movement in this month is due to higher-than-average supplies costs related to the managed service contract. The underspend in non-pay is offset by an overspend in pays due to agency usage to cover current vacancies.

Medical Director - £0.918m underspend

- *Pharmacy, £793k underspend*

New Medicines funding is currently underspent at month 11. Pharmacy are also carrying several vacancies which are impacting their overall position for 2025/26.

- *External Commissioning, £66k 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 £133k overspend*

Unplanned Activity is overspent to month 11 but it's variable by nature and is subject to significant potential movement throughout the year and at year end.

- *Patient Travel, £59k 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 - £0.441m overspend

The Delegated Services budgets report a net overspend of £0.441m, £1.118m operational underspend and £1.558m unachieved savings target (Table 1). Further detail on the operational areas is provided below:

- *Children's Services, £30k underspend*

The underspend in Children's services is in the main related to vacancies in Health Visiting and School Nurses.

- *Primary Care, £588k underspend*

Primary Care General Medical Services is currently underspending (£35k underspend at month 11) due in the main to vacancies. There are also underspends in Primary Care Administration (£206k underspend), Community Nurses (£284k) and Specialist Nurses (£47k underspend).

- *Primary Care – Dental £128k underspend*

The dental underspends relate in the main to Senior Dental and Dental Nursing.

- *Health and Community Care, £293k underspend*

Mental Health Services has an overspend of £2k at month 11. There are also underspends within the Health and Community Care Management Team (£129k underspend) and Intermediate Care Team (£42k underspend).

- *Primary Care Prescribing, £20k underspend*

The Prescribing Unified budget is currently showing an underspend of £4k at the end of period 11 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 £8k at month 11.

Finance - £0.125m underspend

Finance is currently reporting an underspend of £0.125m, with spend broadly in line with the position at month 10.

Estates and Facilities - £0.974m underspend

Estates and Facilities is reporting an underspend of £974k to date, in the main, the underspend is due to vacancies across several services and underspending non pay budgets and energy costs.

Chief Executive - £0.489m underspend

There are several vacancies across the portfolio impacting the month 11 position.

Public Health - £0.147m underspend

Currently reporting an underspend of £147k. There are various over and underspending services in this area.

Human Resources - £0.460m underspend

There are several underspending areas within the service impacting on the overall underspend, this includes vacancies across a number of areas.

Performance and Transformation - £0.143m underspend

There current underspend is mainly related to vacancies with Health Intelligence.

Item 15.2

Planned Care: Key Learning from Reducing 52-Week Waits

Meeting	**NHS Orkney Board**
Meeting date	Thursday, 30 April 2026
Responsible Executive/Non-Executive	• Tammy Sharp, Director of Performance and Transformation
Report Author(s)	• Tammy Sharp, Director of Performance and Transformation • Carrie Somerville, Head of Planning, Performance and Information
Purpose of report	• Assurance
Contribution to Strategic ambition	• Corporate Strategy 2024/28 • Annual Operational Plan • Emerging Issue • Government policy/directive • Legal requirement • Local policy • NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Person Centred
Key points for consideration	• The number of patients waiting over 52 weeks for Planned Care reduced significantly during 2025/26 • Improvements were delivered through strengthened long-wait management, targeted capacity, improved productivity, and enhanced governance oversight. • Controls are in place to sustain this position into 2026/27, with ongoing risks mitigated through proactive planning and continued Board oversight.
Route to meeting	• Paper has been prepared for this meeting
Recommendation(s)	• **Assurance - For members assurance only**

Planned Care: Key Learning from Reducing 52-Week Waits

Tammy Sharp (Director of Performance and Transformation), Carrie Somerville (Head of Planning, Performance and Information).

17/04/2026

1. Situation

1.1 This paper provides an overview to the Board on the progress made during 2025/26 to reduce the number of patients waiting over 52 weeks for Planned Care, outlining the improvements during the year, and sets out how this position will be sustained into 2026/27.

1.2 Throughout the year, reducing waits over 52 weeks has been a national and local priority the longest waits first, strengthening governance grip, and making best use of limited and flexible capacity.

1.3 The paper sets out that the improvement delivered is robust and that appropriate controls are in place to prevent the re-emergence of long waits in 2026/27.

2. Background

2.1 The national expectation to eliminate waits over 52 weeks required focus across planning, performance management, clinical services and Service Level Agreement partners. This paper focuses on what has made the difference, where risks remain, and how the organisation is adapting its approach as the national focus increasingly shifts towards earlier intervention thresholds.

NHS Orkney has continued to operate within available capacity, with particular pressures relating to fragile workforce cover, reliance on visiting clinicians, theatre availability, and the need to utilise regional and national capacity.

Despite these challenges, clear governance oversight has been maintained through regular waiting times meetings, routine reporting through the Integrated Performance Report (IPR), and escalation through established governance committees and meetings (Planned Care Programmed Board and Finance and Performance Committee). Throughout the year, a sustained focus has been placed on addressing the longest waits first, supported by targeted recovery actions and the use of flexible capacity.

3. Assessment

3.1 Analysis

During 2025/26, NHS Orkney has delivered a sustained reduction in the number of patients waiting over 52 weeks for Planned Care appointments and admissions. Improvement has been achieved through a combination of strengthened long-wait management, targeted use of additional capacity, improved productivity in theatres and outpatients, and enhanced governance grip.

Findings from previous years internal audits highlighted the importance of consistent ownership of waiting times including tracking activity, timely validation, and strong alignment between operational delivery and performance oversight.

Action taken in response has included a clearer focus on longest waits first, reinforcing validation checks prior to escalation, and ensuring learning from audits has been factored into operational improvement. These actions have supported greater confidence in the reported position and strengthened the organisation's overall grip on waiting times performance, including a reduction in those waiting longest.

To further address internal audit findings and to ensure more integrated working and reduce duplication, the Waiting Times Co-Ordinator and Cancer Tracking and Audit team has been realigned to sit within the Clinical Administration team. This has strengthened day-to-day grip and control between pathway tracking, booking activity and clinical services, supporting earlier identification of risk and more timely intervention.

Governance arrangements have also been enhanced through more regular discussion of planned versus actual activity at waiting times meetings. This has supported more active management of delivered capacity against planned trajectories, ensuring available appointment slots are maximised and under-utilisation is identified and addressed promptly. This will be further developed moving forward using Demand and Capacity reporting.

A review of appointment slots across services has been undertaken to improve consistency and efficiency, including alignment where appropriate with NHS Grampian clinic templates. This has contributed to improved comparability, supported capacity optimisation, and strengthened regional working arrangements.

3.2 What Worked Well – Key Lessons Learned

- Early identification and proactive management of risk for example horizon-scanning of patients approaching breach thresholds (not just those at 52 weeks) allowed earlier intervention.
- Strong operational grip supported by disciplined governance through regular waiting times review meetings with consistent tracking documentation and escalation routes, enabled timely action.

- Targeted use of additional capacity and funding through deployment of waiting list funding was most effective when aligned to clearly defined cohorts and delivery plans. Close monitoring of activity and spend improved confidence in delivery and ensured value for money.
- Effective regional working including early and consistent engagement with Service Level Agreement providers, including the Golden Jubilee was critical for managing the longest-waiting patients. Shared understanding of patient availability, travel logistics and scheduling of care reduced avoidable disruption.
- Increased focus on data and reporting discipline including the NECU validation and reconciliation processes on a twice yearly basis for each speciality which improved confidence in the reported position. Review of appointment times to align clinics with other Health Boards helped to increase the capacity.

3.3 Key Challenges/Risks and Mitigations

- Sustainability risk - Maintaining zero >52-week waits requires continued vigilance; achievement alone does not remove underlying demand–capacity imbalance in some specialties.
    - Maintain a strong grip on performance through weekly waiting times and performance management meetings, with early identification and escalation of patients at risk of breaching standards.
    - Embed predictive insight and forward planning, using demand and capacity modelling to identify pressure points early and inform targeted interventions by specialty.
    - Continue to prioritise use of additional capacity, including commissioned activity, to protect progress in services where underlying fragility remains.
    - Ensure sustained Board and Committee oversight through routine reporting within the Integrated Performance Report, providing assurance that improvements are being consolidated rather than short-term.

- Shift in national expectations - The anticipated move towards lower thresholds (e.g. 40 or 26 weeks) will require earlier and more predictive intervention, rather than escalation at the point of breach.
    - Strengthen anticipatory governance, shifting focus from breach management to earlier identification of pathway delays and emerging risk well in advance of national thresholds.
    - Continue to align local performance management arrangements with national planning and recovery priorities, ensuring readiness for changes in standards without destabilising current delivery.
    - Maintain close engagement with regional and national partners to ensure shared intelligence and coordinated responses as expectations evolve.

- Fragility in small services - Workforce availability, weather-related disruption and patient choice can disproportionately affect performance in small island services, increasing volatility.

    - Maintain flexible and resilient service models, including contingency planning for weather disruption and variable
    - Strengthen clear, proactive communication with patients, supporting informed choice while managing expectations around travel and scheduling constraints.
    - Use ongoing performance monitoring to identify volatility early, enabling targeted intervention and escalation where small-scale disruption risks disproportionate impact on overall standards.

3.4 Current Position

While the current position represents a significant improvement, the position remains vulnerable to known key challenges and risks associated with workforce fragility, reliance on visiting clinicians, and demand volatility in small services. However, controls identified through lessons learned are in place to mitigate

- Continued use of forward-looking waiting time surveillance, focused on earlier trigger points
- Integration of waiting times oversight within routine performance governance.
- Strengthened relationships with regional partners to support shared planning for high-risk pathways

Provided these controls are maintained, the assessment is that the current position is sustainable in the short to medium term.

3.5 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	Addressing long waits over 52 weeks has had a positive impact on patient safety and experience, particularly through earlier clinical review, prioritisation of patients at risk of harm, and more proactive pathway management.
People	Workforce	Yes	Delivered positive learning, strengthening multidisciplinary working, clarifying escalation routes, and improving shared ownership of waiting list management. More realistic capacity planning, earlier identification of pressure points, and better alignment with the principles of the *Health and Care (Staffing) (Scotland) Act 2019*, including consideration of staff wellbeing and sustainability.
Performance	Finance	Yes	Lessons learned reinforce the importance of earlier intervention, which is more cost-effective than late-stage breach management. Improved use of data, prioritisation, and regional collaboration supports better financial control

			by reducing the need for emergency or premium-cost solutions and helping to balance performance recovery with longer-term affordability.
Potential	Risk Management	Yes	Risks related to workforce availability, weather disruption, and external dependency are now identified earlier and escalated more consistently.
	Digital	Yes	There is a positive impact on accelerating digitisation through better use of performance dashboards and data flows to support proactive management rather than retrospective reporting. This strengthens organisational oversight while reducing manual effort and duplication for staff.
Place	Equality and Diversity including health inequalities	Yes	Reducing waits over 52 weeks supports the Public Sector Equality Duty and Fairer Scotland Duty by addressing prolonged delays that disproportionately affect vulnerable groups, including older people, those with long-term conditions, and patients living on ferry-linked isles.
	Climate Change Sustainability	Yes	Earlier and more planned intervention reduces reliance on last-minute or inefficient travel arrangements, supporting more sustainable models of care and better alignment with environmental considerations. Improved scheduling and use of local or regional capacity reduces unnecessary travel and associated emissions.

4 Recommendations

4.4 Assurance - For members assurance only

4.5 The Board is asked to **note** progress delivered during 2025/26 reducing the number of patients waiting over 52 weeks for Planned Care, take **assurance** that the improvement achieved reflects sustained management actions and strengthened governance grip to sustain the current position into 2026/27.

5. Appendices

There are no appendices included with this report.

Minute Audit and Risk Committee
2 December 2025

Attendance

Hazel Aim (Senior Corporate Governance Officer), Melanie Barnes (Interim Director of Finance), Suzanne Gray (Senior Financial Accountant), Issy Grieve (Non-Executive Board Member), Kat Jenkin (Head of Patient Safety, Quality and Risk), Joanna Kenny - Non-Executive Board Memberf), Dr Anna Lamont (Medical Director), Ryan McLaughlin (Non-Executive Board Member/Employee Director), Tammy Sharp (Director of Performance, Transformation and Deputy CEO), Jason Taylor (Non-Executive Director - Chair)

Guests: Martin Baird (Azets), Rachel King (Azets), Rashpal Khangura (KPMG, Iain Gray (Information Governance Manager and Data Protection Officer)

1. Cover page (Presenter: Chair)

To support the Board in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge

2. Apologies (Presenter: Chair)

The Chair opened the meeting at 0930 and welcomed members to the meeting.

Apologies were received from in Interim Chief Executive, Davie Campbell (Non-Executive Board Member), Rona Gold (Non-Executive Board Member), Stephen Brown (Chief Officer, Integration Joint Board)

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. Minutes of meeting held 2 September 2025 (Presenter: Chair)

The Chair presented the minutes of Audit and Risk Committee meeting held on 2 September 2025

Decision / Conclusion
The minutes of the Audit and Risk Committee were approved as an accurate record of the meeting

4.1. Chairs Assurance Report from meeting on 2 September 2025 (Presenter: Chair)

The Chair presented the Chair's Assurance report from the meeting held on 2 September 2025.

Decision / Conclusion
The committee approved the report.

4.2. ACTION LOG (Presenter: Chair)

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

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

Head of Patient Safety, Quality and Risk sought feedback regarding the presentation of risks, including the additional column to show changes from the original risk position. The chair requested the alignment of risk update cycles with committee meeting dates to enhance scrutiny and ensure updates are timely.

The Medical Director and Head of Patient Quality and Risk advised that aligning updates with committee cycles may require further coordination with risk owners and corporate governance however, this could be achieved early 2026.

They also advised that a revised process for escalation of corporate risks has been agreed by the Senior Leadership Team (SLT), and will be brought to Committee. Draft guidance documents for operational risk registers are in development. Several services, including maternity and acute sectors, are progressing with their own risk registers, with governance arrangements being aligned to agreed processes. Training for staff on the new guidance is anticipated by April.

The Committee was assured that the number of operational risk registers is increasing, with improved scrutiny and accountability through the Risk Management Group and Clinical Governance structures. The new process aims to simplify risk management and enhance responsiveness.

Specific risks discussed included Major Incident Planning, MRI scanner and Fragile Workforce and Clinical Services**.**

The Medical Director expressed her concern in respect of funding for the MRI scanner when the current stream ends, with the risk level currently under review and likely to increase.

The Head of Patient Safety, Quality and Risk advised that they were meeting the Executive Director of Nursing Midwifery and Allied Health Professionals next week to get a partial update to the Fragile Workforce and clinical services and would report back to the Medical Director by 4 November 2025.

Decision / Conclusion
The Committee noted and took assurance on the management of the Corporate Risk Register. They noted comments from the Head of Patient Safety, Quality and Risk that significant amounts of time were being spent seeking updates from Risk Owners. The chair indicated that he would raise the matter with the Interim Chief Executive.

5.1. Risk Management Group Chairs Assurance Reports (Presenter: Head of Patient Safety, Quality and Risk)

Head of Patient Safety, Quality and Risk reported that in October, the Risk Management Group revised its terms of reference to reflect maturity and remit growth. The process for risk escalation was streamlined to a single route, enhancing transparency and alignment with organisational values. Acute operational risk registers were reviewed and managed through the Clinical Quality Group. They also reported in November, discussions focused on essential training definitions and positive assurance regarding policy reviews.

Decision / Conclusion
The Committee noted the Chair's Assurance reports and took assurance from the work being undertaken.

6. RISKS ESCALATED FROM OTHER GOVERNANCE COMMITTEES (Presenter: Chair)

7.

Decision / Conclusion
No risks were escalated from other governance committees.

8. SENIOR LEADERSHIP TEAM CHAIR'S ASSURANCE REPORT

Decision / Conclusion
The Committee noted the Chair's Assurance Reports for Senior Leadership Team with reference to the discussions around Risk.

9. APPROVAL OF AUDIT AND RISK COMMITTEE CORE DOCUMENTS 2026/27 (Presenter: Chair)

Proposed revised documents for Terms of Reference, Workplan and Timetable for Papers for 2026/27 were presented to the Committee.

Decision / Conclusion
The Committee approved the revised documents.

10. PLACE

10.1. No items at this meeting

11. PEOPLE

11.1. No items for this meeting

12. PATIENT SAFETY QUALITY AND EXPERIENCE

12.1. Scottish National Audit Programme Update Cover Paper (Presenter: Head of Patient Safety, Quality and Risk)

12.2.

Head of Patient safety, Quality and Risk updated the committee on the Scottish National Audit Programme (SNAP), which encompasses nine national clinical audit programmes. NHS Orkney actively participates in five of these audits: Scottish Trauma Audit, Stroke Audit, Hip Fracture Audit, Cardiac Audit of Devices and Scottish Intensive Care Society Audit Group (SICSAG).

She advised that audits have now been brought together under the Safety, Quality and Risk banner, with quarterly meetings established for clinical and audit leads. This new structure enables regular review of audit findings, identification of areas for improvement, and escalation of concerns to the Clinical Quality Group and the Committee.

Challenges identified in SICSAG related to limited anaesthetic consultant capacity and training of staff members. Steps are being taken to address.

Decision / Conclusion
The Committee noted the report.

12.3. Risk Management Group Terms of Reference (Presenter: Head of Patient Safety, Quality and Risk)

Head of Patient Safety Quality and Risk presented the proposed revised Terms of Reference for the Risk Management Group. Membership was updated and reporting guidance was made more transparent and included stakeholder engagement and accountability.

The Medical Director commented that the amendments strengthened the scrutiny of risks.

Decision / Conclusion
The Committee approved the amended Terms of Reference for the Risk Management Group

13. PERFORMANCE

13.1. Counter Fraud Strategy Update (Presenter: Interim Director of Finance)

The Interim Director of Finance gave an update on the consolidated Counter Fraud Strategy.

It was reported that there have been no fraud allegations during the period.

Details of monies recovered via Patient Exemption charge errors were also provided.

She advised of recent communications to staff regarding Fraud Awareness Week, which aimed to raise awareness of fraud prevention measures across the organisation, setting clear expectations for staff, suppliers and those acting on behalf of NHS Orkney.

Decision / Conclusion
The Committee noted and were reassured by the ongoing work.

14. POTENTIAL

14.1. Internal Audit

14.1.1. Internal Audit Progress Update and Recommendations Tracker (Presenter: Director of Performance and Transformation)

R King, Azets presented the progress report, confirming that all but one audit - Health and Safety - for the year had been completed and this was scheduled to begin shortly.

M Baird, Azets presented the Final Audit Report for NHSO Information Governance and concluded minor improvements were required with 4 recommendations in relation to the general housekeeping of documentation.

Information Governance Manager and Data Protection Officer welcomed the report and advised that the 2 year mandatory training approach adopted by NHSO will be standardised to an annual cycle across Scotland from March 2026.
They commented that this was sensible but likely to present challenges.

R King, Azets presented the Final Audit Report for NHSO Financial Controls - Payroll. She reported that the audit found substantial improvements were required, highlighting the need for updated policies and procedures, improved sign-off processes, and assurance regarding outsourced payroll arrangements with NHS Grampian. This included the lack of local controls which currently allow staff members to enter information without cross check or validation, and a sample of errors, which in one case related to a £60000 overpayment.

Noting that 21 recommendations had been identified, members discussed the report and expressed their deep concern at the extent of the issues identified, especially given the financial situation the board currently faces. They did however recognize the focus and depth of the audit work and the importance of reviewing a business area previously assumed to be low risk, taking assurance that internal audit was fulfilling its role.

The Chair commented on previous errors that had been presented to committee, relating to a small cadre of staff whereby all but one had seen incorrect information entered in the system which had resulted in quite significant errors of payment.

An updated Internal Audit Recommendation tracker was not presented, due to resource limitations, noting that significant time and effort had to be routinely

applied to obtain updates from recommendation action owners. The Chair queried this and was advised that steps were being taken to have a fully updated report presented at the next meeting. This included support from Azets.

Decision / Conclusion
Medical Director praised the Information Governance Team for the really positive audit report.

The Interim Director of Finance will provide confirmation that the issues relating to staff payment errors have been rectified.

14.2. Draft External Audit Plan 2026/27 (Presenter: External Auditor)

R Khangura, KPMG presented a verbal update on external audit plans for 2026/27. They confirmed that guidance had been received from Audit Scotland and a meeting had been had with the chair. No significant changes are expected in the approach or accounting standards for the coming year. Areas of audit focus will include property, plant and equipment valuation, and fraudulent expenditure recognition, especially in light of the organisation's financial position.

The Chair advised that he had highlighted the finance rapid review to the external auditors as an area to be considered in their planning and audit work.

Decision / Conclusion
The Committee noted the update.

14.2.1. External Audit Recommendations (Presenter: Interim Director of Finance)

Interim Director of Finance confirmed that all recommendations from the External Audit have now been completed and were awaiting review by KPMG as part of the audit cycle.

Decision / Conclusion
The Committee were reassured by this update.

15. ITEMS TO BE INCLUDED ON THE CHAIR'S ASSURANCE REPORT (Presenter: Chair)

The Chair proposed the following to be included in the Chair's Assurance Report

- Approval of Audit and Risk Committee core documents for 2026/27
- Approval of the Risk Management Group terms of reference
- Update on the Scottish National Audit Programme (SNAP)
- Update on the Counter Fraud Strategy
- Discussion and assurance regarding the Corporate Risk Register
- Receipt of internal audit reports (Information Governance and Payroll) and progress update

- Receipt of external audit planning update and confirmation of completed recommendations
- Internal Audit recommendation tracker status
- Concerns regarding ownership of Risk and Audit actions

Decision / Conclusion
The Committee agreed to the above being added into the Chair's Assurance Report.

16. ANY OTHER COMPETENT BUSINESS (Presenter: Chair)

S Gray, Senior Financial Accountant, reported that a paper had been omitted from this meeting regarding the proposal to alter the timing of the year-end audit for the Endowment Fund.

This had been discussed with both the board external auditors and the endowment fund external auditors and in principle neither had any objections. I Grieve reported that it was not uncommon for charities to schedule audits for later in the year but stressed this was a decision for the Endowment Committee.

Decision / Conclusion
It was agreed that the missing paper would be circulated to members to provide comments to the Senior Corporate Governance Officer by close of play today to enable discussion at the Full Trustee Endowment Committee meeting on 4 December 2025

17. ITEMS FOR INFORMATION AND NOTING ONLY (Presenter: Chair)

17.1. Reporting Timetable for 2025/26

Decision / Conclusion
The Committee noted the Timetable for papers 2025/26

17.2. Record of Attendance 2025/26

Decision / Conclusion
The Committee noted the Record of Attendance 2025/26

The Chair closed the meeting at 11.10.

Minute Audit and Risk Committee
2 December 2025

Attendance

Hazel Aim (Senior Corporate Governance Officer), Melanie Barnes (Interim Director of Finance), Suzanne Gray (Senior Financial Accountant), Issy Grieve (Non-Executive Board Member), Kat Jenkin (Head of Patient Safety, Quality and Risk), Joanna Kenny - Non-Executive Board Memberf), Dr Anna Lamont (Medical Director), Ryan McLaughlin (Non-Executive Board Member/Employee Director), Tammy Sharp (Director of Performance, Transformation and Deputy CEO), Jason Taylor (Non-Executive Director - Chair)

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

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Decision / Conclusion
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The Committee was assured that the number of operational risk registers is increasing, with improved scrutiny and accountability through the Risk Management Group and Clinical Governance structures. The new process aims to simplify risk management and enhance responsiveness.

Specific risks discussed included Major Incident Planning, MRI scanner and Fragile Workforce and Clinical Services**.**

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Decision / Conclusion
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Decision / Conclusion
The Committee noted the Chair's Assurance reports and took assurance from the work being undertaken.

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Decision / Conclusion
No risks were escalated from other governance committees.

8. SENIOR LEADERSHIP TEAM CHAIR'S ASSURANCE REPORT

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Challenges identified in SICSAG related to limited anaesthetic consultant capacity and training of staff members. Steps are being taken to address.

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Decision / Conclusion
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13. PERFORMANCE

13.1. Counter Fraud Strategy Update (Presenter: Interim Director of Finance)

The Interim Director of Finance gave an update on the consolidated Counter Fraud Strategy.

It was reported that there have been no fraud allegations during the period.

Details of monies recovered via Patient Exemption charge errors were also provided.

She advised of recent communications to staff regarding Fraud Awareness Week, which aimed to raise awareness of fraud prevention measures across the organisation, setting clear expectations for staff, suppliers and those acting on behalf of NHS Orkney.

Decision / Conclusion
The Committee noted and were reassured by the ongoing work.

14. POTENTIAL

14.1. Internal Audit

14.1.1. Internal Audit Progress Update and Recommendations Tracker (Presenter: Director of Performance and Transformation)

R King, Azets presented the progress report, confirming that all but one audit - Health and Safety - for the year had been completed and this was scheduled to begin shortly.

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The Chair commented on previous errors that had been presented to committee, relating to a small cadre of staff whereby all but one had seen incorrect information entered in the system which had resulted in quite significant errors of payment.

An updated Internal Audit Recommendation tracker was not presented, due to resource limitations, noting that significant time and effort had to be routinely

applied to obtain updates from recommendation action owners. The Chair queried this and was advised that steps were being taken to have a fully updated report presented at the next meeting. This included support from Azets.

Decision / Conclusion
Medical Director praised the Information Governance Team for the really positive audit report.

The Interim Director of Finance will provide confirmation that the issues relating to staff payment errors have been rectified.

14.2. Draft External Audit Plan 2026/27 (Presenter: External Auditor)

R Khangura, KPMG presented a verbal update on external audit plans for 2026/27. They confirmed that guidance had been received from Audit Scotland and a meeting had been had with the chair. No significant changes are expected in the approach or accounting standards for the coming year. Areas of audit focus will include property, plant and equipment valuation, and fraudulent expenditure recognition, especially in light of the organisation's financial position.

The Chair advised that he had highlighted the finance rapid review to the external auditors as an area to be considered in their planning and audit work.

Decision / Conclusion
The Committee noted the update.

14.2.1. External Audit Recommendations (Presenter: Interim Director of Finance)

Interim Director of Finance confirmed that all recommendations from the External Audit have now been completed and were awaiting review by KPMG as part of the audit cycle.

Decision / Conclusion
The Committee were reassured by this update.

15. ITEMS TO BE INCLUDED ON THE CHAIR'S ASSURANCE REPORT (Presenter: Chair)

The Chair proposed the following to be included in the Chair's Assurance Report

- Approval of Audit and Risk Committee core documents for 2026/27
- Approval of the Risk Management Group terms of reference
- Update on the Scottish National Audit Programme (SNAP)
- Update on the Counter Fraud Strategy
- Discussion and assurance regarding the Corporate Risk Register
- Receipt of internal audit reports (Information Governance and Payroll) and progress update

- Receipt of external audit planning update and confirmation of completed recommendations
- Internal Audit recommendation tracker status
- Concerns regarding ownership of Risk and Audit actions

Decision / Conclusion
The Committee agreed to the above being added into the Chair's Assurance Report.

16. ANY OTHER COMPETENT BUSINESS (Presenter: Chair)

S Gray, Senior Financial Accountant, reported that a paper had been omitted from this meeting regarding the proposal to alter the timing of the year-end audit for the Endowment Fund.

This had been discussed with both the board external auditors and the endowment fund external auditors and in principle neither had any objections. I Grieve reported that it was not uncommon for charities to schedule audits for later in the year but stressed this was a decision for the Endowment Committee.

Decision / Conclusion
It was agreed that the missing paper would be circulated to members to provide comments to the Senior Corporate Governance Officer by close of play today to enable discussion at the Full Trustee Endowment Committee meeting on 4 December 2025

17. ITEMS FOR INFORMATION AND NOTING ONLY (Presenter: Chair)

17.1. Reporting Timetable for 2025/26

Decision / Conclusion
The Committee noted the Timetable for papers 2025/26

17.2. Record of Attendance 2025/26

Decision / Conclusion
The Committee noted the Record of Attendance 2025/26

The Chair closed the meeting at 11.10.

Minute Finance and Performance Committee
25 February 2026

Attendance

Fiona MacKay (Chair – Non-executive Board Member), Davie Campbell (Non-Executive Board Member – Interim Board Chair), Melanie Barnes (Interim Director of Finance), Debs Crohn (Head of Corporate Governance), Tammy Sharp (Director of Performance and Transformation), Sam Thomas (Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services, James Goodyear (Interim Chief Executive), Jason Taylor (Non-Executive Board Member), Stephen Brown (Chief Officer IJB), Dave Harris (Director of People and Culture), Sharon Keyes (Head of Facilities and NPD Contract), Jean Stevenson (Non-executive Board Member), Mohammed Sohail (Chief Finance Officer – IJB), Alan Scott (Head of Facilities) and Dr Anna Lamont (Medical Director).

1. Cover Page

Finance and Performance Committee Purpose

To review the financial and non-financial targets of the Board, to ensure appropriate arrangements are in place to deliver against organisational performance measures, to secure economy, efficiency, and effectiveness in the use of all resources, and provide assurance the arrangements are working effectively.

Quorum:

Three members present including at least two non-executive Board Members, one of whom must be Chair or Vice-Chair, and one Executive Member.

2. Welcome and Apologies (Presenter: Chair)

The Chair (Fiona MacKay) opened the meeting at 09.30 am and welcomed members.

No apologies were noted.

Members agreed the meeting was quorate in accordance with the Boards Code of Corporate Governance.

3. Declarations of Interest (Presenter: Chair)

There were no declarations of interest raised.

4. Minute of the Finance and Performance Committee held 28 January 2026 (Presenter: Chair)

The Chair asked for comments on the minutes of the meeting held 28 January 2026. J Taylor asked for clarity on page 3 of the minutes in relation to digital programmes, the potential to reflect escalation to East Boards to be added to the minute.

The Medical deep dive section to be updated to include the WTE medical staffing establishment.

The Interim Board Chair asked for clarity on why the IPR was not presented at Committee. The Director of Performance and Transformation advised as the meeting has been moved to monthly, the IPR will not be presented at every meeting.

Decision/conclusion
Minute of the meetings held on 28 January 2026 were accepted as an accurate record of the meeting and approved subject to the amendment discussed and approved.

5. Matters Arising

The Chair reminded colleagues of risks that have not been updated since the last meeting due to the timing of the meeting.

The Chair asked for an update on the position with Delayed Transfers of Care (DToC), noting recent press coverage. The Chief Officer IJB advised the position has not improved since the last meeting. Unscheduled care funding has been identified to support additional agency staff, the process of handover of the new Care Home facility is nearly complete.

The EDoNMAHP advised the impact of DTOC is now being felt across the whole system, this has been the case since July 2025. Agency staff will provide additional capacity, and work continues in-house in relation to discharge planning,

The Interim Board Chair asked what emergency planning and communications with Scottish Government. The EDoNMAHP advised a weekly submission is presented to Scottish Government and a monthly meeting takes place with the Centre for Sustainable Delivery (CfSD), the performance team are well briefed 50% of our bed base is taken up by DTOC patients.

The Sub-national East of Scotland group are working through an escalation plan, noting there is no ability for our patients to be transferred to a nearby facility.

The Interim CEO reflected reducing the number of DTOC remains a key priority for the organisation. The Chief Officer IJB and EDoNMAHP will present an improvement plan to the Executive Management Team Monday 2 March 2026 noting the impact this is having on our patients and the health and care system.

J Taylor reminded Committee in 2020, in response to the COVID pandemic, the Organisation responded by the flexibility of Hamnavoe House and asked for clarity on what could be applied from experience. The Chief Officer IJB advised the issue is in relation to staffing the facility and will be reliant on agency staffing which could de-stabilise the whole system. Agency staffing continue to support the care at home service.

The Chair asked for confirmation on when the draft financial plan will be submitted to Scottish Government. The Interim Director of Finance advised the draft plan was submitted 2 February 2026, following some amendments the final plan will be submitted to Scottish Government 16 March 2026.

Decision/conclusion
Members noted the update

6. CHAIRS ASSURANCE REPORT - Finance and Performance Committee Chair's Assurance Report – 28 January 2026 (Presenter: Chair)

The Chair presented the Chairs Assurance report of the Finance and Performance Committee meeting held on 28 January 2026 for assurance.

Decision/Conclusion
The committee took assurance on the Chairs Assurance Report from the meeting held 28 January 2026 for onward submission to the Board 26 February 2026.

7. Action Log (Presenter: Head of Corporate Governance)

The Head of Corporate Governance presented the Finance and Performance Committee Action Log 2025/26.

Decision/conclusion
The action log was reviewed, no outstanding issues (see action log for details).

8. Financial (Month 10) and Improving Together Programme Position Presenter: Interim Director of Finance)

The Interim Director of Finance presented the financial (month 10) and Improving Together Programme Position paper to Committee.

There has been a significant improvement in the YTD position as at Month 10 which is predominantly due to the release of reserves by the IJB, additional funding and release of accruals. This is a non-recurring benefit for 2025/26, and the position remains challenging for 2026/27.

At the end of Month 10, the reported financial position an overspend of £2.220m, which is £44k higher than the planned deficit of £2.176m but £195k lower than the planned trajectory.

A revised year-end forecast was submitted to SG in Month 8, predicting a deficit of £4.2m at 31 March 2026. Due to the improvements in Month 9, a revised forecast of £3.6m was submitted. With the release of the IJB reserves, the forecast has been further reduced in Month 10 to £2.7m.

Scottish Government have been notified of our position at the Quarter 3 review meeting and confirmed the transitional funding of £2m will be provided, however any deficit position over £2m will be shown as an overspend in the annual accounts. The risk of Section 22 qualified accounts being given by External Audit therefore remains.

Whilst showing an improved position, the 2026/27 financial position will be as challenging as this financial year.

£1.6m cash releasing savings have been identified through the Improving Together Programme; this has contributed to our current Year End position.

The Interim Board Chair noted the current position brings the Board under the 1% RRL position, which is positive, and asked if the Capital to Revenue funding is included in the year end position. It was confirmed that it was included in the forecast year end position.

The Interim Board Chair asked for confirmation of when the King Street Sale would be complete. The Interim Director of Finance advised this would conclude 1 April 2026 and has been included in the 2026/27 plan.

The Interim Board Chair asked for clarity on moving to the Near Me by default position. The Medical Director advised the NHS Grampian are currently unwilling to move to a Near Me by default position, however patients do have the ability to request Near Me appointments and this is well received. Conversations continue with NHS Grampian Medical Directors and the Executive Team to move to Near Me by default position.

The Interim CEO advised the current uptake of Near Me consultations is 70%, and conversations are taking place with the NHS Grampian CEO in relation to moving to Near Me by default.

J Stevenson asked for clarity on the additional cost pressures in relation to GLP1 medicines and asked if any analysis has been undertaken into the impact of drugs. The Interim Director of Finance advised

the Director of Pharmacy continues to monitor the impact. The Medical Director advised conversations at a national level continue, noting our route for prescribing GLP1 drugs is dependent on NHS Grampian, clinically the position is on hold. Medical Director to bring an update to Committee in the next quarter.

The Interim Board Chair asked for confirmation of the impact on the organisation of vacancies. The Chief Officer IJB advised there is an impact of vacancies, agency staff are required to ensure waiting lists are kept to a minimum.

The Chair noted agency usage has increased. The EDoNMAHP advised work has been undertaken to remove the use of agency staff, some pressures are being felt across Acute services in relation to staff absences.

J Stevenson asked for clarity on the underspends detailed in the paper in IP2 and High Dependency Unit. The EDoNMAHP advised a Band 6 nurse commences 1 April 2026, whilst working as 1 team there are 2 separate budgets

Decision/Conclusion
The committee noted the Month 10 financial position.

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. All risks have been reviewed in line with our risk management framework. Committee noted no risks were put forward for addition or closure, and Risk C-2026-01, Delivery of mandated digital projects, was added to the Corporate Risk Register in January 2026.

The 2 digital risks have now been consolidated into a single risk which will be presented to the Risk Management Group in March 2026.

Financial sustainability remains the highest risk for the Board due to the non-recurrent funding position.

The Interim Board Chari asked Risk 1225 (Social Care Capacity) should be increased. The EDoNMAHP advised the risk will be reviewed and reframed ahead of the next Committee meeting.

Decision/Conclusion
Committee took assurance on the progress and mitigations presented on the latest Corporate Risk Register

10. Code of Corporate Governance - Standing Financial Instructions and Scheme of Delegation (Presenter: Head of Corporate Governance)

The Head of Corporate Governance presented the Code of Corporate Governance Standing Financial Instructions and Scheme of Delegation update for 2026/27 for approval. Committee noted the Standing Financial Instructions remain unchanged from Version 19 and acknowledged the Code will need to be updated prior to being presented to Audit and Risk Committee to reflect the new Director of Finance who joins the Organisation in March 2026.

Committee discussed the removal of names from the Code with job titles being included only. The Medical Director suggested an appendix is included which would be easier to update should staff members leave.

Decision/Conclusion
Committee approved the Standing Financial Instructions and Scheme of Delegation section of the Code of Corporate Governance.

11. DEEP DIVES

11.1. Deep Dive – priorities 2026/27 (Presenter: Director of Performance and Transformation)

The Director of Performance and Transformation presented the deep dive priorities for 2026/26 for discussion outlining the three major transformation priorities following the Clinical Services review: Out of Hours, Isles model of Care, and Digital as an enabler which have been identified as the key 'big ticket' items for 2026/27, each with significant system impact and financial impacts.

The scale of opportunity across these programmes is substantial. All three priorities carry material risks and dependencies considering the Clinical Services Review.

The Chair acknowledged the work undertaken to date on the priorities presented

Out of Hours

The EDoNMAHP provided an overview of the current services with a spend of £900k, modernising the model could potentially result in a saving of £400k at the Hospital Front Door. John Daniels is the Senior Responsible Officer and is working on the project specification and Business Case.

Committee considered the timeline noting the requirement for support from our People and Culture Team. The proposal is to make the changes for a planned go live in September 2026 noting this will require stakeholder engagement.

The Interim CEO acknowledged the level of the detail in the plan and asked the engagement process and timelines are reviewed to ensure we meet the go live date of September 2026.

The Interim Board Chair asked the Board to be added as an internal stakeholder and asked for clarity on the risk in relation to GP resignations and whether the risk is in relation to clinicians. The EDoNMAHP advised there will always be a risk when making changes - people may choose to leave, this will be mitigated through engagement with the British Medical Association and our People and Culture team.

J Taylor asked for confirmation of the role of the Area Clinical Forum and the sequencing of public and patient engagement.

The Medical Director advised moving to this model has already been implemented in Western Isles there is a risk there is currently no clinical governance being provided because of staff vacancies.

The Director of Public Health reminded colleagues an Island Impacts Assesment and Children's Rights Assesment are completed. The EDoNMAHP advised these will be completed.

The Director of Performance and Transformation advised governance for the CSR is through the Improving Together Programme Board, through to JCCGC. The Chair asked that regular finance updates are provided to Finance and Performance Committee.

The Interim CEO advised reporting on progress will be brought to Committee, JCCGC will provide assurance models are clinically appropriate and unintended consequences are monitored.

Digital

The Interim Director of Finance advised the digital workstream is an enabler recognising the need for digital changes.

Key areas of focus are Community EPR. Trakcare and Openeyes delivery is dependent on NHS Grampian.

The Interim Board Chair noted the resource savings and asked if opportunities are being explored at the East of Scotland and opportunities to collaborate. The Interim Director of Finance advised that as a Board work is required to bring our digital systems in line with other Boards, there is a small digital team, there is a real dependency on national systems to support this work.

J Stevenson asked what support NHS Grampian could provide in relation to Trakcare upgrades and staff training. The Interim Director of Finance acknowledged the risk in relation to the dependency on NHS Grampian. There are opportunities as part of the sub national planning to support the digital workstream.

The Interim CEO reminded members there is a need to ensure we move away from localised ways of working.

Isles Model of Care

The Chief Officer IJB reminded members of the amount of money from the General Medical Services contract of £1.5m per year. The current model costs £3.4M and is in breach of the European Working Time directive, this needs to be addressed as a matter of urgency. By resolving the issue, costs will increase. There are risks associated with the current model, there has been some political, community and clinical resistance. Details have been presented to the Leader of the Orkney Islands Council as part of the Public Sector Reform work, it has been agreed nothing is off the table, a plan is being developed with Healthcare Improvement Scotland to plan the engagement detailed in the paper.

There are several models available, there is a clear need for a community planning approach required to design the model.

The Interim CEO acknowledged the complexities in relation to the Isles Model of Care noting the model currently represents poor value for outcomes they deliver for patients, but this does shift the balance from Primary Care which is not the direction of travel set out in the Population Health Framework and Public Sector Reform.

The Interim Board Chair advised managing the risks will be key to the success of the plan and asked if the pre-election period should be built into the plan. The Chief Officer IJB recognised this should be included in the plan.

J Taylor asked for confirmation on what would happen if the decision point was not supported by the IJB. The Chief Officer IJB advised there is no contingency, however, is confident working with communities will bring forward the right model for our communities.

The Medical Director raised concerns in relation to the change being driven by clinical need and not financially driven, the change has already been made in Shetland, the change is needed as it is clinically safer to do so.

The Interim CEO asked the pre-election period is used for planning and background work and engagement with HIS so works carries on.

The Director of People and Culture advised capacity within the People and Culture team is a risk, the mitigations in place will not address the risk.

The Chair thanked the Executive Team for the paper and asked consideration be given to when update reports will be presented to Committee.

Decision/Conclusion
Members welcomed the deep dive and look forward to the Executive Team bringing an update paper to a future meeting.

11.2. Medical Staffing Update – Action Plan (Presenter: Director of Performance and Transformation)

The Director of Performance and Transformation presented the medical staffing action plan following the deep dive at the meeting 28 January 2026.

An action plan with timelines and action owners was presented for discussion. The plan focuses on 5 areas.

The Medical Director thanked the team for bringing the paper together and a real move to a substantive medical workforce. Work has already commenced on the high-risk specialties, for example within our Maternity services. A recruitment workshop has taken place to look at how we recruit and retain our medical workforce.

The Medical Director recognised the need for stability, job planning process is now in place. Work has been undertaken to standardise agency spend.

The EDoNMAHP advised that a piece of work is underway with Plus Us in relation to agency staff.

The Interim CEO welcomed the medical staffing action plan, noting the process of getting to the current position and recognised that we should be back to the required run-rate by the beginning of the next financial year and contribute to bringing our finances back to balance. This is a reduction in the spend of £700k.

J Taylor asked for clarity on the disparity between the WTE and asked if the establishment review will address value for money. The Medical Director recognised the seriousness of the situation, and the need to deliver what is required and not a gold level standard, noting this will require challenging conversations in relation to different ways of working.

The EDoNMAHP confirmed the work set out in the action plan provides a good starting point to address the challenges set out in the paper.

Decision/Conclusion
Members welcomed the action plan.

12. STRATEGIC OBJECTIVE – PLACE – No papers to be presented to Committee

13. STRATEGIC OBJECTIVE - PERFORMANCE

13.1. Subnational Planning and Delivery Committee (East) update (Presenter: Director of Performance and Transformation)

The Director of Performance and Transformation provided an update on the subnational planning and delivery committee (east). The Scottish Government issued DL(2025)25 in November 2025 which mandated Health Boards across Scotland to work more closely on 5 key priorities, and to agree joint plans to deliver these by 31st March 2026.

The DL is clear there is no change to the clinical, workforce, and financial governance accountabilities of any Health Board. Ministerial Direction is to bring forward plans by 31st March against the five key priorities above, expectation SPDCE and SPDCW will continue to work after date to ensure delivery against plans by 31st March 2029.

The Interim Board Chair advised recruitment to sub-regional posts is currently paused.

Decision/Conclusion
Members welcomed the action plan.

13.2 Robertsons Contract Update (Presenter: Head of Facilities and NPD Contract)

The Head of Facilities and NPD contract provided an update to the Committee regarding the Robertsons contract and associated concerns.

Since the last meeting improvements have been made, a new interim contract manager is now in place, several of the outstanding issues and planned maintenance backlog has significantly reduced. Monthly deductions continue, however Roberstons Directors are engaging with NHS Assure.

Decision/conclusion
Members noted the update and welcomed the issues being escalated as a risk on the corporate risk register.

13.3 Corporate Strategy Year 2 2026/27 Quarter 3 Performance Report (Presenter: Interim CEO)

The Interim CEO provided an update on Quarter 3 performance on Year 2 of our Corporate Strategy. There are 15 deliverables in our Year 2 Corporate Strategy Delivery Plan 2025/26. 3 of the deliverables are RAG rated Red, 4 rated Amber and 8 rated Green.

The Chair asked if reporting could be included in the IPR – Head of Corporate Governance advised the Executive Team are looking at the Year 3 Corporate Strategy Delivery Plan, this will be considered

Decision/conclusion
Members noted the update.

13.4 Chair's Assurance Report Improving Together Programme Board (Presenter: Interim CEO)

The Director of Performance and Transformation delivered the Chair's Assurance Report from the Improving Together Programme Board on 26 January 2026.

Decision/conclusion
Members took assurance on the report.

13.5. Strategic Estates and Capital Group Chairs Assurance Report - 16 February 2026 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Chair's Assurance Report from the Strategic Estates and Capital Group meeting 16 February 2026.

Decision/conclusion
Members took assurance on the report.

14 STRATEGIC OBJECTIVE POTENTIAL

14.1 Digital Information Operations (DIOG) Group Chair's Assurance Report 26 January 2026 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Chair's Assurance Report from the Digital Information Operations Group meeting 26 January 2026, confirming the Board is on track to go live with Infix theatre Scheduling system by the 26 February 2026 – feedback will be provided through the next DIOG CAR.

Decision/conclusion
Members took assurance on the report

15 Items agreed for Chairs Assurance Report to Board (Presenter: Chair)

Members agreed on the following items for inclusion in the Chairs Assurance Report to the Board

Areas of concern

- Delayed Transfers of Care
- Financial Performance
- Robertsons Contract

Major work commissioned/underway

- Interim CEO will discuss Near Me by default with NHS Grampian's CEO
- Medical Director to update Committee on GLP1 use at April 2026 meeting.
- EDoNMAHP to review the Risk 1225 (Social Care Capacity) prior to the upcoming Committee meeting.
- Director of Performance and Transformation to confirm reporting cycle for the deep dive and medical Staffing action plan reporting to Committee.

Positive assurance

- Significant improvement in the Year-to-Date position at Month 10
- At present, 70% of consultations make use of Near Me (Virtual appointments)
- Committee took assurance on the progress and mitigations presented on the latest Corporate Risk Register
- Assurance provided on the priorities for 2026/27 from the Clinical Services Review.

- A clear plan is in place for addressing the challenges associated with our current Medical Staffing Model.
- The Subnational Planning and Delivery Committee (East) is advancing the development of the East of Scotland regional plan, with assurance given that a draft will be submitted to the Scottish Government by March 31, 2026
- The committee received assurance on performance of the Corporate Strategy Delivery Plan for Quarter 3, Year 2.

Decisions made

- Minutes and Chair's Assurance Report 26 January 2026 approved
- Code of Corporate Governance Standing Financial Instructions/Scheme of Delegation approved for onward approval by the Audit and Risk Committee.

16 AOCB (Presenter: Chair)

No other business raised.

17 Key Items for Noting (Presenter: Chair)

Members noted Waiting Times Quarter 1 Funding 2026/27

17.1 Attendance Record 2025/26 (Presenter: Chair)

Committee noted the Attendance Record 2025/26

17.2 Timetable for Papers 2025/26 (Presenter: Chair)

Committee noted the Finance and Performance Committee Timetable for Papers 2025/26.

17.3 Evaluation of meeting (Presenter: Chair)

The Chair closed the meeting at 11.40

Joint Clinical and Care Governance Committee Minute
Wednesday 4 February 2026

Attendance

Stephen Brown (Chief Officer, IJB), Dr Kirsty Cole (Area Clinical Forum Chair), Debs Crohn (Head of Corporate Governance), Dr Anna Lamont (Medical Director), James Goodyear (Interim Chief Executive), Jean Stevenson (Orkney Island Council Elected Representative), Councillor Lindsay Hall (Orkney Island Council Elected Representative), Fiona Mackay (Non-Executive Board Member), Councillor Ivan Taylor (Orkney Island Council Elected Representative), John Daniels (Headof Primary Care) and Wendy Lycett (Interim Director of Pharmacy)

Guests

Dr Elvira Garcia (Consultant in Public Health)

1. Cover Page

Joint Clinical and Care Governance Committee's Purpose

The Chair reminded members that the purpose of the Joint Clinical and Care Governance Committee (JCCGC) (the Committee') provides assurance through oversight of NHS Orkney and the Integrated Joint Board. The scope of the Committee's oversight fulfils the purposes of:

- The function of the non-executive members of NHS Orkney and advisors providing the Board of NHS Orkney with the assurance that robust clinical governance controls and management systems are in place and effective in NHS Orkney, in relation to delegated and non-delegated services it delivers.
- The function of providing the Integration Joint Board with assurance that robust clinical and care governance controls and management systems are in place and effective for the functions that NHS Orkney and Orkney Islands Council have delegated to it.

- The requirements set out in MEL (1998)75, MEL (2000)29 and HDL (2001)74 around the guidance on the implementation of Clinical Governance in the NHS in Scotland.

Quoracy

Meetings of the Committee will be quorate when at least four members are present and at least two of whom should be Non-Executive Members of NHS Orkney, one of whom must be the Chair or Vice Chair, and two Orkney Island Council voting members of the Integration Joint Board. Meetings will not take place unless at least one Clinical Executive Director of NHS Orkney and the Chief Social Work Officer, or nominated depute, is present.

2. Apologies (Presenter: Chair)

R Gold (Chair) opened the meeting at 1.00 pm, welcoming members and extending a welcome to Fiona Mackay (Non-Executive Board Member).

Apologies received from Dr Louise Wilson (Director of Public Health), Morven Brooks (CEO, Voluntary Action Orkney), Isssy Grieve (Non-Executive Director), Kat Jenkin (Head of Patient Safety, Quality and Risk, Tammy Sharp, (Director of Performance and Transformation and Deputy CEO) and Sarah Walker (Infection Prevention Control Lead).

Dr 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 recorded.

4. Minutes of Joint Clinical and Care Governance Committee – 1 October 2025 (Presenter: Chair)

Minutes of the Joint Clinical and Care Governance Committee meeting held on I October 2025 were accepted as an accurate record of the meeting.

On page 5, section 10.2, the Chair requested an update on pest control at The Balfour hospital. The EDoNMAHP reported that 99% of work is complete, with the contractor asked to provide assurance on the final outstanding action.

Decision/conclusion
Members approved the minutes of the Joint Clinical Care Governance Committee 1 October 2025.

5. Chair's Assurance Report (CAR) from meeting 1 October 2025.

The Chair presented the Chair's Assurance Reports from the meeting held on the 1 October 2025 noting this was presented to Board in December 2026.

Decision/conclusion
Members took assurance on the Chair's Assurance reports from the meetings held on the 1 October 2025.

6. Action Log (Presenter: Head of Corporate Governance)

The action log was discussed with corrective action taken and providing updates where required. Members were content to close the items listed on the action log, triple AAA data will be circulated to members following the meeting.

One action remains open in relation to smoking cessation targets, this is now included in the Integrated Performance Report discussed later in the meeting.

Decision/conclusion
Members noted the action log updates.

7. Corporate Risks aligned to the Joint Clinical and Care Governance Committee - (Presenter: Medical Director)

The Chair invited questions in relation to the Corporate Risks aligned to the Joint Clinical and Care Governance Committee.

Councilor Hall requested clarification regarding the risks presented. The Medical Director explained that the document provides an overview of the risks aligned with the Joint Clinical Care Governance Committee for scrutiny and assurance, and that these identified risks are included in the Board's Corporate Risk Register.

Councilor Hall requested clarification on risk 122-25 (inability to offload Scottish Ambulance Service (SAS) vehicles). The EDoNMAHP explained that this risk is in relation to patient flow issues in the busy Emergency Department (ED), which can delay transfers from SAS. Mitigation involves reserving a designated bed in the ED for incoming patients. Councilor Hall suggested the risk should be low due to the area's population size.

The Medical Director reminded colleagues that the impact column is the impact of the risk should it occur.

J Stevenson requested clarification on new risk C-2026-01 (delivery of mandated digital projects) and existing risk C-2024-02 (lack of organisational digital maturity). The Medical Director recommended consolidating these two digital risks, which will be discussed at the next Risk Management Group meeting in February 2026, although previous discussions favored keeping them separate. EDoNMAHP noted that the digital risk was not updated in the current paper due to timing constraints.

I Taylor requested an update on risk 122-25 (insufficient capacity in social care). EDoNMAHP confirmed ongoing recruitment challenges and said the risk is being reframed for review by the Risk Management Group in February 2026. The Chair noted that the risk score is rising, and the Committee could not confirm the effectiveness of current mitigations.

Dr Kirsty Cole requested clarification on risk 1227 (recruitment in Mental Health Services). The Chief Officer IJB confirmed it is the same post and the risk register terminology will be updated.

I Taylor requested an update on the fragility of clinical leadership risk (1225) and the recruitment workshop timeline. The Medical Director stated the workshop is scheduled for the week beginning 9 February 2026, recruitment is paused, and a formal update will be provided at the next meeting after the workshop.

The Chair asked for an update on the Public Protection training noting the last update was in November 2025. The EDoNMAHP advised that work is underway, an update will be brought to Committee April 2026.

Dr. K Cole expressed concern regarding the frequency at which risks are updated based on their risk scores and inquired about the possibility of making updates prior to the JCCGC meeting. The Medical Director responded that updates pertaining to low-risk items would not be presented to Committees, noting that the updating of risks currently occurs more frequently than necessary. A key challenge identified is ensuring that risk owners consistently update their respective risks.

The Interim CEO suggested that only updated risks should be brought to the Committee, and that low-level risks should not be shared, this would help the Committee focus on scrutinising significant risks and their management. The Medical Director pointed out that the cover paper highlights the most critical risks and asked members to consider what information should be presented to the Committee in the future, given that the risk register will not be shared.

F Mackay asked for a consistent approach to sharing risks across all Governance Committees.

Decision/conclusion
Members took assurance on the process, noting that the last updates were in November 2025.

8. Integrated Performance Report (IPR) (Presenter: EDoNMAHP)

The Chair invited questions on section 3 of the Integrated Performance Report. The EDoNMAHP highlighted a decline in MEWS performance, an increase in vaccination rates to 53%, and strong smoking cessation results.

Committee noted the complaints response times.

J Stevenson noted that bloodspot screening is at 84.6% (target 100%), shortfall is due to capacity and staffing constraints, assurance provided this has been resolved.

J Stevenson asked when a report on obesity would be presented to Committee. The Consultant in Public Health confirmed that a weight management report will be presented at the next meeting, with the late paper to be circulated to members for information.

The Interim CEO expressed concern regarding the high number of patients falls within our inpatient setting, highlighting that this trend coincides with increased Delayed Transfers of Care. The Interim CEO requested a comprehensive review of patient falls data. The Medical Director acknowledged ongoing challenges with the definition of a fall and noted that a previous deep dive had already been conducted, which prompted consideration of removing this metric from the Integrated Performance Report (IPR). It was confirmed that a repeat analysis remains an option. The EDoNMAHP stated that patient falls are a focus of the Excellence in Care programme, with most incidents relating to a single patient who places themselves in a place of safety esulting in an incident report. Efforts are underway to enhance the presentation of data to the Committee to provide reassurance that patients are not experiencing harm due to falls. The EDoNMAHP assured Committee that no patient has come to harm because of a fall.

The Interim CEO requested that EDoNMAHP evaluate how patient fall data is presented, ensuring it gives sufficient assurance to the Committee.

The Interim Director of Pharmacy questioned whether a review of the capacity to conduct Serious Adverse Event Reviews is necessary, considering the number of outstanding reviews. The Medical Director responded that this continues to be an ongoing issue, as training remains a challenge due to vacancies within the core workforce.

Dr. K Cole inquired about the existence of a national indicator for when SAERs should be conducted. The Medical Director clarified that there are established national procedures which the Board must follow, and SAER processes are initiated when necessary. All pending SAERs require involvement from multiple Boards; their delay is not only due to a shortage of reviewers. This issue is documented in our Risk Register, which includes appropriate mitigation measures.

Decision/conclusion
Members discussed the IPR 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. CHAIR'S ASSURANCE REPORTS

9.1. Area Drugs and Therapeutics Committee Chair's Assurance Report - (Presenter: Medical Director)

The Chair asked members if they had any questions in relation to the report of the meeting held 3 December 2025 advising members that the committee is now well attended and effective.

Dr. K Cole welcomed the update on consultants requesting medication through Primary Care and suggested extending this work to include care setting patients. The Medical Director responded that existing guidance is clear, and the current effort focuses on negotiating between primary and secondary care prescribing, with full consultation from both the GP Sub Committee and hospital clinicians.

J Stevenson requested clarification on medicines of low clinical value. The Medical Director explained the purpose of this work, and the Interim Director of Pharmacy noted that assessing low clinical value is a Scottish Government mandate within the 15-box grid, which evaluates clinical benefit to patients.

Decision/Conclusion
Members took assurance from the update.

9.2. Infection, Prevention Control Committee Chair's Assurance Report - (Presenter: Infection Prevention Manager)

The EDoNMAHP asked members if they had any questions arising from the Chair's Assurance Report from the meeting held 1 December 2025.

I Taylor requested an update on the Care Homes Group referenced in the Chair's Assurance Report. The EDoNMAHP reported that the clinical nurse manager for community is now chairing the Collaborative Care Homes Group, resolving the previous issue.

The Chair requested confirmation of actions from the Chair's Assurance Report and clarification on matters to escalate to the Committee or Board. The EDoNMAHP noted the report is from December 2025, and the latest meeting was held on 4 February 2026.

There remains a risk of higher costs due to limited financial resources and storage space for Personal Protective Equipment.

The EDoNMAHP confirmed that the water tank issue is related to ongoing issues with Robertsons Facilities Management, which are still under discussion.

Decision/Conclusion
Members received escalated items and took assurance on performance.

9.3. Social Work and Social Care Governance Board (SWSCGB) Chair's Assurance Report - (Presenter: Head of Childrens Services, Criminal Justice and Chief Social Worker)

The Chief Officer IJB invited questions in relation to the Chair's Assurance Report from the Social Work and Social Care Governance Board 9 January 2026.

The Chair inquired about the individual responsible for the whistleblowing report referenced in the Chair's Assurance Report. The Chief Officer responded that discussions have been held with the Head of Patient Safety, Quality and Risk to determine whether this should be produced as a consolidated report for both organisations. The SWSCGB will continue to progress this work.

The Chair stated that the IJB has requested a Care Home report, which should be reviewed by the JCCGC before being submitted to the IJB and requested that this report also be presented to both the JCCGC and the SWSCGB.

The Chief Officer IJB advised that a conversation has taken place with the Chair of the IJB in relation to the ask, it was felt that the report would not be appropriate for the JCCGC. The Chief Officer IJB confirmed that Executive Nursing Directors were asked to pick up external scrutiny of Care Homes as a legacy from COVID. It was agreed that the EDoNMAHP will bring a Care Homes Report to Committee April 2026.

Decision/conclusion
Members received escalated items and took assurance on performance.

9.4. Clinical Governance Group Chair's Assurance Report - (Presenter: Medical Director)

The Medical Director invited questions from committee members in relation to the Clinical Governance Group Chairs Assurance Report from the meeting held 2 December 2025. Key risks to escalate are in relation to capacity to deliver SAERs and clinical engagement in the reviews, this remains a challenge.

Decision/Conclusion
Members received escalated items and took assurance on performance.

J Stevenson left the meeting at 15:32.

10. STRATEGIC OBJECTIVE - PLACE

10.1. Port Health Memonrandum of Understanding (MoU) (Presenter: Medical Director)

The Medical Director provided an overview of the Port Health Memorandum of Understanding, which has been revised to address previously identified governance gaps, clarify statutory roles, information sharing, indemnity, and escalation, and reflect current staffing and operational arrangements across NHS Orkney and Orkney Islands Council.

The document has now been agreed in principle by both organisations, with NHS Orkney executive sign-off completing a process to formally embed port health arrangements within each organisation's governance framework, where previously no approved MoU existed.

Approval provides legal and operational assurance that port health functions can be exercised lawfully and consistently, reducing organisational risk in the event of routine activity or a significant public health incident involving vessels or aircraft

Members were advised that the changes outlined below have been made to the MoU circulated with the meeting papers

- Responsible Executive: approval now recorded directly under the Director of Public Health, rather than acting arrangements.
- MoU more explicitly described as part of both NHS Orkney and Orkney Islands Council governance frameworks and clearer accountability arrangements.
- Legal and indemnity clarity improved, including explicit confirmation that named officers are covered by organisational indemnity and that formal authorisation is required to exercise Port Health functions.
- Command, control and escalation wording tightened, with clearer escalation routes
- Information-governance wording refined, with clearer articulation of lawful bases for information sharing under UK GDPR.
- Appendices clarified so that updates to authorised officers (Appendix 6) and contact details (Appendix 7) are explicitly classed as administrative updates that do not require full re-approval.
- Minor editorial amendments throughout, including formatting, consistency of terminology and removal of residual drafting comments; no change to statutory duties or operational arrangements.

Head of Corporate Governance confirmed that in line with our Code of Corporate Governance there is no requirement for the MoU to be presented to Board, assurance will be provided to the Board via the Chair's Assurance Report.

The Chair asked that any further amendments or changes required by Dr K Cole and the EDoNMAHP meet with the Public Health Team, with the MoU being brought back to Committee in April 2026.

Decision/conclusion
Members took assurance on the Port Health Memorandum of Understanding.

11. STRATEGIC OBJECTIVE - PATIENT SAFETY, QUALITY AND EXPERIENCE

11.1. Safety, Quality and Experience Quarter 2 Report 2025/26 - (Presenter: Head of Patient Safety, Quality and Risk)

The Chair invited questions on the Safety, Quality and Experience Quarter 2 Report 2025/26 The Medical Director highlighted the excellent improvement activity undertaken in realistic medicine and excellence in care projects.

The Chair noted the improved closure rates for incidents
The Medical Director highlighted that the number of overdue incidents is now down to its lowest level for several years, progress continues to be made on reducing the backlog of incidents.

I Taylor questioned why complaints training rates are tracked if the training is not mandatory. The Chief Officer IJB explained that it's useful to know how many staff can conduct reviews. The Medical Director clarified that the rates are shared simply to highlight changes, while the focus remains on mandatory training.

Interim Director of Pharmacy noted that complaints in relation to independent contractors may not be accurate and asked if a piece of work needs to be undertaken in relation to encouraging complaints being reported. The Medical Director advised that this is the Quarter 2 report, and data which has been proactively shared with the Board.

F Mackay welcomed inclusion of our behavioral standards framework and asked how we will know we are making progress against the framework. The Interim CEO advised that our Director of People and Culture is undertaking this piece of work, this will be reported through our Staff Governance Committee. The Medical Director advised that the report is in relation to patient experience side of the behavioral framework rather than staff relationships.

The Chair asked what the Board is doing to address concerns in relation to waiting times which has been raised as concern by patients. The Medical Director noted that our Health Board currently has fewer patients waiting over 52 weeks than most others, aiming for zero such cases by 31 March 2026. Urgent cases are always given priority, and various improvements have been made to our outpatient service, including expanding capacity and adding permanent staff members. Members were reminded that while reducing outpatient appointment wait times leads to improvement, it also results in an increase in the number of patients on our inpatient waiting lists.

The Interim CEO asked members to remember that whilst performance is an improving position, long waiting times impact negatively on our patients, this continues to be monitored by the Finance and Performance Committee.

Dr. K. Cole inquired whether compliments are solicited from our independent contractors in the same manner as complaints. The Medical Director clarified that while complaint data is requested, submission of such information is voluntary, and there is no obligation for independent contractors to provide it. Members were encouraged to share positive news stories with the Corporate Communications team for possible inclusion in the Weekly Staff Bulletin.

Decision/conclusion
Members welcomed the Safety, Quality and Experience Quarter 2 Report 2025/26.

Dr Elvira Garcia left the meeting at 16:04

11.2. His Majesty's Inspectorate of Constabulary in Scotland (HMICS) - Draft Custody Inspection Report - (Presenter: Head of Primary Care)

The Head of Primary Care presented an overview of His Majesty's Inspectorate of Constabulary in Scotland Custody Inspection Report.

F Mackay, Dr K Cole and the Interim Director of Pharmacy noted that this report requires a once for Scotland approach noting linkages have been made with NHS Highland and the additional work required by the Head of Primary Care.

The Head of Primary Care acknowledged that conversations took place with Inspectors in relation to the number of Policies and Procedures which are not relevant for our population. Inspectors were keen to find a middle ground, recognising commonality of approach across the East of Scotland.

The Chair welcomed the report, noting collaboration in responding to the inspection, and suggested seeking implementation funding from the Scottish Government. The Chief Officer IJB proposed requesting support from the Community Justice Partnership.

Head of Primary Care to bring progress report to the JCCGC July 2026 meeting.

Decision/conclusion
Members received and took assurance from the inspection report.

11.3. Maternity Peer Review - (Presenter: Interim Deputy Director of Nursing/Lead Midwife)

The EDoNMAHP provided a verbal date on the recent maternity peer review. The review has now been completed, executive summary has been received and discussed.

In January, we conducted a Maternity peer review and received highly positive feedback regarding the quality of our services. Staff particularly commented on feeling safe to raise concerns, the positive culture within our maternity services, and effective pathways with other Health Boards. Peer reviewers highlighted opportunities for enhancement, specifically recommending more proactive engagement with our risk management and clinical governance team.

Users raised concerns in relation to separate entrance for maternity and the lack of a bereavement room at the Balfour.

An action plan is being developed by the Maternity Service to address these recommendations prior to an inspection over the next 12 months by Health Improvement Scotland.

Full report and action plan will be presented to Committee April 2026.

The Chair congratulated the maternity team for engaging with peer review.

Decision/conclusion
Members received and noted the update.

12. STRATEGIC OBJECTIVE - PERFORMANCE

12.1. Approval of JCCGC Core Documents 2026/27 (Presenter: Chair)

The Chair presented the JCCGC Core Documents 2026/27 to Committee for approval

The Chair asked that the Nursing Care Homes Report be added to the Business Cycle and Workplan 2026/27.

F Mackay asked that consideration be given in relation to reporting of the Clinical Services Review to avoid being presented to several Committees. The EDoNMAHP advised that this will be reviewed noting the purpose of the Committee.

Dr K Cole asked for confirmation of third sector or public representation on the Committee – the Chair advised that this will be discussed at the Committee Development session in March 2026 noting the need for a process to be in place to support those attending and the opportunity to create a group to support those with lived experience.

Head of Corporate Governance reminded members of the need to complete the committee self-effectiveness questionnaire by Friday 20 February 2026.

Dr A Lamont left the meeting at 16.30

Decision/conclusion
Members approved the following JCCGC Core Documents for 2026/27

- Terms of Reference
- Business Cycle and Workplan 2026/27
- Reporting Timetable 2026/27

12.2. Chief Social Work Officer (CSWO) Annual Report (Chief Social Work Officer)

The Chief Officer IJB invited questions on the Chief Social Work Officer Annual Report to Committee noting the Chief Social Work Officer was not in attendance at the meeting,

The Chair questioned whether the low number of MARAC cases was due to Orkney's population size or capacity issues and asked if collaboration with a neighbouring health board was possible. The Chief Officer IJB explained that there is still a reluctance to report domestic violence in Orkney, highlighting the need to encourage more people to come forward. The Chief Officer IJB also confirmed that collaborative work with neighbouring health boards is already taking place.

The Chief Officer of the IJB informed the Committee that recent allegations regarding the Chief Social Work Officer have appeared on social media, including claims of an ongoing police investigation. Police Scotland has confirmed that there is no such investigation underway. The IJB and Orkney Islands Council continue to support the Chief Social Work Officer. Additionally,

a briefing paper is being prepared for IJB members, Elected Members, and NHS Orkney Board Members.

Decision/conclusion
Members welcomed the Chief Social Work Officer Annual Report.

13. Emerging issues and key National updates (Presenters: Medical Director, Chief Officer Integration Joint Board, Executive Director of Nursing Midwifery, AHP and Chief Officer Acute, Consultant in Public Health)

The EDoNMAHP invited questions on the Scottish Executive Nurse Directors (SEND) meetings. No questions were raised.

Decision/conclusion
Members welcomed and noted the updates from SEND and Chief Officers network noting the following updates were not received: Scottish Association Medical Directors (SAMD) and Directors of Public Health (DPH)

14. Agree items to be included in Chair's Assurance Report to Board (Presenter: Chair)

Members discussed areas to be included within the Chair's Assurance Report, these include.

Positive assurance

- Corporate risks associated with JCCGC
- Integrated Performance Report (IPR)
- Assurance provided via the Area Drugs and Therapeutics Committee
- Assurance provided from the Infection, Prevention Control Committee
- Assurance taken on the work of the Social Work and Social Care Governance Board (SWSCGB)
- Assurance taken in relation to Clinical Governance via the Clinical Governance Group
- Port Health Memorandum of Understanding
- Overdue incidents are now down to its lowest level for several years
- Quarter 2 Safety, Quality and Experience Report.
- His Majesty's Inspectorate of Constabulary in Scotland (HMICS) - Draft Custody Inspection Action Report
- Peer review of maternity services with strong engagement from our maternity team.
- Chief Social Work Officer Annual Report
- Management of Drug Harms Standard Operating Procedure noted

Risks to be escalated to the Board

- The Public Health Report late paper
- Limited financial resources and storage for Personal Protective Equipment (PPE)
- Insufficient clinical engagement for Serious Adverse Event Reviews

Work underway

- Social care system capacity risk will be reviewed by the Risk Management Group in February 2026.
- EDoNMAHP will review how patient fall data is presented to the Committee and shared with members before the next meeting.
- Consultant in Public Health to provide Weight Management Service update at Committee meeting in April 2026.
- Port Health Memorandum of Understanding – Members to provide feedback to Consultant in Public Health.

Decisions made

- Minutes and Chairs Assurance Report from meeting held 1 October 2025 approved
- JCCGC Terms of Reference, Workplan and Reporting schedule 2026/27 approved.

15. AOCB (Presenter: Chair)

16. ITEMS FOR INFORMATION AND NOTING ONLY

Members welcomed and noted the following papers

- Management of Drug Harms Standard Operating Procedure
- JCCGC Reporting Timetable 2025/26
- Record of Attendance 2025/26
- Information Sharing Protocol - Public Protection and Community Safety

The meeting closed at 16:50

NHS Orkney **Public Board**

Timetable for Submitting Agenda Items and Papers 2026/27

Initial Agenda Planning Meeting[1]	**Final Agenda Setting Meeting**	**Papers in final form**[2]	**Agenda & Papers**	**Meeting** held virtually via **MS Teams**
with Chair, Lead Executive and Corporate Governance[3] *< day of or 1 day after previous meeting>*	with Chair, Lead Executive and Corporate *Governance* ***21 days** before date of meeting*	to be with Corporate Governance ***< 9 days** before Date of Meeting >*	to be issued no later than *< **7 days** before Date of Meeting >*	(unless otherwise notified) *< Day of Meeting >*
26 February 2026	26 March 2026	21 April 2026	23 April 2026	**30 April 2026**
30 April 2026	4 June 2026	16 June 2026	18 June 2026	**25 June 2026**
25 June 2026	6 August 2026	18 August 2026	20 August 2026	**27 August 2026**
27 August 2026	8 October 2026	20 October 2026	22 October 2026	**29 October 2026**
29 October 2026	19 November 2026	1 December 2026	3 December 2026	**10 December 2026**
10 December 2026	4 February 2027	16 February 2027	18 February 2027	**25 February 2027**

1 *Draft minute of previous meeting, action log and business programme to be available*
2 *Any late papers will be placed on the agenda of the following meeting unless the Chair determines that they are urgent*
3 *Draft agenda, minute and action log issued to Directors following meeting*

Chair	Davie Campbell
Vice Chair	Joanna Kenny
Lead Executive	CEO
Corporate Governance Lead	Head of Corporate Governance