



Public Board Meeting- 27 August 2026

NHS Orkney

2026-08-27 09:30 - 12:30 BST

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NHS Orkney Board 27 August 2026

Purpose of Orkney NHS Board

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

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

- Open and honest
- Respect
- Kindness

Our **Strategic Objectives** are:

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

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

People Ensure NHS Orkney is a great place to work

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

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

Quorum:

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

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Minute Public Board Meeting

Thursday 25 June 2026

Present

Dr Kirsty Cole (Chair, Area Clinical Forum), Issy Grieve (Non-Executive Board Member), Joanna Kenny (Non-Executive Board Member), Dr Anna Lamont (Medical Director), James Goodyear (Interim Chief Executive Officer (CEO)), 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), Jason Taylor (Non-Executive Board Member), and Dr Louise Wilson (Director of Public Health).

In attendance

Debs Crohn (Head of Corporate Governance - Minutes), Shona Dart (NHS Orkney Corporate Communications Officer), Dave Harris (Director of People and Culture) and John Daniels (Head of Primary Care Services).

Observers

Michael Morrison, Iain Grant, Andrew Stewart

1. Cover page

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- **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.

Item 4

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

2. Welcome and Apologies (Presenter: Chair)

The Interim CEO presented Michelle Mackie (Interim Deputy Director Nursing and Lead Midwife) with a 45-year long term service award.

The Board Vice Chair opened the meeting at 11.05am and welcomed everyone to the meeting.

Apologies were noted for Davie Campbell (Board Chair), Jean Stevenson (Non-Executive Board Member), Tammy Sharp (Director of Performance and Transformation), Stephen Brown (Chief Officer - Integration Joint Board), and Ryan McLaughlin (Employee Director)

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

3. Declarations of Interest (Presenter: Chair)

No declarations of interest were recorded.

4. Minutes of Previous Meeting 30 April 2026 (Presenter: Chair)

Minutes of the meeting held on 30 April 2026 were accepted and approved as an accurate record of the meeting with the amendments discussed at the meeting.

5. Matters Arising (Presenter: Chair)

No matters arising were raised.

6. Action Log (Presenter: Chair)

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

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

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

Public Service Reform strategy work is moving forward at pace including sub national east of Scotland planning. Significant activity is taking place including a wider focus on planned care and working with other Health Boards to reduce our waiting times.

An event took place on 8 June 2026 with Orkney Islands Council to look at how we can move forward Public Service Reform in Orkney including reducing duplication, streamlining governance and workforce opportunities. This work is very much in line with the direction of travel from Scottish Government and Programme for Government which will be published in September.

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There has been a significant increase in our iMatter scores this year with 78% of staff completing the survey. We have retained our employee engagement score with colleagues reporting they feel supported in working with Board. The next Senior Leadership Team meeting on 9 July 2026 will focus on iMatter action planning with an update being presented to Staff Governance Committee.

The Vice Chair thanked the Interim CEO for the report and reflected on the useful event on the 8 June 2026 in relation to Public Service Reform and welcomed the number of colleagues who completed the iMatter survey.

The Vice-Chair reminded Board that today is Issy Grieve's last Board meeting after 8 years and thanked Issy for the great work they have done for NHS Orkney and the Integration Joint Board and the community of Orkney.

Decision / Conclusion

The Board noted the update provided.

8. CHAIR'S ASSURANCE REPORTS

8.1. Area Clinical Forum 1 June 2026 (Presenter: Dr Kirsty Cole – Chair, Area Clinical Forum)

The Area Clinical Forum Chair presented the Assurance Report from the 1 June 2026 meeting, drawing the Board's attention to the following: Clinical Advisory Groups continue to raise concerns in relation to accommodation, which is impacting start dates for staff.

R Gold asked the Board to acknowledge that the concerns were noted and asked where the issues in relation to accommodation are addressed. The Interim CEO advised that key worker housing has been raised as part of Public Service Reform and that he will have a conversation with James Wylie to consider whether accommodation is best addressed through the PSR leadership group or through the Community Planning Partnership. The Medical Director confirmed that accommodation is provided for medical colleagues taking up employment with the Board.

Digital system pressures are being experienced, and the eHealth team have been asked to present at Clinical Advisory Groups.

Area Clinical Forum raised concerns in relation to clinical colleagues attending recruitment stakeholder events.

The ACF Chair advised Board that work is underway to re-invigorate the Area Medical Committee, the Area Pharmaceutical Committee is now meeting regularly with an educational element incorporated into the meeting.

Decision / Conclusion

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

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8.2. Area Partnership Forum 21 April and 19 May 2026 (Presenter: Interim CEO)

The Chair of the Area Partnership Forum (APF) shared the Assurance Report from the meetings on 21 April and 19 May 2026.

Conversations took place at the April 2026 meeting in relation to our financial plan.

APF noted significant improvements in our statutory/mandatory training, with the Royal College of Nursing representative commenting on our approach to implementing the Agenda for Change reform actions.

The Director of People and Culture is in the process of pulling together a people delivery plan which will be brought back to APF for consultation.

R Gold asked if the accommodation policy referenced in the report will be linked to the issues raised previously in relation to accommodation changes. The Medical Director advised the Board that extensive engagement has taken place with clinical advisory groups and Joint Local Negotiation Committee (JLNC) on amendments to the policy, noting the policy is about equity and fairness for staff.

I Grieve asked for confirmation of the concern for senior leaders to engage in sub-national planning. The Interim CEO advised that engagement will be in line with Healthcare Improvement Scotland's Planning with People, conversations were in relation to what support may be available to support this piece of work.

Decision / Conclusion

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

8.3. Audit and Risk Committee Chair's Assurance Reports 26 May 2026 (Presenter: Jason Taylor- Chair of Audit and Risk Committee)

The Chair of the Audit and Risk Committee presented the Assurance Report from the meeting on 26 May 2026.

Primary business of the meeting was the draft Annual Accounts and Report. Updates were received in relation to Business Continuity Planning and implementation of Health and Safety Internal Audit.

Decision / Conclusion

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

8.4. Finance and Performance Committee Chair's Assurance Reports 29 April and 25 May 2026 (Presenter: Fiona Mackay - Chair of Finance and Performance Committee)

The Chair of the Finance and Performance Committee shared Assurance Reports from the meetings on 29 April and 25 May 2026.

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Positive assurance was provided in relation to the Integrated Performance Report, with a notable improvement in the number of Delayed Transfers of Care.

Committee reviewed and noted the Capital Plan and external funding for a replacement of our CT Scanner.

Concerns in relation to the Month 12 position, financial savings plan and the Robertson Facilities Management Contract were escalated to the Board for consideration. Performance indicators for management of the Robertson Facilities Management Contract will be monitored by the Finance and Performance Committee.

Whilst positive assurance was provided in relation to the Older Persons/Frailty Workstream, concerns were raised in relation to limited progress in the three other key priority areas.

Committee discussed the frequency of meetings, as the Board remains at level 3 escalation it was agreed that Committee will continue to meet monthly.

Decision / Conclusion

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

8.5. Senior Leadership Team Chair's Assurance Report 5 May and 3 June 2026 (Presenter: Interim CEO - Chair of Senior Leadership Team)

The Chair of the Senior Leadership Team (SLT) shared the Assurance Report from meetings held on 5 May and 3 June 2026.

The Interim CEO was reminded by the Board of changes to the SLT which has led to meaningful conversations taking place with our senior leaders.

The meeting in May 2026 was facilitated by Public Service Delivery Scotland in relation to our Equality Outcomes Report and how we take actions forward.

June's SLT meeting focused on our approach to implementing safe care, assessing safe staffing levels and escalation processes. The session was opened up to a wider cohort of senior leaders, with presentations being delivered by our Interim Director of Pharmacy and Lead Nurse Renal, these were well received.

The Interim CEO advised that feedback from SLT members is that the new format is working well.

Decision / Conclusion

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

8.6. Staff Governance Committee Chair's Assurance Report 14 May 2026 (Presenter: J Kenny, Chair Staff Governance Committee)

Item 4

The Chair of the Staff Governance Committee delivered the Chair's Assurance Report from the meeting held on 14 May 2026.

Concerns raised at the meeting were in relation to the lack of JLNC meetings. The Medical Director confirmed a JLNC meeting has now taken place.

Useful conversations took place following presentation of the annual medical education report, with some bright ideas put forward to our Improvement Team.

Ongoing concerns in relation to appraisal rates were discussed, with an improvement plan in progress to increase compliance. Director of People and Culture advised that conversations are taking place with Executive Directors to understand the challenges, this continues to be discussed at the Performance Review Meetings (PRMs).

Decision / Conclusion

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

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

The Medical Director presented the Corporate Risk and Assurance report, providing the Board with an update on the highest corporate risks, which include financial sustainability, insufficient senior leadership capacity and capability, and clinical engagement.

One risk was added to the Risk Register in May with none in June 2026, all risks have been updated within their timescales.

The Medical Director advised that there are changes taking place in relation to how risks are being presented noting this is a process of continuous improvement.

The Risk Management Group (RMG) is now chaired by the Medical Director with risks being approved by the RMG.

Decision / Conclusion

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

10. Integrated Performance Report (IPR) May 2026 (Presenter: Interim CEO)

The Interim CEO reminded members of the areas covered within the Integrated Performance Report (IPR) up till the end of May 2026.

Patient Safety, Quality and Experience.

The EDoNMAHP presented the patient safety, quality and experience report and asked the Board to note that there has been a reduction in the number of falls due to the work being undertaken by clinical teams.

Item 4

The Medical Director asked Board to note the sustained number of reduced longest waits which has been maintained for nearly a year. Board noted that the Treatment Time Guarantee has increased due to the focused attention on reducing our waiting lists.

The Interim CEO noted an increase in the number of stage 2 complaints and asked if a piece of work needs to be undertaken by the Clinical Governance Group. The Medical Director advised that an update will be provided at the next Board meeting.

Sustained improvements in endoscopy were noted, with monitoring meetings with Scottish Government now being stepped down. A data quality issue was noted by Scottish Government at the end of May.

At the end of April 2026, 6-week compliance for Computer Tomography was at 100%. MRI compliance was 79%, with 20 patients waiting more than six weeks. Several delays were due to patient unavailability, including patients declining appointments because they were unavailable.

Ultrasound dropped to 41% seen within 6 weeks, due to staffing challenges although this has seen improvement throughout May 2026. Overall waits for ultrasound scans have dropped from 175 in April to 29 at the end of May 2026, with 6 week compliance increasing to 72%.

The Interim CEO noted the position in relation to ultrasound with no waiting lists.

The Vice Chair asked for an update on compliance in relation to Serious Adverse Event Reviews (SAERs). The Medical Director confirmed that all open reviews are due to awaiting feedback from external organisations, work is underway with the Head of Patient Safety, Quality and Risk to review all cases to ascertain if cross organisational reviews can be closed noting limited number of staff available to complete reviews.

I Grieve asked if low appraisal rates and statutory mandatory training compliance impacted patient safety. The Medical Director advised that the Head of People and Culture continues to work with Executive Directors and provided assurance that this is being addressed.

The Director of People and Culture acknowledged that there has been an improvement on statutory mandatory training rates.

Community

J Daniels provided an update on concerns in relation to Allied Health Professionals. Work is underway to review the AHP structure, noting the Electronic Patient Record currently being used does not capture all activity data. A capacity and demand exercise is currently being undertaken.

Dr K Cole asked for confirmation on the increased number of patients who were seen in May 2026 and its impact. The Head of Primary Care Services advised that this may be due to a data quality issue related to the Phio app, noting that the app has been well received.

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Dr K Cole was disappointed to see the comments in relation to the Primary Care Improvement Plan funding being referenced. J Daniels confirmed that PCIP funding is ringfenced for General Practice only, the absence of First Contact Physiotherapists should have no impact on secondary care. The statement regarding PCIP funding will be removed to avoid confusion.

Community Mental Health waiting times target continues to be met, noting there are areas for improvements.

Population Health

The Director of Public Health advised that uptake of vaccinations remains high, with a MenB vaccination campaign commencing in July 2026.

Smoking remains a challenge with a focus on maternity services with clinic letters being adapted to signpost patients to smoking cessation services.

The Vice-Chair asked for confirmation of the reasons for the drop in uptake of the MMR vaccination. The Director of Public Health advised that this is in part due to the small numbers in Orkney, work is underway to look at the areas of variation.

Workforce

The Director of People and Culture advised that there is a reduction in sickness absence rates, with no data quality issues.

Assurance provided to the Board that the Occupational Health and Wellbeing Committee is now meeting regularly, this includes monitoring statutory/mandatory training.

Overtime and excess hours narrative were not updated in the IPR, the EDoNMAHP apologised. Agency usage has continued to reduce, with the number of bank hours remaining static with overtime increasing due to peak annual leave periods and to filling in gaps within the system. Excess hours are recorded for part-time staff; this is in part due to hospital pressures.

Finance

The Interim Director of Finance highlighted the year-end position of a £2.6 million deficit. Improvements have been seen in relation to the 30-day target for invoices paid.

Decision / Conclusion

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

11. STRATEGIC OBJECTIVE – PLACE

11.1. Integration Joint Board (IJB) key items, decisions and financial update (Presenter: Head of Primary Care Services - John Daniels)

Item 4

The Head of Primary Care Services presented the Integration Joint Board (IJB) key items, decisions and financial update following the IJB meeting 25 June 2026.

The Integration Joint Board approved the appointment of two Service User Representatives to the Board, following the resignation of the previous long standing Service User Representative. It was also agreed to establish a Service User Group to support the new members.

The Board noted the draft Revenue Expenditure Outturn report for the fiscal year 2025/26. The draft position showed an overspend of £0.630 million against the Board-approved budget of £69.129 million, with draft outturn of £69.759 million. For NHS Orkney commissioned services, there was an underspend of £1.350 million following the removal of the £2.4 million savings target.

Discussions took place in relation to the Primary Care Improvement Plan which was approved and moved forward in a constructive way.

Decision / Conclusion

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

11.2. Orkney Integration Scheme (Presenter: Head of Primary Care Services - John Daniels)

The Head of Primary Care Services presented to the Board an overview of changes to the Orkney Integration Scheme for approval.

The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) 2025 Amendment Order will come into effect on 1 September 2026 which extends the voting rights to the third sector, service user and carer representatives on the Integration Joint Board.

The Orkney Integration Scheme has had to be updated to reflect these legal changes.

NHS Orkney and Orkney Islands Council must approve the amended Orkney Integration Scheme which will then be submitted to Scottish Ministers to ensure Orkney is compliant in its statutory requirement.

R Gold was fully supportive of the changes but asked for clarity on the background section of the report (2.5) in relation to reviewing the scheme in light of the work underway on Public Service Reform and asked where the decision was made not to undertake a review.

The Head of Primary Care Services advised that a conversation will take place with the Chief Officer IJB in relation to the decision not to undertake a review with feedback provided to members.

Dr K Cole asked if a process has been undertaken by Scottish Government in relation to supporting patients and carers to attend the IJB. The Vice Chair was not aware of what support

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has been put in place for patients and carers. The Head of Primary Care Services advised that support will be offered to representatives ahead of meetings.

I Grieve advised that there is an induction pack in place for IJB members.

Decision / Conclusion

The Board approved the proposed changes to the Orkney Integration Scheme.

12. PATIENT SAFETY, QUALITY AND EXPERIENCE

12.1 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. 90% compliance with our hand-washing target, hand hygiene day in May 2026 was well received.

Thanks were given to our infection, prevention and control and estates and facilities teams for achieving the targets set in HIART.

Decision / Conclusion

The Board took assurance from the report.

13. STRATEGIC OBJECTIVE – PEOPLE

13.1. Equality and Diversity Monitoring Report 2025 (Presenter: Director of People and Culture)

The Director of People and Culture presented the Equality and Diversity Monitoring Report 2025 for approval noting the gender pay gap was presented last year.

Board was reminded that a commitment has been made to establishing an Equalities Short Life Working Group to take forward our Equalities Outcomes, and data from the report will be included in this piece of work.

J Taylor asked that going forward, where there is a column for 'don't know', wording should be changed to reflect the organisation not being informed, to make it clearer that it was the organisation that did not know, rather than the individual.

J Taylor asked if international recruits not NMC registered are impacting on the figures. Director of People and Culture to confirm.

Decision / Conclusion

The Board approved the Equality and Diversity Monitoring Report 2025.

13.2. Board Walkarounds (Presenter: Interim CEO)

Item 4

The interim CEO presented the Board Walkarounds which took place in May and June 2026, Outpatients and Improvement Team.

The Interim CEO noted that our Director of Performance and Transformation leaving the organisation has impacted on staff morale, plans are in place for the team as part of the transitions to the Director of People and Culture.

Concerns were raised in the Outpatients' walkarounds in relation to capacity and substantive anesthetic cover. Since the walkaround a Clinical Nurse Manager has joined the organisation, as well as recruitment to an additional band 5 post for outpatients.

The Director of People and Culture advised the Board that there is a need to close the loop following board walkaround which is considered by the Executive team.

Board were asked to note the introduction of an action plan following a Board Walkaround and this was welcomed.

The Vice Chair noted the usefulness of Board Walk rounds.

R Gold welcomed the introduction of the action plan and acknowledged they and F MacKay had undertaken a Board Walkaround with Daisy Villa.

Decision / Conclusion

The Board discussed the themes arising from the Board Walkarounds in May and June 2026.

14. Break

15. STRATEGIC OBJECTIVE – PERFORMANCE

15.1. NHS Orkney Annual Report and Annual Accounts Year ended 31 March 2025 (Presenter: External Auditor)

The External Auditor presented the NHS Orkney Annual Report and Annual Accounts Year ended 31 March 2026 for approval which were presented to Audit and Risk Committee 25 June 2026.

Positive assurance was taken from the external audit report and recommendations. The audit opinion statement will be issued by the External Auditor by 30 June 2026.

External auditors returned a grade 1 associated with the potential risks linked to non-delivery of the financial savings plan.

The external audit is now complete, with no unadjusted audit differences identified by the external auditors, as set out by the requirements of Audit Scotland.

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External Auditors expressed their thanks to the Finance team for their work undertaken in producing the Annual Accounts.

The Vice-Chair reminded members that the Annual Accounts paper had been considered by the Audit and Risk Committee prior to Board approval.

J Taylor (Chair of Audit and Risk Committee) confirmed that the report had been reviewed and recommended for approval, with no significant matters of concern.

The Vice-Chair thanked external auditors and those involved in producing the annual accounts and report 2025/26.

Decision / Conclusion

The Board approved the NHS Orkney Annual Report and Annual Accounts Year ended 31 March 2026 following the recommendation from the Audit and Risk Committee.

15.2. Financial performance report May 2026 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Month 2 finance position and Improving Together (efficiency) Programme progress report and asked the Board to note a correction to the savings to date: £289k against a plan of £100k, which is a favourable position.

The financial plan is favourable against plan in the first two months of the year, noting that there is a need to improve the run rate over the remainder of the year. This will be challenging to achieve compared with previous years.

The Board were asked to note a backdated fuel bill for The Balfour of £188k accrued from last financial year.

The Medical Director asked a question in relation to the costs associated with oil compared with the use of air source heating. The Interim Director of Finance recognised that a comparison of the two costs is required.

I Grieve asked the Interim Director of Finance where the sale of King Street features in the financial savings plan. The Interim Director of Finance advised that the sale of King Street is a benefit in relation to capital and agreed to provide more detail to the Board going forward.

F MacKay asked the Executive Team for assurance on delivery of the transformational priorities, noting the targets in the savings plan for 2026/27. The Interim CEO advised that there is risk in the current position; however, work has been undertaken to validate savings schemes with greater depth and realism, noting there is a potential gap of £800k. There is also a significant level of delivery risk within the corporate schemes, particularly Isles Model of Care, Out of Hours and medical staffing.

The Interim Director of Finance advised that run rate controls are in place and this continues to be monitored.

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Decision / Conclusion

The Board discussed and noted Month 2 financial performance.

15.3. NHS Orkney Delivery Planning 2026/27 (Presenter: Interim CEO)

The Interim CEO presented the NHS Orkney Delivery Planning 2026/27 report for assurance as set out in the NHS Scotland sub national regional planning structures as well as our local priorities.

Board was asked to note that there may be additional asks from the national and regional planning space following publication of the Programme for Government. Any additional asks will be included in our Improving Together Programme Plan.

The Vice Chair asked if there were any implications for the Board arising from the First Minister's 100-day plan. The Interim CEO advised that these have been included in the NHS Scotland activities.

I Grieve asked how our local priorities dovetail with the national and regional plans. The Interim CEO advised that all of the national asks can be mapped to our local 5 Ps (Place, Patient Safety, People, Performance and Potential) priorities and all Boards have been asked to work at an East of Scotland level with a clear focus on reducing waiting times, more efficient and productive.

Decision / Conclusion

The Board discussed and welcomed the update.

16. STRATEGIC OBJECTIVE – POTENTIAL

No papers were presented.

17. ANY OTHER COMPETENT BUSINESS (AOCB)

No other competent business raised.

18. APPROVED MINUTES FROM GOVERNANCE COMMITTEE MEETINGS

19. Area Partnership Forum – 18 March and 21 April 2026

Members noted the minutes of the Area Partnership Forum held on 18 March and 21 April 2026.

20. Area Clinical Forum – 4 February 2026

Members noted the minutes of the Area Clinical Forum held on 4 February 2026.

21. Audit and Risk Committee – 3 March 2026

Members noted the minutes of the Audit and Risk Committee held on 3 March 2026.

22. Finance and Performance Committee – 25 March and 29 April 2026

Members noted the minutes of the Finance and Performance Committee held on 25 March and 29 April 2026.

23. Staff Governance Committee – 12 February 2026

Members noted the minutes of the Staff Governance Committee held on 12 February 2026.

24. QUESTIONS FROM THE PUBLIC

25. ITEMS FOR INFORMATION

25.1. Items for awareness — no items presented.

25.2. Correspondence for noting - no items presented.

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

Members noted the meeting schedule 2026/27.

25.4 Record of attendance 2026/27 (Presenter: Chair)

Members noted the record of attendance 2026/27.

The Vice-Chair closed the meeting at 13:41.

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Board Chair and Chief Executive Report to the Board

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 2026
Responsible Executive/Non-Executive	- James Goodyear, Interim Chief Executive - Davie Campbell, Board Chair
Report Author(s)	- James Goodyear, Interim Chief Executive - Davie Campbell, 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 - 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 July - August 2026, including meetings with external stakeholders and partners.
Route to meeting	Prepared for NHS Orkney Board – 27 August 2026
Recommendation(s)	Assurance - For members assurance only

Board Chair and Chief Executive Report to the Board

James Goodyear, Interim Chief Executive

Davie Campbell, Board Chair

07/08/2026

1. Situation

- 1.1 This report provides an update to the Board on our performance, operational standards, key external and internal events, and activities from July to August 2026, including meetings with external stakeholders and partners.

2. Assessment

2.1 A summary of our overall performance

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

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

2.1.2 Diagnostics

At the end of July, diagnostic performance varied across modalities. Endoscopy six-week compliance reduced to 74.67%, compared with the previous position of 94.34%. Diagnostic imaging six-week performance increased to 86.29%, compared with 56.67%.

2.1.3 Emergency Department (ED)

Compliance with the A&E four-hour standard reduced slightly to 91.87% in July; this was recorded at 93.81% in April 2026. This performance is indicative of increased patient acuity and ongoing system flow challenges, particularly those associated with delayed discharges.

Adherence to the 12-hour standard remains robust and for July performance was reported as 100% again, providing assurance that extended waiting times continue to be effectively minimised.

2.1.4 Cancer Standards

Cancer performance in relation to the 31-day standard remains strong, with 100% compliance. In relation to the 62-day standard, performance for the latest reporting period was 37.5%, with 3 of 8 patients treated within the standard and 5 patients treated outside the target. Breach analysis has been completed for all patients treated outside the standard to identify the causes of delay and support shared learning and service improvement.

2.1.5 People & Culture

Sickness absence increased to 7.25% in May, compared with 4.41% in February 2026.

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Appraisal compliance is still low at 37.17% compared to 36.59% in the previous reported period; the risk is being actively addressed as a corporate risk.

2.1.6 Finance

NHS Orkney's financial situation continues to be challenging. In terms of financial performance against plan, at the end of June 2026 the board is reporting £1,031,000 against a budget of £1,417,000.

2.1.7 Patient Safety, Quality & Experience

Patient safety performance remains mixed, with some deterioration observed since the last reporting period. Areas not meeting agreed targets include one inpatient-acquired pressure ulcer reported in July 2026, response compliance for Stage 1 and Stage 2 complaints, and inpatient falls, which increased to 19 compared with 15 in April.

Incident reporting and seven-day review compliance remain at 100%, reflecting continued strong performance in these areas.

2.1.8 New Outpatients

Compliance with the New Outpatients (NOP) 12-week standard remains below target at 51.02%, against a target of 95%. This reflects downstream constraints, including theatre capacity, diagnostic availability and workforce pressures. At the end of July 2026, a total of 1,459 people were waiting for new outpatient appointments.

2.1.9 Treatment Time Guarantee

Compliance with the Treatment Time Guarantee remains below target at 48.99%, a deterioration compared with 53.63% in April 2026. This reflects increasing demand and downstream constraints, including theatre capacity, diagnostic availability and workforce pressures.

2.1.10 Delayed Transfers of Care

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

- 40.91% of patients were discharged within two weeks compared to 64.29% at the previous reported period (target: 100%)
- 7 patients experienced delays at the census point compared to 7 at the end of April (target: 4)
- 299 bed days were lost to delayed discharge during the month, compared to 219 for the previous reporting period.

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

2.2.1 Board Chair - Davie Campbell

On 12 August 2026, we welcomed Ms Constance, Cabinet Secretary for Health and Social Care, to The Balfour. The visit provided an important opportunity to showcase service

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across the hospital, including Dialysis, Outpatients, the Emergency Department and Scottish Ambulance Service station, MRI, Macmillan, inpatient wards, Dental, Pharmacy, Laboratory and Maternity services. The programme also included focused discussions on the Healthcare Improvement Scotland maternity services inspection, Discharge without Delay, the operation of ambulance services in a rural area and Project SEARCH/Innovation, as well as media opportunities with the local press. The visit enabled Ms Constance to meet colleagues across a range of services, hear directly about the opportunities and challenges of delivering health and care in an island context, and see first-hand the commitment, professionalism and innovation of teams across NHS Orkney.

I have continued to work with Board Chairs across the East of Scotland to progress sub-national planning, with a focus on strengthening collaboration between Boards, identifying shared opportunities and ensuring that island and rural considerations are reflected in regional discussions. This work has included engagement on how Boards can work together more effectively to support sustainable services, improve resilience and align local priorities with national direction, while ensuring that the specific needs of NHS Orkney and the communities we serve remain visible within wider planning arrangements.

I have supported the induction of the three new Non-Executive Board Members, ensuring they have had the opportunity to meet key colleagues, understand the Board's governance arrangements and familiarise themselves with the strategic and operational context for NHS Orkney. The wider Board has been advised of the induction process and the ongoing support available to the new members, recognising the important contribution they will make to Board discussion, scrutiny and assurance as they settle into their roles.

The Board is asked to note that Dave Harris, our substantive Chief Executive, will commence in post on 14 September 2026. James Goodyear, Interim Chief Executive, will conclude his time with NHS Orkney on 10 September 2026. I would like to take this opportunity to thank James for his leadership, commitment and support during his time with the organisation, and to wish him well for the future. I would also like to extend a warm welcome to Dave as he takes up the substantive Chief Executive role and wish him every success as he leads NHS Orkney through the next stage of our work.

2.2.2 Interim Chief Executive – James Goodyear

National Priorities

I have continued to work with Chief Executives across the East of Scotland health boards to advance implementation of the requirements set out in DL(2025)25 relating to sub-national planning, collaboration and direction. Discussions have focused on the agreed regional priorities and the opportunities for Boards to strengthen collaborative working arrangements in support of service sustainability, organisational resilience, and the reduction of unwarranted variation.

Chief Executives have considered how greater alignment in planning, decision-making and resource utilisation can support the delivery of safe, effective and person-centred services across the region. This work is helping to identify areas where collective approaches, shared capacity and regional solutions can add value while recognising the distinct responsibilities of individual Boards.

Throughout these discussions, particular emphasis has been placed on ensuring that the unique challenges, opportunities and service considerations associated with NHS Orkney's

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rural and island context are appropriately reflected within both regional planning arrangements and wider national strategic developments.

Speaking up standards

Healthcare Improvement Scotland has published updated national guidance on speaking up within NHS Scotland. The guidance provides a clearer and more consistent framework for staff, volunteers, students and contractors, setting out how concerns can be raised, the support available, and the protections afforded to those who speak up.

An organisational culture that supports openness and transparency is fundamental to patient safety, quality improvement and effective governance. Evidence across healthcare systems consistently demonstrates that opportunities to address concerns and mitigate risk can be missed when individuals do not feel able, supported or confident to raise matters of concern. Equally, there is a responsibility on organisations to ensure that concerns are received and considered constructively, with openness, respect and a commitment to learning and improvement.

Members are invited to note the publication of the national guidance and to familiarise themselves with its content. Further local resources and supporting information will be communicated in the coming weeks to support implementation and awareness across NHS Orkney. The Board is asked to confirm its commitment to promoting a positive speaking up culture, where all individuals feel safe and supported to raise concerns and contribute to improvements in the delivery of care and services.

Diagnostics

I was delighted to receive confirmation of continued funding from Scottish Government for the NHS Orkney MRI service. This allows most patients to be scanned locally, avoiding unnecessary travel to Aberdeen and speeding up diagnosis.

Later this year, we are planning to replace our CT scanner to ensure that our community can access scans using the most up-to-date equipment.

Director of Medical Education

Congratulations to Dr Chetana Patil, who has been appointed as Director of Medical Education for NHS Orkney. Chetana is a Consultant Child and Adolescent Psychiatrist working across both NHS Orkney and NHS Grampian, and is also the Clinical Director for Orkney CAMHS. Chetana has significant experience in medical education, having previously been a foundation programme training director and contributed to policy at a national level. She will work with colleagues to strengthen our approach to training, supervision and support for trainees.

Population Health Organisation

Last month, the Board spent time together considering how we can become a population health organisation and embed prevention across all that we do. We developed a baseline using a maturity matrix from Public Health Scotland to consider where we are now and where we have the greatest opportunities to go further in improving outcomes for our community. This will be presented to the Board once finalised.

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Public Service Reform

Senior leaders from NHS Orkney, Orkney Islands Council and the Integration Joint Board continue to progress the Routemap to Reform for Orkney, reflecting a shared commitment to advancing reform in a coordinated, outcome-focused and practical manner. Ongoing discussions have centred on opportunities to strengthen collaborative working across organisational boundaries, with a particular focus on service integration and redesign, workforce sustainability and resilience, prevention and early intervention, and the streamlining of governance and decision-making processes.

Local engagement

Since the last Board meeting, I have met with colleagues and stakeholders throughout the organisation.

The Senior Leadership Team (SLT) met in July 2026 to review the iMatter staff survey feedback and agree a focused set of actions to support staff engagement, visible leadership and organisational improvement. Key outcomes included agreement to strengthen staff communications through a “we said, we did” approach, invite staff representatives to attend monthly SLT meetings, and reset the organisation’s approach to education, learning and development.

SLT also agreed to make better use of internal communication spaces, explore opportunities to support coaching and mentoring through the Endowment Fund, create listening spaces for open discussion of complex issues, and relaunch the Bright Ideas Scheme. These actions reflect a commitment to listening to staff, improving feedback loops and creating practical opportunities for colleagues to contribute to improvement across NHS Orkney.

In August 2026, SLT held a focused and constructive discussion on strengthening understanding of the 2026/27 budget-setting process and supporting the delivery of cost control measures. It was agreed that the current budget position would be clarified for budget holders, who will be asked to review their budgets and confirm whether they can remain within allocation or exceed proposed savings targets. SLT also agreed to use peer support to identify and discuss further opportunities, while ensuring that any concerns about potential unintended consequences arising from savings targets are escalated appropriately. This approach is intended to support shared ownership of financial sustainability, strengthen accountability and ensure that savings are delivered in a considered and proportionate way.

I was also delighted to hear that Thisbe Sinclair in our School Nursing team has been accepted for a prestigious fellowship exploring the prevention of suicide in young people. This is a hugely important issue, and one that aligns closely with our aspirations as a Board.

Corporate Risk and Assurance Report

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 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	• Corporate Risk 510 has been reviewed and updated, with the risk score reduced from very high to high and currently assessed at 16. • Corporate Risks C-2024-01 and C-2024-13 have been reviewed and updated to reflect the current risk position. Alongside Risk 510, these updates are awaiting review and approval by the Risk Management Group before being fully incorporated into the Corporate Risk Register.
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
07/08/2026

1. Situation

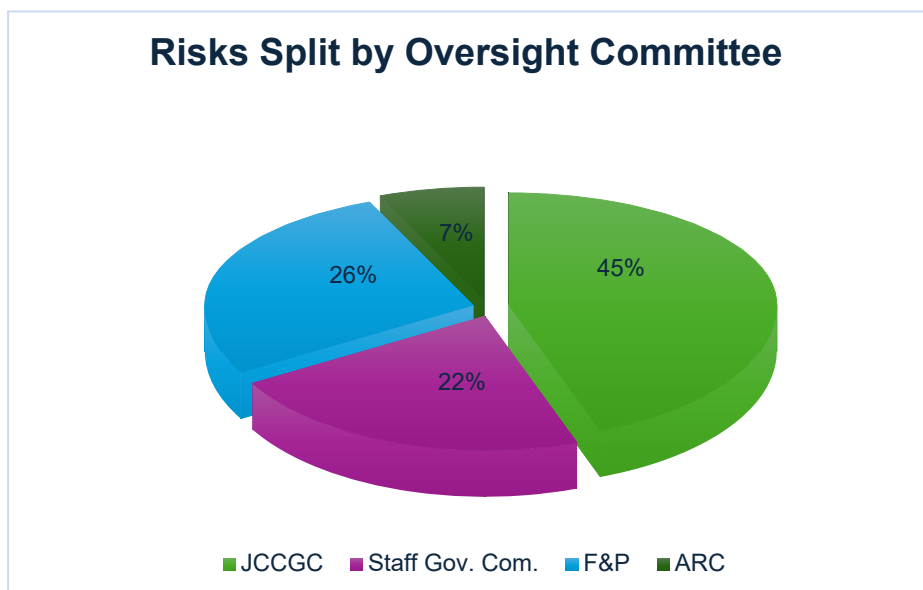
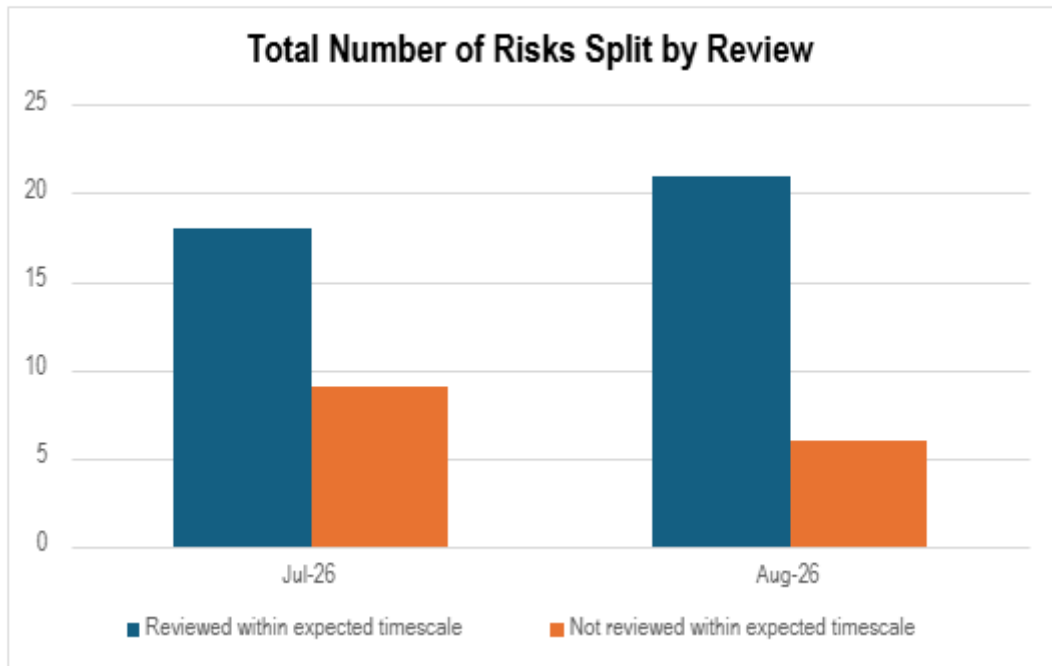
- 1.1 The Corporate Risk Register Report is presented to the Board to provide clarity, oversight, and strengthen organisational scrutiny. This report offers a concise view of changes over the past two months and illustrates how risks are distributed across governance committees.

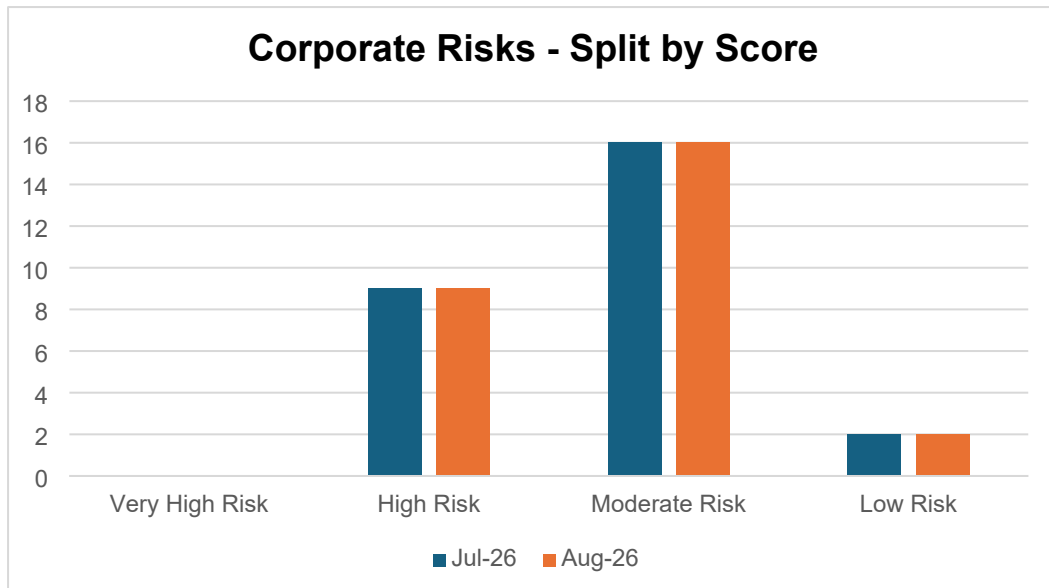
2. Background

- 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 Risk 501 – Corporate Financial sustainability; has been reviewed and an update provided on the current position. This would have normally been agreed by the Risk Management Group (RMG) prior to adding to the corporate risk register, but due to the timing of meetings has not been seen and approved yet, the update is shown here for assurance. The score has been revised and reduced to 16 from 20.
- 3.3 Risk C-2024-02 – Lack of organisational digital maturity; has had the ownership of the risk changed from the Head of Improvement to the Director of Finance due to a change in roles and remits.
- 3.4 Risks C-2024-01 formally Lack of senior Leadership Capacity and Capability and C-2024-13 formally Workforce Experience and Wellbeing; have both been reviewed and revised to reflect the current risks more accurately. Due to the timings of meetings, these have not yet been approved by the RMG so are shown as draft in the Corporate Risk Register as per Risk 510 to provide assurance of process.





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

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	4	16	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 29/06/2026 Control totals added to 2926/27 budgets, limiting spend to 2025/26 levels	Update 29/06/2026 - 2026/27 deficit support is £2.4m so need to deliver 3% efficiency this year. While plans are in place some are high risk and there is a need to ensure costs are controlled through the current year. Impact score reduced to 4 meaning risk score reduced initially 16 but may increase if efficiencies are delayed. 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.
C-2024-01	Lack of senior leadership capacity and capability Lack of Leadership Capability (Capacity, Competence)	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 Remuneration committee	Update 20/7/26 - Risk, title, description and impact revised to reflect current risk. Mitigating actions reviewed and added to. If amendments accepted then additional actions will be identified. Update 19/01/2026 - Interim Director of Finance appointed and substantive Chair and CEO recruitment being progressed with Scottish Government.

	and Confidence) and Succession Planning					1. Substantive recruitment to Board roles supplemented by interim recruitment as required 2. Management and leadership development programme to build consistent leadership capability across operational, clinical and corporate areas. To be delivered in collaboration with PDS. 3. Executive and senior leadership succession planning, including critical role mapping, deputy arrangements and development plans for potential successors. 4. Distributed leadership approach to reduce over-reliance on a small number of Executive and senior leaders. 5. Structured induction and support for new senior leaders, including clarity on objectives, governance expectations and key risks.	
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.

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 11/05/2026 - Risk Description revised to provide clarity of the risk and impact also revised to provide the same. 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.
C-2025-06	Strategic Clinical Leadership and Engagement Capacity	4	4	16	8	1. Clinical Advisory Group Improvement Plan By 30 September 2025, complete and implement the improvement plan for clinical advisory groups, aligned with the review of operational governance. This will include: - Defined administrative support and resource commitments to support clinical advisory groups, noting that Copilot is now available to help minimise admin burden for notetaking at least. - Monthly Executive attendance rota established and monitored. - Formalised escalation process for advisory groups via Chair's Assurance Reports, with documented feedback loops to confirm action and closure. 2. By 31 December 2025 - implement the CSR Recommendations relevant to the risk:	Update 25 May 2026 1. CLOSED Reported to Area Clinical Forum 6 May 2026. All active Clinical Advisory Groups have administrative support, consistent Executive attendance, and a formalised escalation pathway with Chair's Assurance Reports and documented feedback loops. Three groups remain inactive and are monitored: Hospital Sub-Committee: two unsuccessful rounds to identify a chair. Area Pharmacy Committee and Area Dental Committee: in abeyance due to limited contractor appetite for additional evening meetings. No further remediation planned. 2. ONGOING Project management and Improvement Team support in place for clinical and operational redesign work however is fragile and resource does not meet organisational needs for transformation. Clinical lead workstream meetings established using CSR templates; outcomes reported to the Improving Together Programme Board. Substantive consultants engaged in national planning forums including pharmacogenetics, thrombectomy for stroke management, and senior mental health representation.

					• 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. 3. By 30 September 2025 review Workforce Models and Experience • Commence the exploration of innovative workforce models and regional collaboration to attract and retain senior clinicians in key service leadership positions, recognising the challenges of remote and rural recruitment. • Explore opportunities to improve experience across the employee journey, particularly recruitment, experience for existing clinical staff, and succession planning. Including ensuring all clinical vacancies are advertised promptly, training and development of existing staff, and a named support contact for new senior staff. • Use the iMatter action planning process to co-design improvements in experience for consultants.	3. ONGOING Associate Medical Director (AMD) (Primary Care) and AMD (Acute) posts remain vacant under non-recurring savings; this represents a continuing gap in strategic clinical leadership. Ongoing operational governance limitations. iMatter action planning process to continue to be used to co-design improvements in experience. Director of Medical Education and Appraisal Lead, Recruitment underway following resignation and retirement respectively of previous postholders. Applicants received at time of this update; outcome to follow. Area Medical Committee, re-establishment of an Area Medical Committee to strengthen collective clinical leadership, engagement, and succession planning remains a priority action for Q2 2026 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 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.
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3.6 Impact Assessment

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

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

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 No one**, Corporate Risk Register

Integrated Performance Report (IPR) August 2026

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 2026
Responsible Executive/Non-Executive	John Daniels, Interim Chief Officer - Acute Services & Head of Primary Care Services
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	- Progress continues in reducing long waits and improving diagnostic capacity; however, national standards for Treatment Time Guarantee, New Outpatients and some diagnostic services remain challenging due to workforce and capacity constraints. - Performance across Unscheduled care, Delayed Discharge and Community Services continues to reflect wider system pressures. Work remains underway with Health and Social Care partners to improve patient flow, timely discharge and access to services. - While the financial position remains broadly aligned to the Board's recovery trajectory, delivery of recurring efficiencies, workforce availability, sickness absence and recruitment challenges continue to present risks to sustainable service delivery and achievement of performance standards.

Route to meeting	• The full Integrated Performance Report has been approved by the Executive Team on 17 August 2026. • The Finance, Community and Operational chapters was presented to Finance and Performance Committee on 25 August 2026. • People and Culture chapter was presented to the Staff Governance Committee on 20 August 2026.
Recommendation(s)	• Assurance - For members assurance only

Integrated Performance Report (IPR) August 2026

Report Author – Carrie Somerville

17/08/2026

1. Situation

- 1.1 The Integrated Performance Report (IPR) – August 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) – August 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 July 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

We continue to make progress across several key performance areas, particularly in the delivery of Diagnostic Services and the reduction of some of our longest waits for treatment. Improvements in local service provision and targeted capacity initiatives have supported increased activity and improved access for patients across several specialties. Cancer treatment performance remains strong against the 31-day standard, and a number of preventative and screening programmes continue to perform well.

Despite these improvements, the organisation continues to face challenges relating to workforce availability, recruitment difficulties and sustained demand for services. These pressures continue to impact Waiting Times in some specialties, particularly Ophthalmology and community-based services, and remain a contributing factor to performance against national standards for Planned and Unscheduled Care. We continue to work with Regional and National partners to secure additional capacity and develop more sustainable service models.

Improving patient flow and reducing delayed discharge remain key priorities for NHS Orkney. Work is ongoing across Health and Social Care services to support timely discharge, strengthen pathways of care and ensure patients receive treatment in the most appropriate setting. Alongside this, targeted actions continue to support workforce wellbeing, improve attendance and increase appraisal compliance.

The Board's financial position continues to show signs of improvement, supported by focused recovery actions and scrutiny of expenditure. Whilst risks remain, particularly in relation to the delivery of recurring efficiencies, we remain committed to providing safe, effective and person-centred care whilst maintaining progress towards financial sustainability.

Key Performance Considerations

- Diagnostic services continue to improve, particularly within Cardiology and Imaging, supported by increased local resilience and substantive staffing arrangements. Endoscopy and some diagnostic services remain vulnerable due to continued reliance on visiting clinicians.
- Treatment Time Guarantee (TTG) and New Outpatient (NOP) performance remain below national standards, with Ophthalmology continuing to represent the most significant area of pressure. Additional capacity measures and longer-term solutions are being progressed.
- Cancer performance continues to achieve the 31-day treatment standard. Performance against the 62-day standard is below target and can be significantly affected by individual patient pathways within a small population setting.
- Unscheduled Care performance remains below the 95% four-hour standard, reflecting increased complexity and acuity of presentations. Compliance with the 12-hour standard remains above target.
- Patient Safety: Pressure ulcer incidence remained low with one reported case during the period, and MEWS compliance remained high as midwifery teams implemented revised national tools supported by training. PEWS compliance within the Emergency Department continues to be a focus, with staffing pressures affecting sustainability of training; however, clinical escalation of concerns for unwell children occurs in real time and remains embedded in practice. Reported

inpatient falls currently include all falls with and without harm, but the introduction of the revised national SPSP definition for falls with harm from 1 September 2026 is expected to result in a significantly reduced number of reported falls in future reporting cycles.

- Delayed discharge continues to present a challenge, with ongoing focus across Health and Social Care partners to improve patient flow and reduce avoidable delays.
- Access pressures remain within several community services, particularly MSK and Orthotic services, where recruitment and workforce availability continue to impact capacity.
- Immunisation uptake remains above the national average across several programmes, although some measures remain marginally below target and require ongoing monitoring.
- Workforce indicators remain mixed, with sickness absence increasing to its highest level in the past 12 months and appraisal compliance remaining below expectation. Mandatory training compliance remains close to target.
- The financial position continues to track broadly in line with the Board's recovery trajectory; however, delivery of recurring efficiencies remains a key risk, alongside ongoing pressures within medical and dental pay 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) August 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 No 1**, The Integrated Performance Report (IPR) August 2026

Integrated Performance Report

Interim Chief Executive:
James Goodyear

August 2026



HEALTH Intelligence

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.

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.

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	1	Red	↑	31/07/2026
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	19	Amber	↓	31/07/2026
5 Patient Safety, Quality, and Experience	Complaints	Number of complaints received.	Medical Director	0	8	Grey	↑	31/07/2026
6 Patient Safety, Quality, and Experience	Complaints	Complaints Received - Stage 1 5 Working Day Response Compliance	Medical Director	100%	75.00%	Red	↓	31/07/2026
7 Patient Safety, Quality, and Experience	Complaints	Complaints Received - Stage 2 20 Working Day Response Compliance	Medical Director	100%	50.00%	Red	↓	30/06/2026
8 Patient Safety, Quality, and Experience	Complaints	Complaints upheld and partially upheld by SPSO	Medical Director	0	0	Green	*	30/06/2026
9 Patient Safety, Quality, and Experience	Incident Reporting	Incident Reporting and 7 Working Day Review Compliance	Medical Director	100%	100.00%	Green	↔	31/07/2026
10 Patient Safety, Quality, and Experience	Significant Adverse Event Reviews	Significant Adverse Event Review Compliance (closed within target date)	Medical Director	100%	20.00%	Red	↑	31/07/2026
12 Patient Safety, Quality, and Experience	Women and Children	Maternal Early Warning Score Observations	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	95%	100.00%	Green	↔	31/05/2026
13 Patient Safety, Quality, and Experience	Women and Children	Maternal Early Warning Score Escalation	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	95%	100.00%	Green	↔	31/05/2026
14 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%	77.78%	Red	↓	31/07/2026
15 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%	0.00%	Red	↓	31/07/2026
16 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	↑	31/07/2026
17 Operational Standards	Planned Care	10% reduction in waiting times for Treatment Time Guarantee patients	Medical Director	-10%	7.35%	Red	↓	31/07/2026
18 Operational Standards	Planned Care	10% reduction in waiting times for New Outpatients	Medical Director	-10%	9.85%	Red	↑	31/07/2026
19 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%	51.02%	Red	↓	31/07/2026
21 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%	74.67%	Red	↓	31/07/2026
22 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%	86.29%	Red	↑	31/07/2026
23 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%	89.47%	Red	↓	31/07/2026
24 Operational Standards	Planned Care	0 patients waiting more than 52 weeks on a New Outpatient or Treatment Time Guarantee waiting list	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	55	117	Red	↑	31/07/2026
25 Operational Standards	Cancer	90% of those referred urgently with a suspicion of cancer are to begin treatment within 62 days of receipt of referral	Medical Director	95%	37.50%	Red	↓	31/05/2026
26 Operational Standards	Cancer	95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat	Medical Director	95%	100.00%	Green	↔	31/05/2026
27 Operational Standards	Theatre	Theatre Utilisation	Medical Director	N/A	61.00%	Grey	↓	31/07/2026
29 Operational Standards	Inpatients	Pre-noon discharges	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	25.0%	18.68%	Amber	↑	31/07/2026
30 Operational Standards	Unscheduled Care	95% of patients wait no longer than four hours from arrival to admission, discharge, or transfer for A&E treatment. Boards work towards 98%.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	95%	91.87%	Amber	↓	31/07/2026
31 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%	99.88%	Green	↓	31/07/2026
32 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	00:34:56	Green	↑	31/07/2026
33 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%	40.91%	Red	↓	31/07/2026
34 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	7	Red	↓	31/07/2026
35 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	299	Red	↑	31/07/2026
36 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%	100.00%	Green	*	31/03/2026
37 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%	100.00%	Green	↔	31/07/2026
38 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%	55.56%	Green	↑	30/06/2026
40 Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	24.02%	Red	↓	30/04/2026
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 podiatry musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	12.50%	Red	↓	30/04/2026
42 Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led physiotherapy musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	25.16%	Amber	↑	30/04/2026
43 Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led orthotics musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	18.75%	Red	↓	30/04/2026
45 Community	Child and Adolescent Mental Health Service (CAMHS)	90% of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral.	Chief Officer (Integration Joint Board)	90%	100.00%	Green	↔	31/05/2026
46 Community	Psychological Therapies	18 Week Referral to Treatment	Chief Officer (Integration Joint Board)	90%	100.00%	Green	↑	30/06/2026
47 Population Health	Promoting health and wellbeing outcomes	Increase smoking cessation active clients year-on-year	Director of Public Health	18	16	Red	↔	04/08/2026
48 Population Health	Promoting health and wellbeing outcomes	NHS Boards to sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas (60% in the Island Boards)	Director of Public Health	3	2	Red	↑	30/04/2026
49 Population Health	Prevention of Disease	Immunisation uptake rate 6-in-1 primary Course by 12 months (rolling 3-month average)	Director of Public Health	95.0%	93.40%	Red	↓	31/03/2026
50 Population Health	Prevention of Disease	Immunisation uptake rate MMR2 by 6 years of age (rolling 3-month average)	Director of Public Health	95.0%	94.17%	Red	↓	31/03/2026
51 Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered trisomy screening no later than 20+0 weeks gestation.	Director of Public Health	100.0%	100.00%	Green	↔	31/07/2026
52 Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered haemoglobinopathies screening.	Director of Public Health	100.0%	100.00%	Green	↔	31/07/2026
53 Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered infectious diseases screening	Director of Public Health	100.0%	100.00%	Green	↔	31/07/2026
54 Population Health	Promoting health and wellbeing outcomes	Bloodspot Screening - 100% of newborn babies have bloodspot Screening completed by day 5	Director of Public Health	100.0%	100.00%	Green	↑	31/07/2026
55 Workforce	Sickness Absence	Monthly sickness absence rates below national average	Director of People and Culture	6.27%	7.25%	Red	↓	31/05/2026
56 Workforce	Sickness Absence	Monthly comparison for previous 12 months NHS Scotland and NHS Orkney	Director of People and Culture	6.61%	6.26%	Green	↑	31/05/2026
57 Workforce	Appraisals	Appraisal compliance rate over the previous 12 months	Director of People and Culture	60.00%	37.17%	Red	↑	31/07/2026
58 Workforce	Statutory/Mandatory Training	Statutory/Mandatory eLearning Compliance	Director of People and Culture	85.00%	82.52%	Amber	↑	31/07/2026
59 Workforce	Hours Utilised	Agency hours used vs. average.	Director of People and Culture		3110	Grey	↑	30/06/2026
60 Workforce	Hours Utilised	Bank hours used vs. average.	Director of People and Culture		4372	Grey	↓	31/07/2026
61 Workforce	Hours Utilised	Overtime hours used vs. average.	Director of People and Culture		388	Grey	↓	31/07/2026
62 Workforce	Hours Utilised	Excess hours used vs. average.	Director of People and Culture		798	Grey	↓	31/07/2026
63 Finance	Finance	Financial performance against plan - YTD.	Director of Finance	£1,417,000	£1,031,000	Green	*	30/06/2026
64 Finance	Finance	Financial performance against plan - Forecast.	Director of Finance	£2,400,000	£2,400,000	Green	*	30/06/2026
65 Finance	Finance	Efficiency performance against plan - YTD.	Director of Finance	£473,000	£366,000	Red	*	30/06/2026
66 Finance	Finance	Efficiency performance against plan - Forecast.	Director of Finance	£3,865,000	£2,814,000	Red	*	30/06/2026
67 Finance	Finance	Efficiency programme recurrent savings against plan.	Director of Finance	£1,190,000	£1,654,000	Green	↑	30/06/2026
68 Finance	Finance	Capital performance against plan - YTD.	Director of Finance	£270,000	£88,000	Red	*	30/06/2026
69 Finance	Finance	Capital performance against plan - Forecast.	Director of Finance	£1,078,000	£1,078,000	Green	*	30/06/2026
70 Finance	Finance	75% of invoices to be paid within 10 days of receipt - local target	Director of Finance	75.00%	78.46%	Green	↑	31/07/2026
71 Finance	Finance	90% of invoices to be paid within 30 days of receipt - local target	Director of Finance	90.00%	94.32%	Green	↑	31/07/2026

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 August 2026.

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

Patient Safety, Quality, and Experience

Section Lead(s):

Medical Director

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

What's Going Well?

Although the number of complaints has increased this quarter, this is in line with variation from last year. The number of complaints closed at 5 days has increased.

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

Quarterly clinical governance returns from clinical areas have increased, with collaborative review at CGov group to a return for JCCGC.

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.

SAER completion within timescales remains a significant challenge, primarily due to the reviews requiring cross board evidence and input. Completion of outstanding reviews remains a focus for the SQE team.

Patient Safety, Quality, and Experience

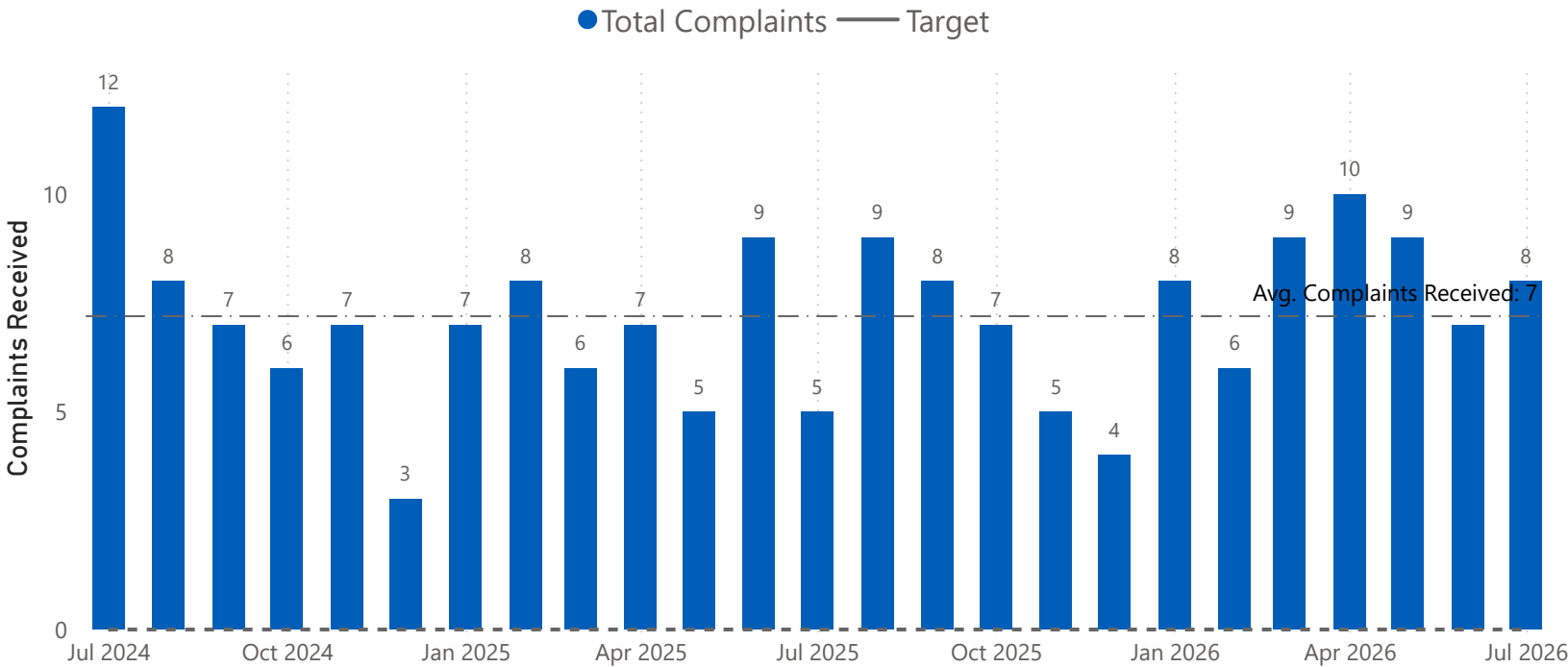
Complaints Received

Compliance

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

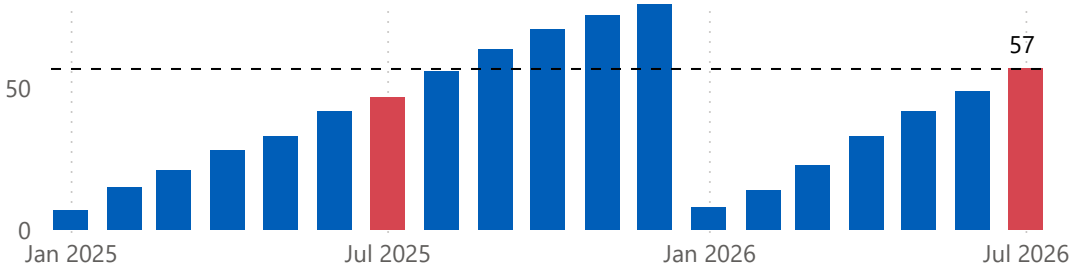
Action	Target Date	Owner	Status
No target set, actions and target to be updated.			

Total Complaints Received



Complaints Received vs. Previous Years

Complaints Received Running Total per Year

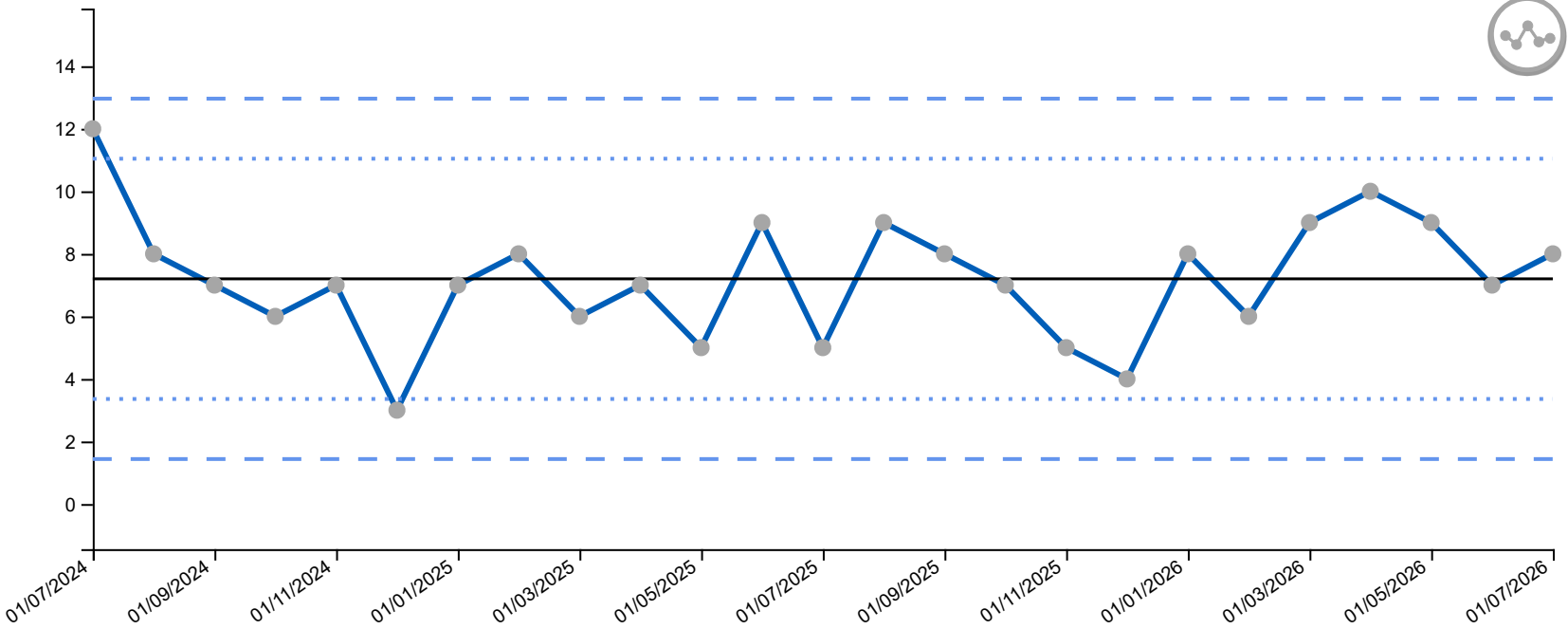


Statistical Process Control

Date	Value	Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	12	7	1	13	3	11	None
01/08/2024	8	7	1	13	3	11	None
01/09/2024	7	7	1	13	3	11	None
01/10/2024	6	7	1	13	3	11	None
01/11/2024	7	7	1	13	3	11	None
01/12/2024	3	7	1	13	3	11	None
01/01/2025	7	7	1	13	3	11	None
01/02/2025	8	7	1	13	3	11	None
01/03/2025	6	7	1	13	3	11	None
01/04/2025	7	7	1	13	3	11	None
01/05/2025	5	7	1	13	3	11	None
01/06/2025	9	7	1	13	3	11	None
01/07/2025	5	7	1	13	3	11	None
01/08/2025	9	7	1	13	3	11	None
01/09/2025	8	7	1	13	3	11	None
01/10/2025	7	7	1	13	3	11	None
01/11/2025	5	7	1	13	3	11	None
01/12/2025	4	7	1	13	3	11	None
01/01/2026	8	7	1	13	3	11	None
01/02/2026	6	7	1	13	3	11	None
01/03/2026	9	7	1	13	3	11	None
01/04/2026	10	7	1	13	3	11	None
01/05/2026	9	7	1	13	3	11	None
01/06/2026	7	7	1	13	3	11	None
01/07/2026	8	7	1	13	3	11	None

Total Complaints Received

Lower is Better



Comments From Executive Lead

While there is no target or KPI for complaints, to note that our current level is consistent with previous years and remains within control margins.

Dr Anna Lamont, Medical Director

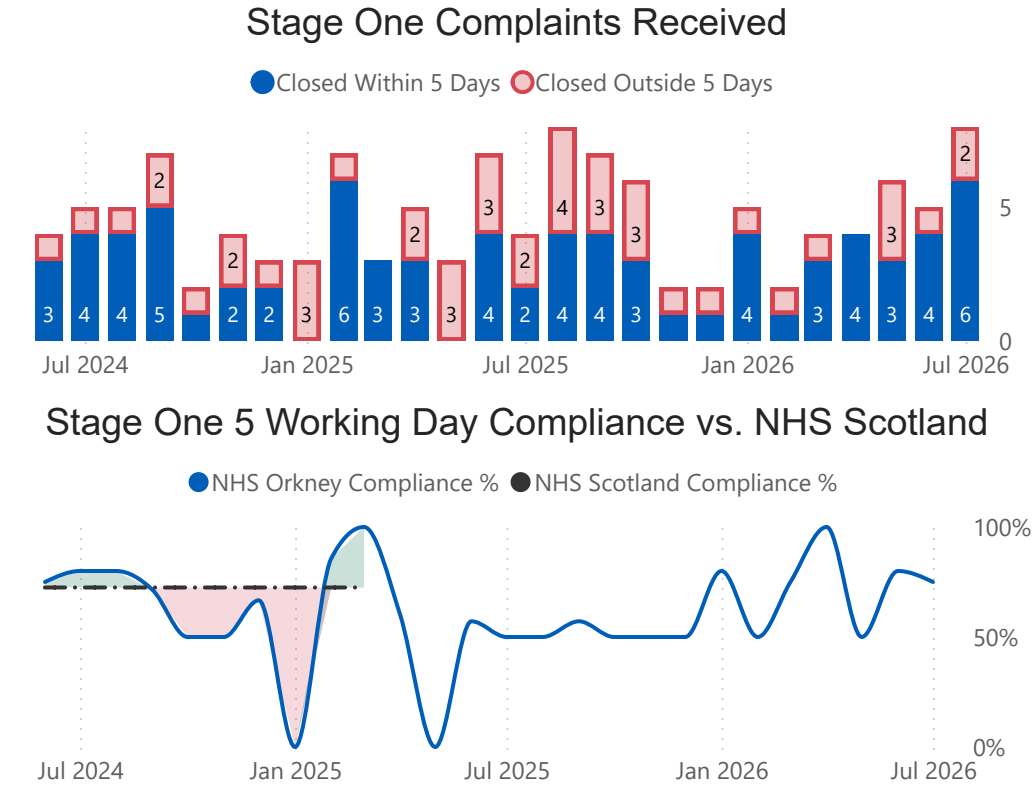
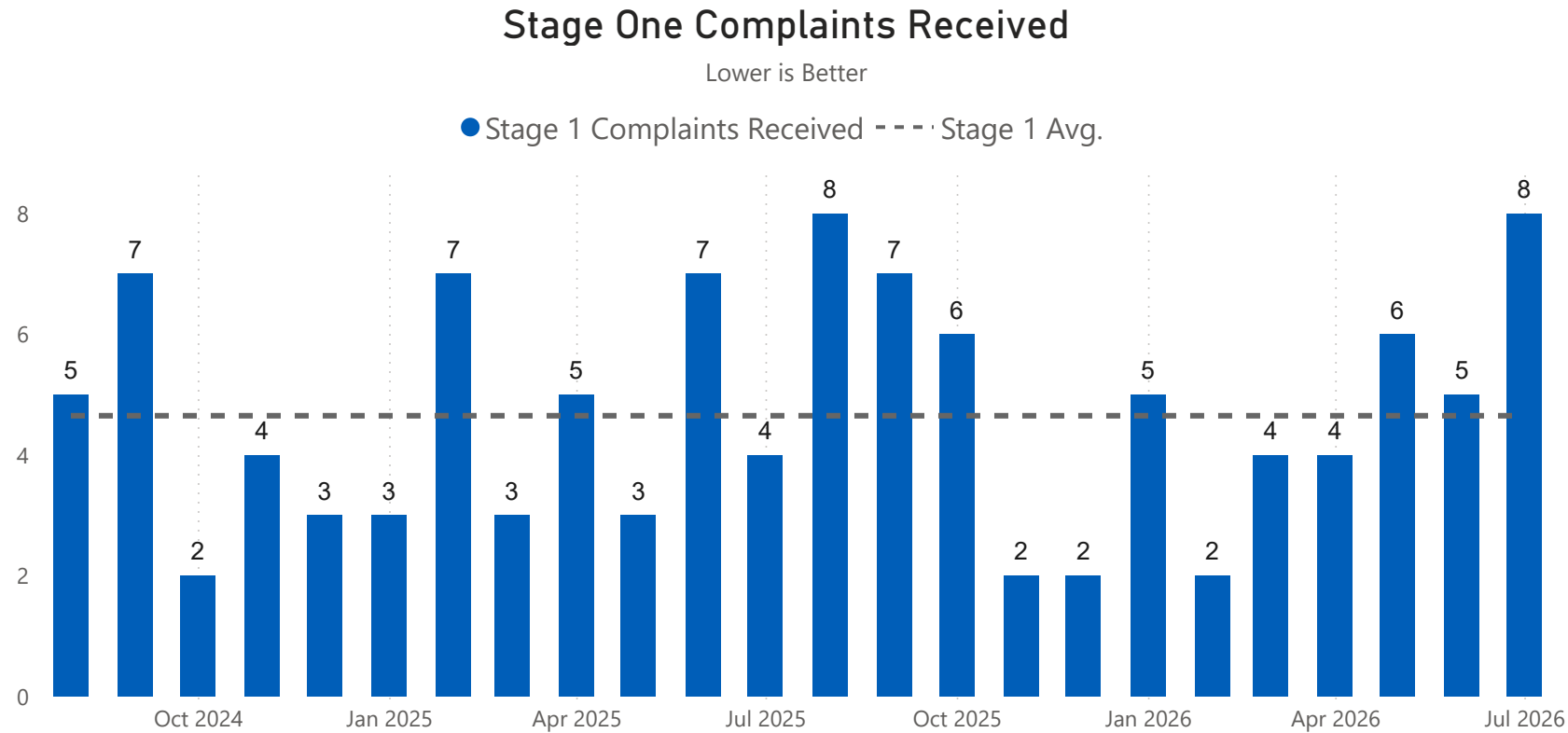


Patient Safety, Quality, and Experience

Stage One Complaints

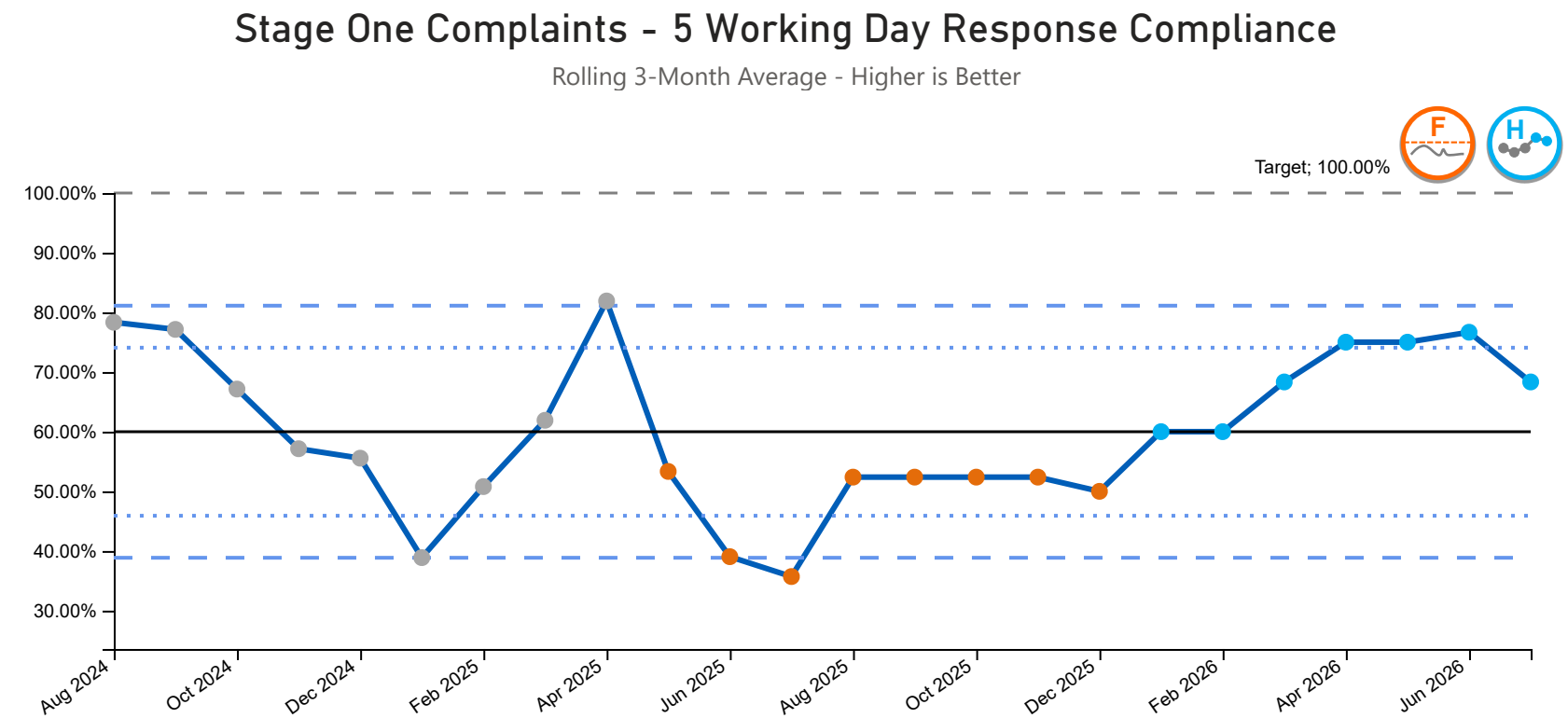
Compliance

KPI	Target	Actual	RAG Value
Complaints Received - Stage 1 5 Working Day Response Compliance	100%	75.00%	Red
Action	Target Date	Owner	Status
Targeted workshops on complaints management to be held	31/08/2026	A Lamont	In Progress



Statistical Process Control

Date	Value	Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/08/2024	78.33	59.99	38.86	81.12	45.91	74.07	None
01/09/2024	77.14	59.99	38.86	81.12	45.91	74.07	None
01/10/2024	67.14	59.99	38.86	81.12	45.91	74.07	None
01/11/2024	57.14	59.99	38.86	81.12	45.91	74.07	None
01/12/2024	55.56	59.99	38.86	81.12	45.91	74.07	None
01/01/2025	38.89	59.99	38.86	81.12	45.91	74.07	None
01/02/2025	50.79	59.99	38.86	81.12	45.91	74.07	None
01/03/2025	61.90	59.99	38.86	81.12	45.91	74.07	None
01/04/2025	81.90	59.99	38.86	81.12	45.91	74.07	None
01/05/2025	53.33	59.99	38.86	81.12	45.91	74.07	Deterioration
01/06/2025	39.05	59.99	38.86	81.12	45.91	74.07	Deterioration
01/07/2025	35.71	59.99	38.86	81.12	45.91	74.07	Deterioration
01/08/2025	52.38	59.99	38.86	81.12	45.91	74.07	Deterioration
01/09/2025	52.38	59.99	38.86	81.12	45.91	74.07	Deterioration
01/10/2025	52.38	59.99	38.86	81.12	45.91	74.07	Deterioration
01/11/2025	52.38	59.99	38.86	81.12	45.91	74.07	Deterioration
01/12/2025	50.00	59.99	38.86	81.12	45.91	74.07	Deterioration
01/01/2026	60.00	59.99	38.86	81.12	45.91	74.07	Improvement
01/02/2026	60.00	59.99	38.86	81.12	45.91	74.07	Improvement
01/03/2026	68.33	59.99	38.86	81.12	45.91	74.07	Improvement
01/04/2026	75.00	59.99	38.86	81.12	45.91	74.07	Improvement
01/05/2026	75.00	59.99	38.86	81.12	45.91	74.07	Improvement
01/06/2026	76.67	59.99	38.86	81.12	45.91	74.07	Improvement
01/07/2026	68.33	59.99	38.86	81.12	45.91	74.07	Improvement



Comments From Executive Lead

There has been a recent increase in the number of stage one complaints received though still a similar increase was seen in 2025, and the proportion of stage one complaints closed has increased, so maintaining response compliance at a similar level. Response compliance to stage one complaints remains a function of small teams, and 100% remains an aspirational target. NHSO remains above NHS Scotland compliance % as last reported.

Dr Anna Lamont, Medical Director



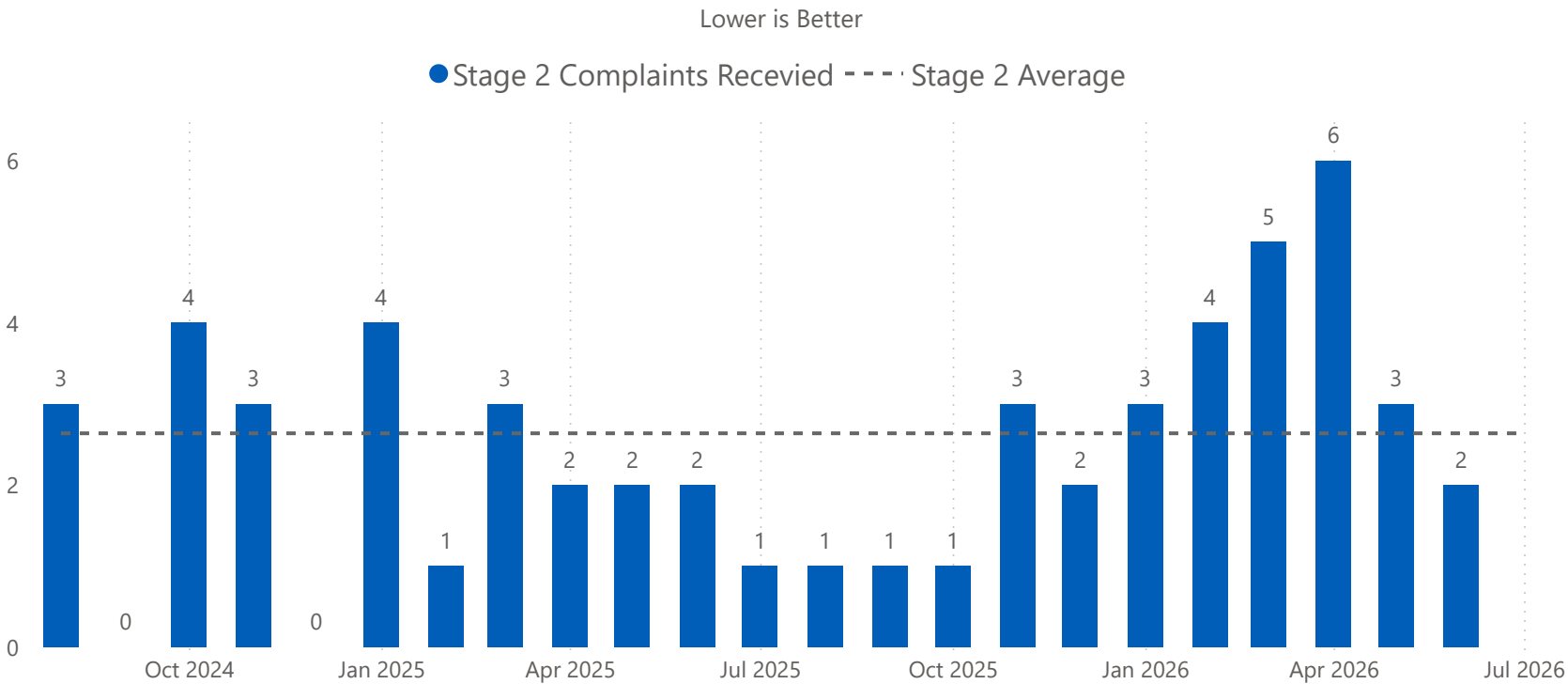
Patient Safety, Quality, and Experience

Stage Two Complaints

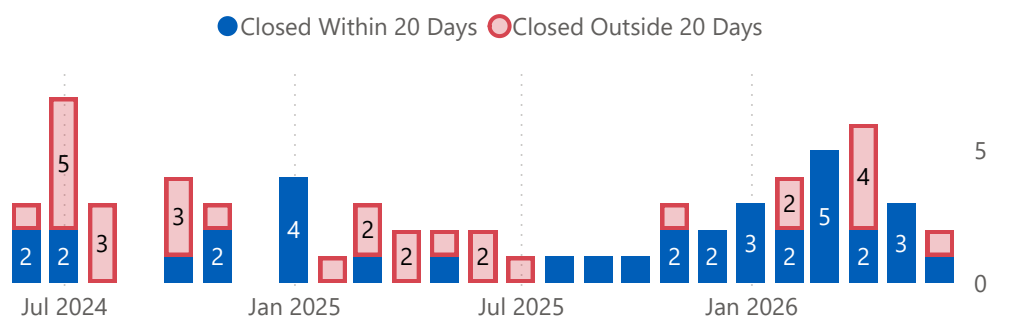
Compliance

KPI	Target	Actual	RAG Value
Complaints Received - Stage 2 20 Working Day Response Compliance	100%	50.00%	Red
Action	Target Date	Owner	Status
Targeted workshops on complaints management to be held		A Lamont	Completed
Training workshops completed last year, and additional support to complaint responses from within the SQE team.		A Lamont	In Progress

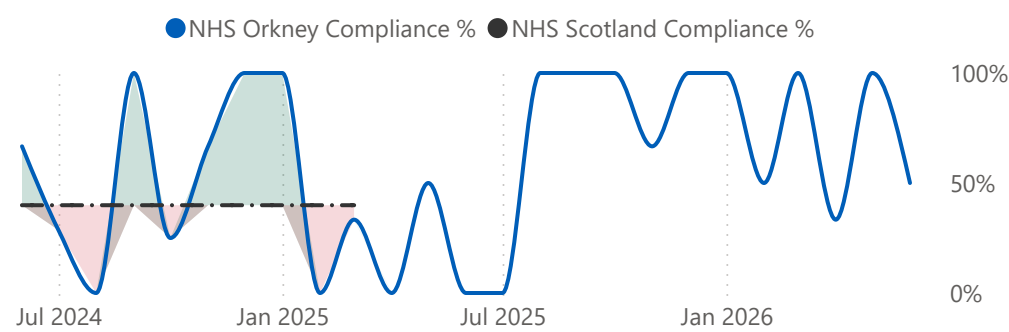
Stage Two Complaints Received



Stage Two Complaints Received



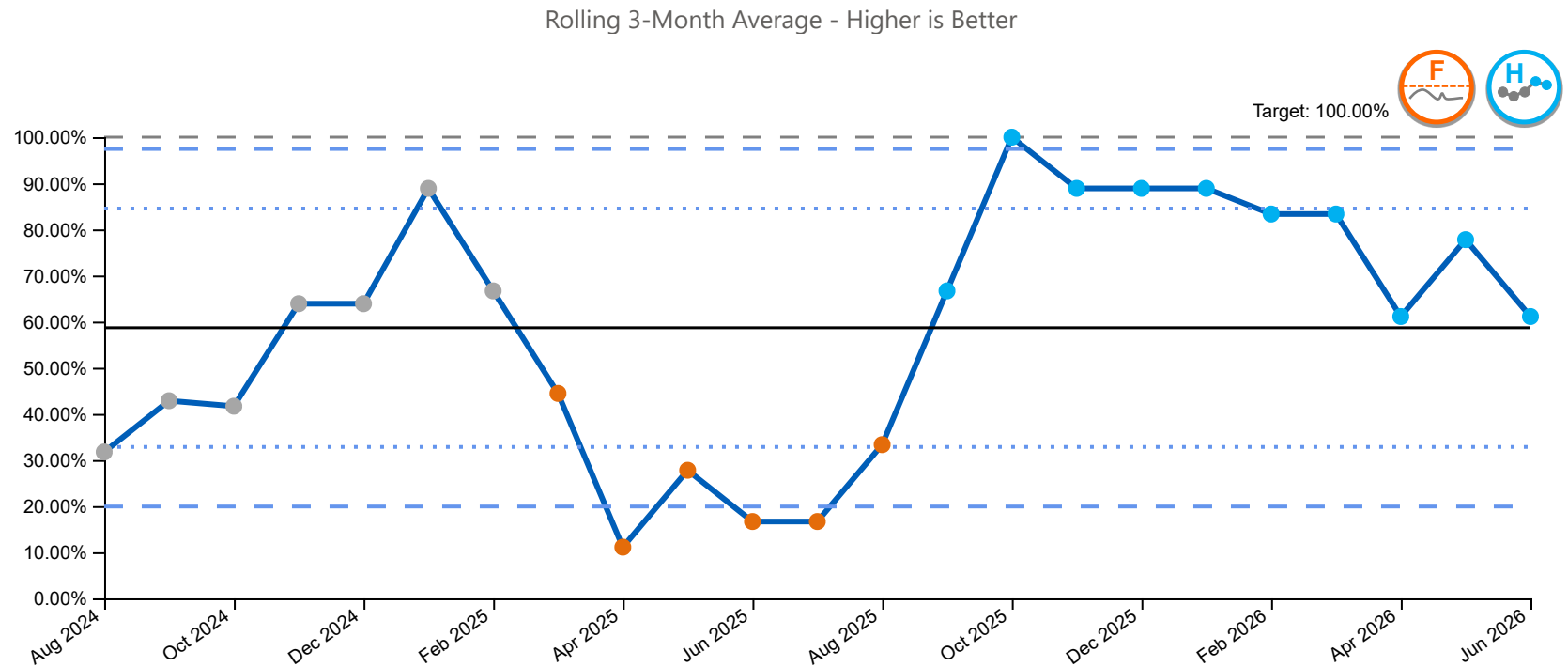
Stage Two 20 Working Day Compliance vs. NHS Scotland



Statistical Process Control

Date	Value	Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/08/2024	31.75	58.68	19.92	97.44	32.84	84.52	None
01/09/2024	42.86	58.68	19.92	97.44	32.84	84.52	None
01/10/2024	41.67	58.68	19.92	97.44	32.84	84.52	None
01/11/2024	63.89	58.68	19.92	97.44	32.84	84.52	None
01/12/2024	63.89	58.68	19.92	97.44	32.84	84.52	None
01/01/2025	88.89	58.68	19.92	97.44	32.84	84.52	None
01/02/2025	66.67	58.68	19.92	97.44	32.84	84.52	None
01/03/2025	44.44	58.68	19.92	97.44	32.84	84.52	Deterioration
01/04/2025	11.11	58.68	19.92	97.44	32.84	84.52	Deterioration
01/05/2025	27.78	58.68	19.92	97.44	32.84	84.52	Deterioration
01/06/2025	16.67	58.68	19.92	97.44	32.84	84.52	Deterioration
01/07/2025	16.67	58.68	19.92	97.44	32.84	84.52	Deterioration
01/08/2025	33.33	58.68	19.92	97.44	32.84	84.52	Deterioration
01/09/2025	66.67	58.68	19.92	97.44	32.84	84.52	Improvement
01/10/2025	100.00	58.68	19.92	97.44	32.84	84.52	Improvement
01/11/2025	88.89	58.68	19.92	97.44	32.84	84.52	Improvement
01/12/2025	88.89	58.68	19.92	97.44	32.84	84.52	Improvement
01/01/2026	88.89	58.68	19.92	97.44	32.84	84.52	Improvement
01/02/2026	83.33	58.68	19.92	97.44	32.84	84.52	Improvement
01/03/2026	83.33	58.68	19.92	97.44	32.84	84.52	Improvement
01/04/2026	61.11	58.68	19.92	97.44	32.84	84.52	Improvement
01/05/2026	77.78	58.68	19.92	97.44	32.84	84.52	Improvement
01/06/2026	61.11	58.68	19.92	97.44	32.84	84.52	Improvement

Stage Two Complaints - 20 Working Day Response Compliance



Comments From Executive Lead

Despite the low numbers, stage two complaint compliance remains challenged by our need as a small organisation to seek outside expert review and input. Compliance has fallen from the great improvement last year, and is expected to improve again now senior nursing roles have been filled. This remains a very challenging KPI for a small team.

Dr Anna Lamont, Medical Director



Patient Safety, Quality, and Experience

Complaints Upheld by Scottish Public Services Ombudsman (SPSO)

Data Source

Latest Data

Patient Experience Officer

July 2026

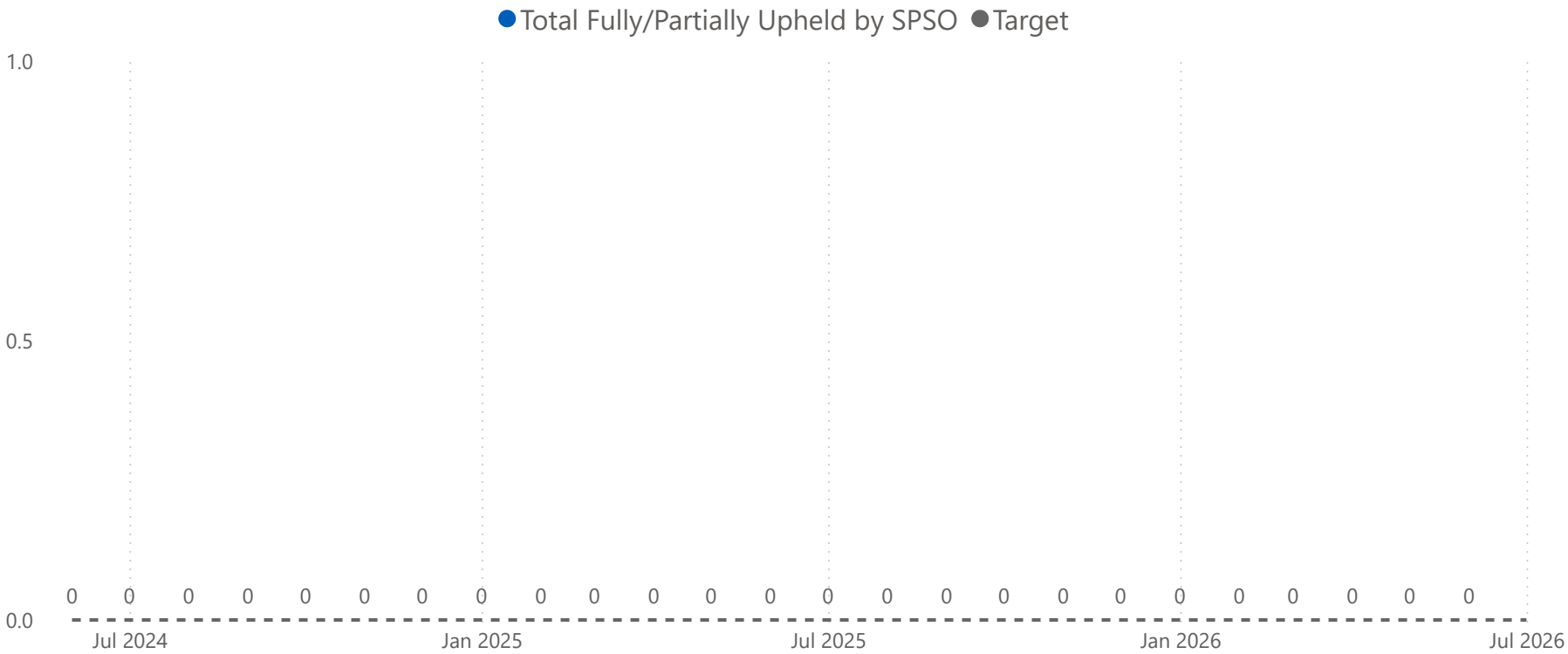
Compliance

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

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

Total Complaints Upheld/Partially Upheld by SPSO



Comments From Executive Lead

Dr Anna Lamont, Medical Director

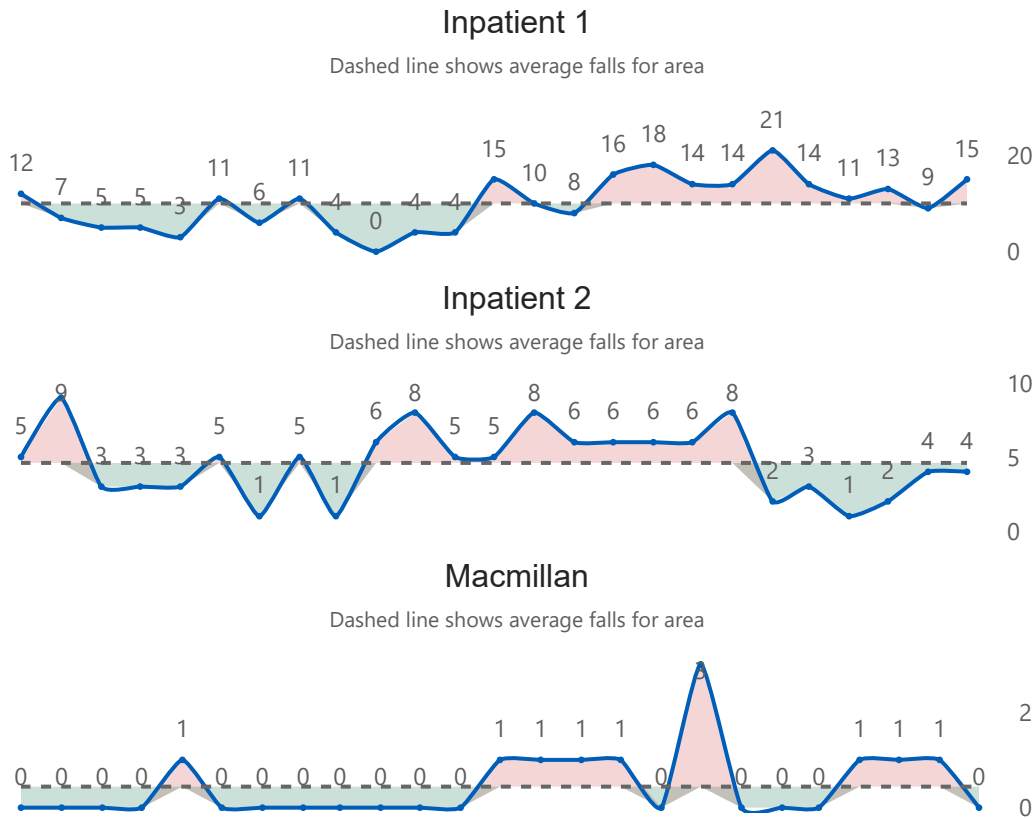
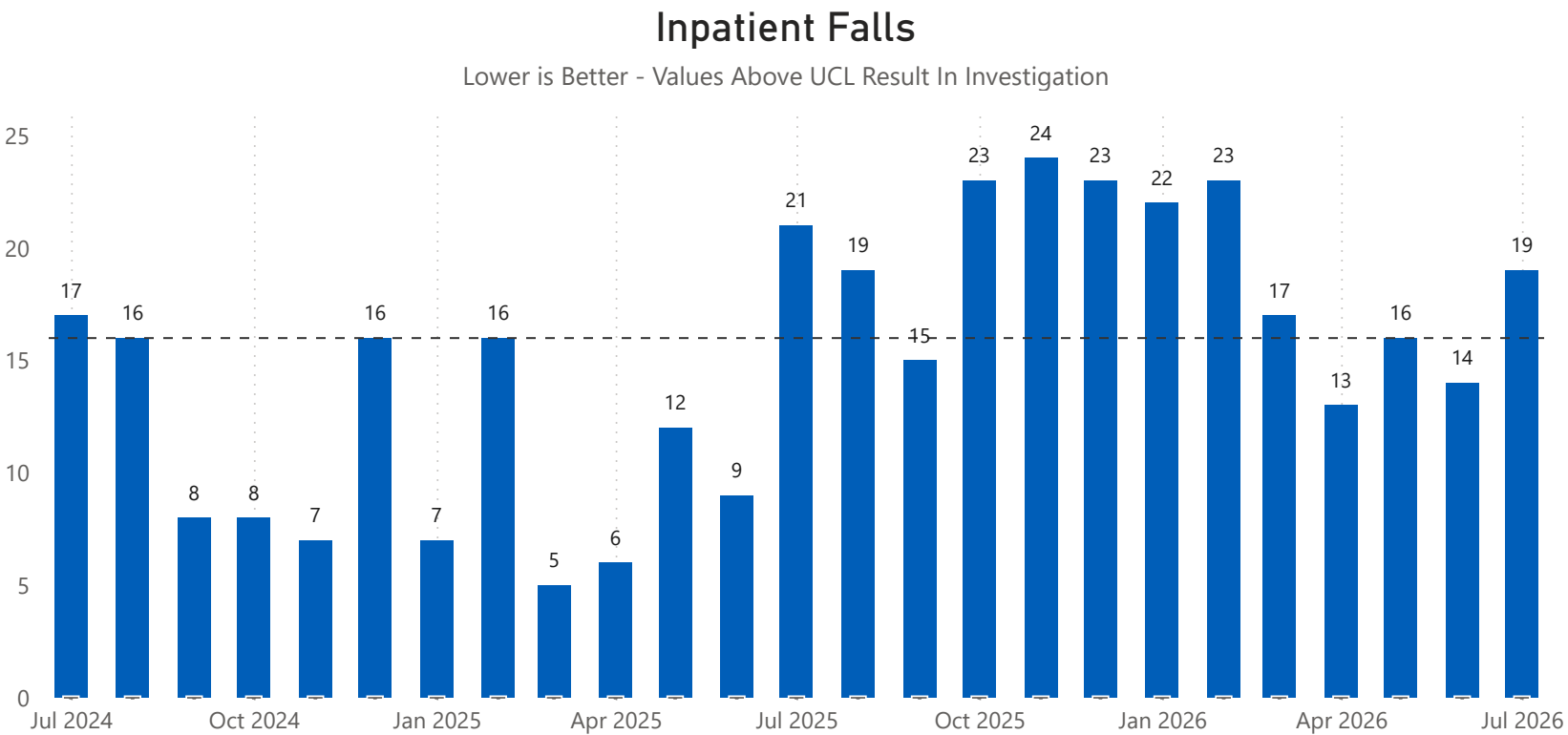


Patient Safety, Quality, and Experience
Inpatient Falls (Without Harm)

Data Source: Datix, Ward Documentation
Latest Data: July 2026

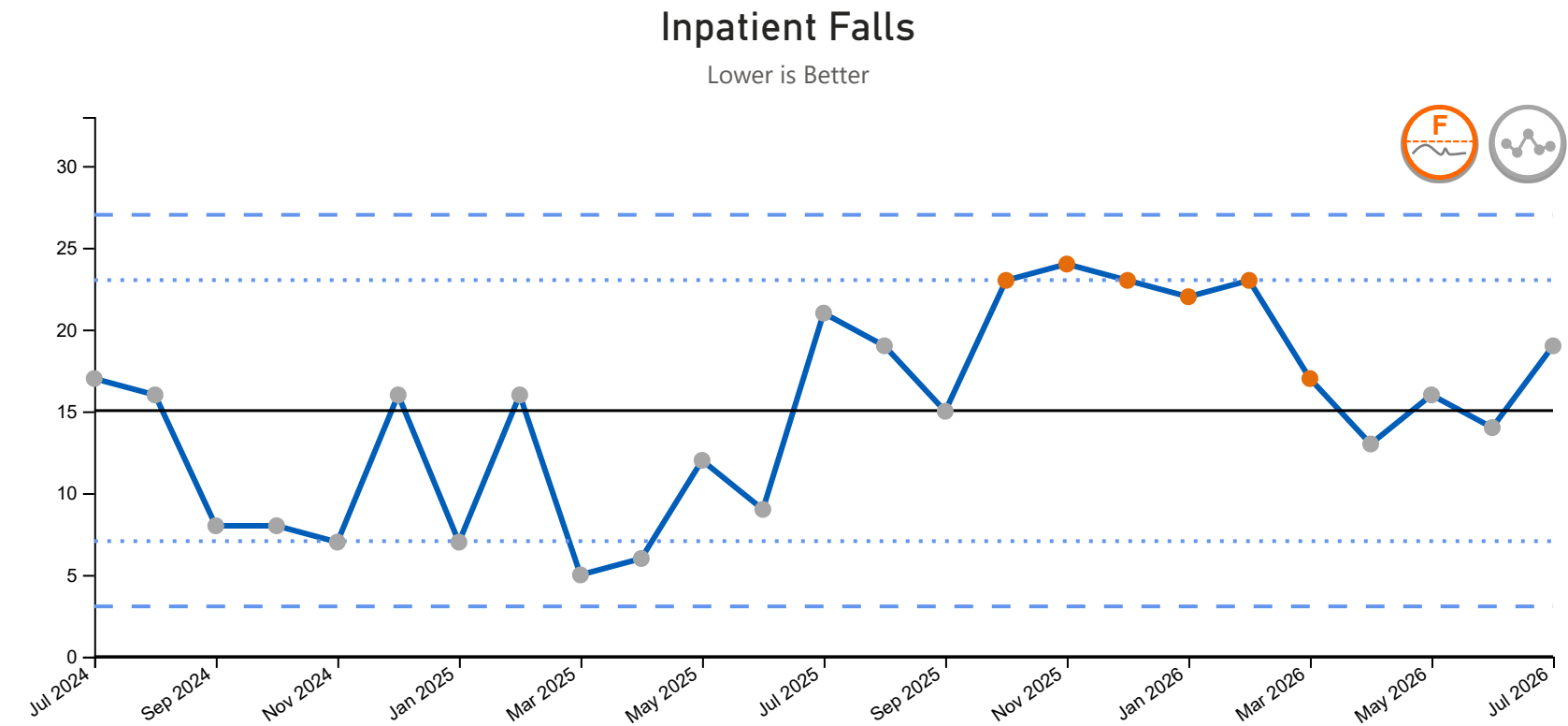
Compliance

Table with 4 columns: KPI, Target, Actual, RAG Value. Row 1: Inpatient falls (an event which results in a person coming to rest unintentionally on the ground or floor or other lower level), 0, 19, Amber. Row 2: Action, Target Date, Owner, Status. Row 3: Deep dive data review of falls in the last 12 months, 31/03/2026, S Thomas, Completed. Row 4: Improvement work continues with close links with the Scottish Patient Safety Programme (SPSP) falls initiative, 31/08/2026, S Thomas, In Progress.



Statistical Process Control

Table with 9 columns: Date, Value, Target, Alt. Target, LL 99%, UL 99%, LL 95%, UL 95%, Shift. Rows show daily data from 01/07/2024 to 01/07/2026, with values fluctuating around a target of 15.04.



Comments From Executive Lead

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 with sustained improvement seen over the last two months. Whilst not shown in the data here, there were 11 falls in May 2026 demonstrating continued improvement.

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

July 2026

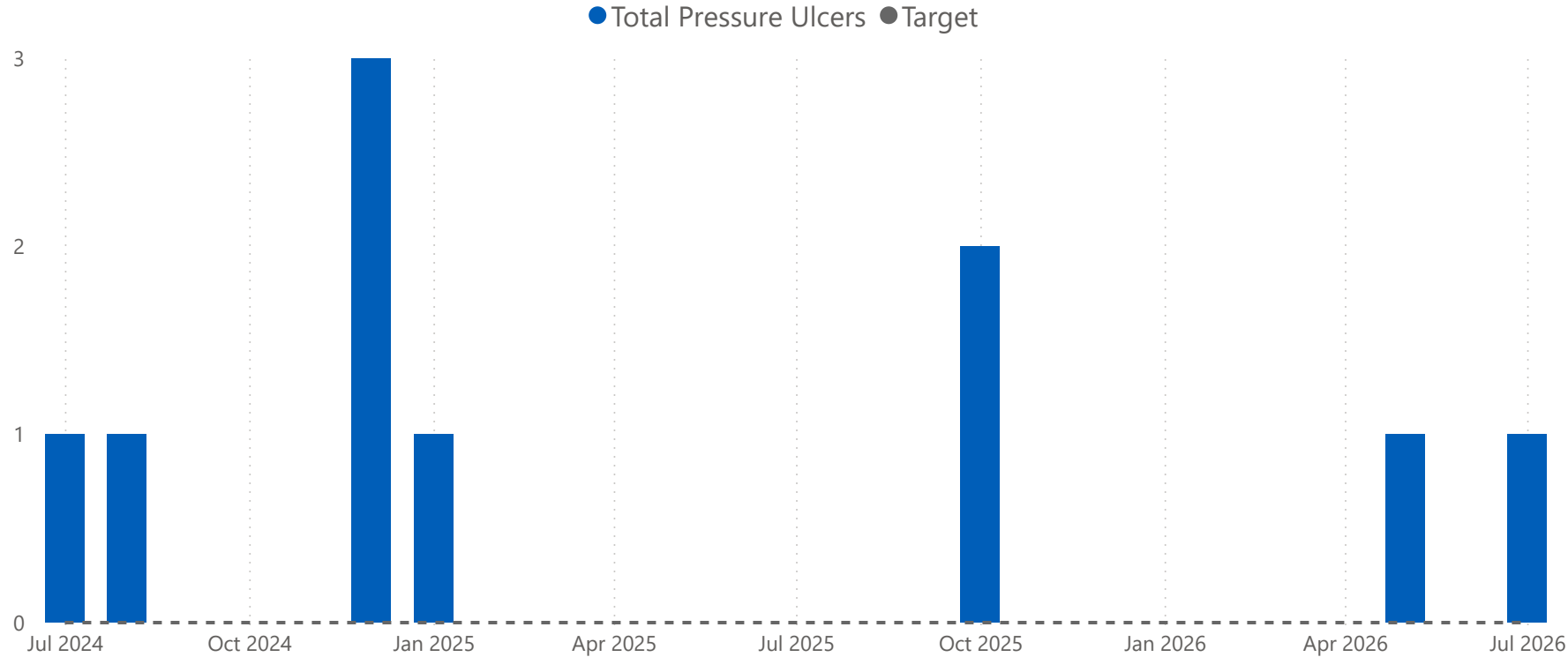
Compliance

KPI	Target	Actual	RAG Value
Number of inpatient acquired pressure ulcers this month	0	1	Red

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

KPI off-target, actions to be updated.

Inpatient Acquired Pressure Ulcers



Comments From Executive Lead

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



Patient Safety, Quality, and Experience

Incident Reporting and Review

Data Source

Datix

Latest Month

July 2026

Compliance

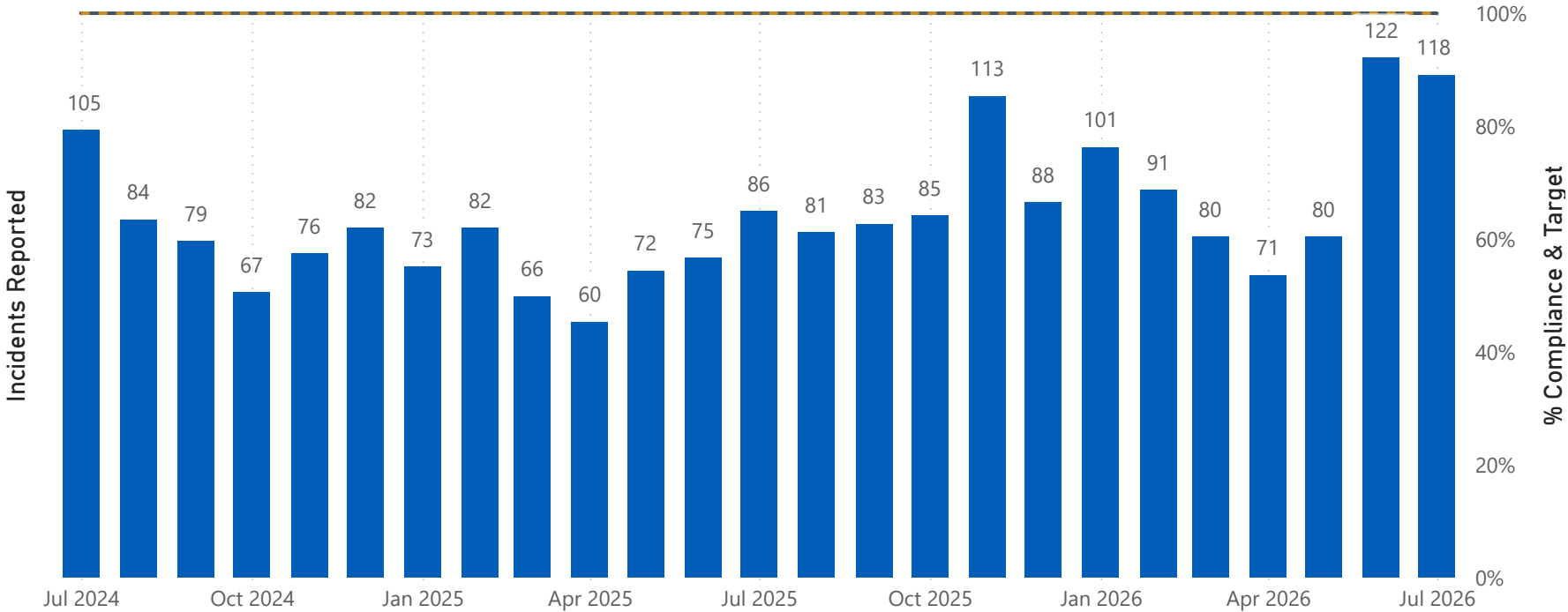
KPI	Target	Actual	RAG Value
Incident Reporting and 7 Working Day Review Compliance	100%	100.00%	Green

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

KPI on target, no actions required at this time.

Incident Reporting - 7 Day Review Compliance

● Incidents Reported ● % Incidents Reviewed in 7 Days ● Target



Comments From Executive Lead

Dr Anna Lamont, Medical Director



Patient Safety, Quality, and Experience

Significant Adverse Event Reviews (SAERs)

Data Source

Datix

Latest Data

July 2026

Compliance

KPI	Target	Actual	RAG Value
Significant Adverse Event Review Compliance (closed within target date)	100%	20.00%	Red

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

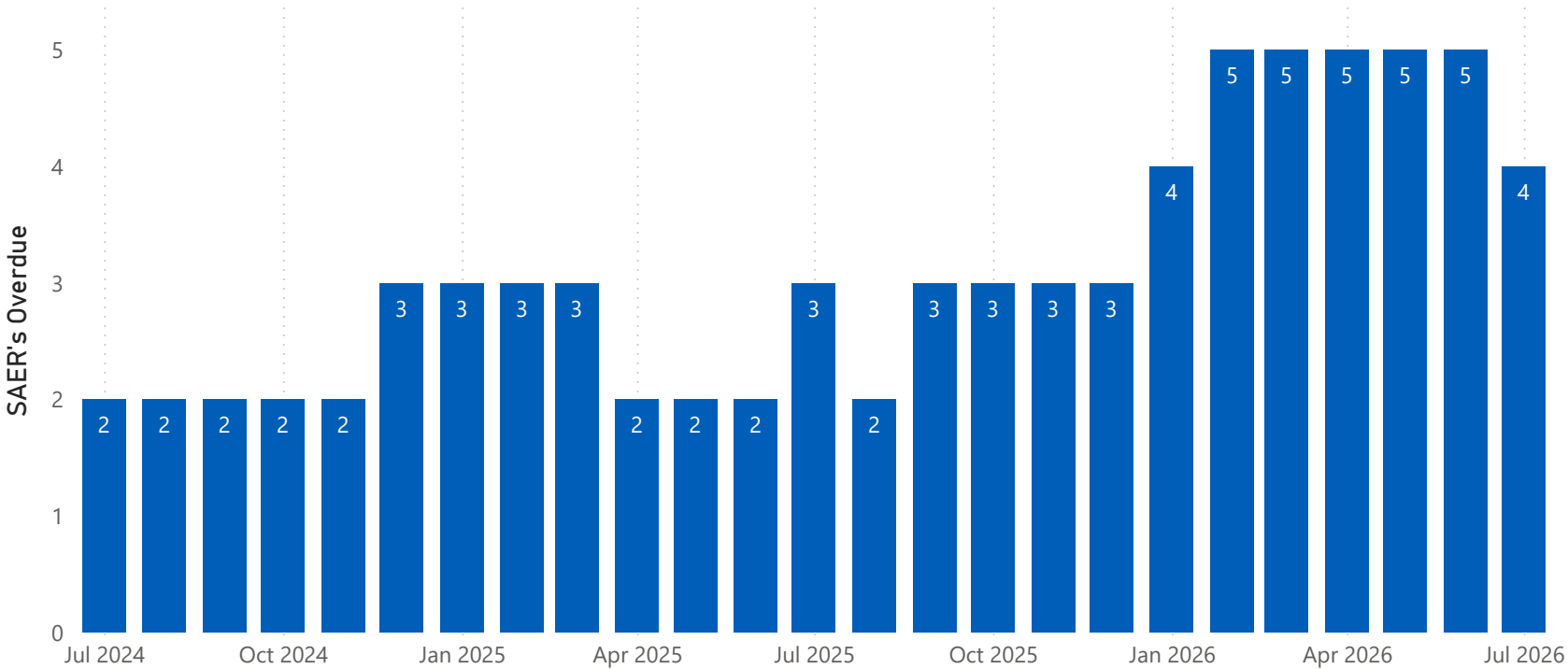
Monitor and support the timely closure of currently open SAERs via the Clinical Governance Group

31/12/2026

A Lamont

In Progress

Significant Adverse Events - SAERs Overdue

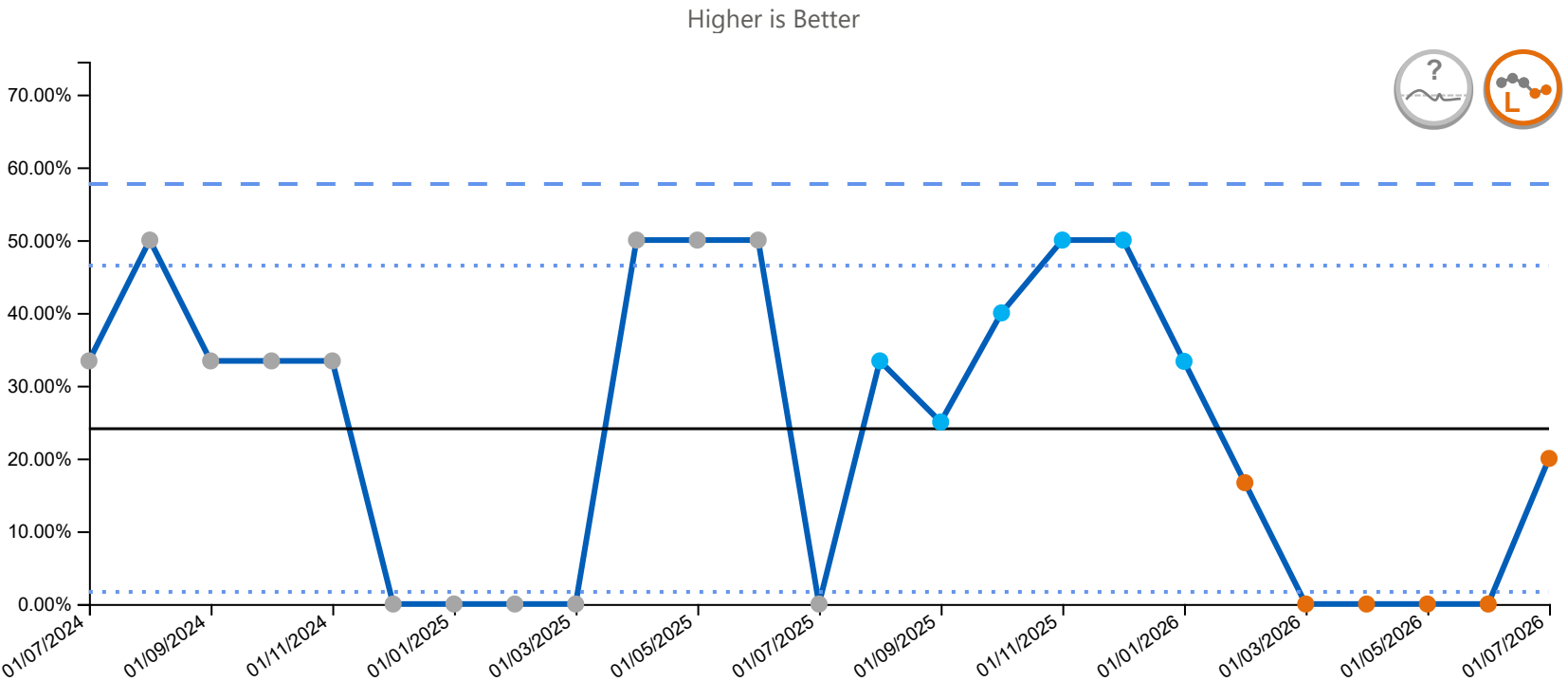


Month	SAER's commissioned	SAER's overdue	% SAER Compliance	Target
April 2025	2	2	50.00%	100.00%
May 2025	0	2	50.00%	100.00%
June 2025	0	2	50.00%	100.00%
July 2025	0	3	0.00%	100.00%
August 2025	0	2	33.40%	100.00%
September 2025	1	3	25.00%	100.00%
October 2025	1	3	40.00%	100.00%
November 2025	1	3	50.00%	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%
March 2026	0	5	0.00%	100.00%
April 2026	0	5	0.00%	100.00%
May 2026	0	5	0.00%	100.00%
June 2026	0	5	0.00%	100.00%
July 2026	1	4	20.00%	100.00%

Statistical Process Control

Date	Value	Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	33.40	24.08	0.00	57.70	1.67	46.49	None
01/08/2024	50.00	24.08	0.00	57.70	1.67	46.49	None
01/09/2024	33.40	24.08	0.00	57.70	1.67	46.49	None
01/10/2024	33.40	24.08	0.00	57.70	1.67	46.49	None
01/11/2024	33.40	24.08	0.00	57.70	1.67	46.49	None
01/12/2024	0.00	24.08	0.00	57.70	1.67	46.49	None
01/01/2025	0.00	24.08	0.00	57.70	1.67	46.49	None
01/02/2025	0.00	24.08	0.00	57.70	1.67	46.49	None
01/03/2025	0.00	24.08	0.00	57.70	1.67	46.49	None
01/04/2025	50.00	24.08	0.00	57.70	1.67	46.49	None
01/05/2025	50.00	24.08	0.00	57.70	1.67	46.49	None
01/06/2025	50.00	24.08	0.00	57.70	1.67	46.49	None
01/07/2025	0.00	24.08	0.00	57.70	1.67	46.49	None
01/08/2025	33.40	24.08	0.00	57.70	1.67	46.49	Improvement
01/09/2025	25.00	24.08	0.00	57.70	1.67	46.49	Improvement
01/10/2025	40.00	24.08	0.00	57.70	1.67	46.49	Improvement
01/11/2025	50.00	24.08	0.00	57.70	1.67	46.49	Improvement
01/12/2025	50.00	24.08	0.00	57.70	1.67	46.49	Improvement
01/01/2026	33.34	24.08	0.00	57.70	1.67	46.49	Improvement
01/02/2026	16.67	24.08	0.00	57.70	1.67	46.49	Deterioration
01/03/2026	0.00	24.08	0.00	57.70	1.67	46.49	Deterioration
01/04/2026	0.00	24.08	0.00	57.70	1.67	46.49	Deterioration
01/05/2026	0.00	24.08	0.00	57.70	1.67	46.49	Deterioration
01/06/2026	0.00	24.08	0.00	57.70	1.67	46.49	Deterioration
01/07/2026	20.00	24.08	0.00	57.70	1.67	46.49	Deterioration

Significant Adverse Events - Review Compliance



Comments From Executive Lead

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

Dr Anna Lamont, Medical Director



Patient Safety, Quality, and Experience

Maternal Early Warning Score Escalation

Data Source

Clinical Records

Latest Data

May 2026

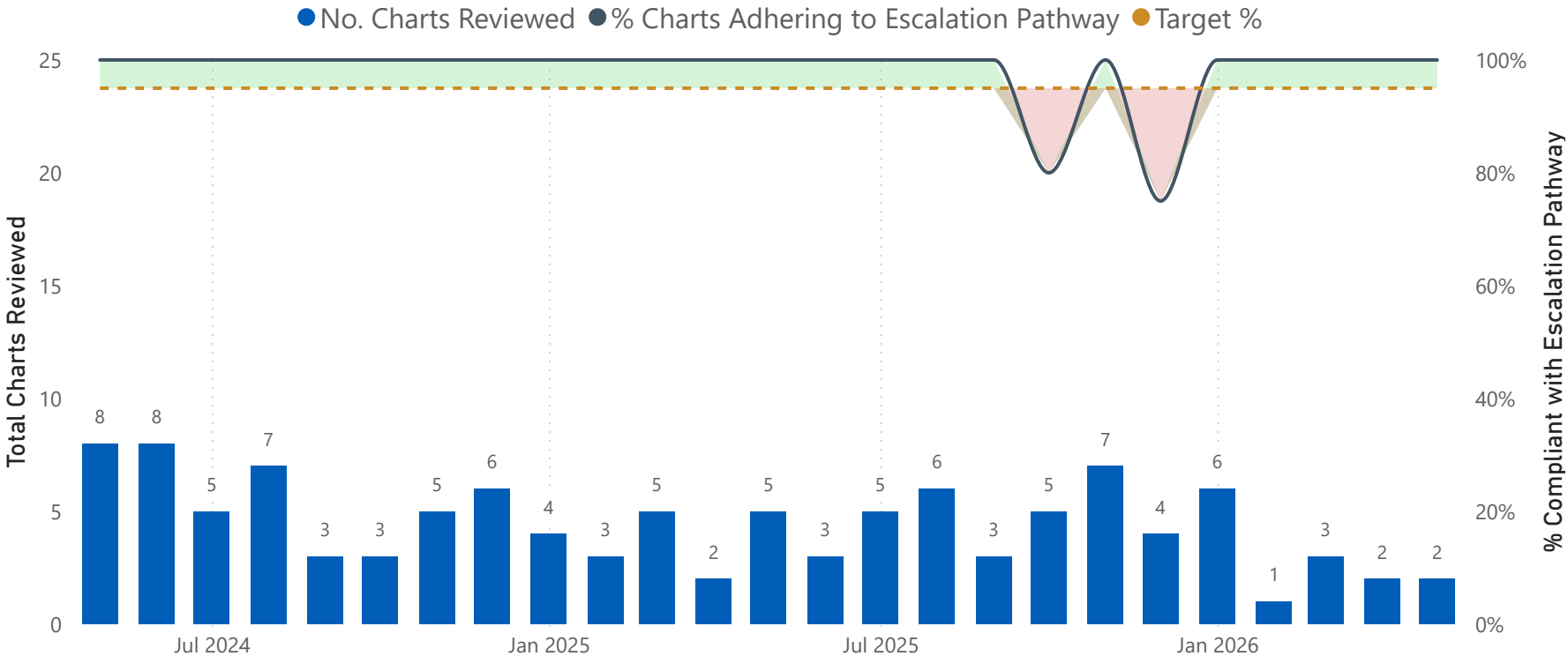
Compliance

KPI	Target	Actual	RAG Value
Maternal Early Warning Score Escalation	95%	100.00%	Green

Action	Target Date	Owner	Status
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All current actions completed/closed.

Maternal Early Warning Score Observations



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

May 2026

Compliance

KPI	Target	Actual	RAG Value
Maternal Early Warning Score Observations	95%	100.00%	Green

Action

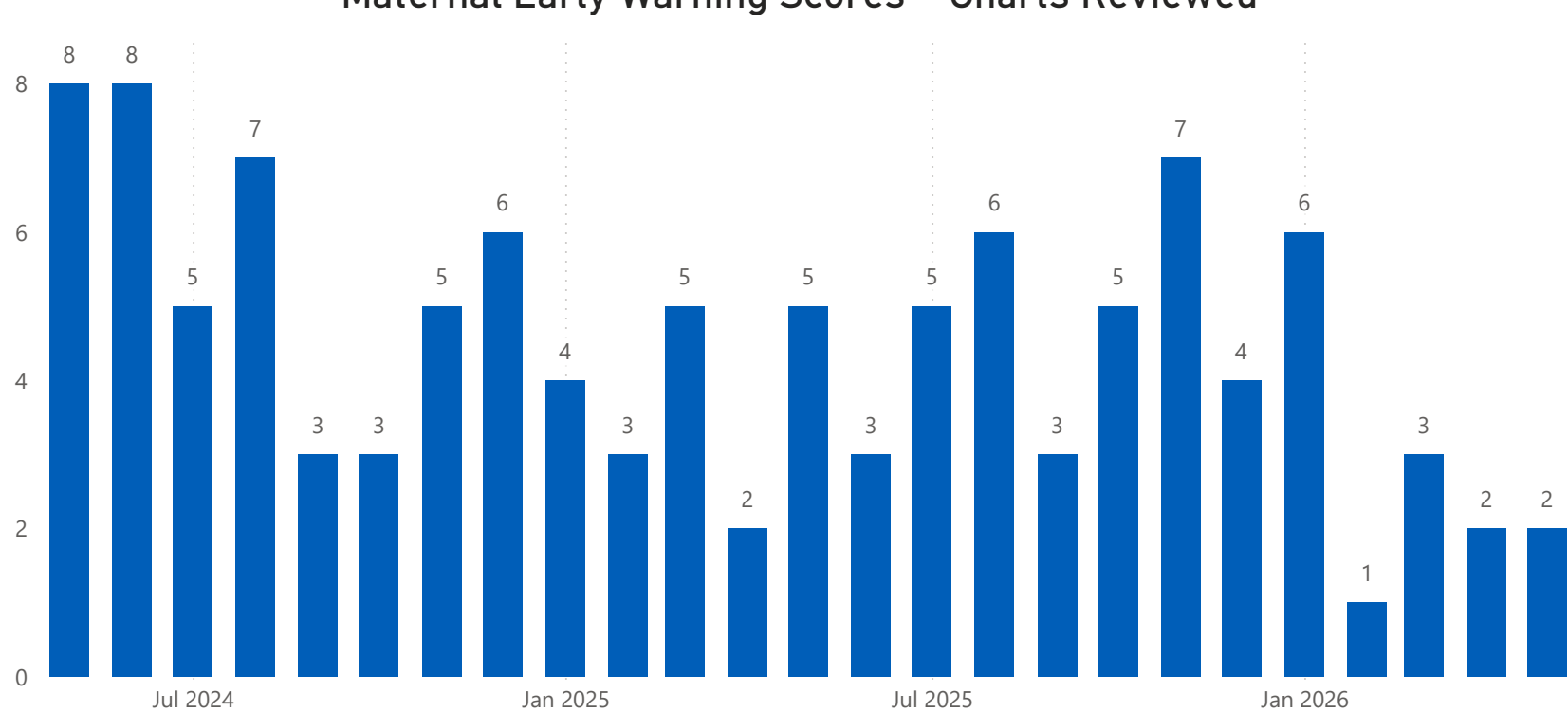
Target Date

Owner

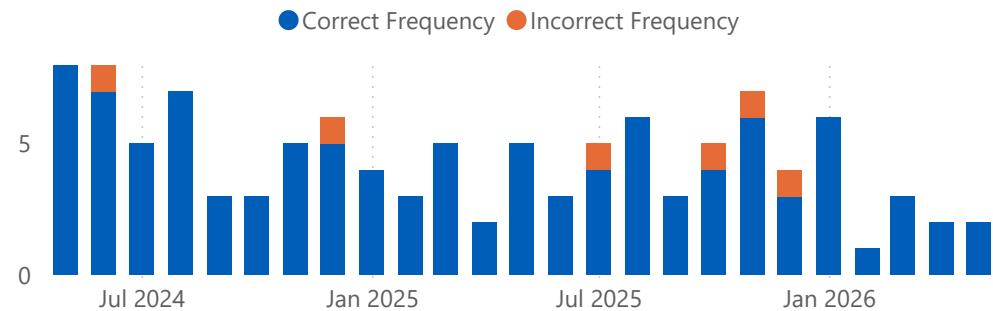
Status

All current actions completed/closed.

Maternal Early Warning Scores - Charts Reviewed



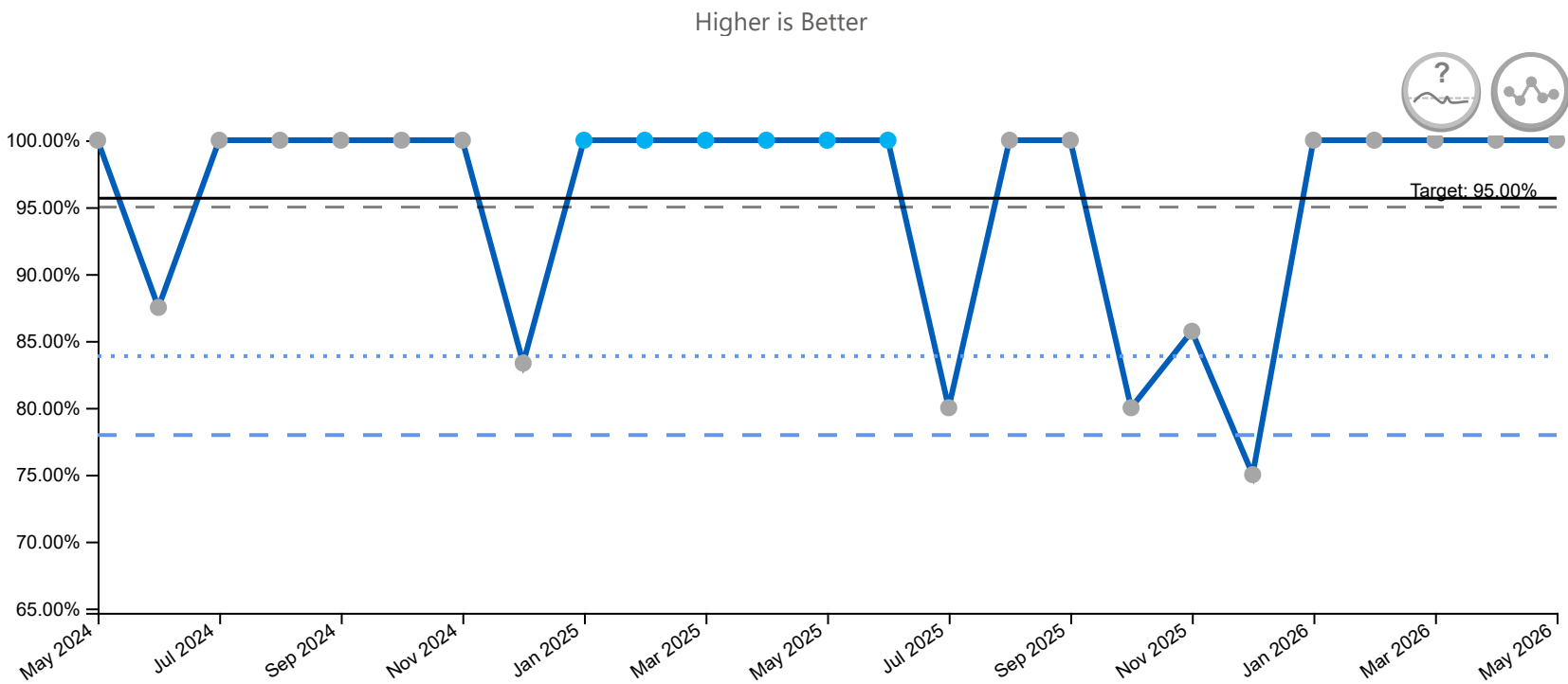
Maternal Early Warning Scores - Frequencies



Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/05/2024	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/06/2024	87.50	95.66	95.00	80.08	100.00	85.27	100.00	None
01/07/2024	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/08/2024	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/09/2024	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/10/2024	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/11/2024	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/12/2024	83.33	95.66	95.00	80.08	100.00	85.27	100.00	None
01/01/2025	100.00	95.66	95.00	80.08	100.00	85.27	100.00	Improvement
01/02/2025	100.00	95.66	95.00	80.08	100.00	85.27	100.00	Improvement
01/03/2025	100.00	95.66	95.00	80.08	100.00	85.27	100.00	Improvement
01/04/2025	100.00	95.66	95.00	80.08	100.00	85.27	100.00	Improvement
01/05/2025	100.00	95.66	95.00	80.08	100.00	85.27	100.00	Improvement
01/06/2025	100.00	95.66	95.00	80.08	100.00	85.27	100.00	Improvement
01/07/2025	80.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/08/2025	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/09/2025	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/10/2025	80.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/11/2025	85.71	95.66	95.00	80.08	100.00	85.27	100.00	None
01/12/2025	75.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/01/2026	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/02/2026	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/03/2026	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/04/2026	100.00	95.66	95.00	80.08	100.00	85.27	100.00	None
01/05/2026	100.00	95.66	95.00	80.08	100.00	85.27	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

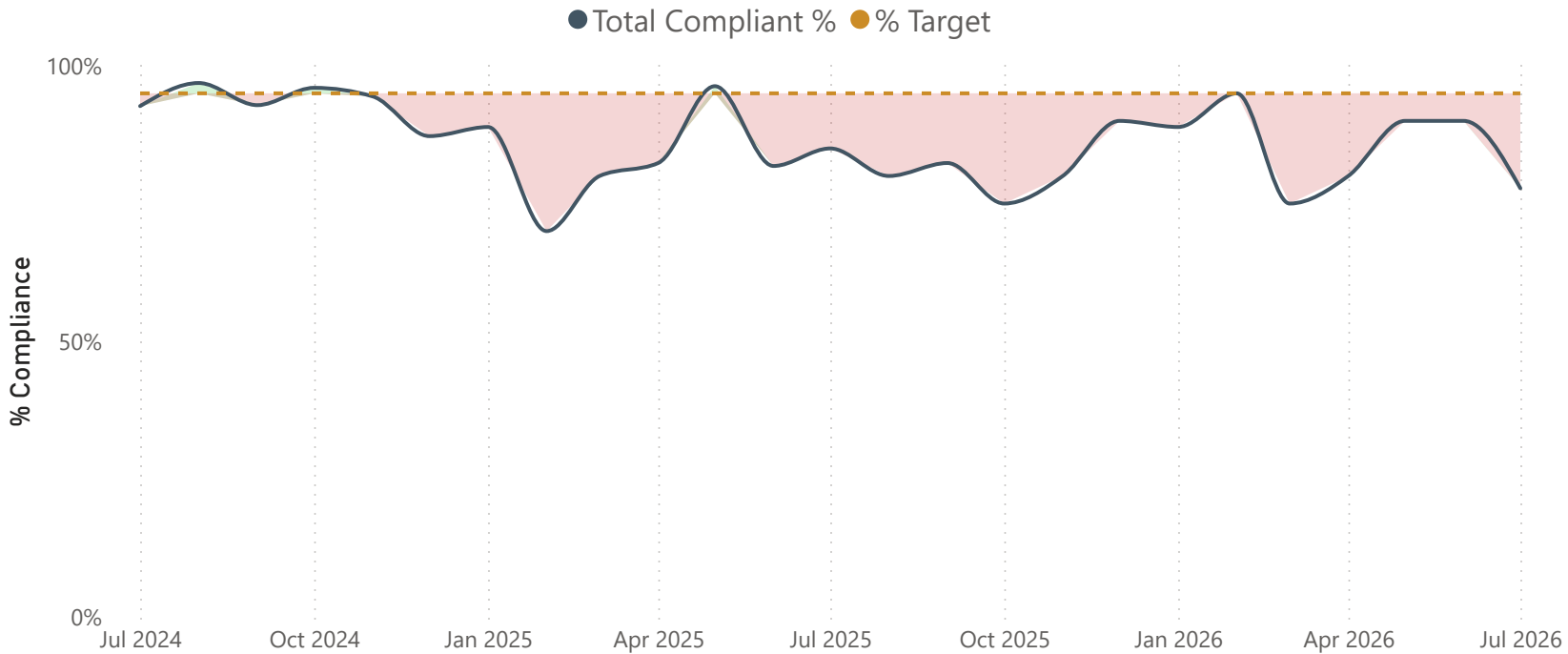
Compliance

KPI	Target	Actual	RAG Value
Paediatric Early Warning Score (PEWs) - % Compliance with PEWS Bundle	95%	77.78%	Red

Action	Target Date	Owner	Status
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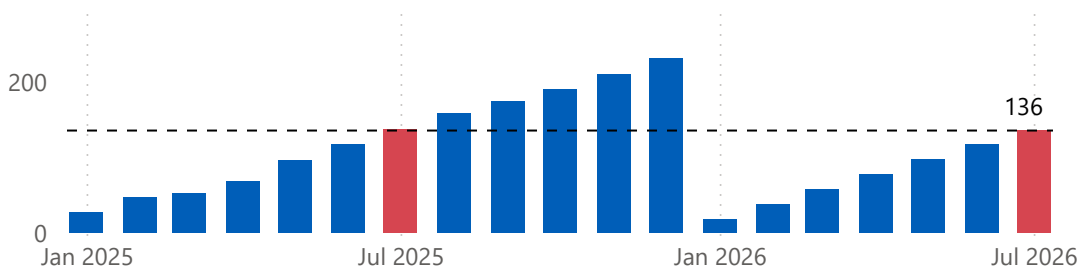
All current actions completed/closed.

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

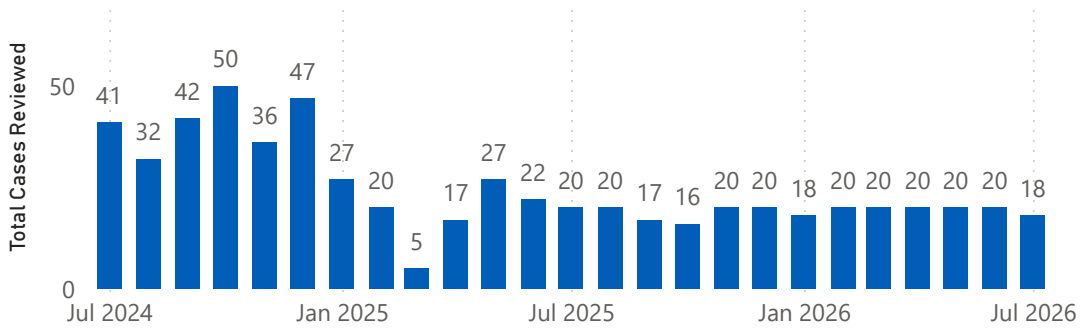


Paediatric Early Warning Scores Cases Reviewed

PEWS Cases Reviewed Running Total per Year



Paediatric Early Warning Score Cases Reviewed

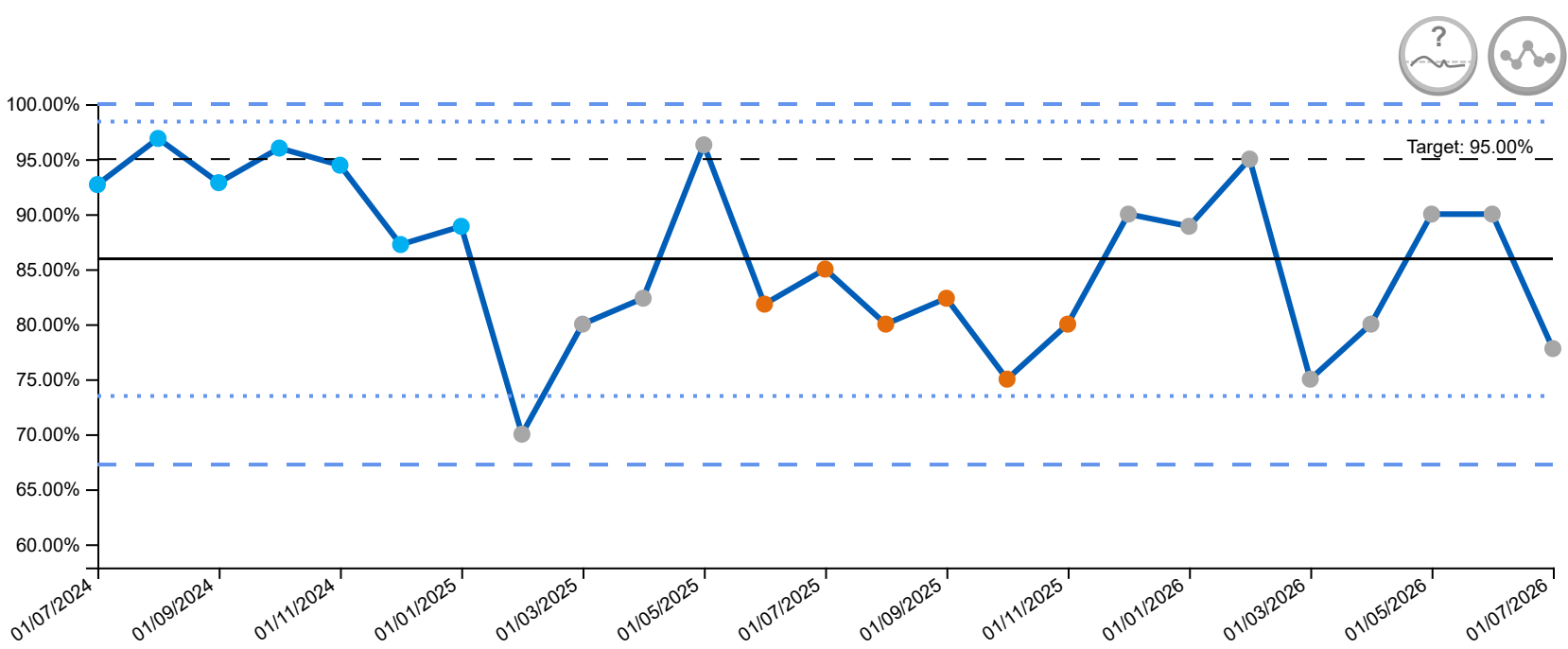


Statistical Process Control

Date	Value	Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	92.68	85.94	67.24	100.00	73.47	98.41	Improvement
01/08/2024	96.88	85.94	67.24	100.00	73.47	98.41	Improvement
01/09/2024	92.86	85.94	67.24	100.00	73.47	98.41	Improvement
01/10/2024	96.00	85.94	67.24	100.00	73.47	98.41	Improvement
01/11/2024	94.44	85.94	67.24	100.00	73.47	98.41	Improvement
01/12/2024	87.23	85.94	67.24	100.00	73.47	98.41	Improvement
01/01/2025	88.89	85.94	67.24	100.00	73.47	98.41	Improvement
01/02/2025	70.00	85.94	67.24	100.00	73.47	98.41	None
01/03/2025	80.00	85.94	67.24	100.00	73.47	98.41	None
01/04/2025	82.35	85.94	67.24	100.00	73.47	98.41	None
01/05/2025	96.30	85.94	67.24	100.00	73.47	98.41	None
01/06/2025	81.82	85.94	67.24	100.00	73.47	98.41	Deterioration
01/07/2025	85.00	85.94	67.24	100.00	73.47	98.41	Deterioration
01/08/2025	80.00	85.94	67.24	100.00	73.47	98.41	Deterioration
01/09/2025	82.35	85.94	67.24	100.00	73.47	98.41	Deterioration
01/10/2025	75.00	85.94	67.24	100.00	73.47	98.41	Deterioration
01/11/2025	80.00	85.94	67.24	100.00	73.47	98.41	Deterioration
01/12/2025	90.00	85.94	67.24	100.00	73.47	98.41	None
01/01/2026	88.89	85.94	67.24	100.00	73.47	98.41	None
01/02/2026	95.00	85.94	67.24	100.00	73.47	98.41	None
01/03/2026	75.00	85.94	67.24	100.00	73.47	98.41	None
01/04/2026	80.00	85.94	67.24	100.00	73.47	98.41	None
01/05/2026	90.00	85.94	67.24	100.00	73.47	98.41	None
01/06/2026	90.00	85.94	67.24	100.00	73.47	98.41	None
01/07/2026	77.78	85.94	67.24	100.00	73.47	98.41	None

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

Higher is Better



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

July 2026

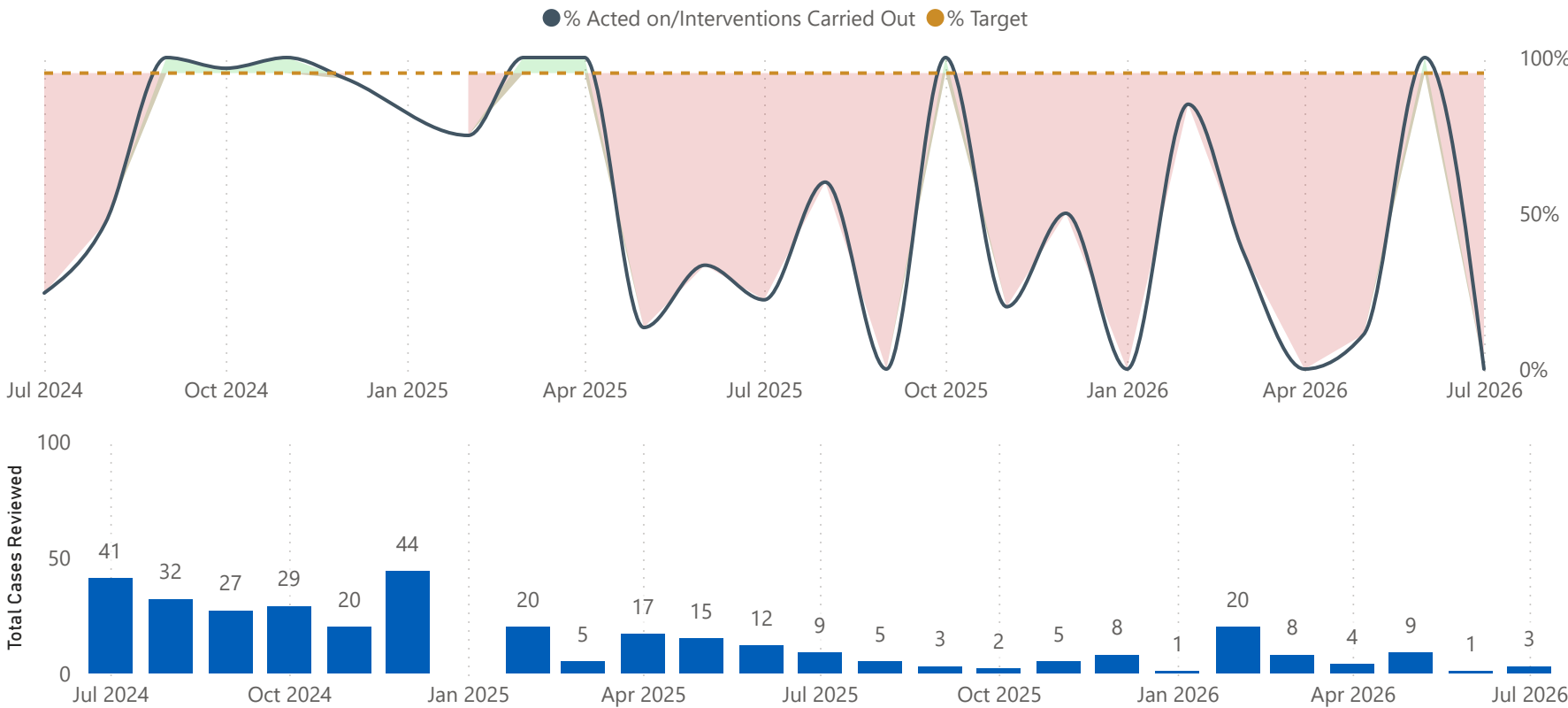
Compliance

KPI	Target	Actual	RAG Value
Paediatric Early Warning Score (PEWs) - % 'at-risk' observations identified and acted upon	95%	0.00%	Red

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

All current actions completed/closed.

Paediatric Early Warning Score 'At-Risk' Compliance



Comments From Executive Lead

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.

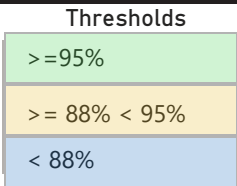
Operational Standards
Accident & Emergency 4-Hour Compliance

Compliance

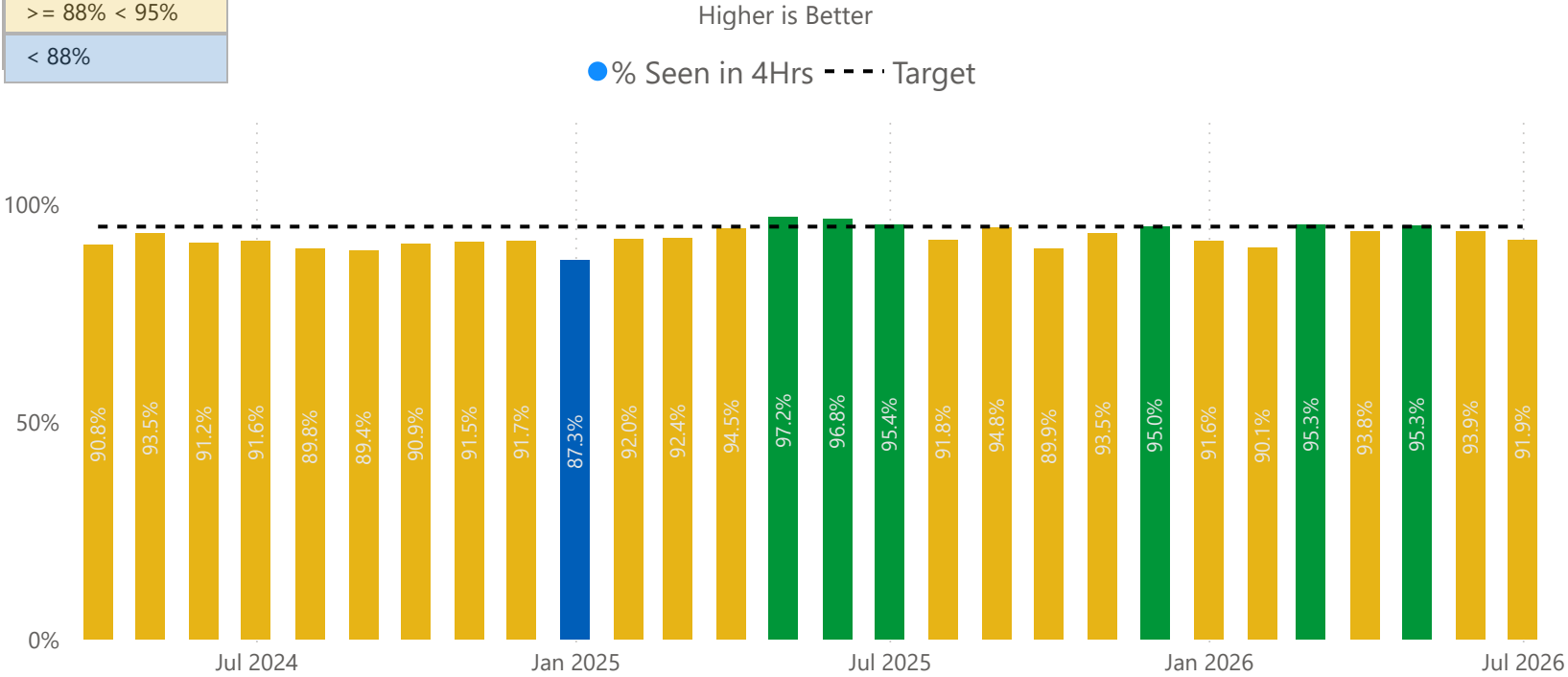
KPI	Target	Actual	RAG Value
95% of patients wait no longer than four hours from arrival to admission, discharge, or transfer for A&E treatment. Boards work towards 98%.	95%	91.87%	Amber

Action	Target Date	Owner	Status
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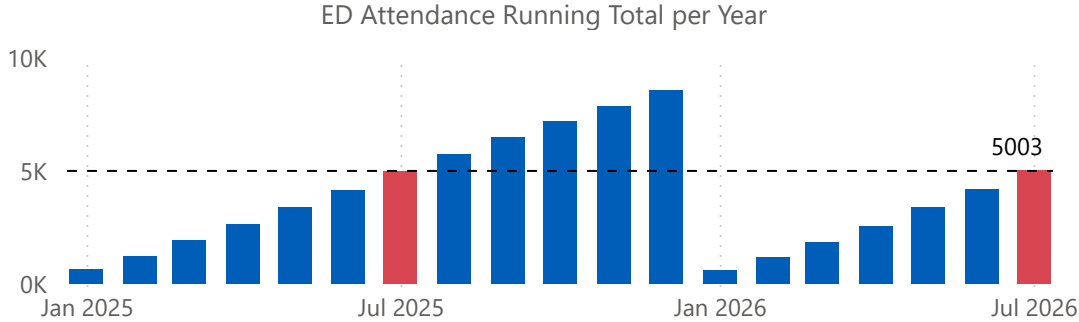
All current actions completed/closed.



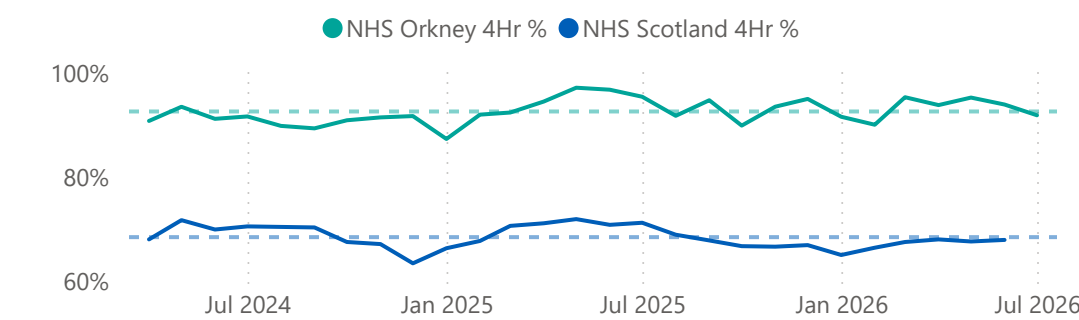
Accident & Emergency 4-Hour Standard Compliance



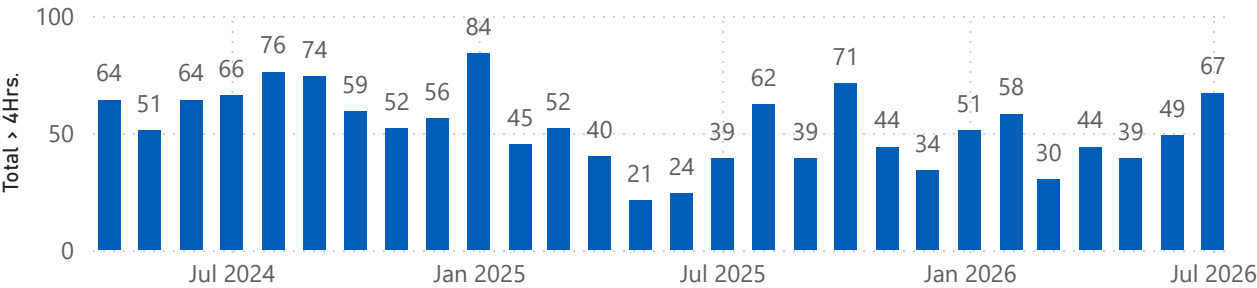
Accident & Emergency Attendances Yearly Comparison



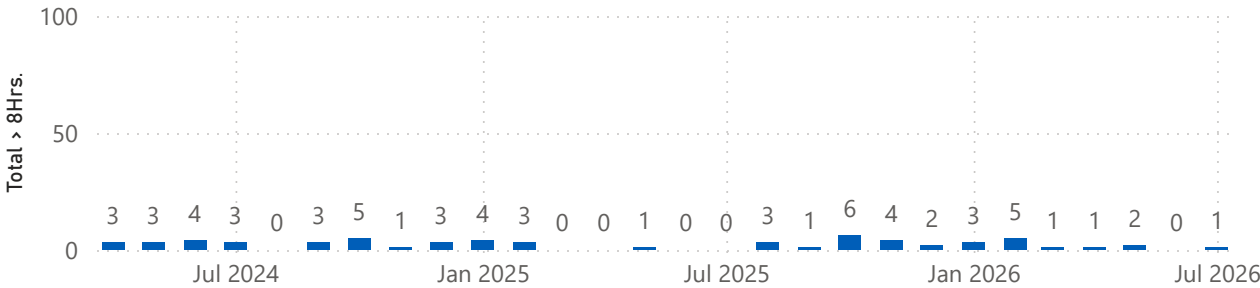
4Hr Standard Compliance vs. National



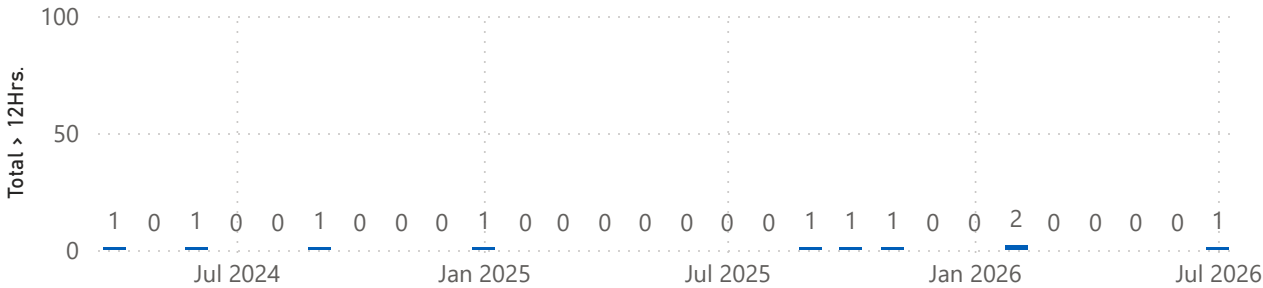
No. of Attendances > 4 Hours



No. of Attendances > 8 Hours



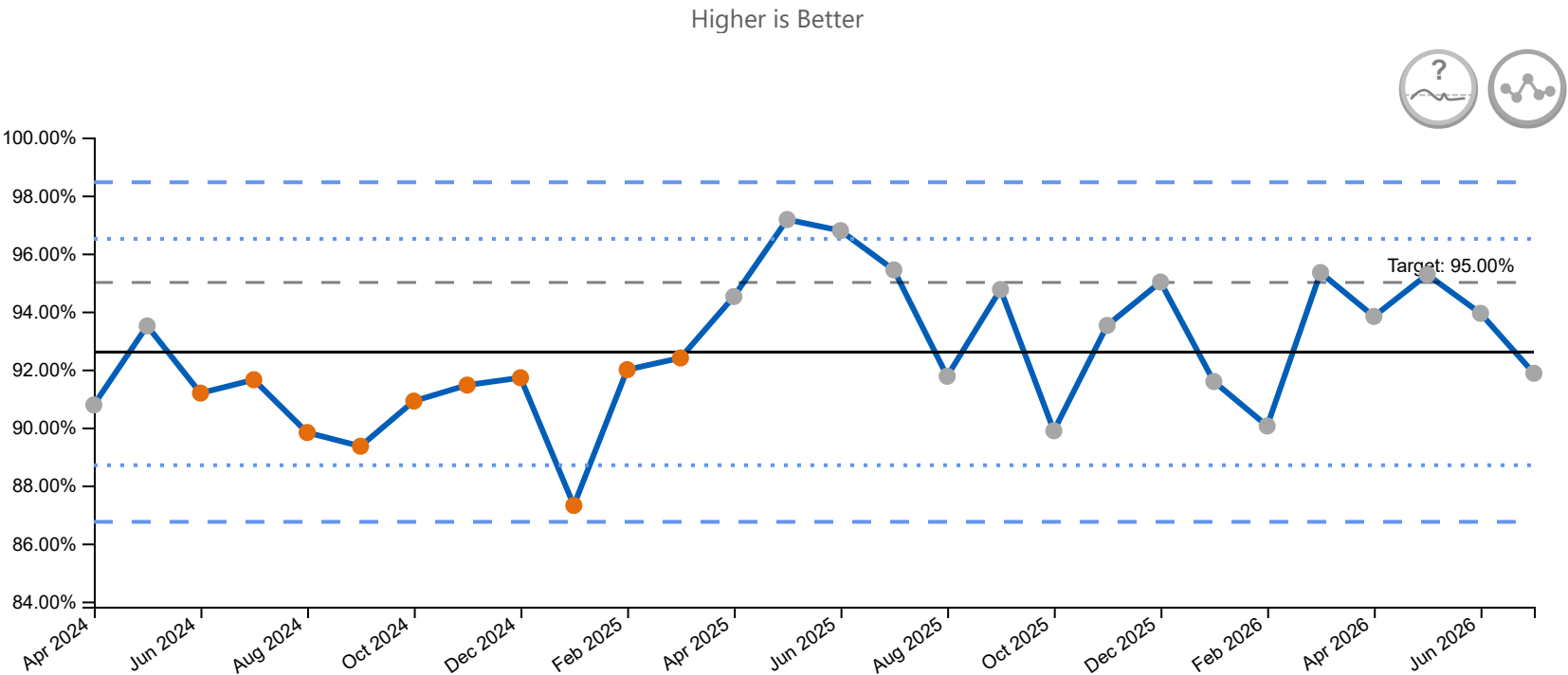
No. of Attendances > 12 Hours



Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/04/2024	90.78	92.60	95.00	86.75	98.45	88.70	96.50	None
01/05/2024	93.50	92.60	95.00	86.75	98.45	88.70	96.50	None
01/06/2024	91.18	92.60	95.00	86.75	98.45	88.70	96.50	Deterioration
01/07/2024	91.65	92.60	95.00	86.75	98.45	88.70	96.50	Deterioration
01/08/2024	89.83	92.60	95.00	86.75	98.45	88.70	96.50	Deterioration
01/09/2024	89.35	92.60	95.00	86.75	98.45	88.70	96.50	Deterioration
01/10/2024	90.91	92.60	95.00	86.75	98.45	88.70	96.50	Deterioration
01/11/2024	91.46	92.60	95.00	86.75	98.45	88.70	96.50	Deterioration
01/12/2024	91.72	92.60	95.00	86.75	98.45	88.70	96.50	Deterioration
01/01/2025	87.31	92.60	95.00	86.75	98.45	88.70	96.50	Deterioration
01/02/2025	91.99	92.60	95.00	86.75	98.45	88.70	96.50	Deterioration
01/03/2025	92.40	92.60	95.00	86.75	98.45	88.70	96.50	Deterioration
01/04/2025	94.51	92.60	95.00	86.75	98.45	88.70	96.50	None
01/05/2025	97.17	92.60	95.00	86.75	98.45	88.70	96.50	None
01/06/2025	96.79	92.60	95.00	86.75	98.45	88.70	96.50	None
01/07/2025	95.43	92.60	95.00	86.75	98.45	88.70	96.50	None
01/08/2025	91.77	92.60	95.00	86.75	98.45	88.70	96.50	None
01/09/2025	94.76	92.60	95.00	86.75	98.45	88.70	96.50	None
01/10/2025	89.89	92.60	95.00	86.75	98.45	88.70	96.50	None
01/11/2025	93.52	92.60	95.00	86.75	98.45	88.70	96.50	None
01/12/2025	95.01	92.60	95.00	86.75	98.45	88.70	96.50	None
01/01/2026	91.58	92.60	95.00	86.75	98.45	88.70	96.50	None
01/02/2026	90.05	92.60	95.00	86.75	98.45	88.70	96.50	None
01/03/2026	95.34	92.60	95.00	86.75	98.45	88.70	96.50	None
01/04/2026	93.83	92.60	95.00	86.75	98.45	88.70	96.50	None
01/05/2026	95.27	92.60	95.00	86.75	98.45	88.70	96.50	None
01/06/2026	93.94	92.60	95.00	86.75	98.45	88.70	96.50	None
01/07/2026	91.87	92.60	95.00	86.75	98.45	88.70	96.50	None

Accident & Emergency 4-Hour Standard Compliance



Comments From Executive Lead

Current ED performance has dipped below 95%. This has been due to the increased acuity of patients attending. Weekly review of data is undertaken and collaborative work with CfSD and SNE continues.

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

July 2026

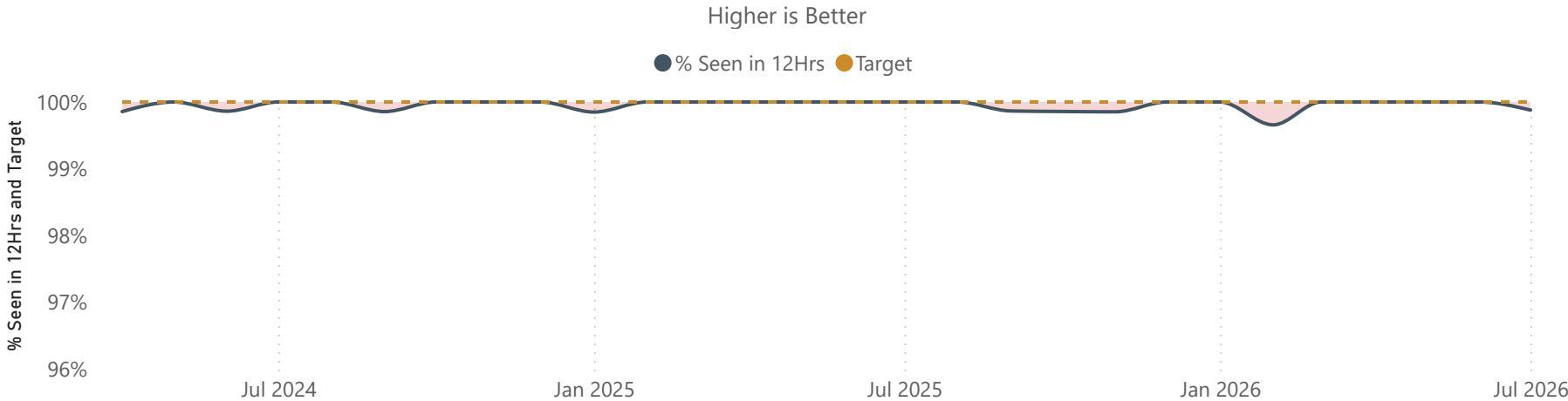
Compliance

KPI	Target	Actual	RAG Value
Patients wait less than 12 hours to admission, discharge, or transfer from A&E	99.5%	99.88%	Green

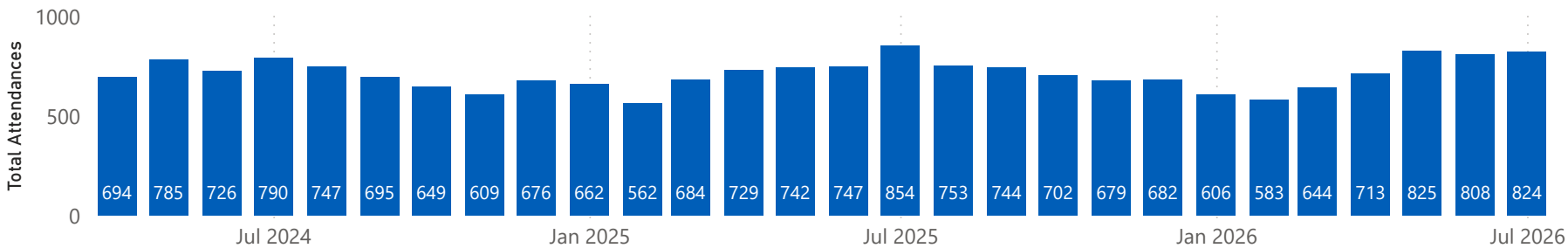
Action	Target Date	Owner	Status
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All current actions completed/closed.

Accident & Emergency 12-Hour Standard Compliance



Accident & Emergency Total Number of Attendances



Comments From Executive Lead

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



Operational Standards

Scottish Ambulance Service Turnaround Times

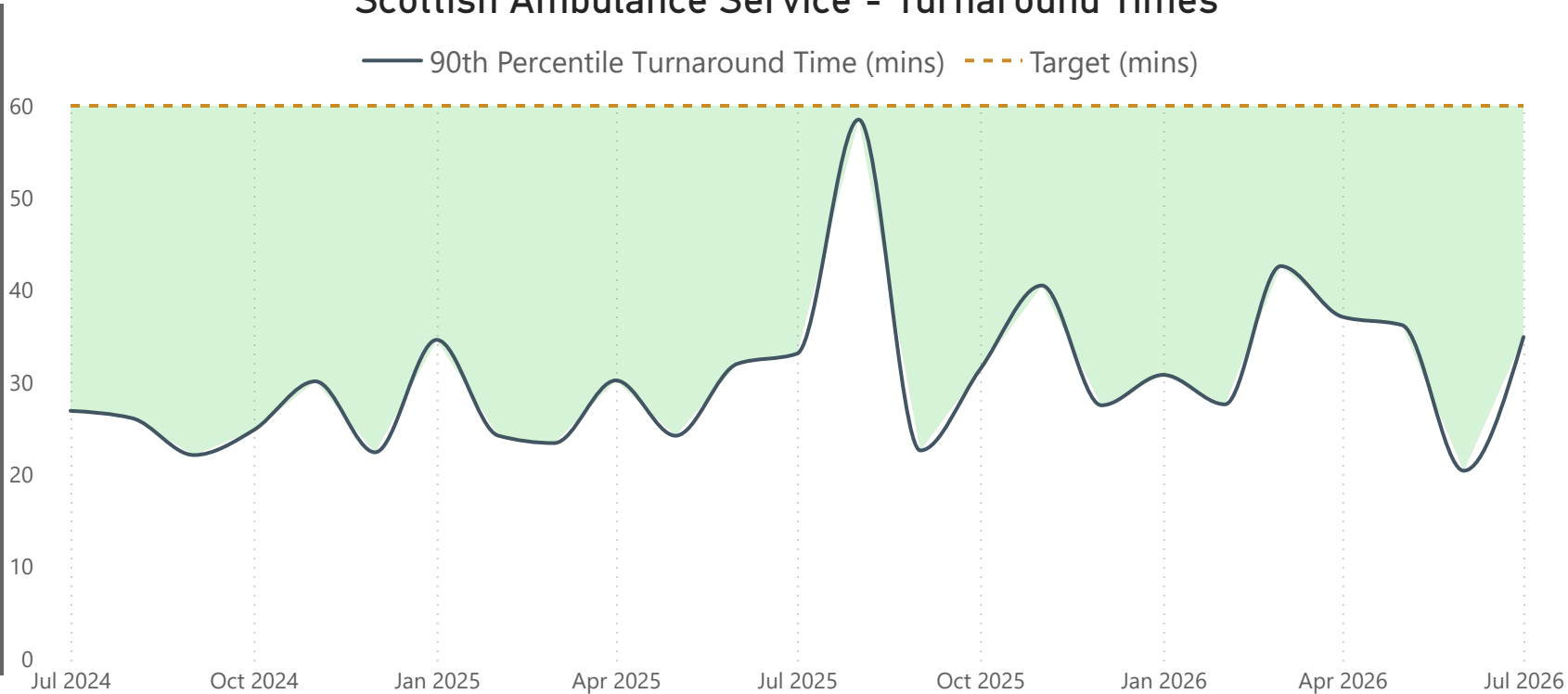
Compliance

KPI	Target	Actual	RAG Value
Scottish Ambulance Service Turnaround Times - 90th percentile within 60 minutes	60:00	00:34:56	Green

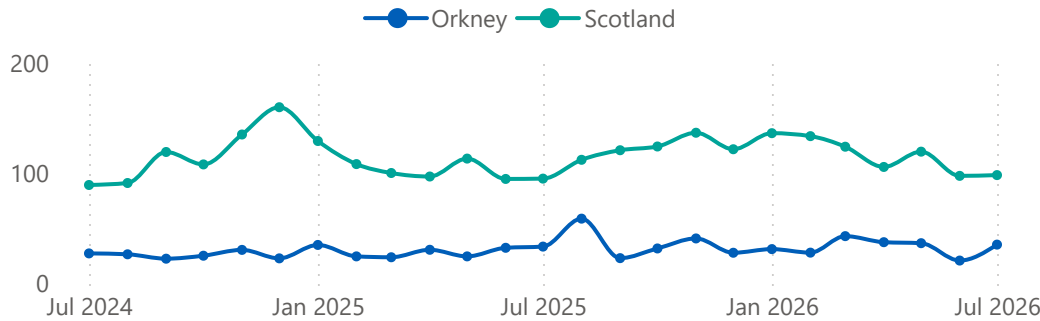
Action	Target Date	Owner	Status
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KPI on target, no actions required at this time.

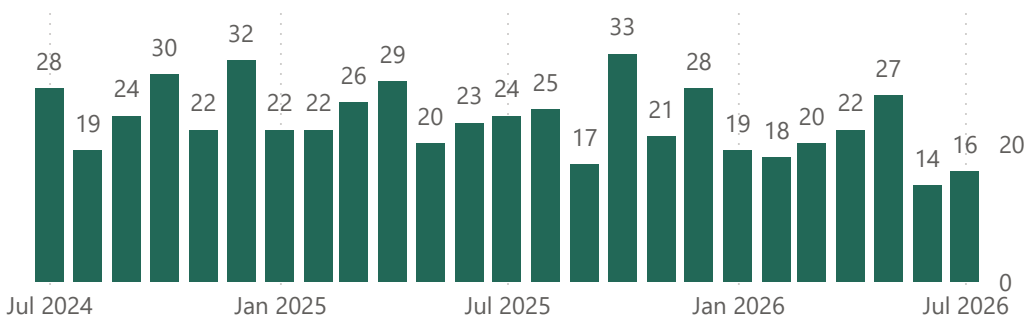
Scottish Ambulance Service - Turnaround Times



Scottish Ambulance Service - Turnaround Times (90th Percentile, mins)



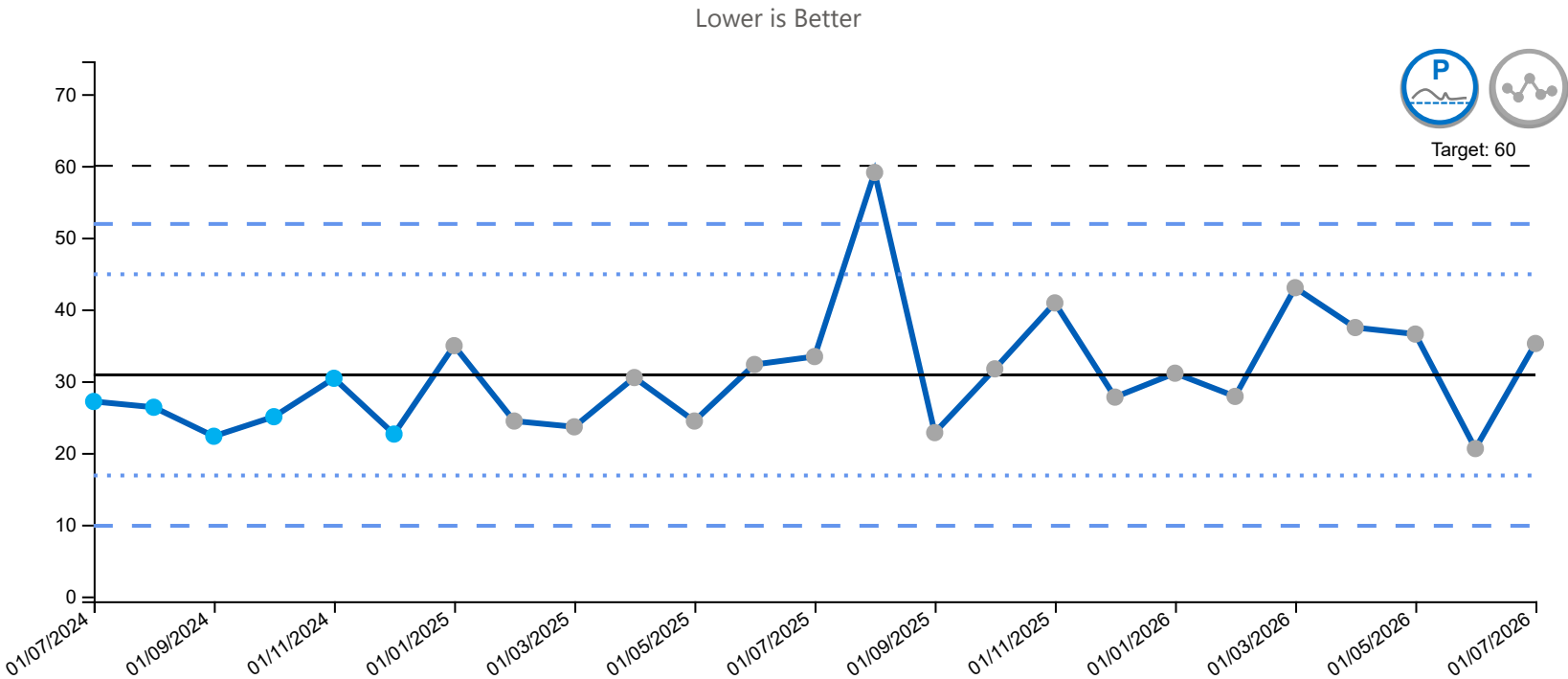
Scottish Ambulance Service - Incidents Conveyed (Orkney)



Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	27	31	60	10	51	17	44	Improvement
01/08/2024	26	31	60	10	51	17	44	Improvement
01/09/2024	22	31	60	10	51	17	44	Improvement
01/10/2024	25	31	60	10	51	17	44	Improvement
01/11/2024	30	31	60	10	51	17	44	Improvement
01/12/2024	22	31	60	10	51	17	44	Improvement
01/01/2025	35	31	60	10	51	17	44	None
01/02/2025	24	31	60	10	51	17	44	None
01/03/2025	23	31	60	10	51	17	44	None
01/04/2025	30	31	60	10	51	17	44	None
01/05/2025	24	31	60	10	51	17	44	None
01/06/2025	32	31	60	10	51	17	44	None
01/07/2025	33	31	60	10	51	17	44	None
01/08/2025	59	31	60	10	51	17	44	None
01/09/2025	23	31	60	10	51	17	44	None
01/10/2025	31	31	60	10	51	17	44	None
01/11/2025	41	31	60	10	51	17	44	None
01/12/2025	28	31	60	10	51	17	44	None
01/01/2026	31	31	60	10	51	17	44	None
01/02/2026	28	31	60	10	51	17	44	None
01/03/2026	43	31	60	10	51	17	44	None
01/04/2026	37	31	60	10	51	17	44	None
01/05/2026	36	31	60	10	51	17	44	None
01/06/2026	20	31	60	10	51	17	44	None
01/07/2026	35	31	60	10	51	17	44	None

Scottish Ambulance Service - Turnaround Times (Mins)



Comments From Executive Lead

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



Operational Standards

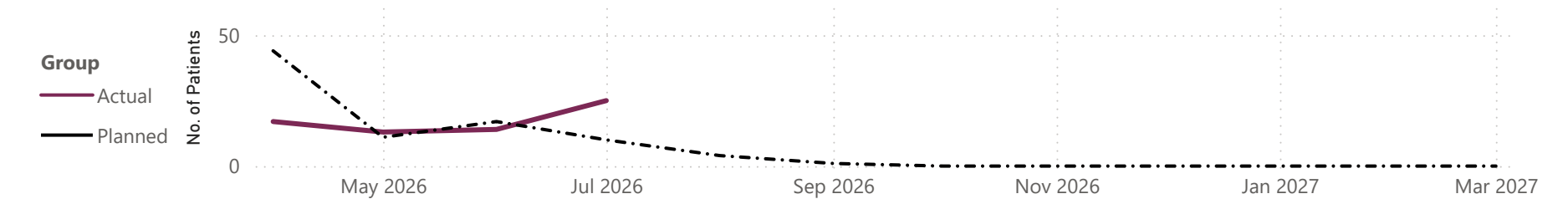
52-Week Waits Summary (NOP & TTG)

Compliance

KPI	Target	Actual	RAG Value
0 patients waiting more than 52 weeks on a New Outpatient or Treatment Time Guarantee waiting list	55	117	Red

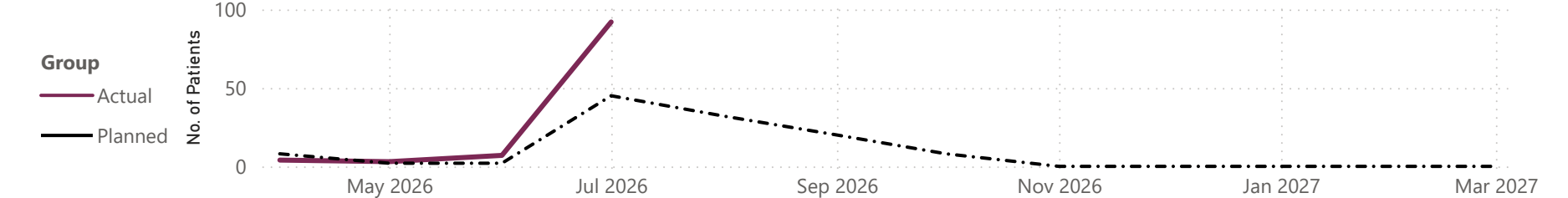
Action	Target Date	Owner	Status
External Capacity Review – Service Level Agreements being reviewed to ensure they meet demand and reduce delays	31/03/2027	C Somerville	In Progress
Finalise plan to address identified gaps for 2026/27, covering next 12 months –to be reviewed via through Weekly Waiting Times meeting	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 52-Week Waits (Planned vs. Actual)



Area	Group	Apr-2026	May-2026	Jun-2026	Jul-2026	Aug-2026	Sep-2026	Oct-2026	Nov-2026	Dec-2026	Jan-2027	Feb-2027	Mar-2027
New Outpatients	Planned	44	11	17	10	4	1	0	0	0	0	0	0
	Actual	17	13	14	25								
	+/-	-27	2	-3	15								

Treatment Time Guarantee 52-Week Waits (Planned vs. Actual)



Area	Group	Apr-2026	May-2026	Jun-2026	Jul-2026	Aug-2026	Sep-2026	Oct-2026	Nov-2026	Dec-2026	Jan-2027	Feb-2027	Mar-2027
Treatment Time Guarantee	Planned	8	2	2	45	32	20	8	0	0	0	0	0
	Actual	4	3	7	92								
	+/-	-4	1	5	47								

Comments From Executive Lead

At the end of July, 110 patients were waiting over 52 weeks, with 95 awaiting treatment. Ophthalmology accounts for 92 of these patients. A number of these breaches occurred in the past 2 weeks and reflect patients who have reached the 52-week threshold following the delivery of non-recurring additional capacity last year. Work continues to increase recurring capacity within the service to support sustained management of demand and reduce future long waits.

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

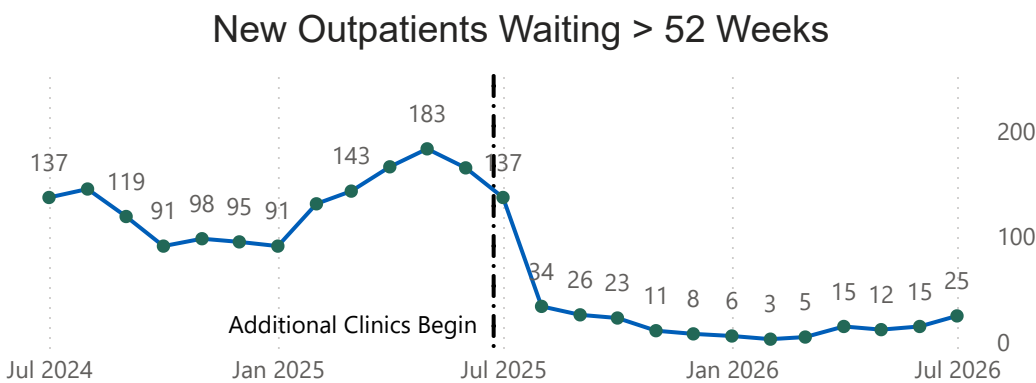
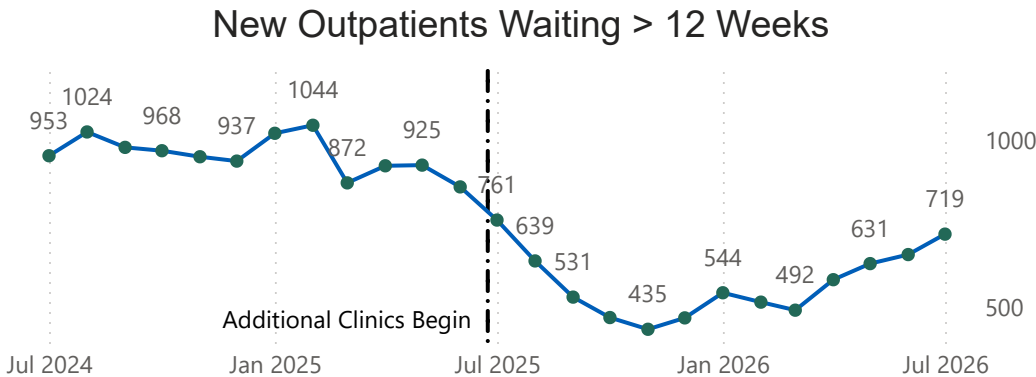
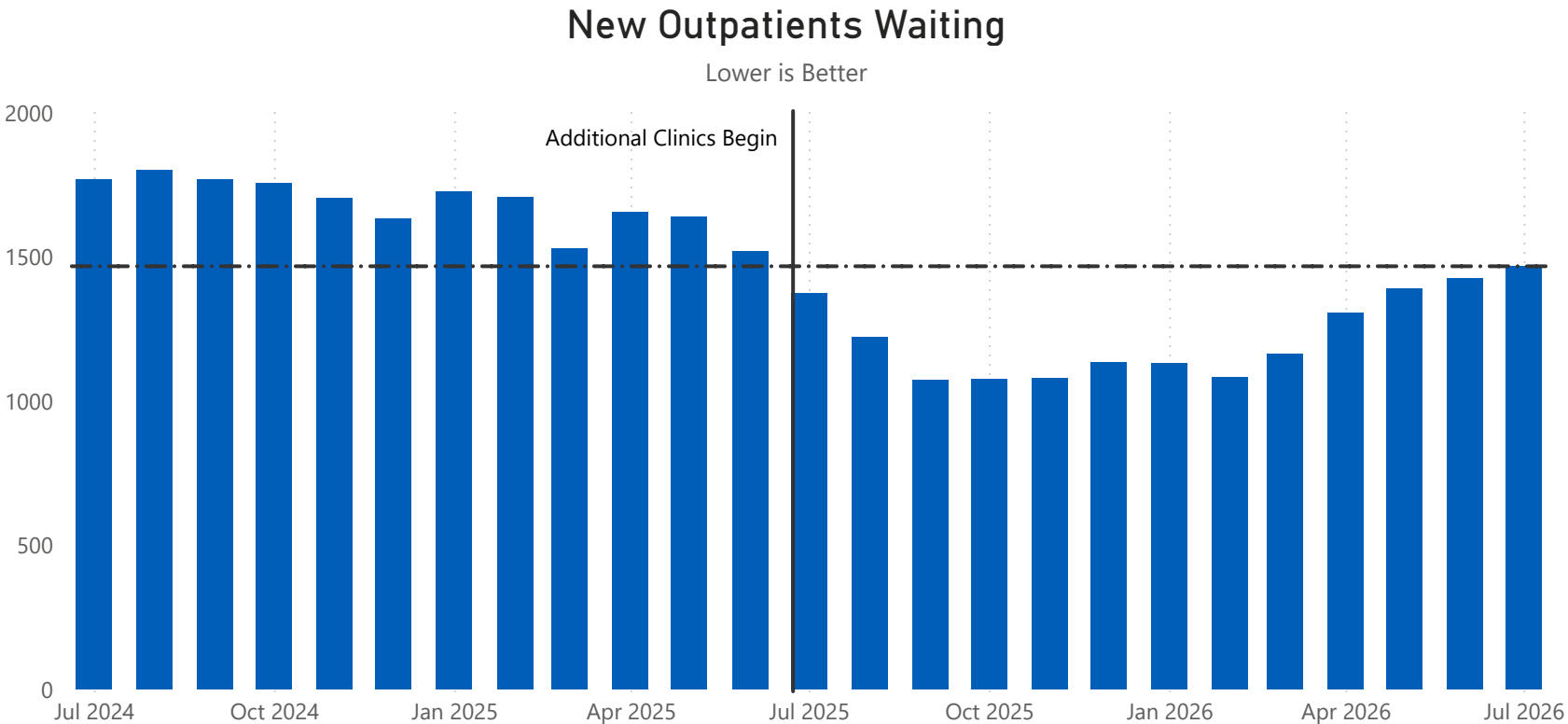


Operational Standards

New Outpatients (NOP) 12 Week Compliance

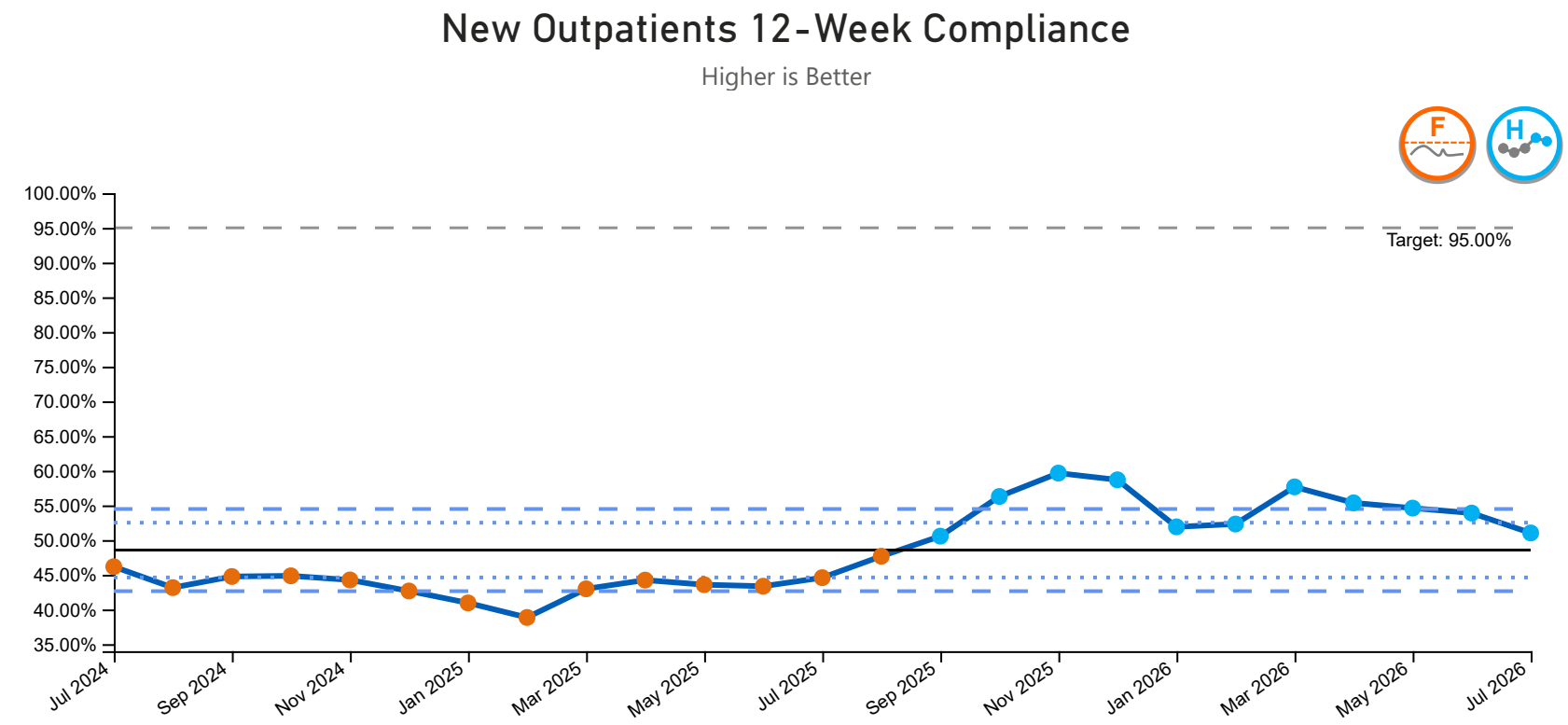
Compliance

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%	51.02%	Red
Action	Target Date	Owner	Status
Finalise additional capacity requirements for Q2 and Q3	31/08/2026	C Somerville	In Progress
Finalise operational delivery plans for additional outpatient activity and secure capacity to maximise delivery. Maintain weekly performance reviews with the CEO to monitor activity levels, waiting list trajectories, and implementation of recovery actions to support achievement of the trajectory	31/08/2026	C Somerville	In Progress
SLA discussions and capacity planning across Community Child Health, Orthopaedics, Ophthalmology, Rheumatology, Dermatology and ENT	31/08/2026	C Somerville, K Francis	In Progress
Start a one stop cataract assessment clinic to free consultant capacity for specialist activity	31/08/2026	C Somerville	In Progress
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	31/08/2026	C Somerville	In Progress



Statistical Process Control

Date	Value	Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	46	49	43	54	45	53	Deterioration
01/08/2024	43	49	43	54	45	53	Deterioration
01/09/2024	45	49	43	54	45	53	Deterioration
01/10/2024	45	49	43	54	45	53	Deterioration
01/11/2024	44	49	43	54	45	53	Deterioration
01/12/2024	43	49	43	54	45	53	Deterioration
01/01/2025	41	49	43	54	45	53	Deterioration
01/02/2025	39	49	43	54	45	53	Deterioration
01/03/2025	43	49	43	54	45	53	Deterioration
01/04/2025	44	49	43	54	45	53	Deterioration
01/05/2025	44	49	43	54	45	53	Deterioration
01/06/2025	43	49	43	54	45	53	Deterioration
01/07/2025	45	49	43	54	45	53	Deterioration
01/08/2025	48	49	43	54	45	53	Deterioration
01/09/2025	51	49	43	54	45	53	Improvement
01/10/2025	56	49	43	54	45	53	Improvement
01/11/2025	60	49	43	54	45	53	Improvement
01/12/2025	59	49	43	54	45	53	Improvement
01/01/2026	52	49	43	54	45	53	Improvement
01/02/2026	52	49	43	54	45	53	Improvement
01/03/2026	58	49	43	54	45	53	Improvement
01/04/2026	55	49	43	54	45	53	Improvement
01/05/2026	55	49	43	54	45	53	Improvement
01/06/2026	54	49	43	54	45	53	Improvement
01/07/2026	51	49	43	54	45	53	Improvement



Comments From Executive Lead

At the end of July, 1,444 patients were waiting for a new outpatient appointment, 29 more than forecast. Although activity was below plan, this largely reflects a deliberate decision to defer additional capacity to ensure its delivery was optimised and aligned to service needs.

At the end of July, 23 patients were waiting over 52 weeks on the Paediatric waiting list. Actions to address these longer waits are progressing, supported by collaboration with local and regional colleagues to increase access to appointments

Dr Anna Lamont, Medical Director



Operational Standards

New Outpatients (NOP) Local Improvement Target

Data Source

OP Recovery Weekly Return

Latest Data

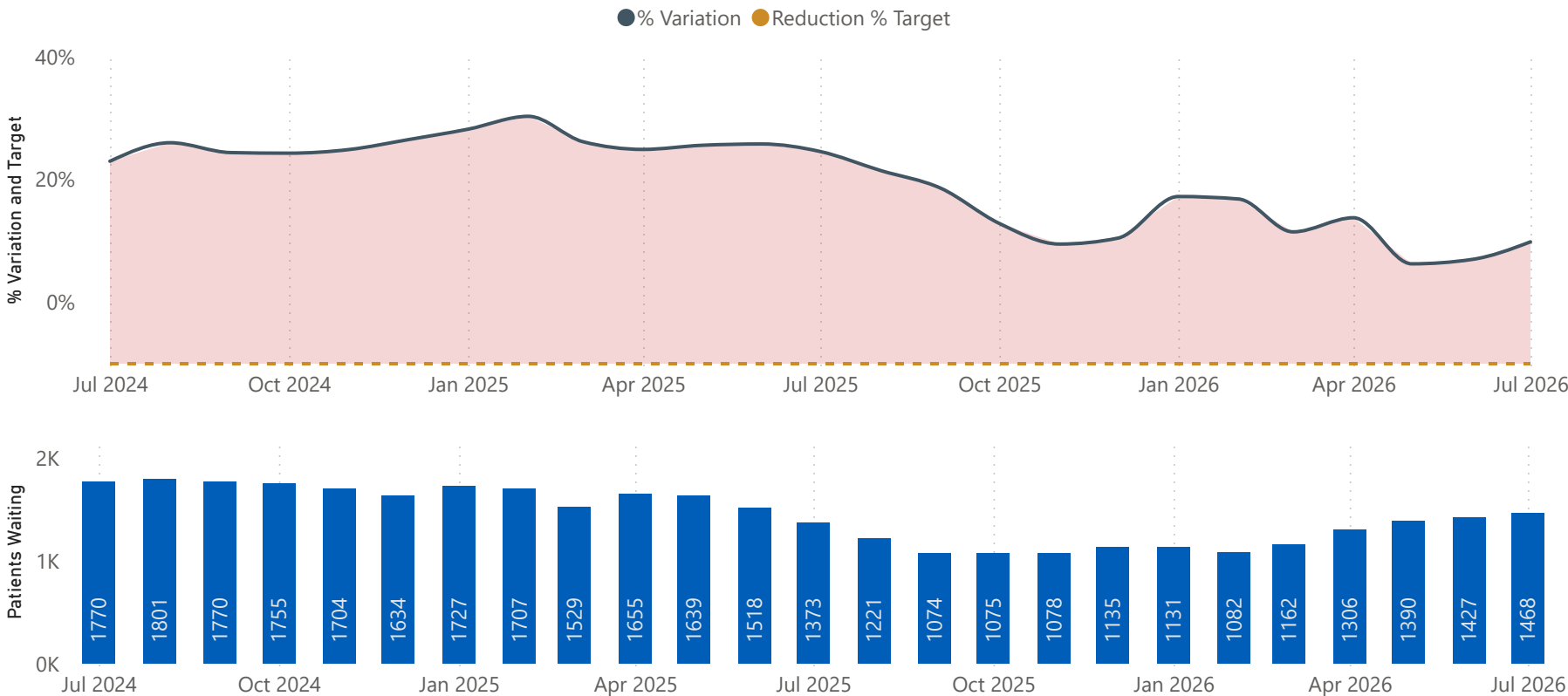
July 2026

Compliance

KPI	Target	Actual	RAG Value
10% reduction in waiting times for New Outpatients	-10%	9.85%	Red

Action	Target Date	Owner	Status
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	31/08/2026	C Somerville	In Progress

New Outpatients - Local 10% Waiting Times Reduction Compliance



Comments From Executive Lead

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

Dr Anna Lamont, Medical Director



Operational Standards

Treatment Time Guarantee (TTG) 12 Week Compliance

Data Source

TTG Weekly Return

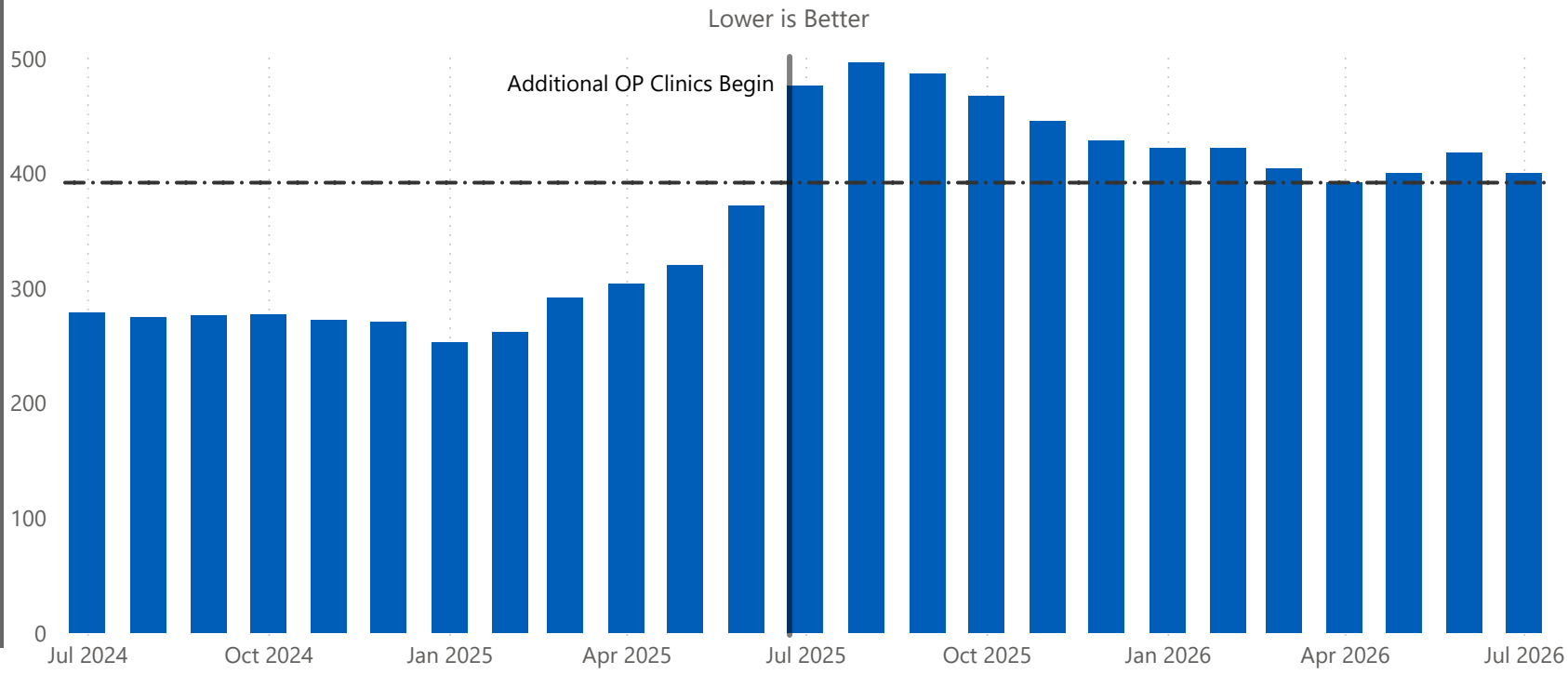
Latest Data

July 2026

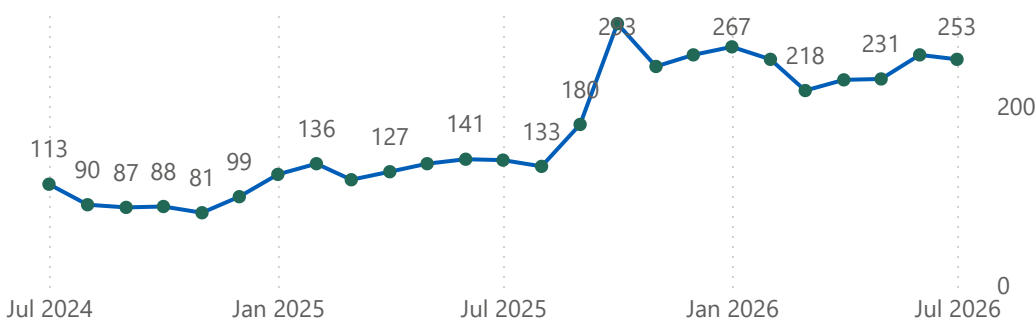
Compliance

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
Agree additional capacity requirements for Q2 and Q3, relating to Ophthalmology and Community Child Health and ENT	31/08/2026	C Somerville	In Progress
Continue to review the process for checking pre admission requirements, including pre operative assessment and biometry, to ensure patients are admission ready and allocated without delay.	31/08/2026	C Somerville	In Progress
Finalise operational delivery plans for additional funded activity and secure the required workforce and partner-board capacity to support delivery. Continue weekly review meetings with the CEO to monitor planned versus actual activity, identify risks to delivery, and implement corrective actions where required.	31/08/2026	C Somerville	In Progress
SLA discussions and capacity planning across Community Child Health, Orthopaedics, Ophthalmology, Rheumatology, Dermatology and ENT	31/08/2026	C Somerville, K Francis	In Progress
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	31/08/2026	C Somerville	In Progress

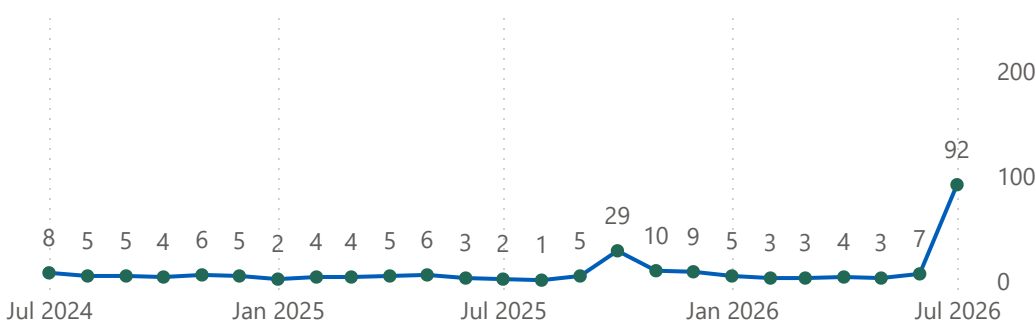
Treatment Time Guarantee Patients Waiting



TTG Patients Waiting > 12 Weeks



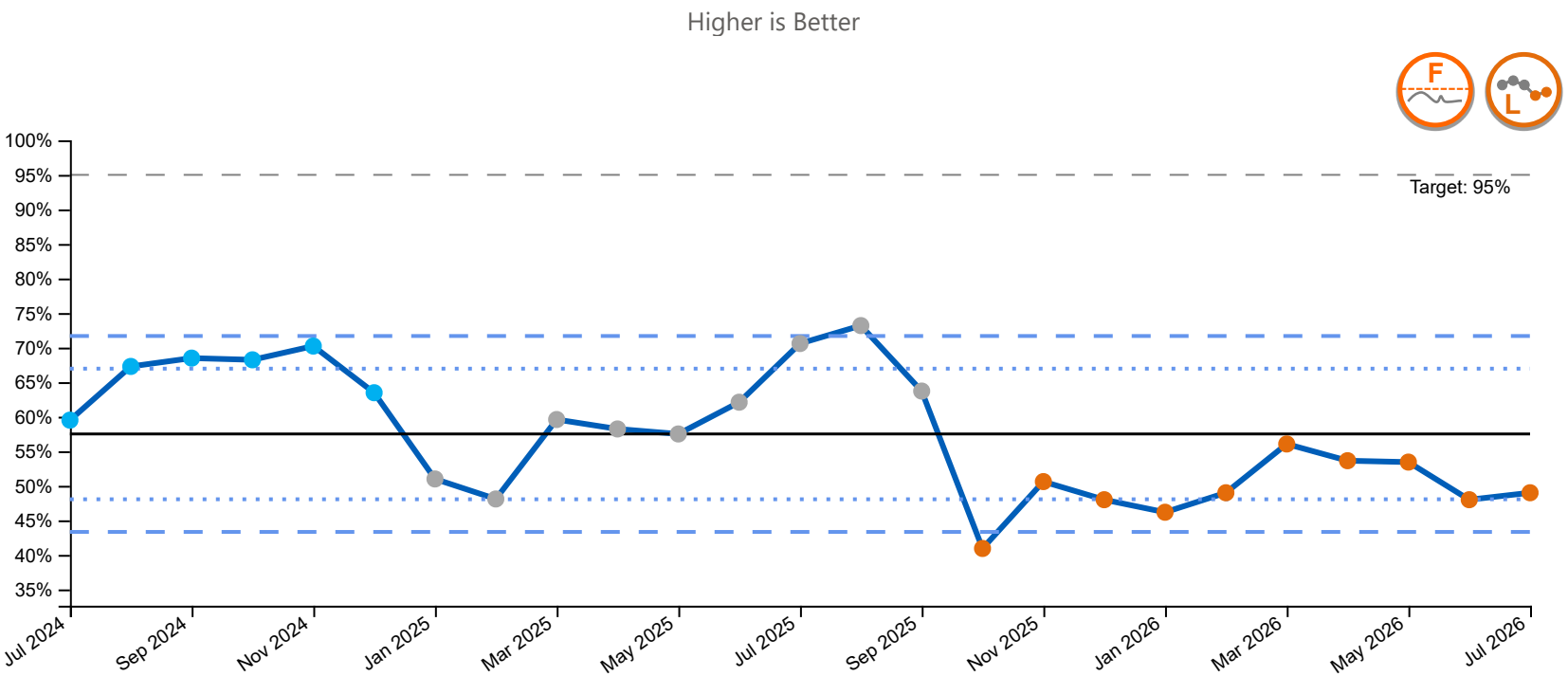
TTG Patients Waiting > 52 Weeks



Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	59	57	95	43	72	48	67	Improvement
01/08/2024	67	57	95	43	72	48	67	Improvement
01/09/2024	68	57	95	43	72	48	67	Improvement
01/10/2024	68	57	95	43	72	48	67	Improvement
01/11/2024	70	57	95	43	72	48	67	Improvement
01/12/2024	63	57	95	43	72	48	67	Improvement
01/01/2025	51	57	95	43	72	48	67	None
01/02/2025	48	57	95	43	72	48	67	None
01/03/2025	60	57	95	43	72	48	67	None
01/04/2025	58	57	95	43	72	48	67	None
01/05/2025	57	57	95	43	72	48	67	None
01/06/2025	62	57	95	43	72	48	67	None
01/07/2025	71	57	95	43	72	48	67	None
01/08/2025	73	57	95	43	72	48	67	None
01/09/2025	64	57	95	43	72	48	67	None
01/10/2025	41	57	95	43	72	48	67	Deterioration
01/11/2025	51	57	95	43	72	48	67	Deterioration
01/12/2025	48	57	95	43	72	48	67	Deterioration
01/01/2026	46	57	95	43	72	48	67	Deterioration
01/02/2026	49	57	95	43	72	48	67	Deterioration
01/03/2026	56	57	95	43	72	48	67	Deterioration
01/04/2026	54	57	95	43	72	48	67	Deterioration
01/05/2026	53	57	95	43	72	48	67	Deterioration
01/06/2026	48	57	95	43	72	48	67	Deterioration
01/07/2026	49	57	95	43	72	48	67	Deterioration

Treatment Time Guarantee 12-Week Compliance



Comments From Executive Lead

At the end of July, 391 patients were waiting for inpatient or day case procedures, compared with a forecast position of 403, indicating that overall waiting list levels remain broadly in line with plan. A total of 105 patients were forecast to receive treatment during July; however, 74 patients were treated. Whilst this represents an adverse position against plan, core planned activity levels were achieved, with the variance largely attributable to lower than anticipated levels of additional activity.

Of those waiting at end of July, 91 patients had been waiting longer than 52 weeks for Ophthalmology treatment. A significant proportion of these patients moved into a 52-week breach position within the last 2 to 4 weeks, reflecting the increase in outpatient capacity delivered during 2025 and the subsequent identification of patients requiring treatment. Additional Ophthalmology treatment capacity has been secured for September, with plans to treat a minimum of 60 long-waiting patients. Further treatment dates are also being actively explored, providing confidence that capacity can be increased further to support ongoing recovery. Alongside efforts to secure additional treatment capacity, we continue to work with our partners and Agreement providers to develop more sustainable pathways that can better manage demand and capacity challenges.



Dr Anna Lamont, Medical Director

Operational Standards

Treatment Time Guarantee (TTG) Local Improvement Target

Data Source

TTG Weekly Return

Latest Data

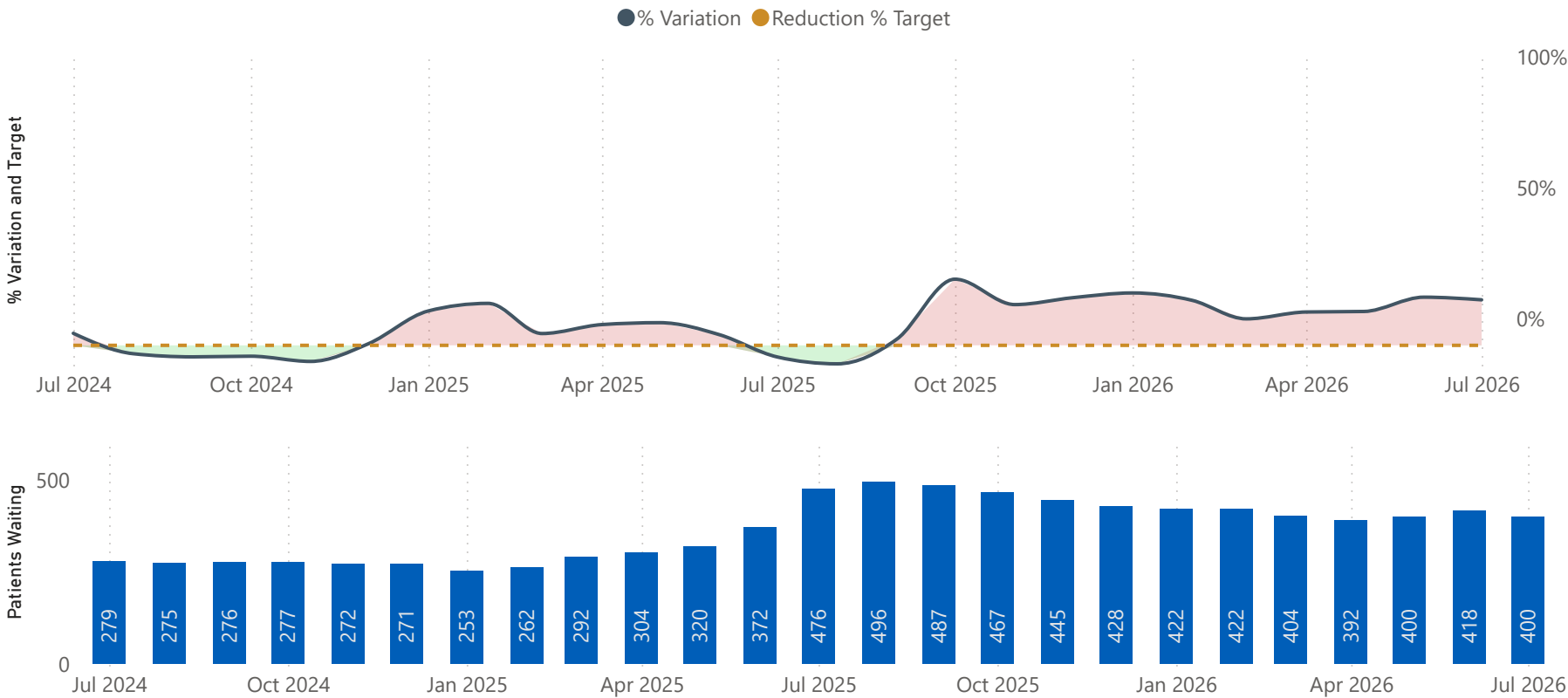
31/07/2026

Compliance

KPI	Target	Actual	RAG Value
10% reduction in waiting times for Treatment Time Guarantee patients	-10%	7.35%	Red

Action	Target Date	Owner	Status
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	31/08/2026	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

Treatment Time Guarantee - Local 10% Waiting Times Reduction Compliance



Comments From Executive Lead

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

Dr Anna Lamont, Medical Director



Operational Standards

Diagnostic Endoscopy 6 Week Compliance

Data Source

DMMI Monthly Return

Latest Data

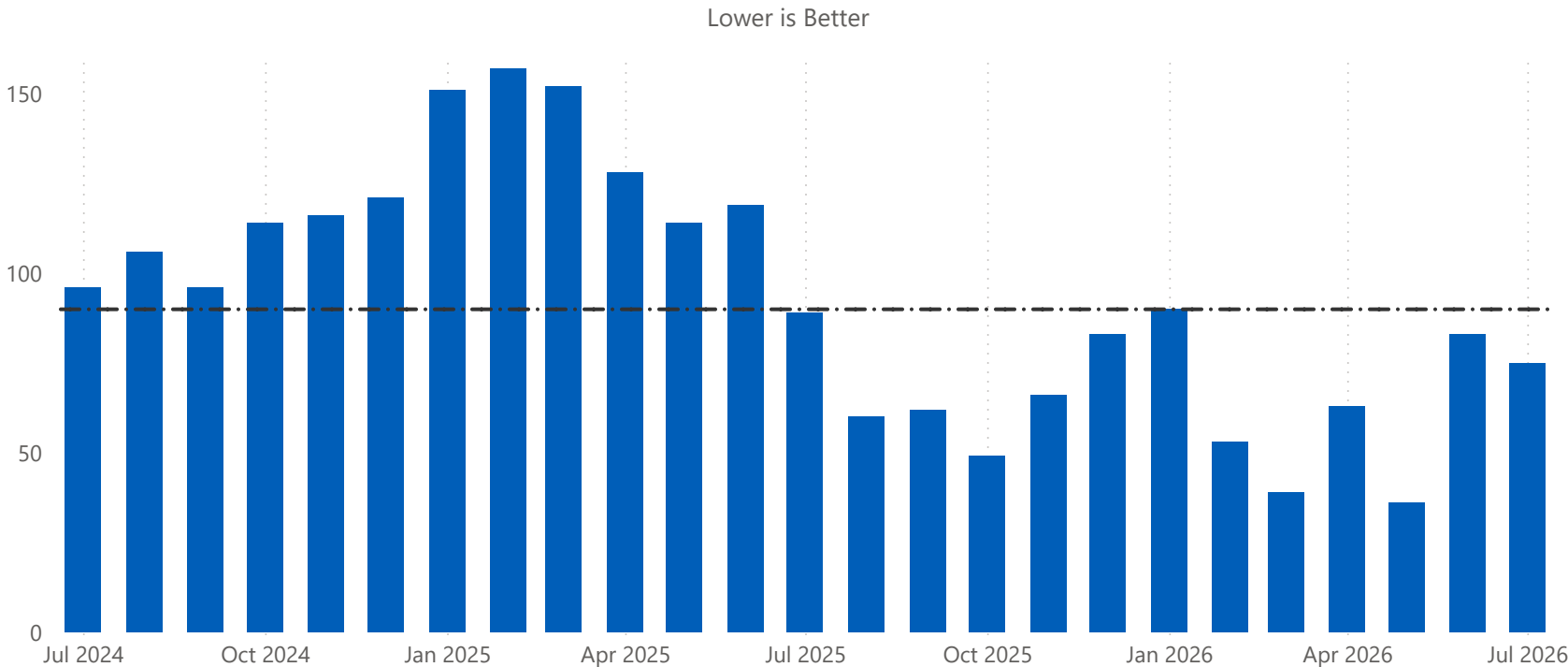
July 2026

Compliance

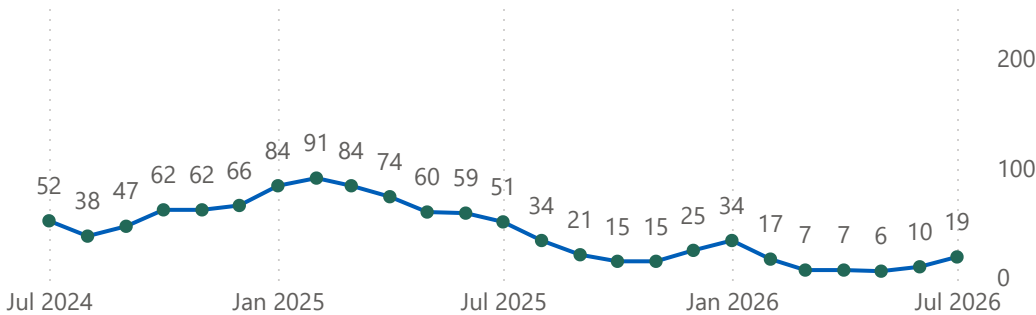
KPI	Target	Actual	RAG Value
100% of patients waiting for key endoscopy diagnostic tests and investigations should wait no longer than six weeks (42 days).	100%	74.67%	Red

Action	Target Date	Owner	Status
Endoscopy capacity secured through planned visiting specialists. Weekly monitoring of waiting times and utilisation to ensure available capacity is maximised and emerging delays are addressed promptly.	31/08/2026	C Somerville	In Progress

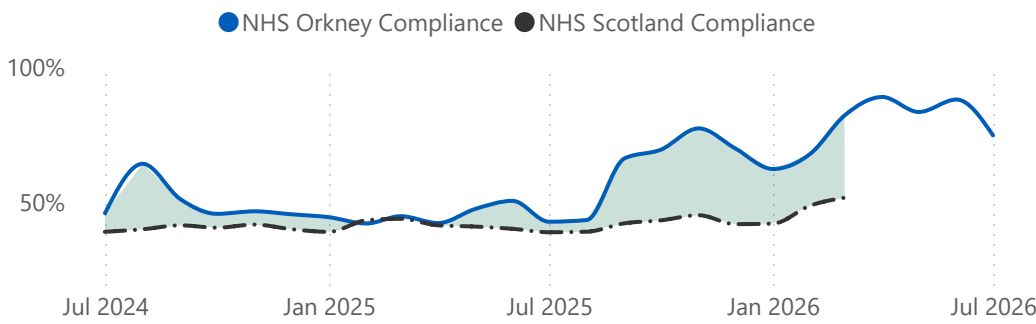
Diagnostic Endoscopy Patients Waiting



DMMI Endoscopy Patients Waiting > 6 Weeks



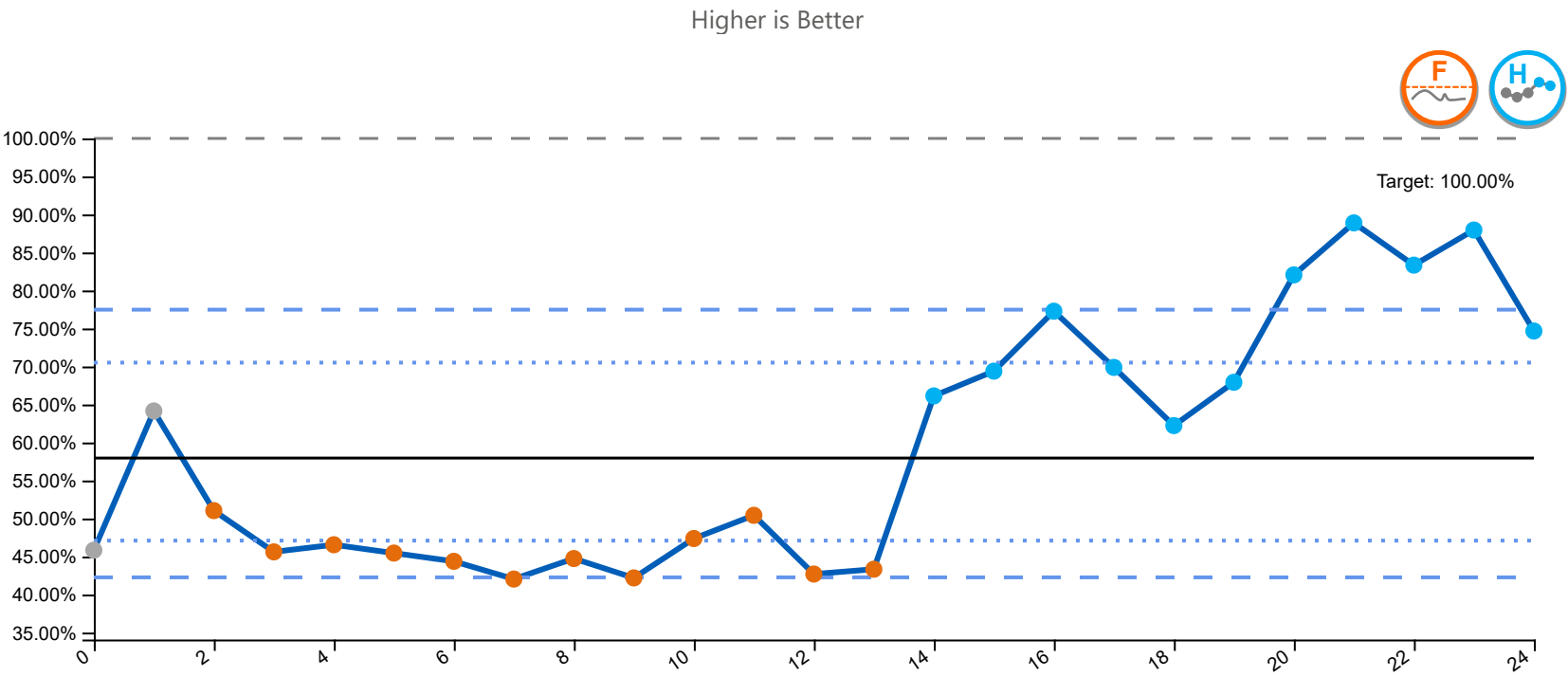
DMMI Endoscopy Compliance vs. National



Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
0	45.83	57.95	100.00	42.26	77.47	47.10	70.51	None
1	64.15	57.95	100.00	42.26	77.47	47.10	70.51	None
2	51.04	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
3	45.61	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
4	46.55	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
5	45.45	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
6	44.37	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
7	42.04	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
8	44.74	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
9	42.19	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
10	47.37	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
11	50.42	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
12	42.70	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
13	43.33	57.95	100.00	42.26	77.47	47.10	70.51	Deterioration
14	66.13	57.95	100.00	42.26	77.47	47.10	70.51	Improvement
15	69.39	57.95	100.00	42.26	77.47	47.10	70.51	Improvement
16	77.27	57.95	100.00	42.26	77.47	47.10	70.51	Improvement
17	69.88	57.95	100.00	42.26	77.47	47.10	70.51	Improvement
18	62.22	57.95	100.00	42.26	77.47	47.10	70.51	Improvement
19	67.92	57.95	100.00	42.26	77.47	47.10	70.51	Improvement
20	82.05	57.95	100.00	42.26	77.47	47.10	70.51	Improvement
21	88.89	57.95	100.00	42.26	77.47	47.10	70.51	Improvement
22	83.33	57.95	100.00	42.26	77.47	47.10	70.51	Improvement
23	87.95	57.95	100.00	42.26	77.47	47.10	70.51	Improvement
24	74.67	57.95	100.00	42.26	77.47	47.10	70.51	Improvement

Diagnostic Endoscopy 6-Week Compliance



Comments From Executive Lead

At the end of July, 71 patients were awaiting key endoscopy diagnostic tests. 12 patients had waited longer than six weeks (Upper Endoscopy: 3, Lower Endoscopy: 2, Colonoscopy: 7). All patients breaching the six-week standard at month end had appointments booked, and the position continues to be closely monitored to minimise extended waits and support timely access to diagnostics.

Dr Anna Lamont, Medical Director



Operational Standards

Diagnostic Imaging 6 Week Compliance

Data Source

DMMI Monthly Return

Latest Data

July 2026

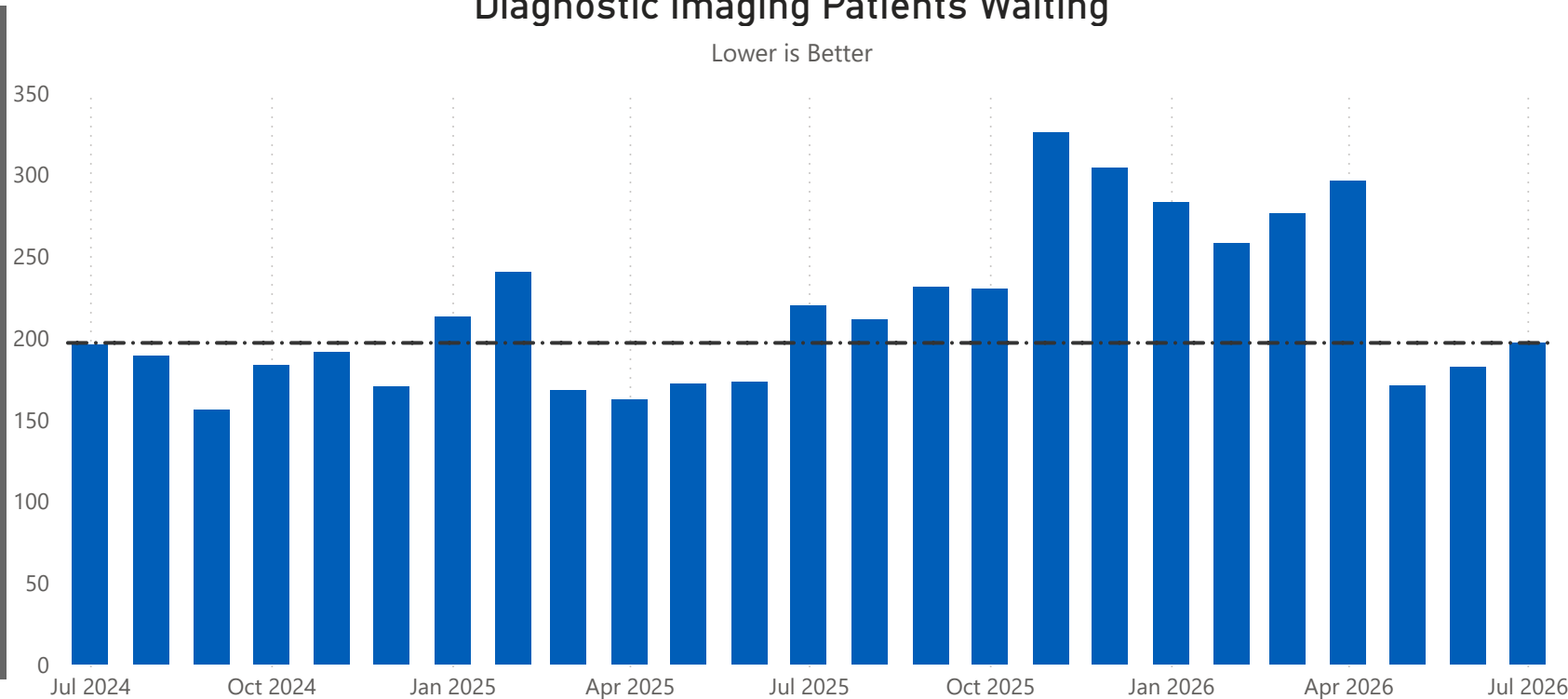
Compliance

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%	86.29%	Red

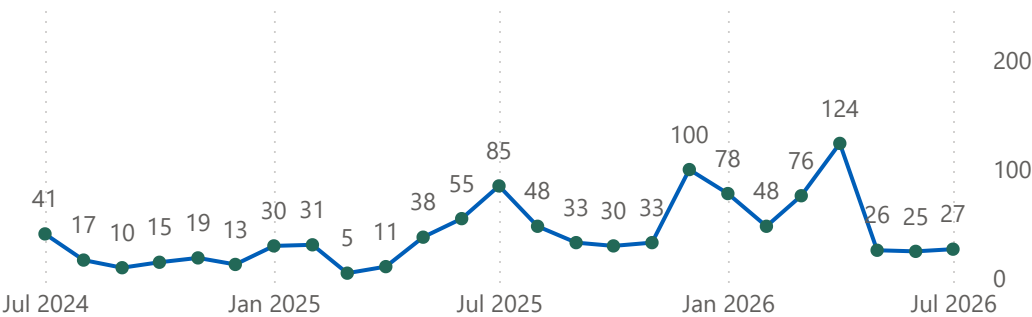
Action	Target Date	Owner	Status
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All current actions completed/closed.

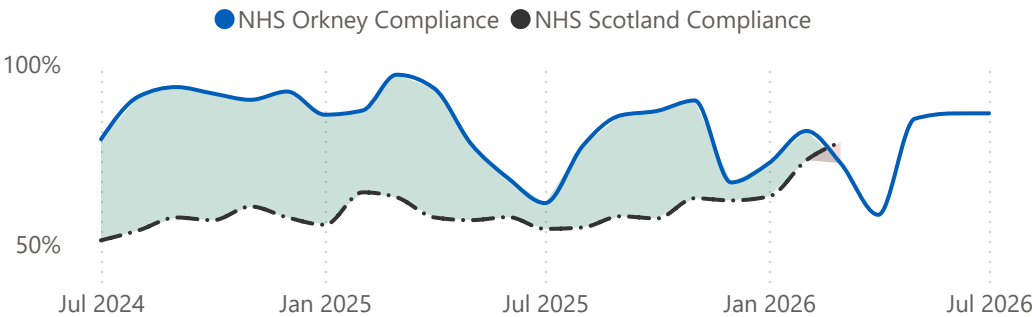
Diagnostic Imaging Patients Waiting



DMMI Imaging Patients Waiting > 6 Weeks



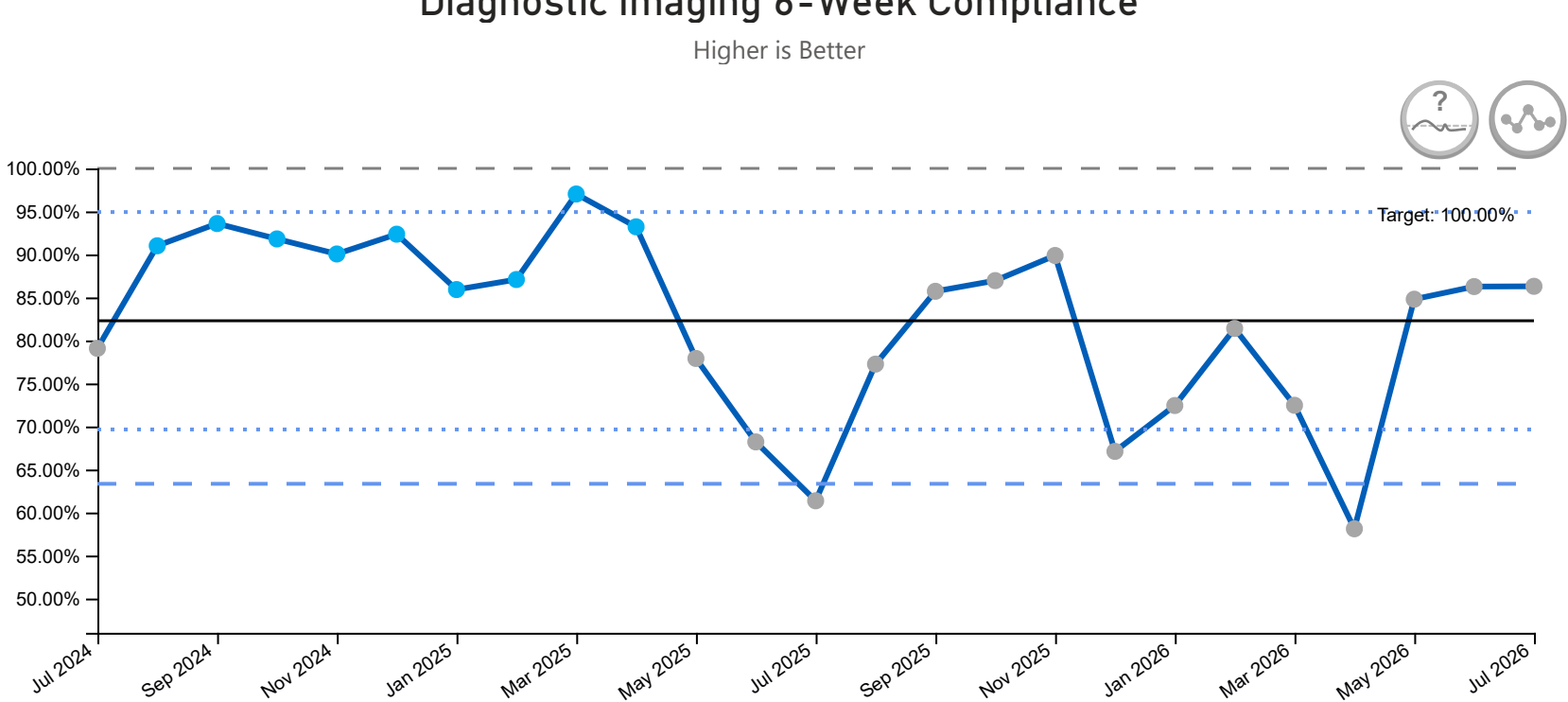
DMMI Imaging Compliance vs. National



Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	79.08	82.29	100.00	63.34	101.24	69.65	94.93	None
01/08/2024	91.01	82.29	100.00	63.34	101.24	69.65	94.93	Improvement
01/09/2024	93.59	82.29	100.00	63.34	101.24	69.65	94.93	Improvement
01/10/2024	91.80	82.29	100.00	63.34	101.24	69.65	94.93	Improvement
01/11/2024	90.05	82.29	100.00	63.34	101.24	69.65	94.93	Improvement
01/12/2024	92.35	82.29	100.00	63.34	101.24	69.65	94.93	Improvement
01/01/2025	85.92	82.29	100.00	63.34	101.24	69.65	94.93	Improvement
01/02/2025	87.08	82.29	100.00	63.34	101.24	69.65	94.93	Improvement
01/03/2025	97.02	82.29	100.00	63.34	101.24	69.65	94.93	Improvement
01/04/2025	93.21	82.29	100.00	63.34	101.24	69.65	94.93	Improvement
01/05/2025	77.91	82.29	100.00	63.34	101.24	69.65	94.93	None
01/06/2025	68.21	82.29	100.00	63.34	101.24	69.65	94.93	None
01/07/2025	61.36	82.29	100.00	63.34	101.24	69.65	94.93	None
01/08/2025	77.25	82.29	100.00	63.34	101.24	69.65	94.93	None
01/09/2025	85.71	82.29	100.00	63.34	101.24	69.65	94.93	None
01/10/2025	86.96	82.29	100.00	63.34	101.24	69.65	94.93	None
01/11/2025	89.88	82.29	100.00	63.34	101.24	69.65	94.93	None
01/12/2025	67.11	82.29	100.00	63.34	101.24	69.65	94.93	None
01/01/2026	72.44	82.29	100.00	63.34	101.24	69.65	94.93	None
01/02/2026	81.40	82.29	100.00	63.34	101.24	69.65	94.93	None
01/03/2026	72.46	82.29	100.00	63.34	101.24	69.65	94.93	None
01/04/2026	58.11	82.29	100.00	63.34	101.24	69.65	94.93	None
01/05/2026	84.80	82.29	100.00	63.34	101.24	69.65	94.93	None
01/06/2026	86.26	82.29	100.00	63.34	101.24	69.65	94.93	None
01/07/2026	86.29	82.29	100.00	63.34	101.24	69.65	94.93	None

Diagnostic Imaging 6-Week Compliance



Comments From Executive Lead

At the end of April 2026, 6 week compliance for Computer Tomography was at 100%.

MRI shows a compliance figure of 79% with 20 patients waiting over 6 weeks. A number of these are due to unavailability.

Ultrasound dropped to 41% seen within 6 weeks, mainly due to staffing challenges although this has seen improvement throughout May 2026. Overall waits for ultrasound scans have dropped from 175 in April to 29 at the end of May 2026, with 6 week compliance increasing to 72%.

Dr Anna Lamont, Medical Director



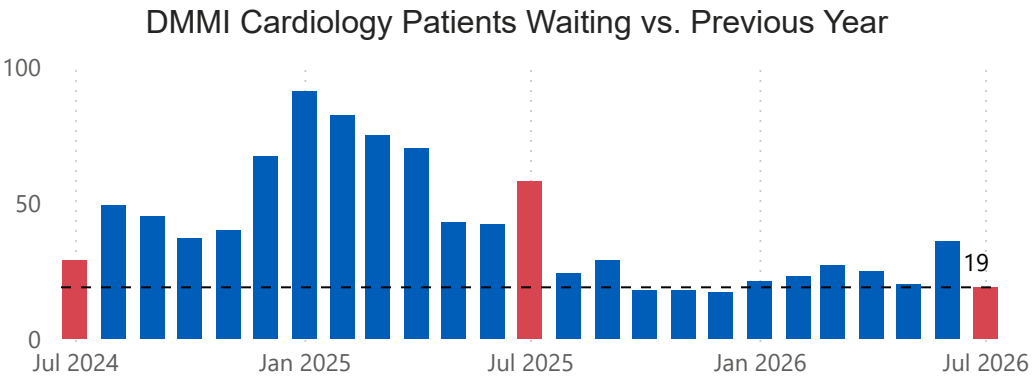
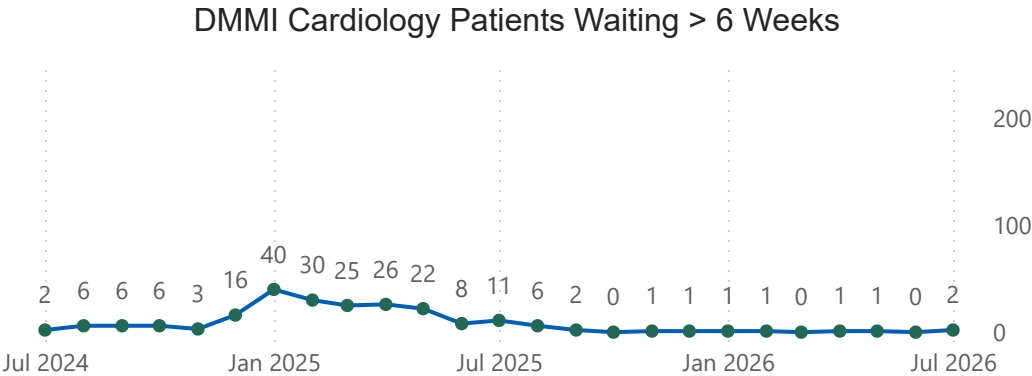
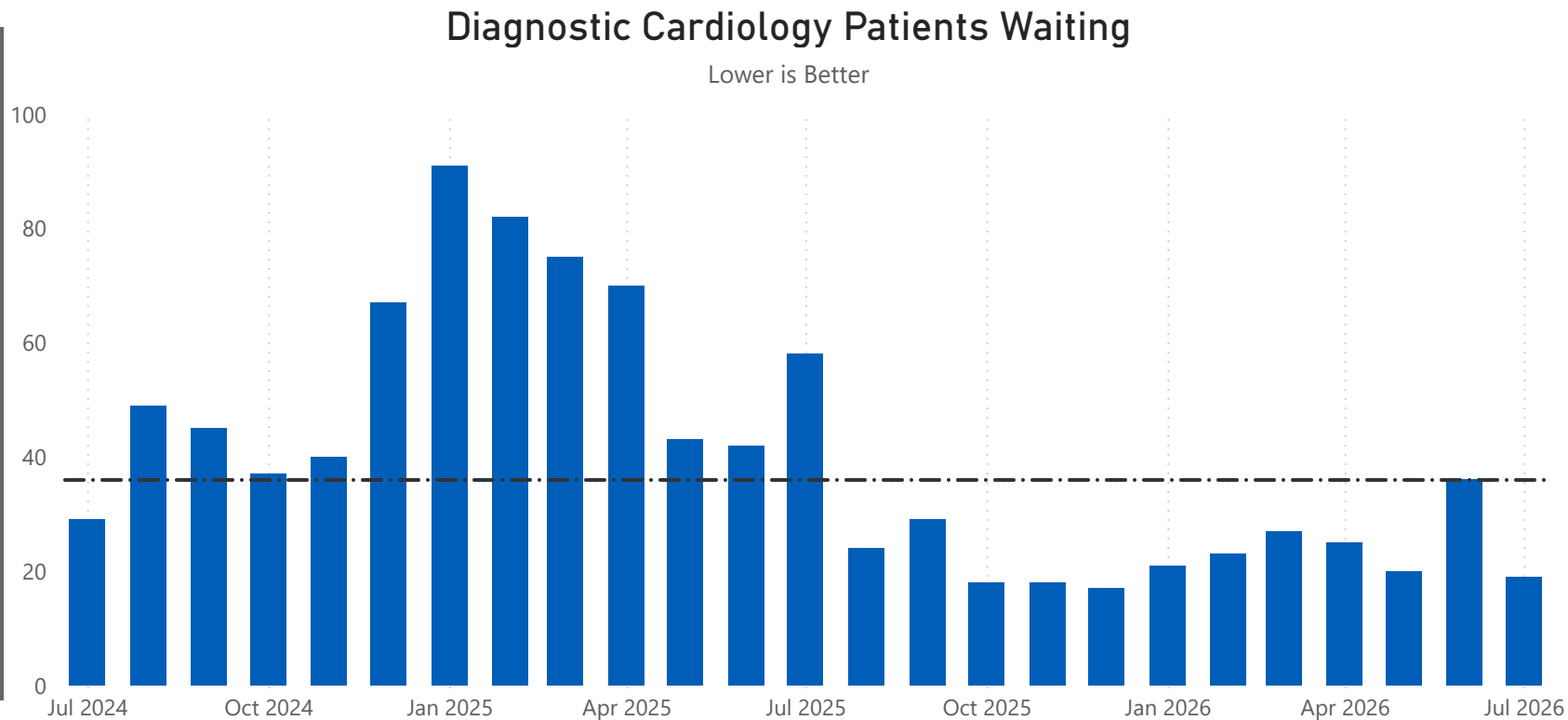
Operational Standards

Diagnostic Cardiology 6 Week Compliance

Compliance

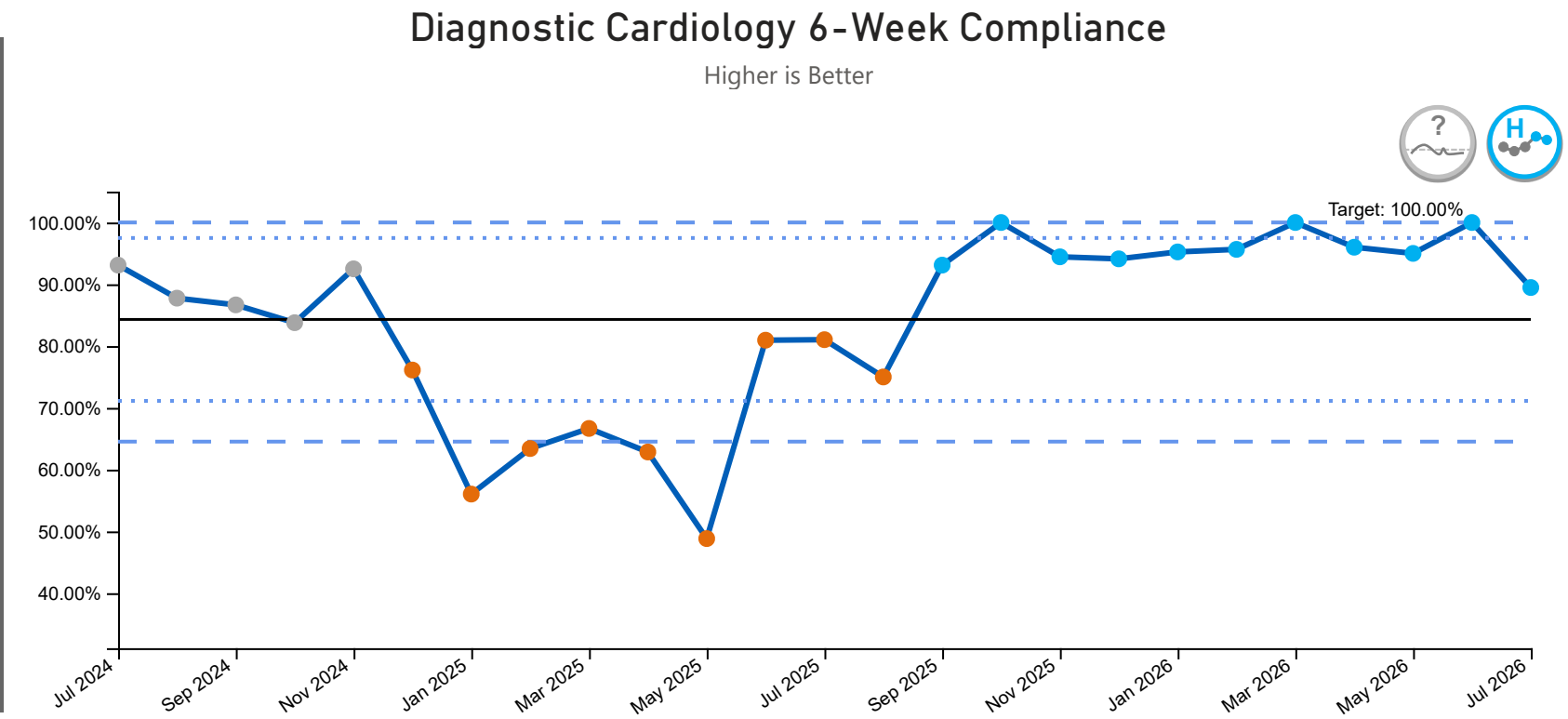
KPI	Target	Actual	RAG Value
100% of patients waiting for key cardiology diagnostic tests and investigations should wait no longer than six weeks (42 days).	100%	89.47%	Red

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
01/07/2024	93.10	84.31	100.00	64.53	104.09	71.13	97.50	None
01/08/2024	87.76	84.31	100.00	64.53	104.09	71.13	97.50	None
01/09/2024	86.67	84.31	100.00	64.53	104.09	71.13	97.50	None
01/10/2024	83.78	84.31	100.00	64.53	104.09	71.13	97.50	None
01/11/2024	92.50	84.31	100.00	64.53	104.09	71.13	97.50	None
01/12/2024	76.12	84.31	100.00	64.53	104.09	71.13	97.50	Deterioration
01/01/2025	56.04	84.31	100.00	64.53	104.09	71.13	97.50	Deterioration
01/02/2025	63.41	84.31	100.00	64.53	104.09	71.13	97.50	Deterioration
01/03/2025	66.67	84.31	100.00	64.53	104.09	71.13	97.50	Deterioration
01/04/2025	62.86	84.31	100.00	64.53	104.09	71.13	97.50	Deterioration
01/05/2025	48.84	84.31	100.00	64.53	104.09	71.13	97.50	Deterioration
01/06/2025	80.95	84.31	100.00	64.53	104.09	71.13	97.50	Deterioration
01/07/2025	81.03	84.31	100.00	64.53	104.09	71.13	97.50	Deterioration
01/08/2025	75.00	84.31	100.00	64.53	104.09	71.13	97.50	Deterioration
01/09/2025	93.10	84.31	100.00	64.53	104.09	71.13	97.50	Improvement
01/10/2025	100.00	84.31	100.00	64.53	104.09	71.13	97.50	Improvement
01/11/2025	94.44	84.31	100.00	64.53	104.09	71.13	97.50	Improvement
01/12/2025	94.12	84.31	100.00	64.53	104.09	71.13	97.50	Improvement
01/01/2026	95.24	84.31	100.00	64.53	104.09	71.13	97.50	Improvement
01/02/2026	95.65	84.31	100.00	64.53	104.09	71.13	97.50	Improvement
01/03/2026	100.00	84.31	100.00	64.53	104.09	71.13	97.50	Improvement
01/04/2026	96.00	84.31	100.00	64.53	104.09	71.13	97.50	Improvement
01/05/2026	95.00	84.31	100.00	64.53	104.09	71.13	97.50	Improvement
01/06/2026	100.00	84.31	100.00	64.53	104.09	71.13	97.50	Improvement
01/07/2026	89.47	84.31	100.00	64.53	104.09	71.13	97.50	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

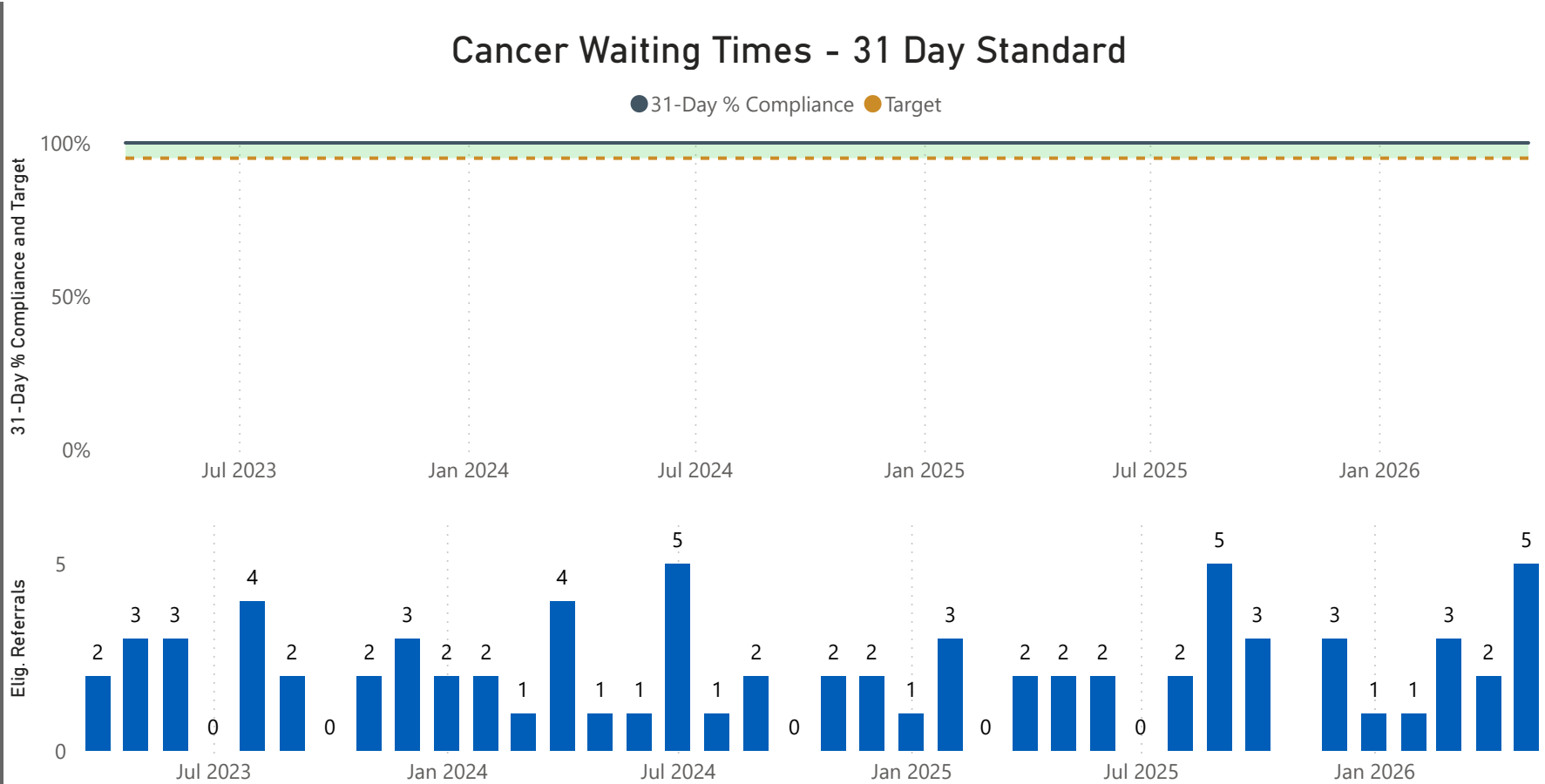
May 2026

Compliance

KPI	Target	Actual	RAG Value
95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat	95%	100.00%	Green

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



Comments From Executive Lead

It is anticipated the 100% of patients will have been treated within standard at the end of Julyl.

Dr Anna Lamont, Medical Director



Operational Standards

Cancer Waiting Times 62-Day Standard

Data Source

Discovery

Latest Data

May 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	95%	37.50%	Red

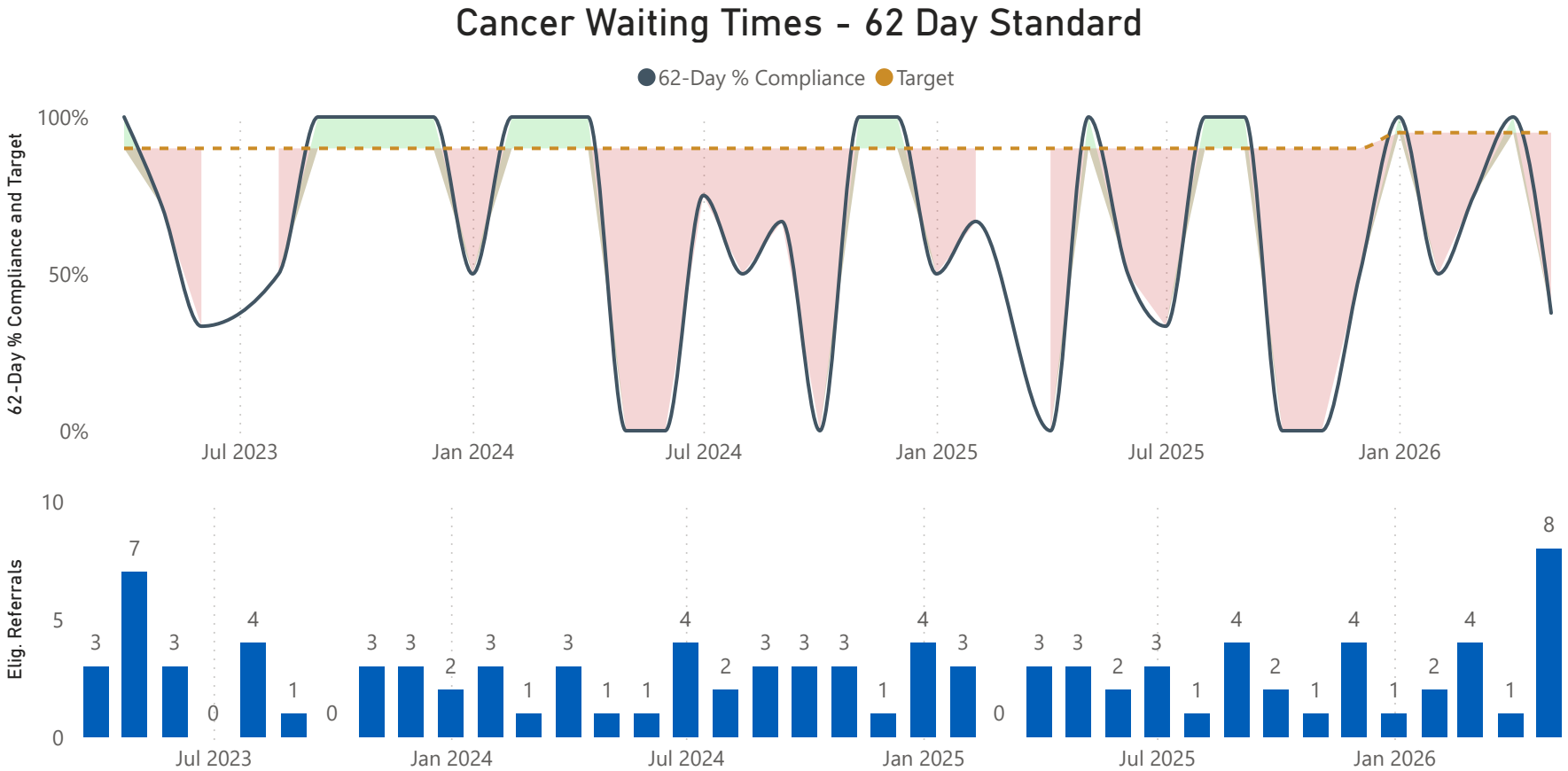
Action	Target Date	Owner	Status
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Complete a breach review for the patient treated on day 98 to identify contributing factors, lessons learned, and any required pathway improvements. Findings to be shared with relevant leads and incorporated into ongoing cancer performance monitoring arrangements.

31/08/2026

C Somerville

In Progress



Comments From Executive Lead

It is anticipated 3 patients were treated within July, of those treated 2 breached the 62-day standard. Both patients were treated in Grampian, and a review of the breach timeline has been carried out.

Dr Anna Lamont, Medical Director



Operational Standards

Inpatient Pre-Noon Discharges

Data Source

Latest Data

TrakCare

July 2026

Compliance

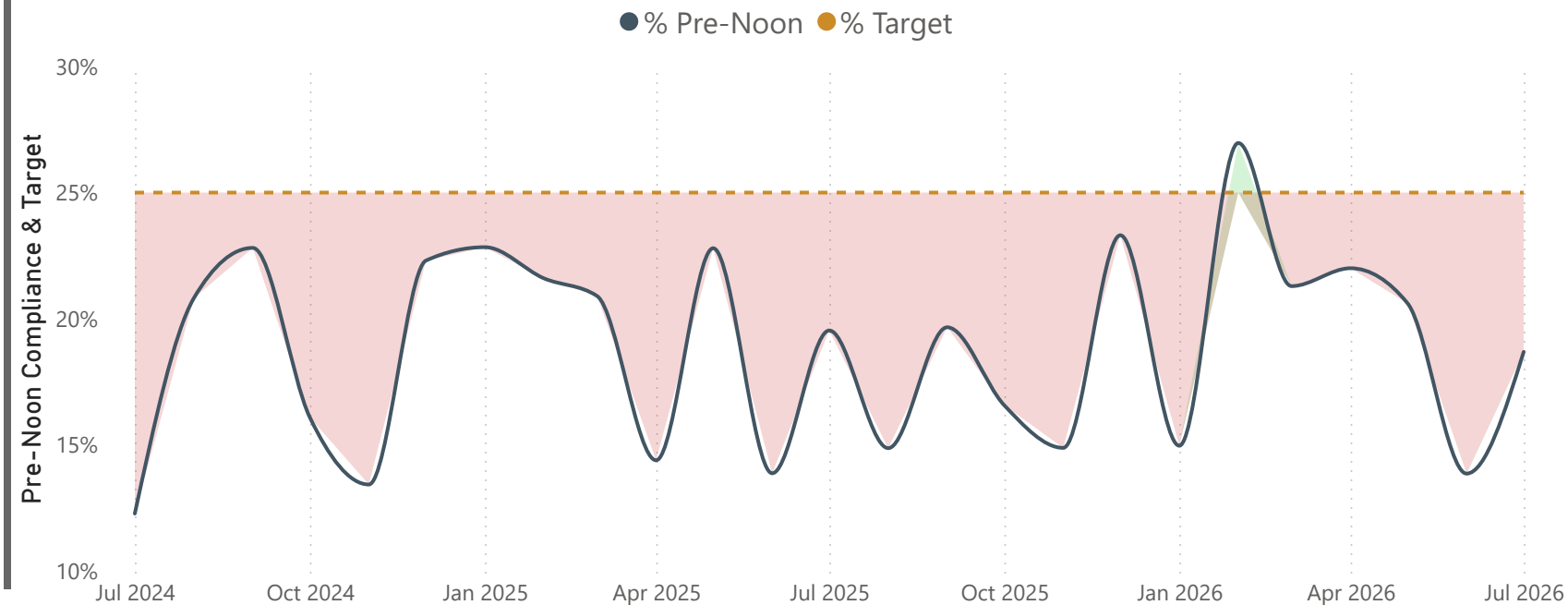
KPI	Target	Actual	RAG Value
Pre-noon discharges	25.0%	18.68%	Amber

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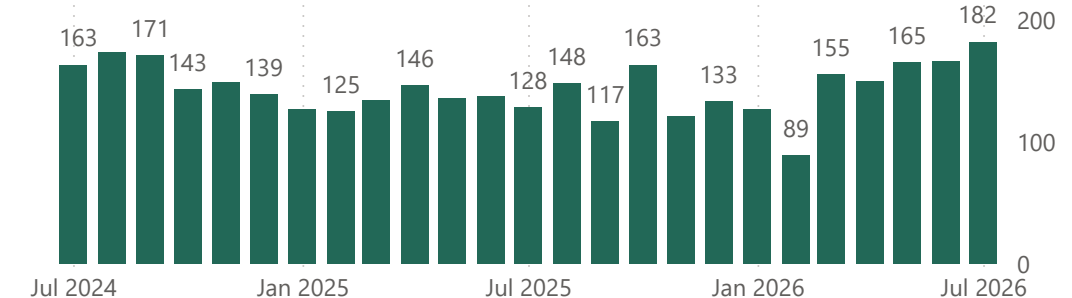
KPI off-target, actions to be updated.

Inpatient Discharges - Pre-Noon Compliance

Compliance for Inpatient 1 & Inpatient 2 Only



Number of Inpatient Discharges



Pre-Noon Discharges - Last 6 Months

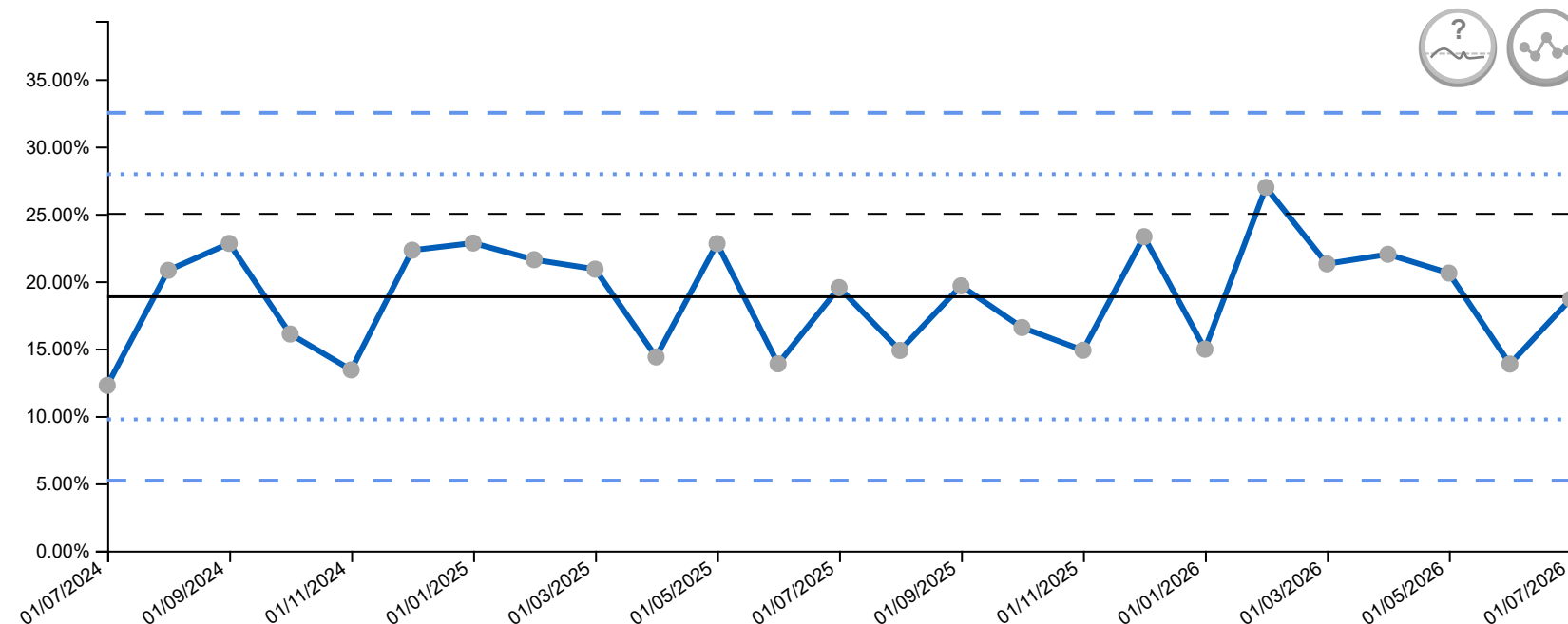
Month	Discharges	% Pre-Noon	RAG Value
February 2026	89	26.97%	Green
March 2026	155	21.29%	Amber
April 2026	150	22.00%	Amber
May 2026	165	20.61%	Amber
June 2026	166	13.86%	Red
July 2026	182	18.68%	Amber

Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	12.27	18.85	25.00	5.20	32.50	9.75	27.95	None
01/08/2024	20.81	18.85	25.00	5.20	32.50	9.75	27.95	None
01/09/2024	22.81	18.85	25.00	5.20	32.50	9.75	27.95	None
01/10/2024	16.08	18.85	25.00	5.20	32.50	9.75	27.95	None
01/11/2024	13.42	18.85	25.00	5.20	32.50	9.75	27.95	None
01/12/2024	22.30	18.85	25.00	5.20	32.50	9.75	27.95	None
01/01/2025	22.83	18.85	25.00	5.20	32.50	9.75	27.95	None
01/02/2025	21.60	18.85	25.00	5.20	32.50	9.75	27.95	None
01/03/2025	20.90	18.85	25.00	5.20	32.50	9.75	27.95	None
01/04/2025	14.38	18.85	25.00	5.20	32.50	9.75	27.95	None
01/05/2025	22.79	18.85	25.00	5.20	32.50	9.75	27.95	None
01/06/2025	13.87	18.85	25.00	5.20	32.50	9.75	27.95	None
01/07/2025	19.53	18.85	25.00	5.20	32.50	9.75	27.95	None
01/08/2025	14.86	18.85	25.00	5.20	32.50	9.75	27.95	None
01/09/2025	19.66	18.85	25.00	5.20	32.50	9.75	27.95	None
01/10/2025	16.56	18.85	25.00	5.20	32.50	9.75	27.95	None
01/11/2025	14.88	18.85	25.00	5.20	32.50	9.75	27.95	None
01/12/2025	23.31	18.85	25.00	5.20	32.50	9.75	27.95	None
01/01/2026	14.96	18.85	25.00	5.20	32.50	9.75	27.95	None
01/02/2026	26.97	18.85	25.00	5.20	32.50	9.75	27.95	None
01/03/2026	21.29	18.85	25.00	5.20	32.50	9.75	27.95	None
01/04/2026	22.00	18.85	25.00	5.20	32.50	9.75	27.95	None
01/05/2026	20.61	18.85	25.00	5.20	32.50	9.75	27.95	None
01/06/2026	13.86	18.85	25.00	5.20	32.50	9.75	27.95	None
01/07/2026	18.68	18.85	25.00	5.20	32.50	9.75	27.95	None

Inpatient Discharges - Pre-Noon Compliance

Compliance for Inpatient 1 & Inpatient 2 Only



Comments From Executive Lead

Discharge without delay planning remains a key focus over the next quarter with PDD setting and compliance with red, amber, green pathway documentation.

System wide review of discharge planning is closely linked to the older persons and frailty workstream with clinical teams working together to ensure best practice guidance embedded.

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



Operational Standards

Delayed Transfers of Care Discharge Compliance

Data Source

Latest Data

Delayed Discharges Monthly Return

July 2026

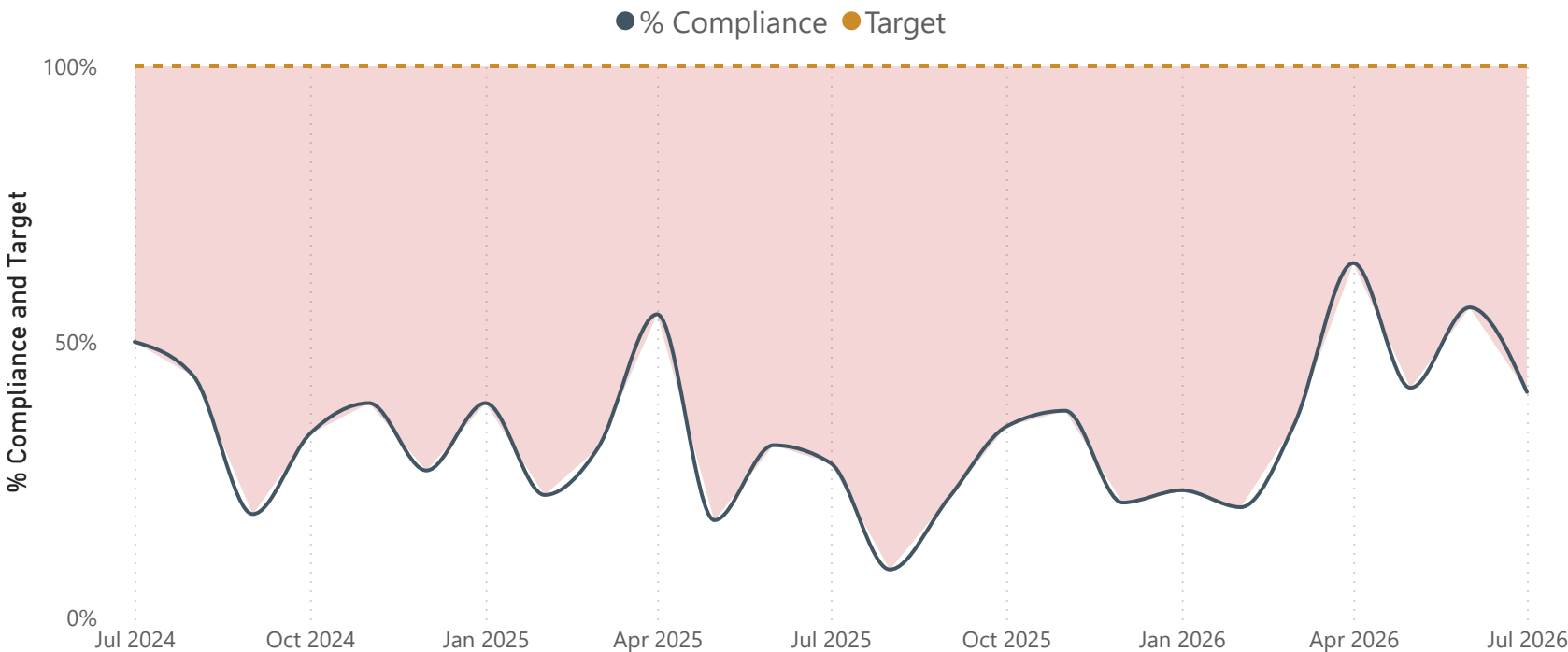
Compliance

KPI	Target	Actual	RAG Value
Number of people experiencing a delay discharged within 2 weeks (excluding complex code 9 delays)	100%	40.91%	Red

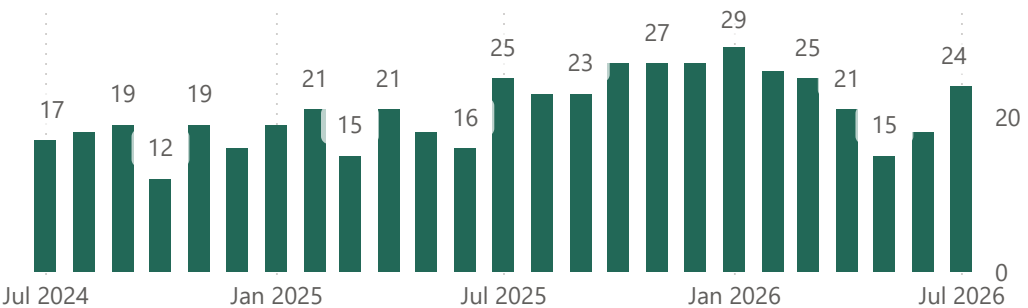
Action	Target Date	Owner	Status
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All current actions completed/closed.

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



Number of Delayed Transfers of Care



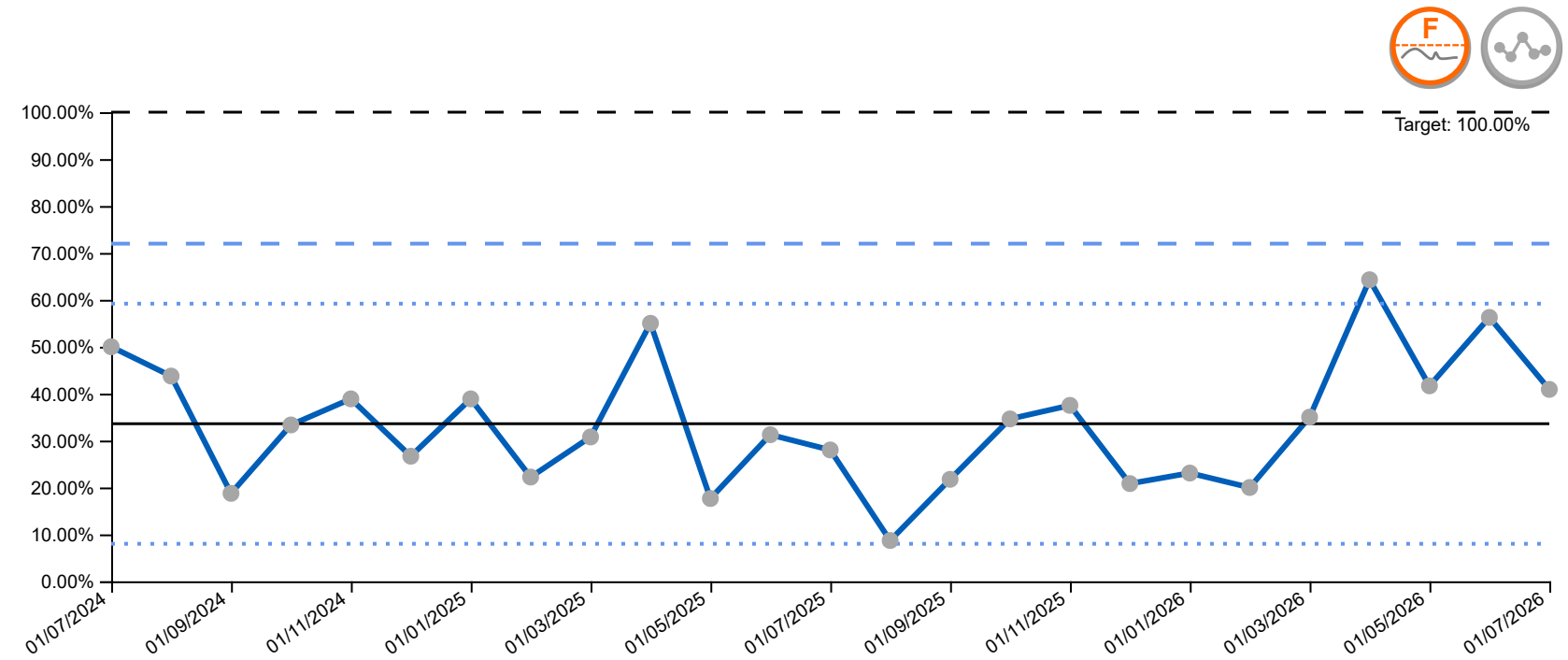
DToC 2 Week Discharge Compliance - Last 6 Months

Month	Total Delays	Delayed >2Wks.	% Compliance	RAG Value
February 2026	26	20	20.00%	Red
March 2026	25	13	35.00%	Red
April 2026	21	5	64.29%	Red
May 2026	15	7	41.67%	Red
June 2026	18	7	56.25%	Red
July 2026	24	13	40.91%	Red

Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	50.00	33.59	100.00	0.00	71.98	8.00	59.18	None
01/08/2024	43.75	33.59	100.00	0.00	71.98	8.00	59.18	None
01/09/2024	18.75	33.59	100.00	0.00	71.98	8.00	59.18	None
01/10/2024	33.33	33.59	100.00	0.00	71.98	8.00	59.18	None
01/11/2024	38.89	33.59	100.00	0.00	71.98	8.00	59.18	None
01/12/2024	26.67	33.59	100.00	0.00	71.98	8.00	59.18	None
01/01/2025	38.89	33.59	100.00	0.00	71.98	8.00	59.18	None
01/02/2025	22.22	33.59	100.00	0.00	71.98	8.00	59.18	None
01/03/2025	30.77	33.59	100.00	0.00	71.98	8.00	59.18	None
01/04/2025	55.00	33.59	100.00	0.00	71.98	8.00	59.18	None
01/05/2025	17.65	33.59	100.00	0.00	71.98	8.00	59.18	None
01/06/2025	31.25	33.59	100.00	0.00	71.98	8.00	59.18	None
01/07/2025	28.00	33.59	100.00	0.00	71.98	8.00	59.18	None
01/08/2025	8.70	33.59	100.00	0.00	71.98	8.00	59.18	None
01/09/2025	21.74	33.59	100.00	0.00	71.98	8.00	59.18	None
01/10/2025	34.62	33.59	100.00	0.00	71.98	8.00	59.18	None
01/11/2025	37.50	33.59	100.00	0.00	71.98	8.00	59.18	None
01/12/2025	20.83	33.59	100.00	0.00	71.98	8.00	59.18	None
01/01/2026	23.08	33.59	100.00	0.00	71.98	8.00	59.18	None
01/02/2026	20.00	33.59	100.00	0.00	71.98	8.00	59.18	None
01/03/2026	35.00	33.59	100.00	0.00	71.98	8.00	59.18	None
01/04/2026	64.29	33.59	100.00	0.00	71.98	8.00	59.18	None
01/05/2026	41.67	33.59	100.00	0.00	71.98	8.00	59.18	None
01/06/2026	56.25	33.59	100.00	0.00	71.98	8.00	59.18	None
01/07/2026	40.91	33.59	100.00	0.00	71.98	8.00	59.18	None

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



Comments From Executive Lead

As of 11th June there were 5 delayed transfers of care. Whilst not necessarily complex there are 3 patients without capacity and no legal ability at present to facilitate a move. The work required is underway in respect of these individuals.

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



Operational Standards

Delayed Transfers of Care at Census Date

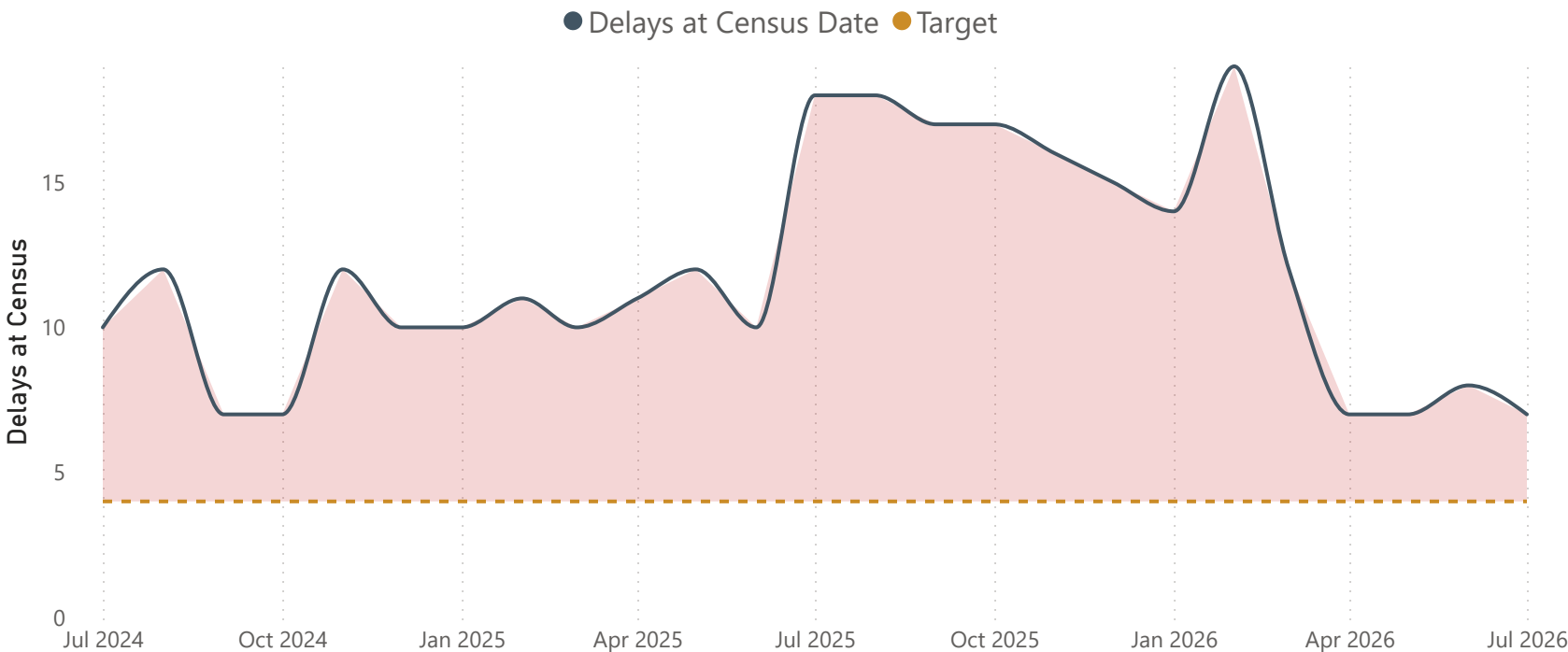
Compliance

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	7	Red

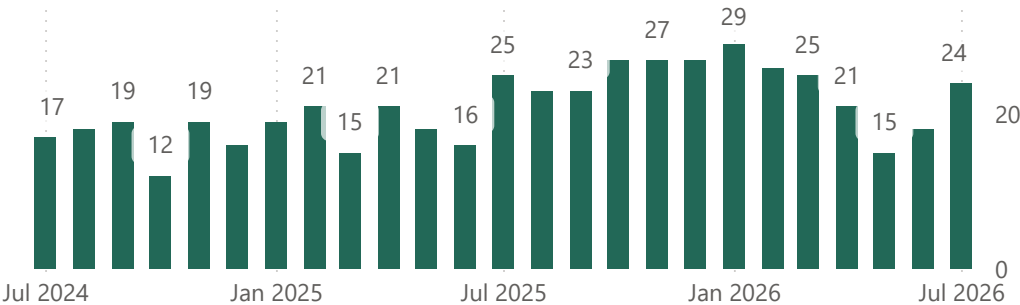
Action	Target Date	Owner	Status
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All current actions completed/closed.

Delayed Transfers of Care - Delays at Census Date



Number of Delayed Transfers of Care



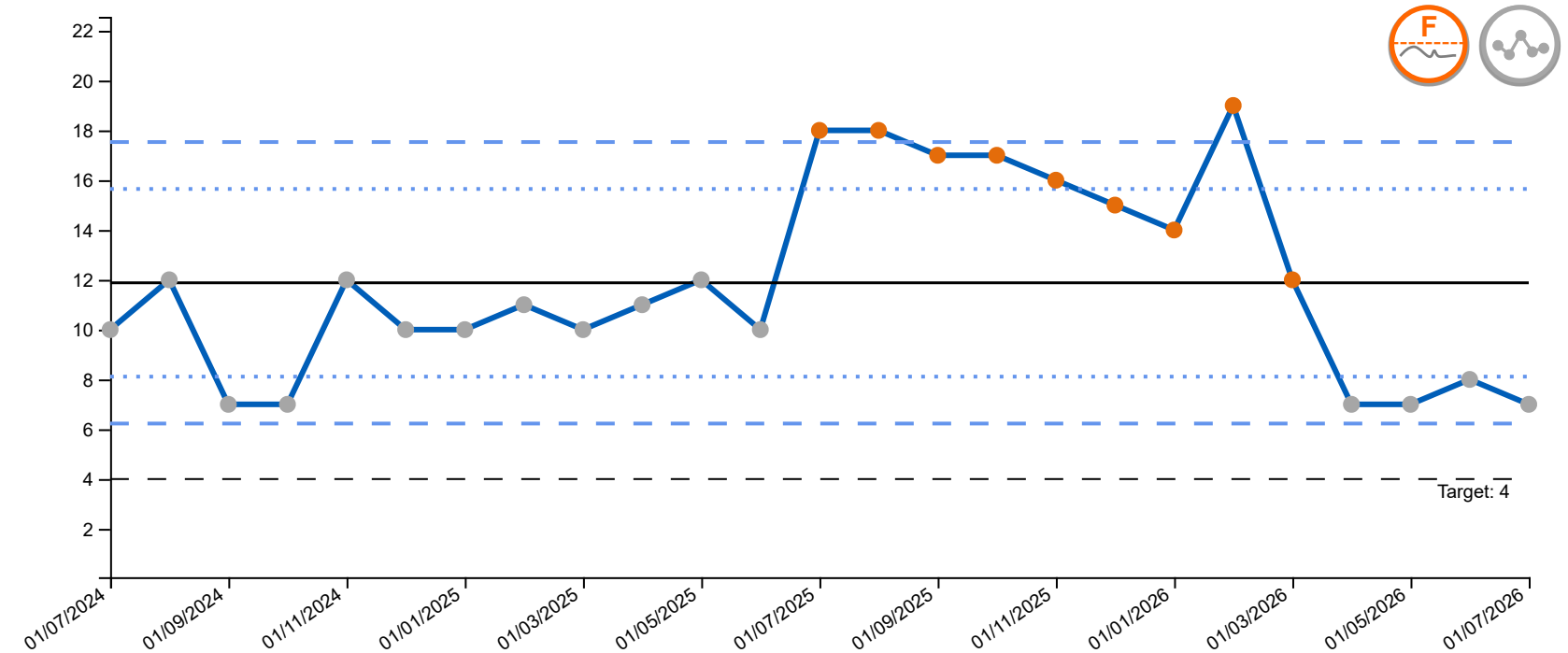
DToC 2 Week Discharge Compliance - Last 6 Months

Month	Total Delays	Census Delays	Target	RAG Value
February 2026	26	19	4	Red
March 2026	25	12	4	Red
April 2026	21	7	4	Red
May 2026	15	7	4	Red
June 2026	18	8	4	Red
July 2026	24	7	4	Red

Statistical Process Control

Date	Value	Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	10	12	6	18	8	16	None
01/08/2024	12	12	6	18	8	16	None
01/09/2024	7	12	6	18	8	16	None
01/10/2024	7	12	6	18	8	16	None
01/11/2024	12	12	6	18	8	16	None
01/12/2024	10	12	6	18	8	16	None
01/01/2025	10	12	6	18	8	16	None
01/02/2025	11	12	6	18	8	16	None
01/03/2025	10	12	6	18	8	16	None
01/04/2025	11	12	6	18	8	16	None
01/05/2025	12	12	6	18	8	16	None
01/06/2025	10	12	6	18	8	16	None
01/07/2025	18	12	6	18	8	16	Deterioration
01/08/2025	18	12	6	18	8	16	Deterioration
01/09/2025	17	12	6	18	8	16	Deterioration
01/10/2025	17	12	6	18	8	16	Deterioration
01/11/2025	16	12	6	18	8	16	Deterioration
01/12/2025	15	12	6	18	8	16	Deterioration
01/01/2026	14	12	6	18	8	16	Deterioration
01/02/2026	19	12	6	18	8	16	Deterioration
01/03/2026	12	12	6	18	8	16	Deterioration
01/04/2026	7	12	6	18	8	16	None
01/05/2026	7	12	6	18	8	16	None
01/06/2026	8	12	6	18	8	16	None
01/07/2026	7	12	6	18	8	16	None

Delayed Transfers of Care - Delays at Census Date



Comments From Executive Lead

As of 11th June there were 5 delayed transfers of care. Whilst not necessarily complex there are 3 patients without capacity and no legal ability at present to facilitate a move. The work required is underway in respect of these individuals.

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



Operational Standards

Delayed Transfers of Care Bed Days Occupied

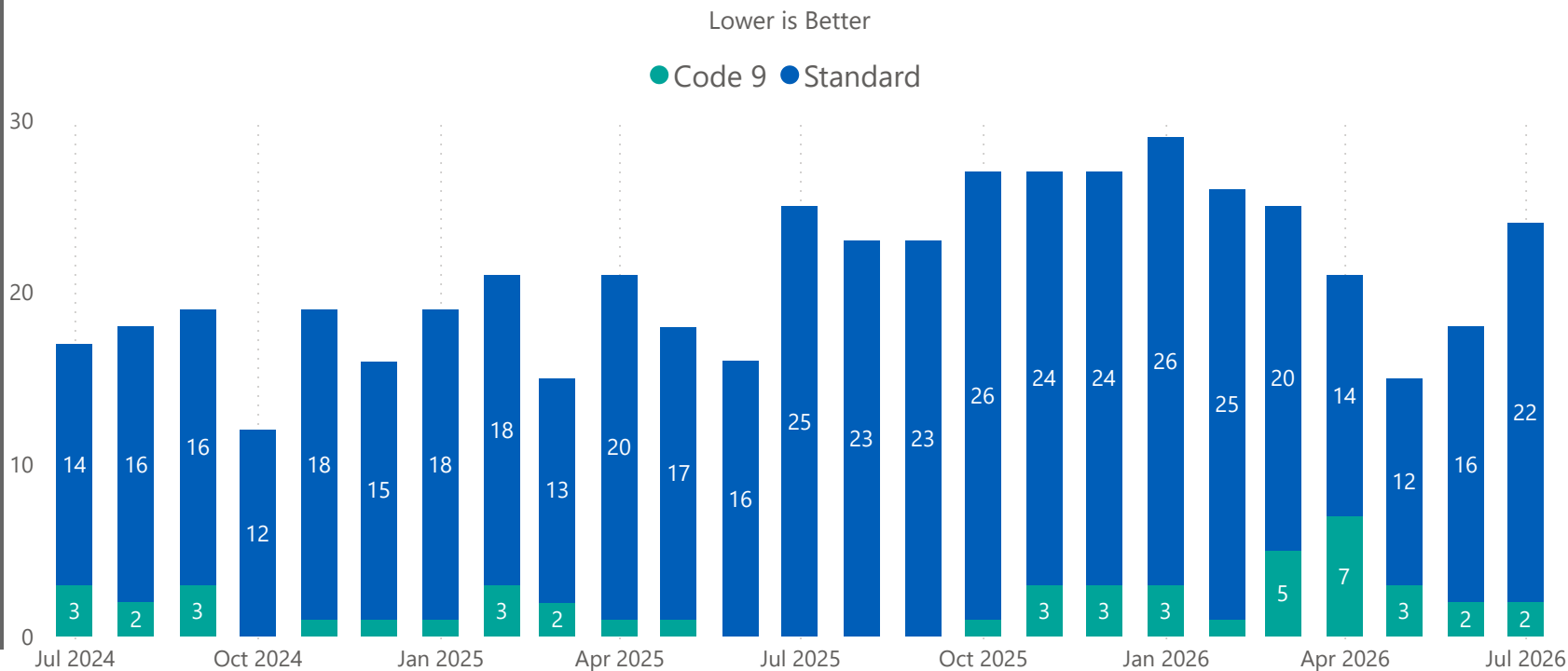
Compliance

KPI	Target	Actual	RAG Value
Number of hospital bed days associated with delayed discharges (any length or reason) in the calendar month.	56	299	Red

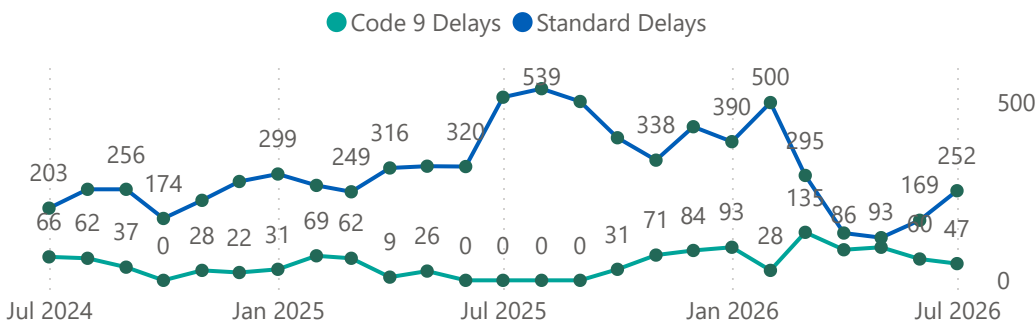
Action	Target Date	Owner	Status
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All current actions completed/closed.

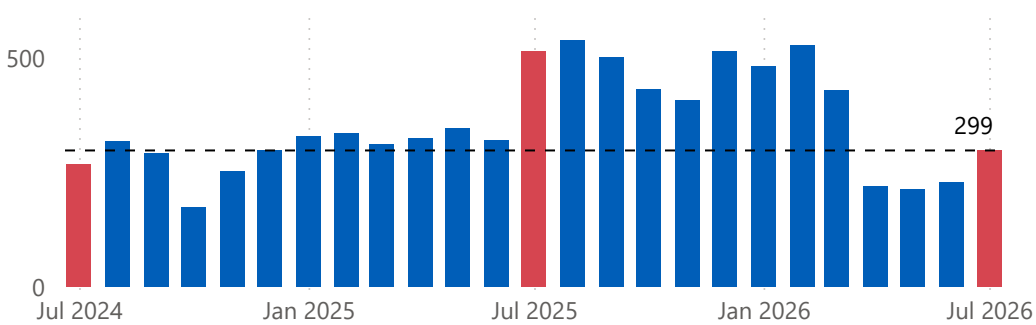
Delayed Transfers of Care - Delays by Type & Month



DToC Bed Days By Delay Type



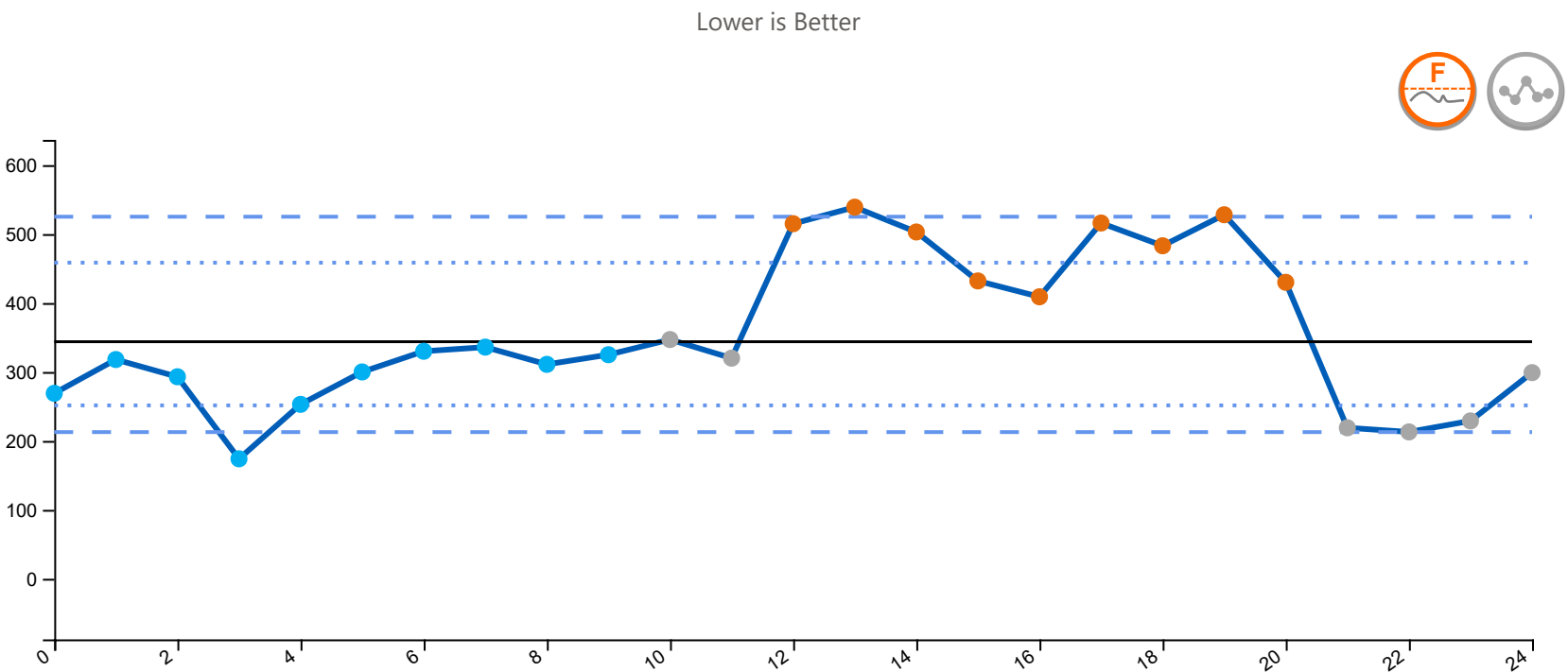
DToC Occupied Bed Days vs. Previous Year



Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
0	269	344	56	227	499	262	443	Improvement
1	318	344	56	227	499	262	443	Improvement
2	293	344	56	227	499	262	443	Improvement
3	174	344	56	227	499	262	443	Improvement
4	253	344	56	227	499	262	443	Improvement
5	300	344	56	227	499	262	443	Improvement
6	330	344	56	227	499	262	443	Improvement
7	336	344	56	227	499	262	443	Improvement
8	311	344	56	227	499	262	443	Improvement
9	325	344	56	227	499	262	443	Improvement
10	347	344	56	227	499	262	443	None
11	320	344	56	227	499	262	443	None
12	515	344	56	227	499	262	443	Deterioration
13	539	344	56	227	499	262	443	Deterioration
14	503	344	56	227	499	262	443	Deterioration
15	432	344	56	227	499	262	443	Deterioration
16	409	344	56	227	499	262	443	Deterioration
17	516	344	56	227	499	262	443	Deterioration
18	483	344	56	227	499	262	443	Deterioration
19	528	344	56	227	499	262	443	Deterioration
20	430	344	56	227	499	262	443	Deterioration
21	219	344	56	227	499	262	443	None
22	213	344	56	227	499	262	443	None
23	229	344	56	227	499	262	443	None
24	299	344	56	227	499	262	443	None

Delayed Transfers of Care - Occupied Bed Days



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

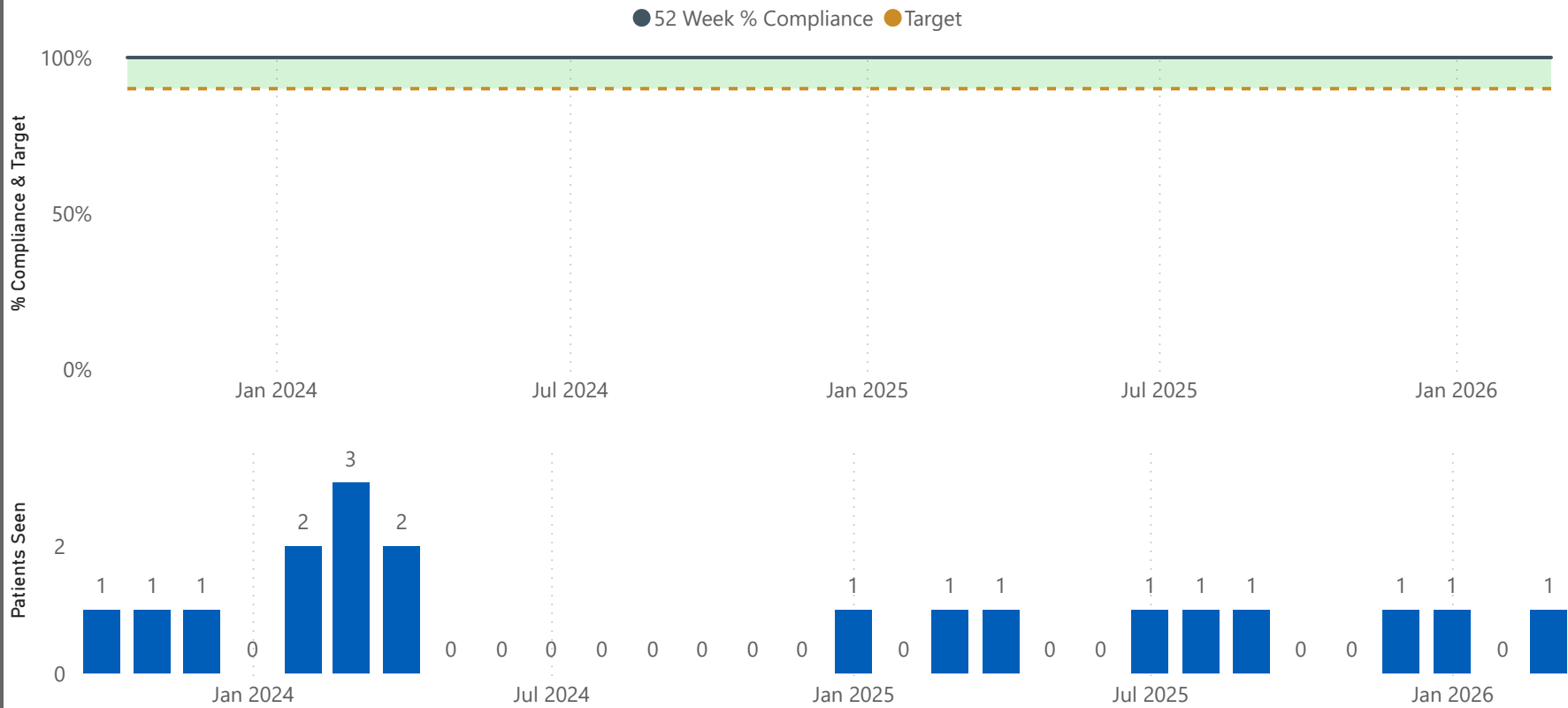
Compliance

KPI	Target	Actual	RAG Value
90% of eligible patients to commence IVF treatment within 12 months of referral	90%	100.00%	Green

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

KPI on target, no actions required at this time.

In Vitro Fertilisation (IVF) 52 Week Screening Compliance



Comments From Executive Lead

100% Although reached budget ceiling for IVF 2025/26, there were no new referrals received and therefore no delays in access to treatment.

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

July 2026

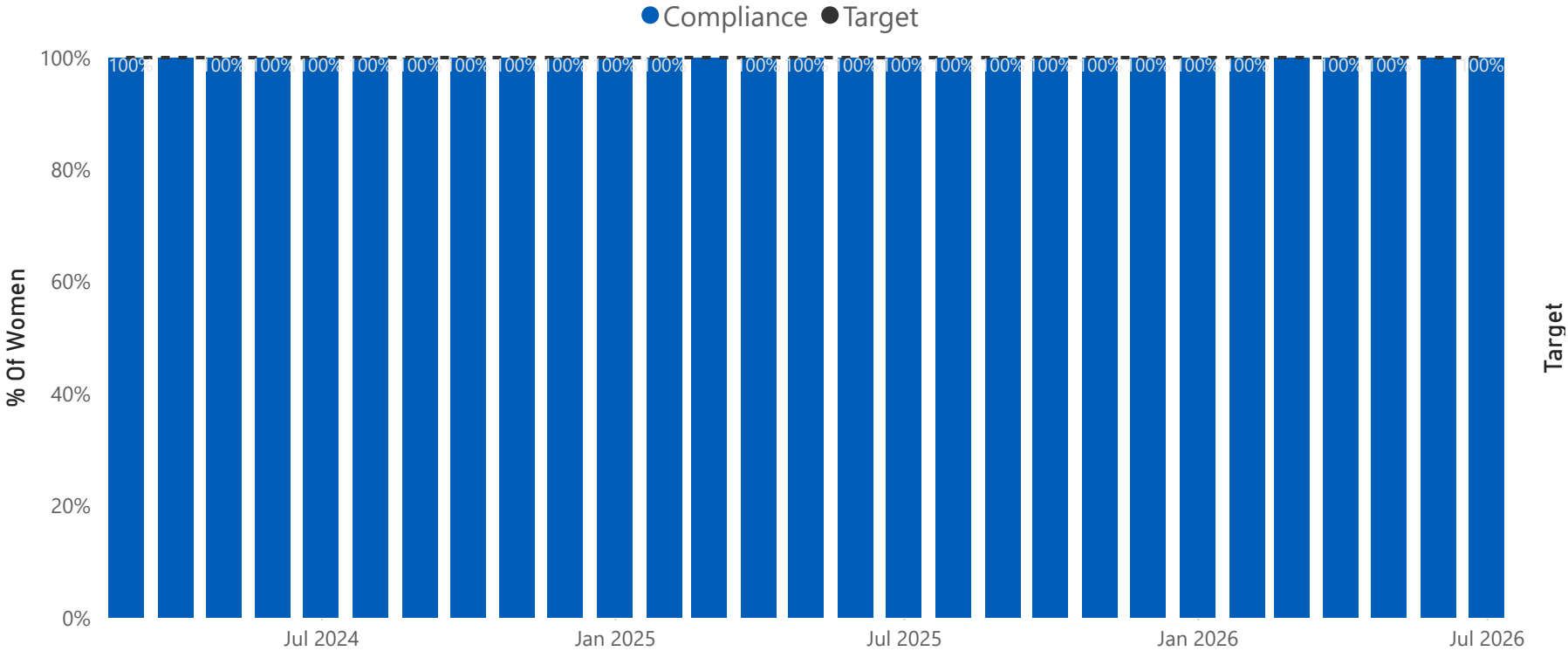
Compliance

KPI	Target	Actual	RAG Value
100% of women booking in a Board allocated to a primary midwife	100%	100.00%	Green

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

KPI on target, no actions required at this time.

Antenatal Care Appointment Delivery - Primary/Buddy Midwife %



Comments From Executive Lead

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



Community

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

What's Going Well?

A limited All Age Psychiatric Liaison service has been introduced, by the sole practitioner, for the Hospital and very recently a limited introduction liaison service for GPs has commenced.

Interviews are scheduled for 14 August for an Older Adult Psychiatrist.

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

There have been challenges recruiting to the remainder of the All Age Nurse Led Psychiatric Liaison Service, following discussions a different approach is now being explored.

Recruitment challenges and capacity issues continue in a number of community professions such as the allied health professions and social care positions.

Community Child & Adolescent Mental Health 18 Week Compliance

Data Source

Latest Data

CAMHS Monthly Return

May 2026

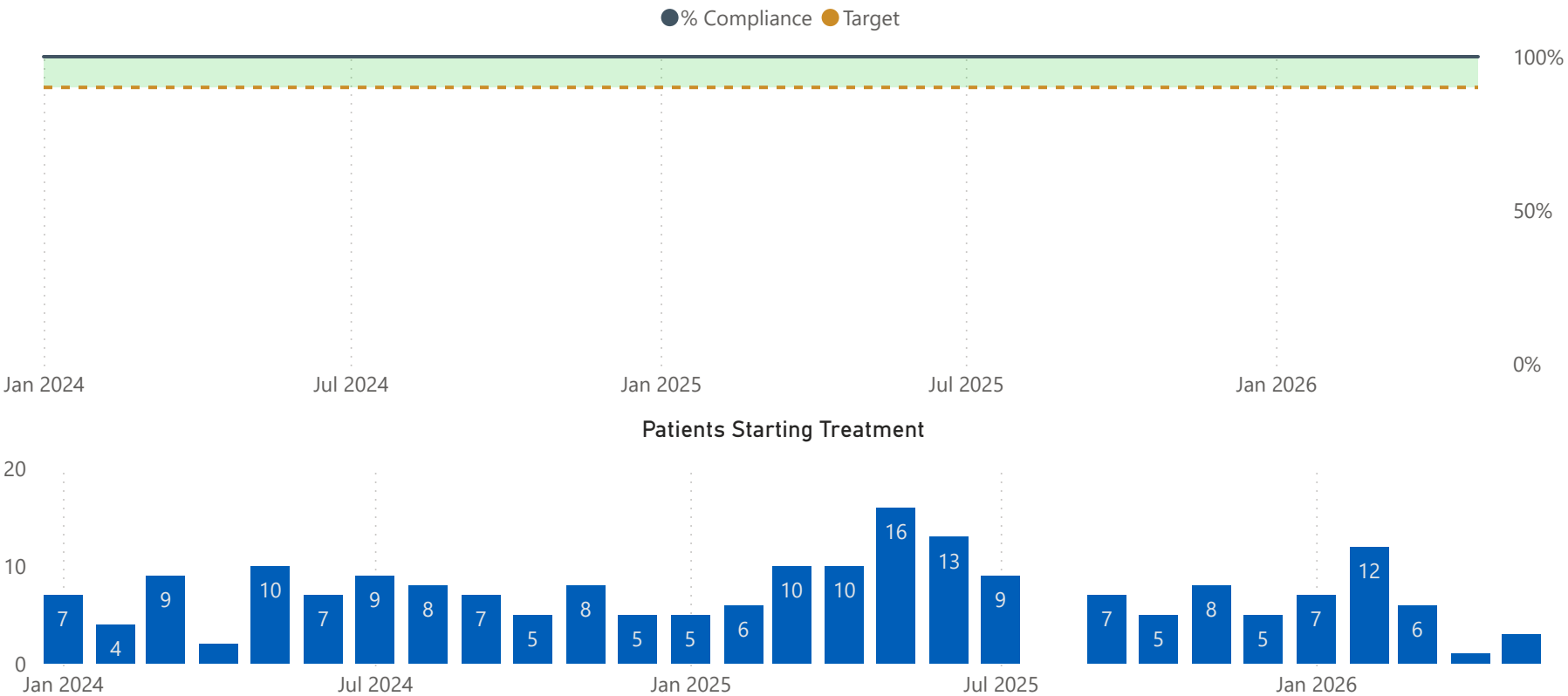
Compliance

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%	100.00%	Green

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

KPI on target, no actions required at this time.

Child & Adolescent Mental Health - 18 Week Compliance



Comments From Executive Lead

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

Stephen Brown, Chief Officer of the
Integration Joint Board



Community Psychological Therapies 18 Week Compliance

Data Source

PT Monthly Return

Latest Data

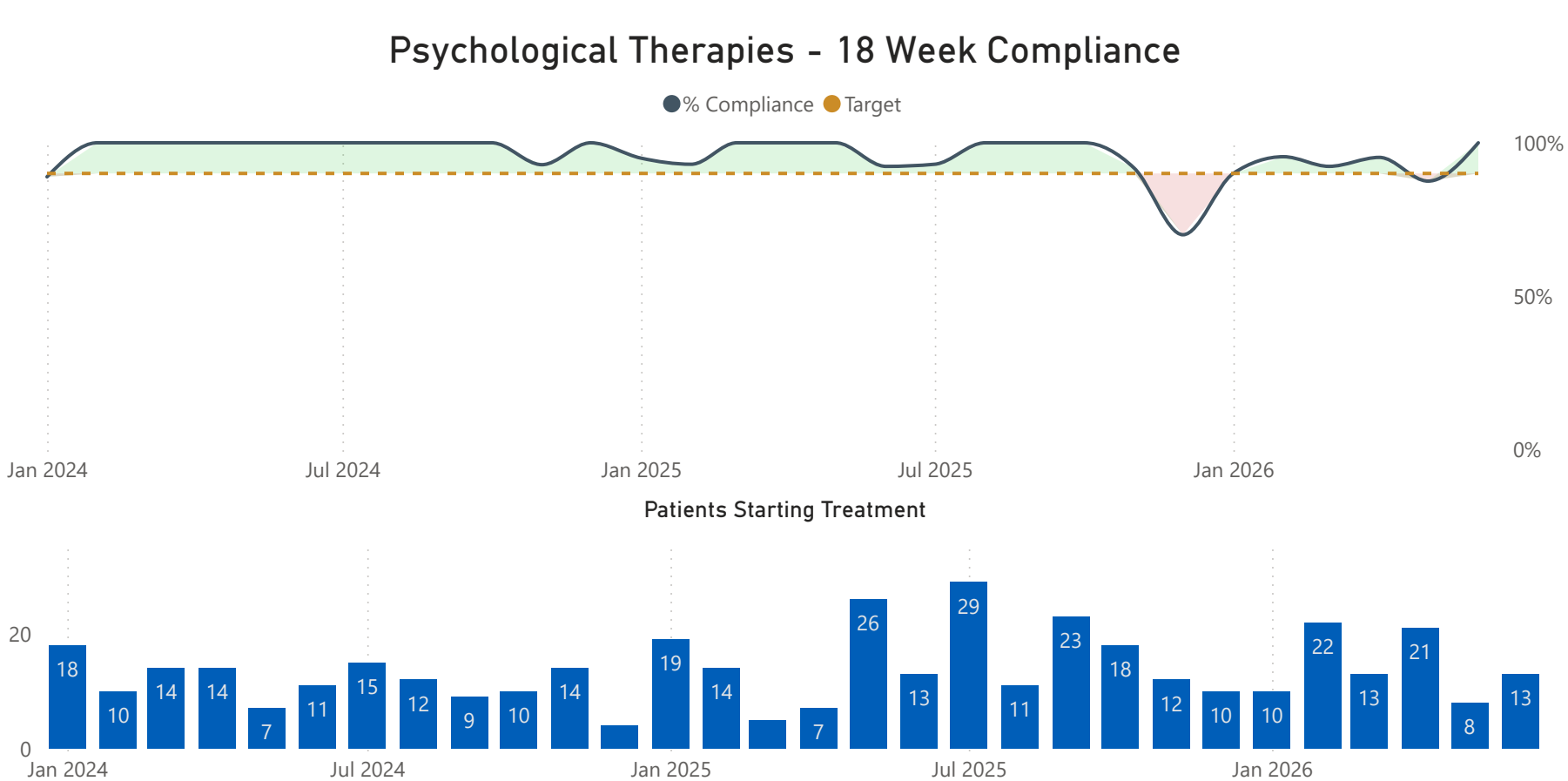
June 2026

Compliance

KPI	Target	Actual	RAG Value
18 Week Referral to Treatment	90%	100.00%	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

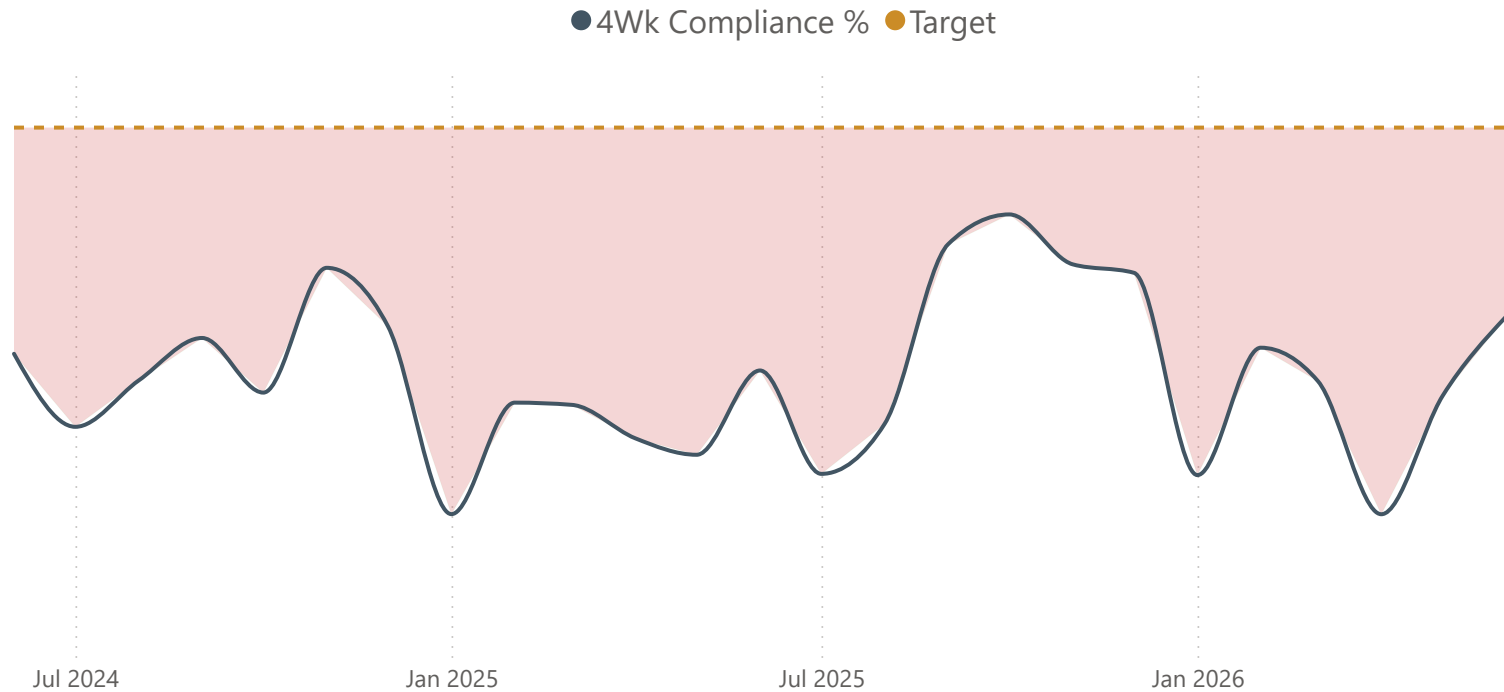
Latest Data

June 2026

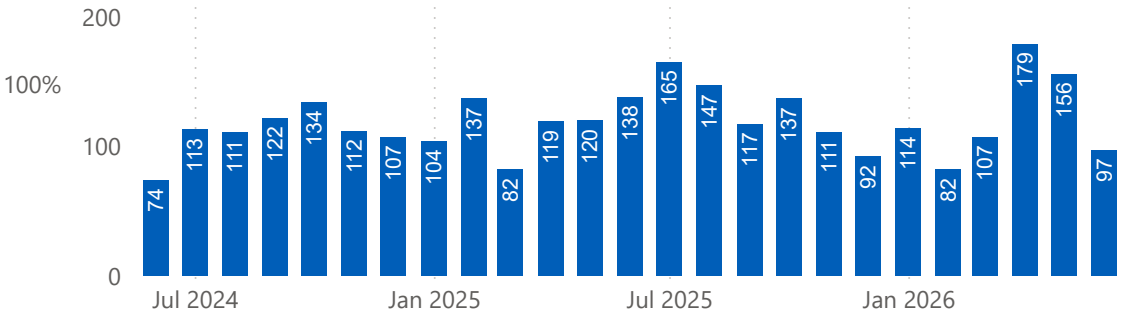
Compliance

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%	24.02%	Red
Action	Target Date	Owner	Status
Specific actions applied to individual service areas in the preceding pages.			

AHP MSK All Specialties - 4 Week Compliance



AHP MSK All Specialties - Patients Seen



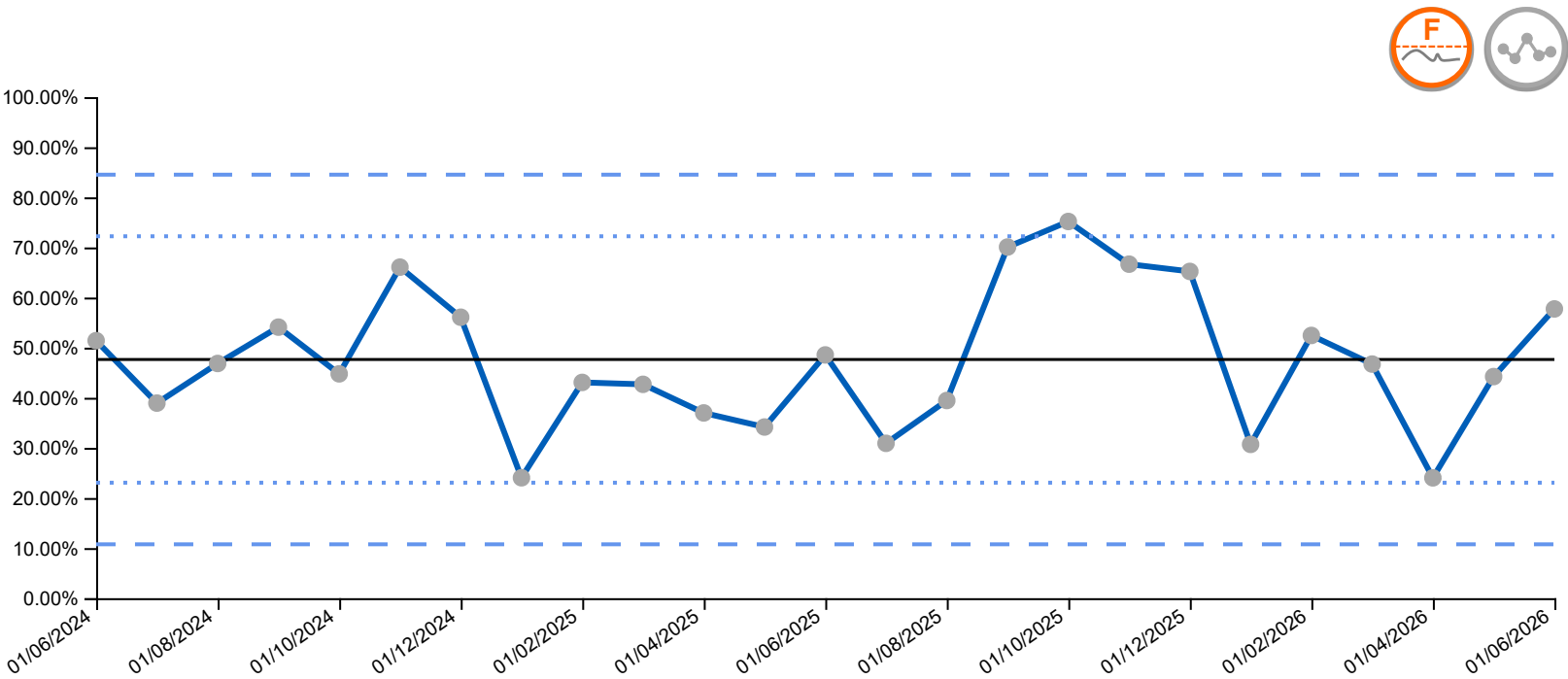
AHP MSK All Specialties - Last 6 Months

Month	Patients Seen	0 - 4 weeks (%)	Target	RAG Value
January 2026	114	30.70%	90.00%	Red
February 2026	82	52.44%	90.00%	Red
March 2026	107	46.73%	90.00%	Red
April 2026	179	24.02%	90.00%	Red
May 2026	156	44.23%	90.00%	Red
June 2026	97	57.73%	90.00%	Red

Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/06/2024	51.40	47.64	90.00	10.76	84.53	23.05	72.23	None
01/07/2024	38.94	47.64	90.00	10.76	84.53	23.05	72.23	None
01/08/2024	46.85	47.64	90.00	10.76	84.53	23.05	72.23	None
01/09/2024	54.10	47.64	90.00	10.76	84.53	23.05	72.23	None
01/10/2024	44.78	47.64	90.00	10.76	84.53	23.05	72.23	None
01/11/2024	66.07	47.64	90.00	10.76	84.53	23.05	72.23	None
01/12/2024	56.07	47.64	90.00	10.76	84.53	23.05	72.23	None
01/01/2025	24.04	47.64	90.00	10.76	84.53	23.05	72.23	None
01/02/2025	43.07	47.64	90.00	10.76	84.53	23.05	72.23	None
01/03/2025	42.68	47.64	90.00	10.76	84.53	23.05	72.23	None
01/04/2025	36.97	47.64	90.00	10.76	84.53	23.05	72.23	None
01/05/2025	34.17	47.64	90.00	10.76	84.53	23.05	72.23	None
01/06/2025	48.55	47.64	90.00	10.76	84.53	23.05	72.23	None
01/07/2025	30.91	47.64	90.00	10.76	84.53	23.05	72.23	None
01/08/2025	39.46	47.64	90.00	10.76	84.53	23.05	72.23	None
01/09/2025	70.09	47.64	90.00	10.76	84.53	23.05	72.23	None
01/10/2025	75.18	47.64	90.00	10.76	84.53	23.05	72.23	None
01/11/2025	66.67	47.64	90.00	10.76	84.53	23.05	72.23	None
01/12/2025	65.22	47.64	90.00	10.76	84.53	23.05	72.23	None
01/01/2026	30.70	47.64	90.00	10.76	84.53	23.05	72.23	None
01/02/2026	52.44	47.64	90.00	10.76	84.53	23.05	72.23	None
01/03/2026	46.73	47.64	90.00	10.76	84.53	23.05	72.23	None
01/04/2026	24.02	47.64	90.00	10.76	84.53	23.05	72.23	None
01/05/2026	44.23	47.64	90.00	10.76	84.53	23.05	72.23	None
01/06/2026	57.73	47.64	90.00	10.76	84.53	23.05	72.23	None

AHP MSK All Specialties - 4 Week Compliance



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.

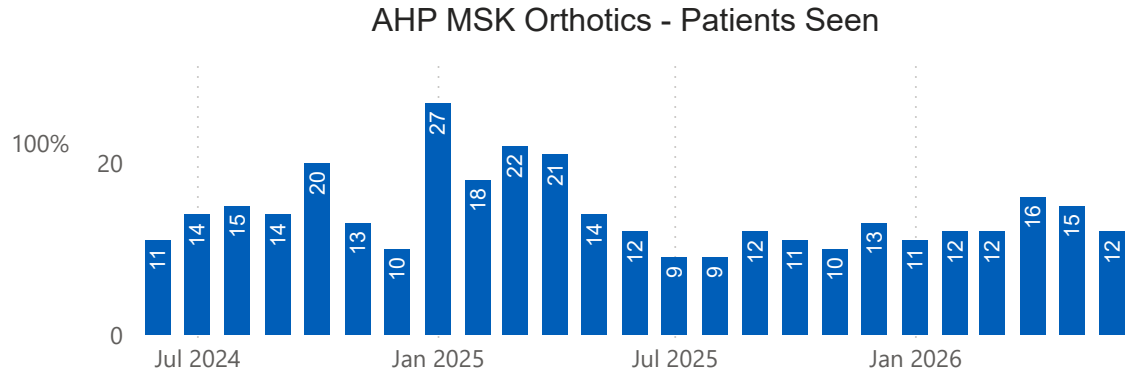
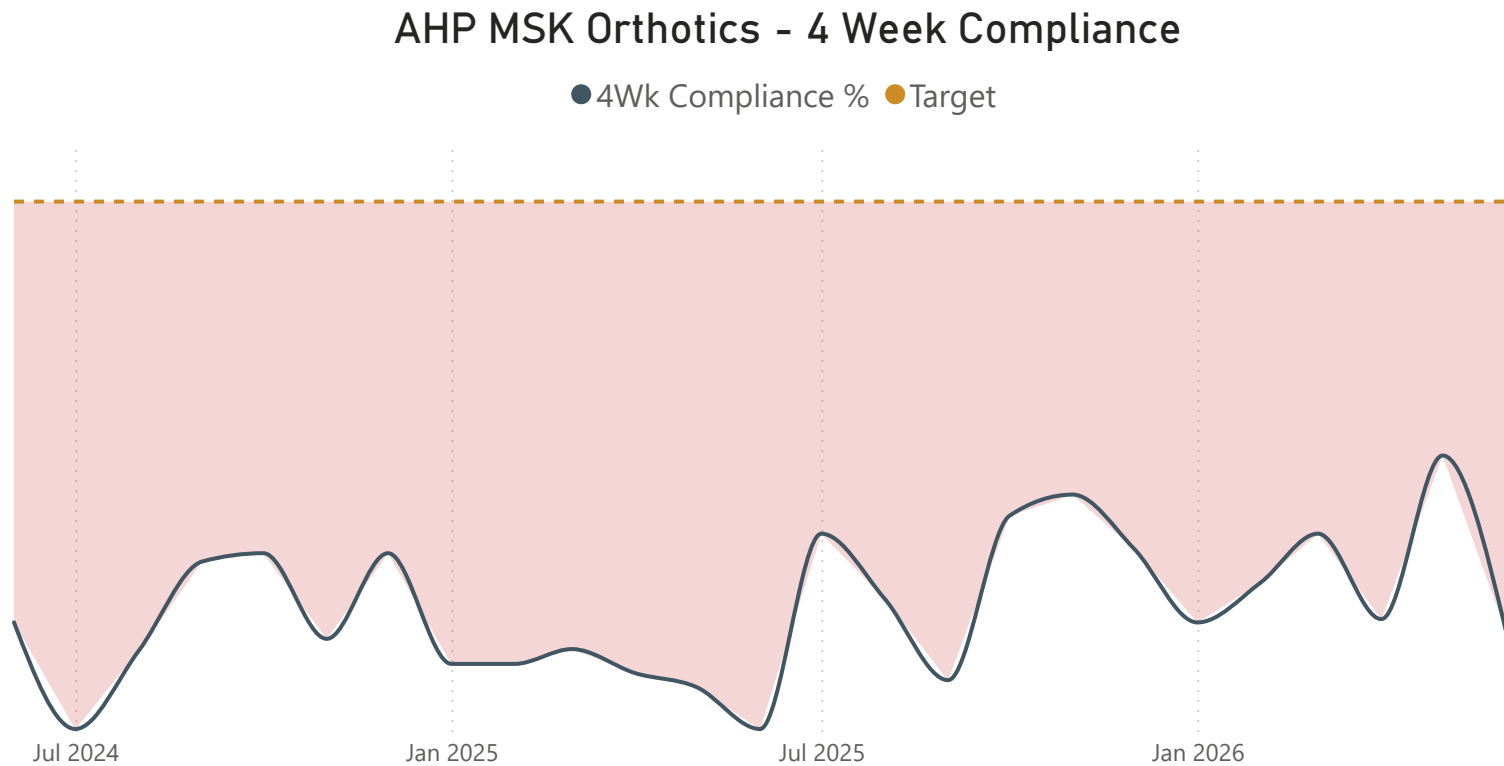
Stephen Brown, Chief Officer of the
Integration Joint Board



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

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%	18.75%	Red
Action	Target Date	Owner	Status
Monitor referral numbers and performance	31/12/2026		In Progress

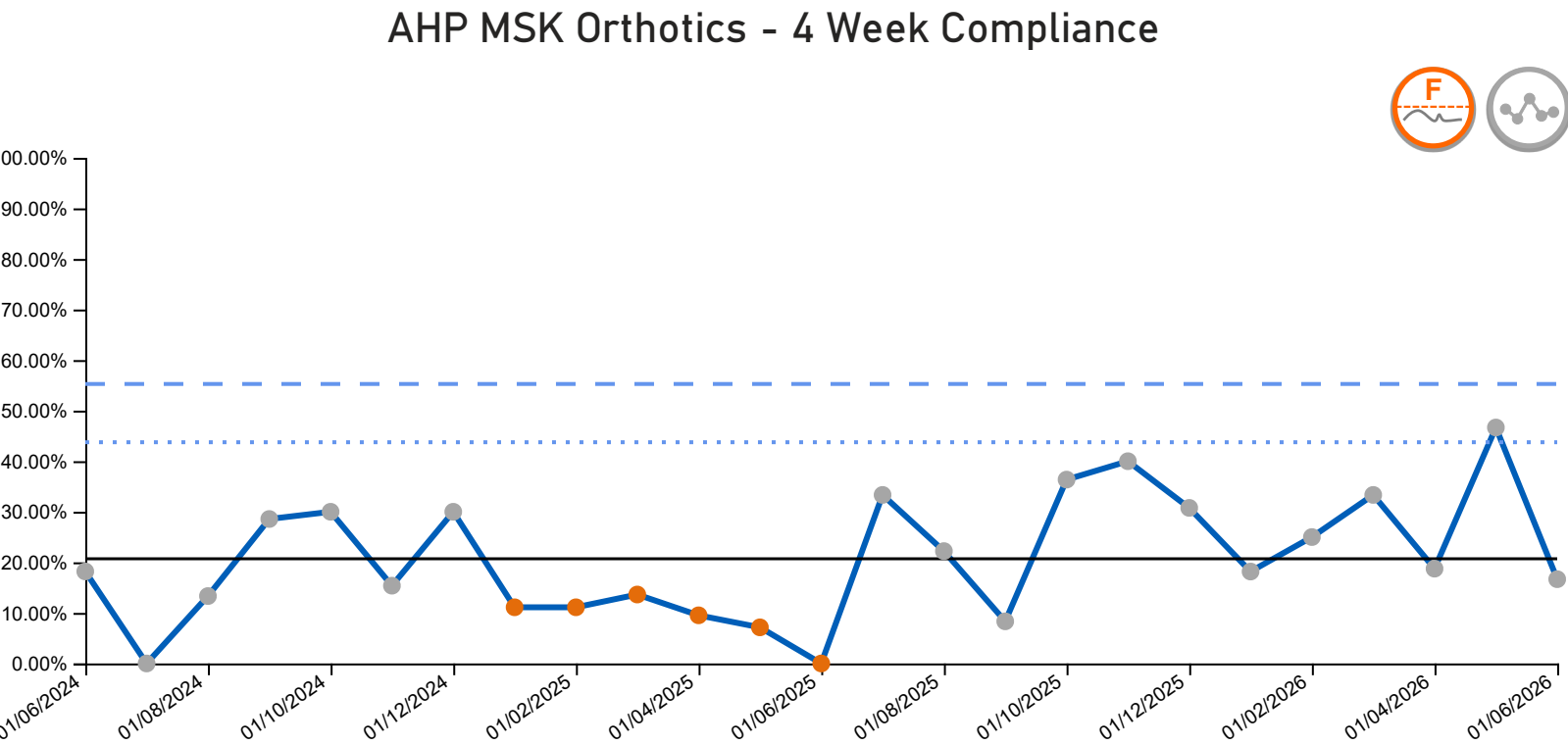


AHP MSK Orthotics - Last 6 Months

Month	Patients Seen	0 - 4 weeks (%)	Target	RAG Value
January 2026	11	18.18%	90.00%	Red
February 2026	12	25.00%	90.00%	Red
March 2026	12	33.33%	90.00%	Red
April 2026	16	18.75%	90.00%	Red
May 2026	15	46.67%	90.00%	Red
June 2026	12	16.67%	90.00%	Red

Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/06/2024	18.20	20.71	90.00	0.00	55.27	0.00	43.75	None
01/07/2024	0.00	20.71	90.00	0.00	55.27	0.00	43.75	None
01/08/2024	13.33	20.71	90.00	0.00	55.27	0.00	43.75	None
01/09/2024	28.57	20.71	90.00	0.00	55.27	0.00	43.75	None
01/10/2024	30.00	20.71	90.00	0.00	55.27	0.00	43.75	None
01/11/2024	15.38	20.71	90.00	0.00	55.27	0.00	43.75	None
01/12/2024	30.00	20.71	90.00	0.00	55.27	0.00	43.75	None
01/01/2025	11.11	20.71	90.00	0.00	55.27	0.00	43.75	Deterioration
01/02/2025	11.11	20.71	90.00	0.00	55.27	0.00	43.75	Deterioration
01/03/2025	13.64	20.71	90.00	0.00	55.27	0.00	43.75	Deterioration
01/04/2025	9.52	20.71	90.00	0.00	55.27	0.00	43.75	Deterioration
01/05/2025	7.14	20.71	90.00	0.00	55.27	0.00	43.75	Deterioration
01/06/2025	0.00	20.71	90.00	0.00	55.27	0.00	43.75	Deterioration
01/07/2025	33.33	20.71	90.00	0.00	55.27	0.00	43.75	None
01/08/2025	22.22	20.71	90.00	0.00	55.27	0.00	43.75	None
01/09/2025	8.33	20.71	90.00	0.00	55.27	0.00	43.75	None
01/10/2025	36.36	20.71	90.00	0.00	55.27	0.00	43.75	None
01/11/2025	40.00	20.71	90.00	0.00	55.27	0.00	43.75	None
01/12/2025	30.77	20.71	90.00	0.00	55.27	0.00	43.75	None
01/01/2026	18.18	20.71	90.00	0.00	55.27	0.00	43.75	None
01/02/2026	25.00	20.71	90.00	0.00	55.27	0.00	43.75	None
01/03/2026	33.33	20.71	90.00	0.00	55.27	0.00	43.75	None
01/04/2026	18.75	20.71	90.00	0.00	55.27	0.00	43.75	None
01/05/2026	46.67	20.71	90.00	0.00	55.27	0.00	43.75	None
01/06/2026	16.67	20.71	90.00	0.00	55.27	0.00	43.75	None



Comments From Executive Lead

This target will continue to be a struggle without further investment in additional clinics from the visiting service.

Stephen Brown, Chief Officer of the Integration Joint Board



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

Data Source

TrakCare

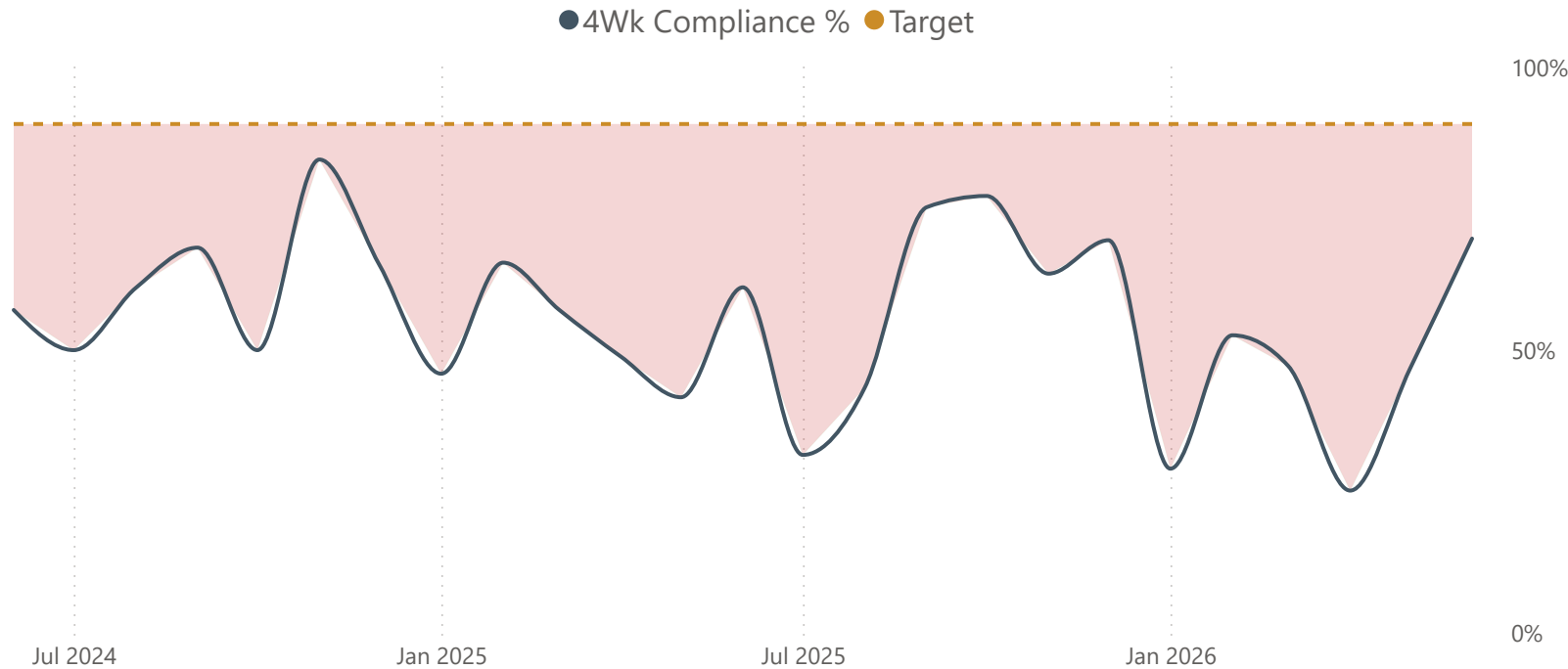
Latest Data

June 2026

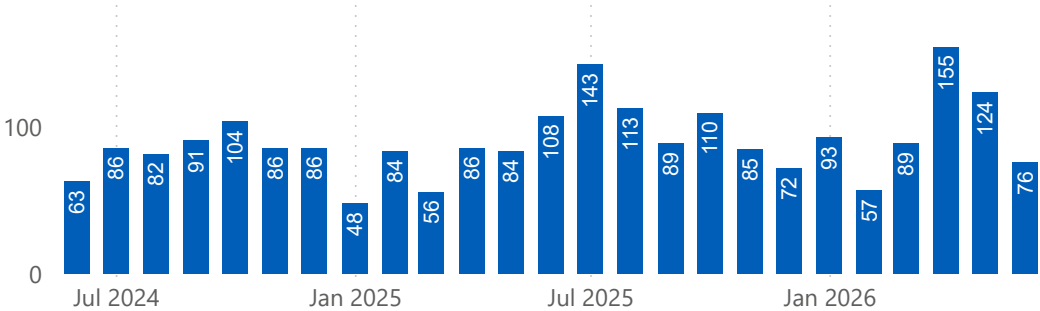
Compliance

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%	25.16%	Amber
Action	Target Date	Owner	Status
All current actions completed/closed.			

AHP MSK Physiotherapy - 4 Week Compliance



AHP MSK Physiotherapy - Patients Seen



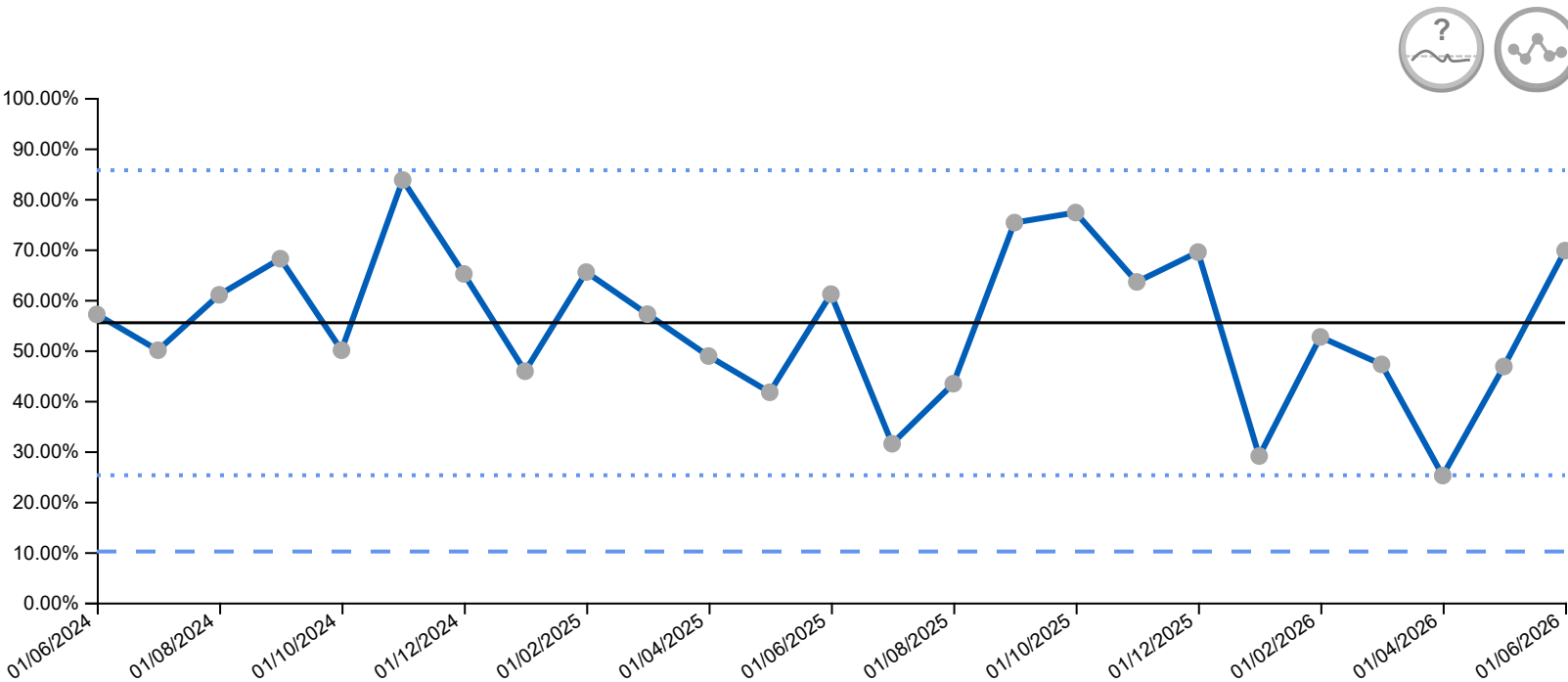
AHP MSK Physiotherapy - Last 6 Months

Month	Patients Seen	0 - 4 weeks (%)	Target	RAG Value
January 2026	93	29.03%	90.00%	Red
February 2026	57	52.63%	90.00%	Red
March 2026	89	47.19%	90.00%	Red
April 2026	155	25.16%	90.00%	Red
May 2026	124	46.77%	90.00%	Red
June 2026	76	69.74%	90.00%	Red

Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/06/2024	57.10	55.44	90.00	10.11	100.00	25.22	85.66	None
01/07/2024	50.00	55.44	90.00	10.11	100.00	25.22	85.66	None
01/08/2024	60.98	55.44	90.00	10.11	100.00	25.22	85.66	None
01/09/2024	68.13	55.44	90.00	10.11	100.00	25.22	85.66	None
01/10/2024	50.00	55.44	90.00	10.11	100.00	25.22	85.66	None
01/11/2024	83.72	55.44	90.00	10.11	100.00	25.22	85.66	None
01/12/2024	65.12	55.44	90.00	10.11	100.00	25.22	85.66	None
01/01/2025	45.83	55.44	90.00	10.11	100.00	25.22	85.66	None
01/02/2025	65.48	55.44	90.00	10.11	100.00	25.22	85.66	None
01/03/2025	57.14	55.44	90.00	10.11	100.00	25.22	85.66	None
01/04/2025	48.84	55.44	90.00	10.11	100.00	25.22	85.66	None
01/05/2025	41.67	55.44	90.00	10.11	100.00	25.22	85.66	None
01/06/2025	61.11	55.44	90.00	10.11	100.00	25.22	85.66	None
01/07/2025	31.47	55.44	90.00	10.11	100.00	25.22	85.66	None
01/08/2025	43.36	55.44	90.00	10.11	100.00	25.22	85.66	None
01/09/2025	75.28	55.44	90.00	10.11	100.00	25.22	85.66	None
01/10/2025	77.27	55.44	90.00	10.11	100.00	25.22	85.66	None
01/11/2025	63.53	55.44	90.00	10.11	100.00	25.22	85.66	None
01/12/2025	69.44	55.44	90.00	10.11	100.00	25.22	85.66	None
01/01/2026	29.03	55.44	90.00	10.11	100.00	25.22	85.66	None
01/02/2026	52.63	55.44	90.00	10.11	100.00	25.22	85.66	None
01/03/2026	47.19	55.44	90.00	10.11	100.00	25.22	85.66	None
01/04/2026	25.16	55.44	90.00	10.11	100.00	25.22	85.66	None
01/05/2026	46.77	55.44	90.00	10.11	100.00	25.22	85.66	None
01/06/2026	69.74	55.44	90.00	10.11	100.00	25.22	85.66	None

AHP MSK Physiotherapy - 4 Week Compliance



Comments From Executive Lead

Although still some way short of the 90% target, improvement has occurred in the last two periods.

Stephen Brown, Chief Officer of the Integration Joint Board



Community

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

Data Source

TrakCare

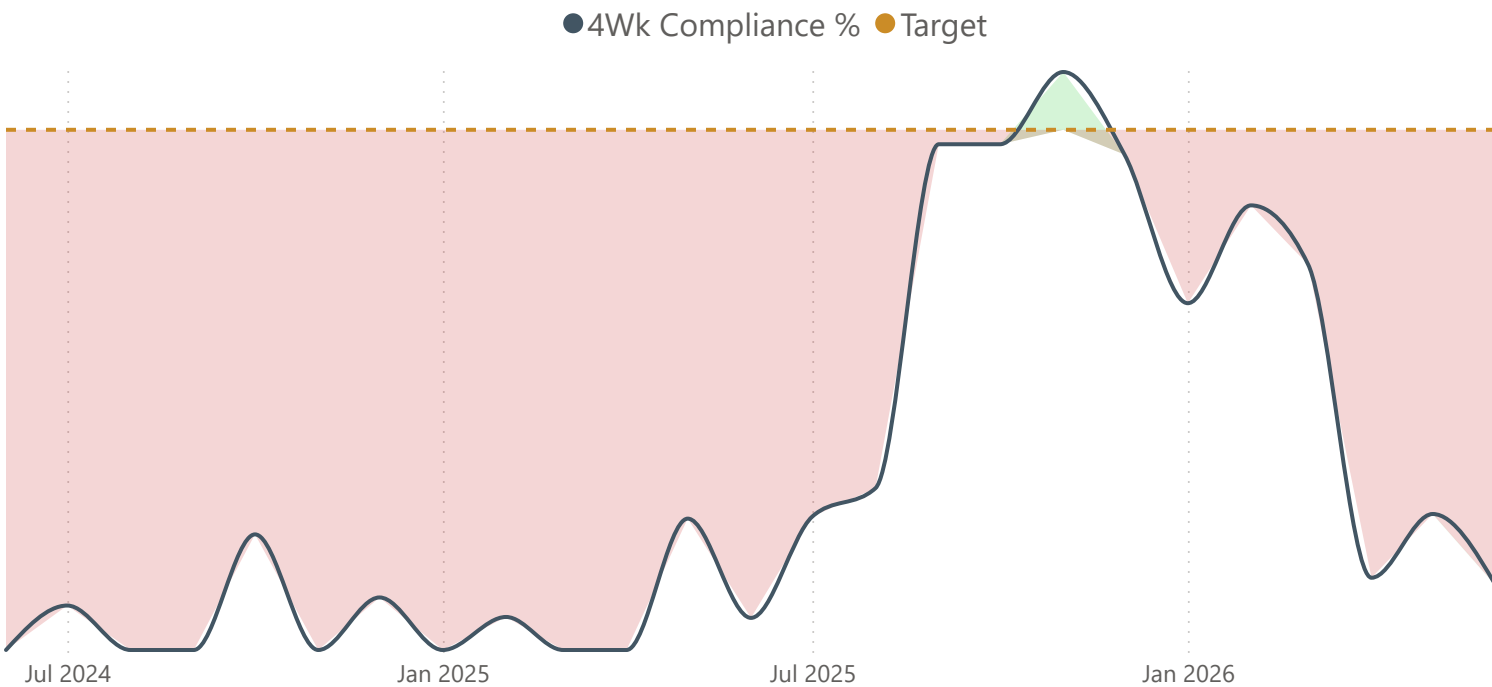
Latest Data

June 2026

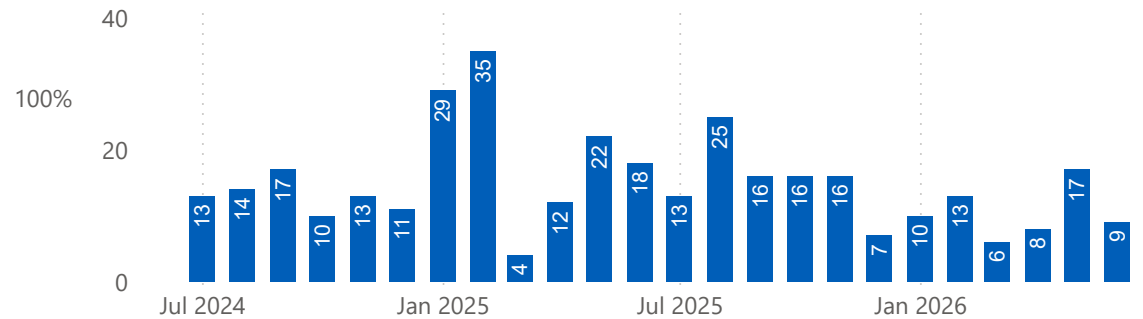
Compliance

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%	12.50%	Red
Action	Target Date	Owner	Status
Work to identify space to deliver 1 additional MSK clinic weekly.	30/09/2026		In Progress
Recruitment to a Podiatry bank post, utilising the spare hours, and explore other opportunities.	31/12/2027		In Progress

AHP MSK Podiatry - 4 Week Compliance



AHP MSK Podiatry - Patients Seen



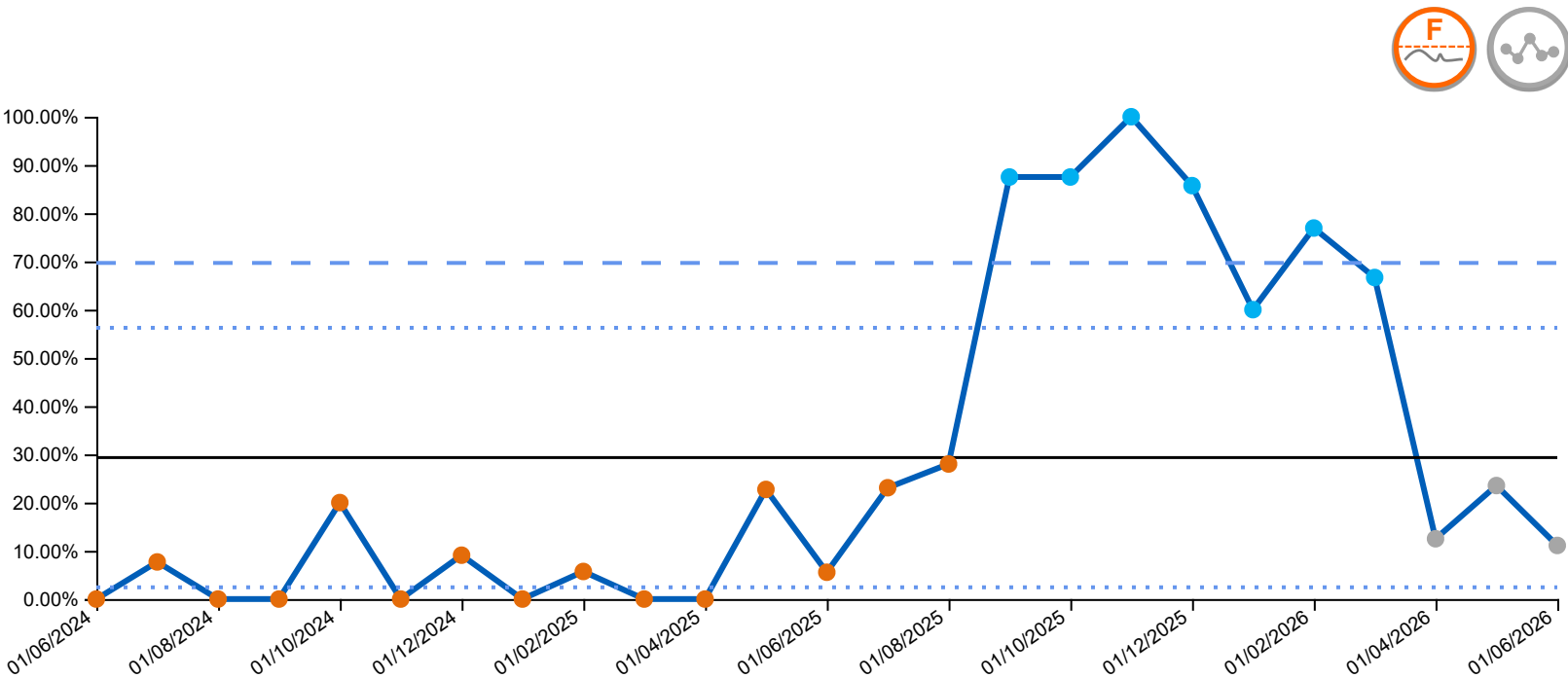
AHP MSK Podiatry - Last 6 Months

Month	Patients Seen	0 - 4 weeks (%)	Target	RAG Value
January 2026	10	60.00%	90.00%	Red
February 2026	13	76.92%	90.00%	Red
March 2026	6	66.67%	90.00%	Red
April 2026	8	12.50%	90.00%	Red
May 2026	17	23.53%	90.00%	Red
June 2026	9	11.11%	90.00%	Red

Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/06/2024	0.00	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/07/2024	7.69	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/08/2024	0.00	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/09/2024	0.00	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/10/2024	20.00	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/11/2024	0.00	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/12/2024	9.09	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/01/2025	0.00	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/02/2025	5.71	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/03/2025	0.00	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/04/2025	0.00	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/05/2025	22.73	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/06/2025	5.56	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/07/2025	23.08	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/08/2025	28.00	29.33	90.00	0.00	59.61	9.15	49.52	Deterioration
01/09/2025	87.50	29.33	90.00	0.00	59.61	9.15	49.52	Improvement
01/10/2025	87.50	29.33	90.00	0.00	59.61	9.15	49.52	Improvement
01/11/2025	100.00	29.33	90.00	0.00	59.61	9.15	49.52	Improvement
01/12/2025	85.71	29.33	90.00	0.00	59.61	9.15	49.52	Improvement
01/01/2026	60.00	29.33	90.00	0.00	59.61	9.15	49.52	Improvement
01/02/2026	76.92	29.33	90.00	0.00	59.61	9.15	49.52	Improvement
01/03/2026	66.67	29.33	90.00	0.00	59.61	9.15	49.52	Improvement
01/04/2026	12.50	29.33	90.00	0.00	59.61	9.15	49.52	None
01/05/2026	23.53	29.33	90.00	0.00	59.61	9.15	49.52	None
01/06/2026	11.11	29.33	90.00	0.00	59.61	9.15	49.52	None

AHP MSK Podiatry - 4 Week Compliance



Comments From Executive Lead

Following significant work by the team to reduce the lengthiest waits and meet the four-week target, staffing gaps have impacted considerably upon the recent performance. In the meantime, a locum podiatrist has been secured to assist.

Stephen Brown, Chief Officer of the Integration Joint Board



Population Health

Section Lead:
Director of Public Health

What's Going Well?

Referral number to smoking cessation remain high with 11 in May, 10 in June and 9 in July.

Childhood immunisation uptake of 6-in-1 and MMR2 remains above Scottish average.

Maternity and Pregnancy screening metrics show 100% compliance. The Pregnancy & Newborn Screening Oversight Group has reviewed variance in the bloodspot KPI and agreed to implement actions in relation to children born in NHS Grampian sites.

Profile of services being raised through community roadshows.

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

During the end of July and August, the Smoking Cessation Team has experienced high levels of staff absence which will impact the delivery of the service at this time.

Childhood immunisation rates in Orkney fluctuate due to small population numbers. There is a light downward trend, mirroring the national picture but with less pronounced decline. Ongoing monitoring is in place through the Vaccination Management Group, with a particular focus on potential impact of the Child Health IT system update and follow-up of children who miss scheduled appointments.

New nationally procured child health system has issues in scheduling of vaccinations requiring local workarounds – national incident management meetings.

Expanded vaccination schedules for autumn/winter is challenging for boards.

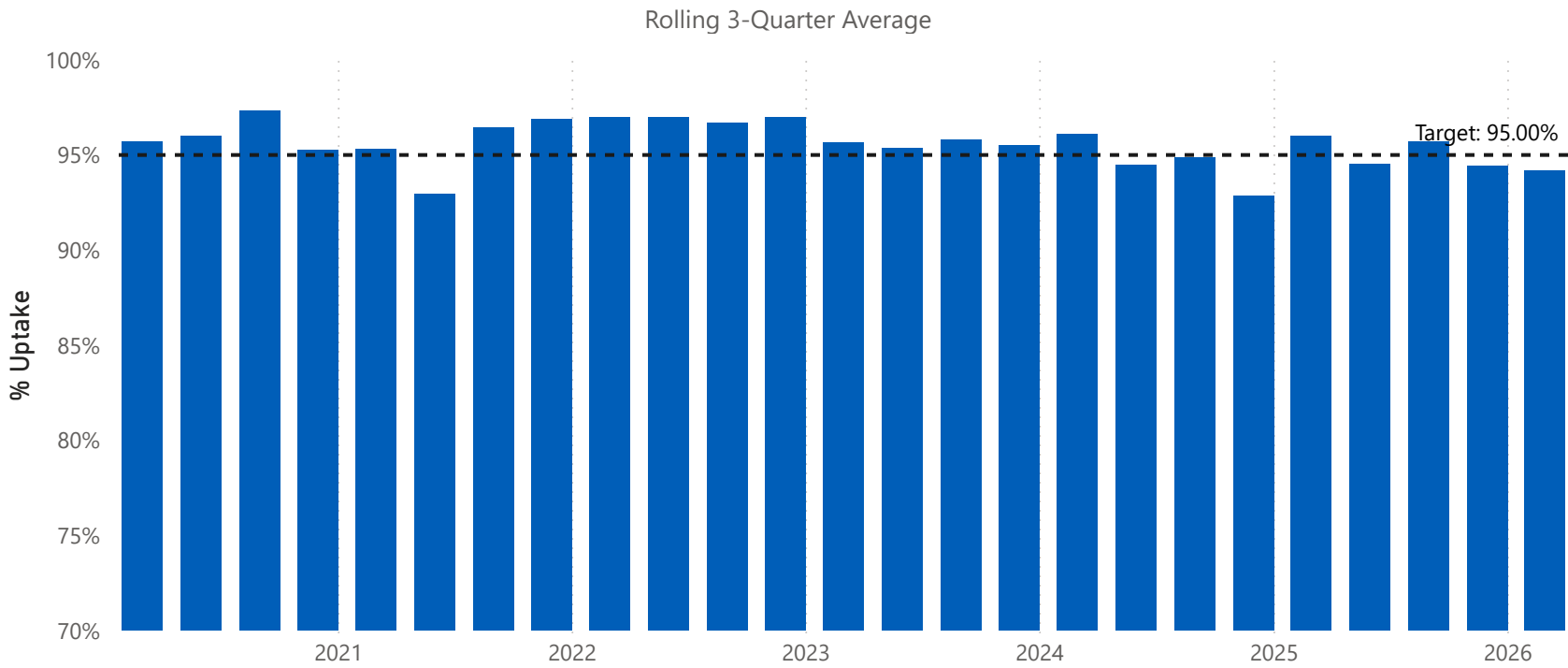
Population Health

Immunisation Uptake Rate MMR by 6 Years of Age

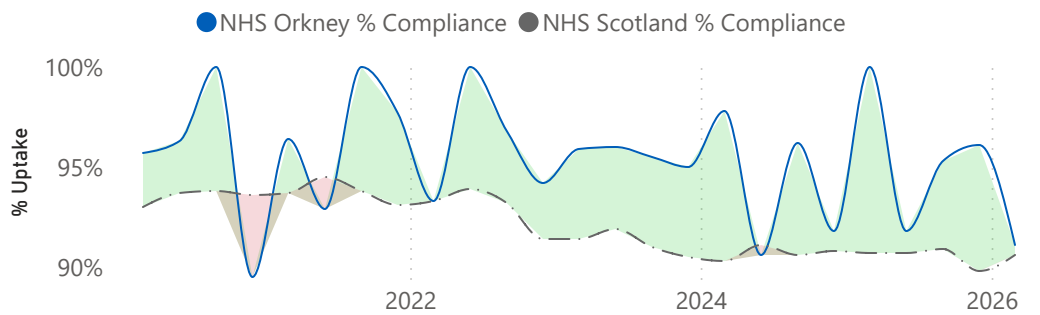
Compliance

KPI	Target	Actual	RAG Value
Immunisation uptake rate MMR2 by 6 years of age (rolling 3-month average)	95.0%	94.17%	Red
Action	Target Date	Owner	Status
Continue ongoing immunisation uptake monitoring through the Vaccination Management Group, with a particular focus on potential impact of the Child Health IT system update and follow-up of children who miss scheduled appointments.	31/10/2026	E Garcia	In Progress
Review of process for children who do not attend vaccination appointments with health visiting team.	31/05/2026	E Garcia	Completed

Immunisation Uptake - MMR by 6 Years of Age Compliance



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



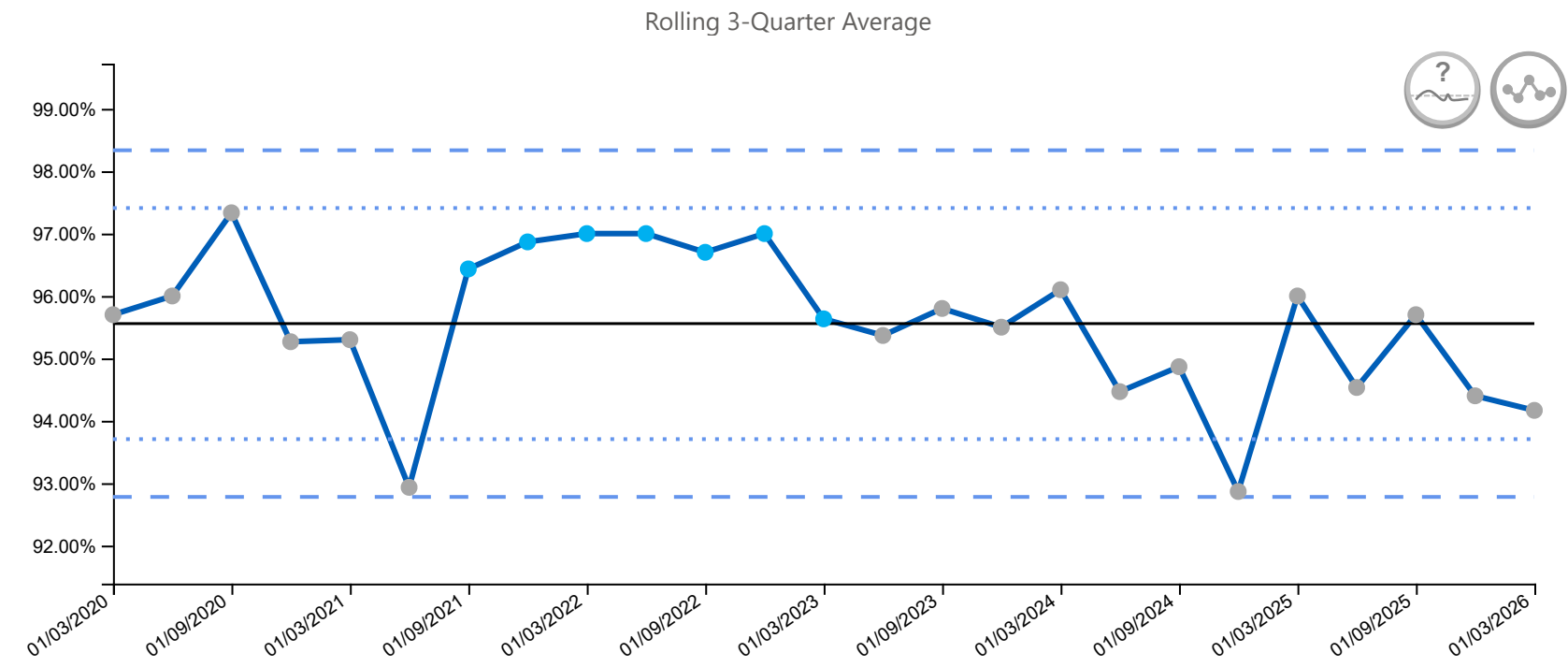
MMR Immunisation Uptake - Last 6 Quarters

End Of Quarter	Orkney	3-Quarter Avg.	Target	RAG Value
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
March 2026	91.10%	94.17%	95.00%	Red

Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/03/2020	95.70	95.56	95.00	92.78	98.34	93.71	97.41	None
01/06/2020	96.00	95.56	95.00	92.78	98.34	93.71	97.41	None
01/09/2020	97.33	95.56	95.00	92.78	98.34	93.71	97.41	None
01/12/2020	95.27	95.56	95.00	92.78	98.34	93.71	97.41	None
01/03/2021	95.30	95.56	95.00	92.78	98.34	93.71	97.41	None
01/06/2021	92.93	95.56	95.00	92.78	98.34	93.71	97.41	None
01/09/2021	96.43	95.56	95.00	92.78	98.34	93.71	97.41	Improvement
01/12/2021	96.87	95.56	95.00	92.78	98.34	93.71	97.41	Improvement
01/03/2022	97.00	95.56	95.00	92.78	98.34	93.71	97.41	Improvement
01/06/2022	97.00	95.56	95.00	92.78	98.34	93.71	97.41	Improvement
01/09/2022	96.70	95.56	95.00	92.78	98.34	93.71	97.41	Improvement
01/12/2022	97.00	95.56	95.00	92.78	98.34	93.71	97.41	Improvement
01/03/2023	95.63	95.56	95.00	92.78	98.34	93.71	97.41	Improvement
01/06/2023	95.37	95.56	95.00	92.78	98.34	93.71	97.41	None
01/09/2023	95.80	95.56	95.00	92.78	98.34	93.71	97.41	None
01/12/2023	95.50	95.56	95.00	92.78	98.34	93.71	97.41	None
01/03/2024	96.10	95.56	95.00	92.78	98.34	93.71	97.41	None
01/06/2024	94.47	95.56	95.00	92.78	98.34	93.71	97.41	None
01/09/2024	94.87	95.56	95.00	92.78	98.34	93.71	97.41	None
01/12/2024	92.87	95.56	95.00	92.78	98.34	93.71	97.41	None
01/03/2025	96.00	95.56	95.00	92.78	98.34	93.71	97.41	None
01/06/2025	94.53	95.56	95.00	92.78	98.34	93.71	97.41	None
01/09/2025	95.70	95.56	95.00	92.78	98.34	93.71	97.41	None
01/12/2025	94.40	95.56	95.00	92.78	98.34	93.71	97.41	None
01/03/2026	94.17	95.56	95.00	92.78	98.34	93.71	97.41	None

Immunisation Uptake - MMR by 6 Years of Age Compliance



Comments From Executive Lead

Uptake remains above the Scottish average. Childhood immunisation rates in Orkney fluctuate due to small population numbers. Ongoing monitoring is in place through the Vaccination Management Group, with a particular focus on potential impact of the Child Health IT system update and follow-up of children who miss scheduled appointments

Dr. Louise Wilson, Director of Public Health



Population Health

6-in-1 Immunisation Uptake

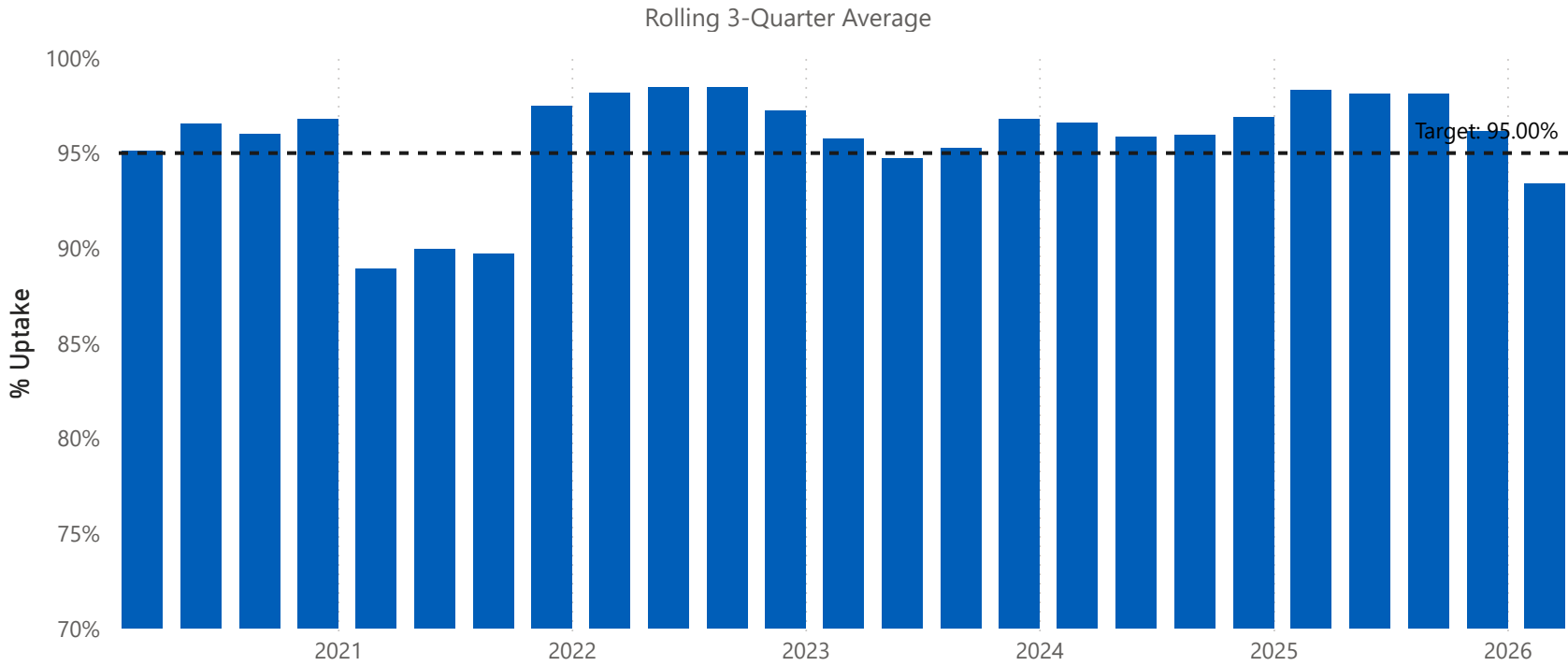
Compliance

KPI	Target	Actual	RAG Value
Immunisation uptake rate 6-in-1 primary Course by 12 months (rolling 3-month average)	95.0%	93.40%	Red

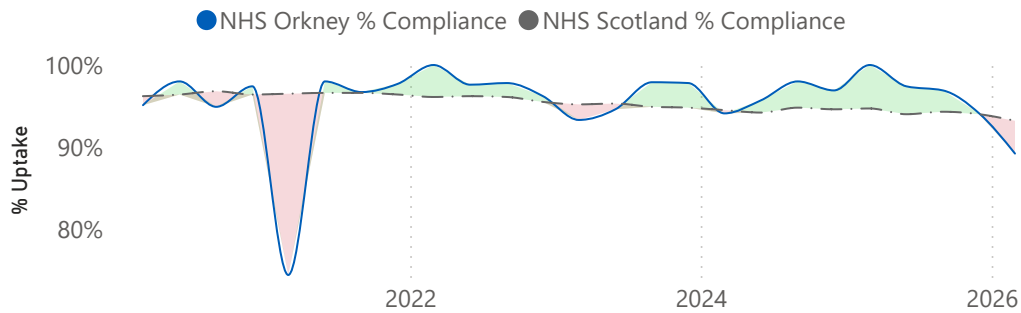
Action	Target Date	Owner	Status
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KPI on target, no actions required at this time.

Immunisation Uptake - 6 in 1 by 12 Months Compliance



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



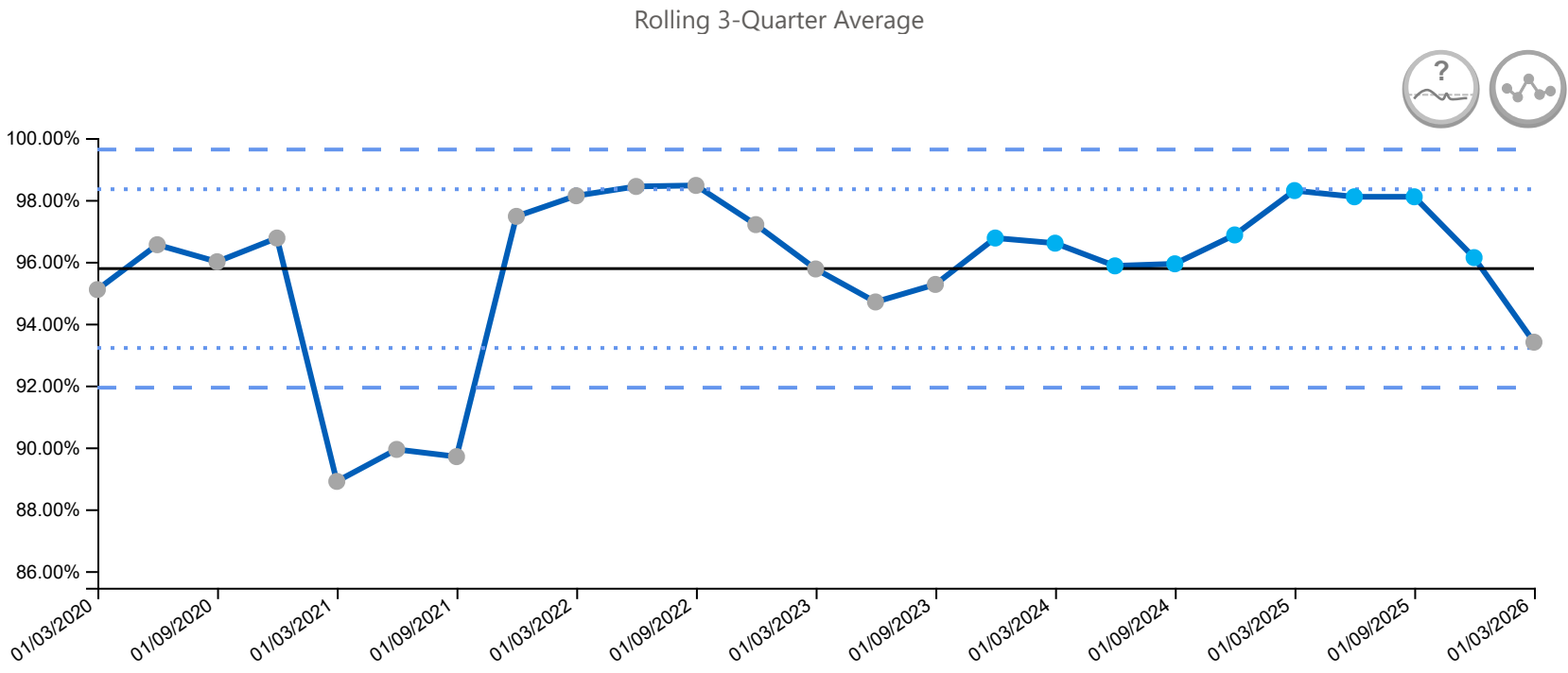
6-in-1 Immunisation Uptake - Last 6 Quarters

End Of Quarter	Orkney	3-Quarter Avg.	Target	RAG Value
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
March 2026	89.20%	93.40%	95.00%	Red

Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/03/2020	95.10	95.78	95.00	91.93	99.63	93.21	98.34	None
01/06/2020	96.55	95.78	95.00	91.93	99.63	93.21	98.34	None
01/09/2020	96.00	95.78	95.00	91.93	99.63	93.21	98.34	None
01/12/2020	96.77	95.78	95.00	91.93	99.63	93.21	98.34	None
01/03/2021	88.90	95.78	95.00	91.93	99.63	93.21	98.34	None
01/06/2021	89.93	95.78	95.00	91.93	99.63	93.21	98.34	None
01/09/2021	89.70	95.78	95.00	91.93	99.63	93.21	98.34	None
01/12/2021	97.47	95.78	95.00	91.93	99.63	93.21	98.34	None
01/03/2022	98.13	95.78	95.00	91.93	99.63	93.21	98.34	None
01/06/2022	98.43	95.78	95.00	91.93	99.63	93.21	98.34	None
01/09/2022	98.47	95.78	95.00	91.93	99.63	93.21	98.34	None
01/12/2022	97.20	95.78	95.00	91.93	99.63	93.21	98.34	None
01/03/2023	95.77	95.78	95.00	91.93	99.63	93.21	98.34	None
01/06/2023	94.70	95.78	95.00	91.93	99.63	93.21	98.34	None
01/09/2023	95.27	95.78	95.00	91.93	99.63	93.21	98.34	None
01/12/2023	96.77	95.78	95.00	91.93	99.63	93.21	98.34	Improvement
01/03/2024	96.60	95.78	95.00	91.93	99.63	93.21	98.34	Improvement
01/06/2024	95.87	95.78	95.00	91.93	99.63	93.21	98.34	Improvement
01/09/2024	95.93	95.78	95.00	91.93	99.63	93.21	98.34	Improvement
01/12/2024	96.87	95.78	95.00	91.93	99.63	93.21	98.34	Improvement
01/03/2025	98.30	95.78	95.00	91.93	99.63	93.21	98.34	Improvement
01/06/2025	98.10	95.78	95.00	91.93	99.63	93.21	98.34	Improvement
01/09/2025	98.10	95.78	95.00	91.93	99.63	93.21	98.34	Improvement
01/12/2025	96.13	95.78	95.00	91.93	99.63	93.21	98.34	Improvement
01/03/2026	93.40	95.78	95.00	91.93	99.63	93.21	98.34	None

Immunisation Uptake - 6 in 1 by 12 Months Compliance



Comments From Executive Lead

Uptake remains above the Scottish average. Childhood immunisation rates in Orkney fluctuate due to small population numbers. Ongoing monitoring is in place through the Vaccination Management Group, with a particular focus on potential impact of the Child Health IT system update and follow-up of 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

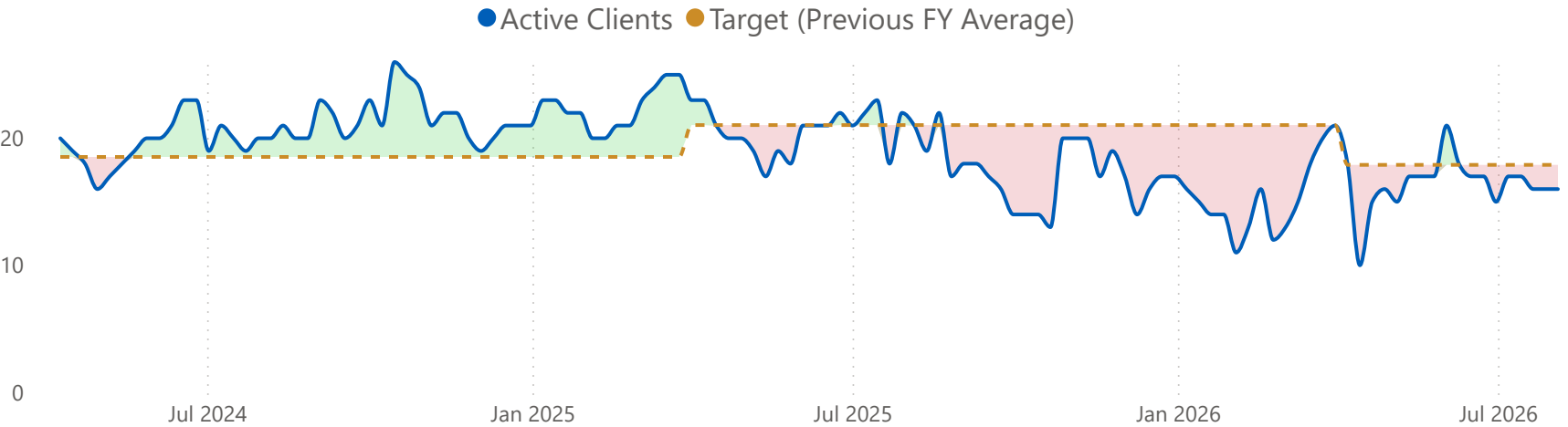
04/08/2026

Compliance

KPI	Target	Actual	RAG Value
Increase smoking cessation active clients year-on-year	18	16	Red

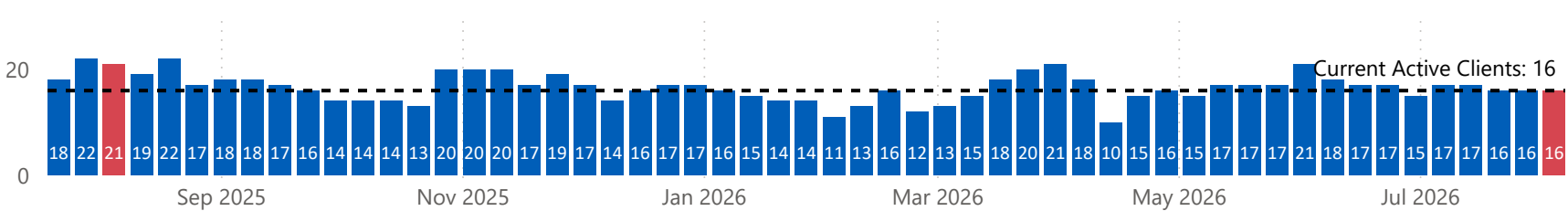
Action	Target Date	Owner	Status
Engagement work with wards	01/05/2026	J Strawson	Completed
Continued delivery of a sustainable model for specialist stop smoking service (Quit Your Way Orkney)	01/06/2026	J Strawson	Completed
Very brief intervention training delivered to staff groups in Orkney	01/06/2026	J Strawson	Completed
Continue key group engagement, in August this will be to engage the new resident doctors.	30/08/2026	J Strawson	In Progress
Develop easy-to-use process for capturing case studies of service user stories for their use in future promotional work.	01/10/2026	J Strawson	In Progress
Lead review of smoke free site policy and seek approval for any proposed changes.	01/10/2026	J Strawson	In Progress
In 2026/27, we will ensure the focus of the	31/03/2027	J Strawson	In Progress

Smoking Cessation - Weekly Active Clients vs. Average



Smoking Cessation - Weekly Active Clients

Red Shows Same Period 12 months Previous



Comments From Executive Lead

As the smoking prevalence is reducing year on year, this target should be re-considered. A target to maintain the level of active clients may be more realistic. Referrals have increased, but the level of staff absence in July and August will impact the level of current active clients. However resources are being prioritised to focus on this target.

Dr. Louise Wilson, Director of Public Health



Population Health

Smoking Cessation 12-Week Quits

Data Source

Public Health Team

Latest Data

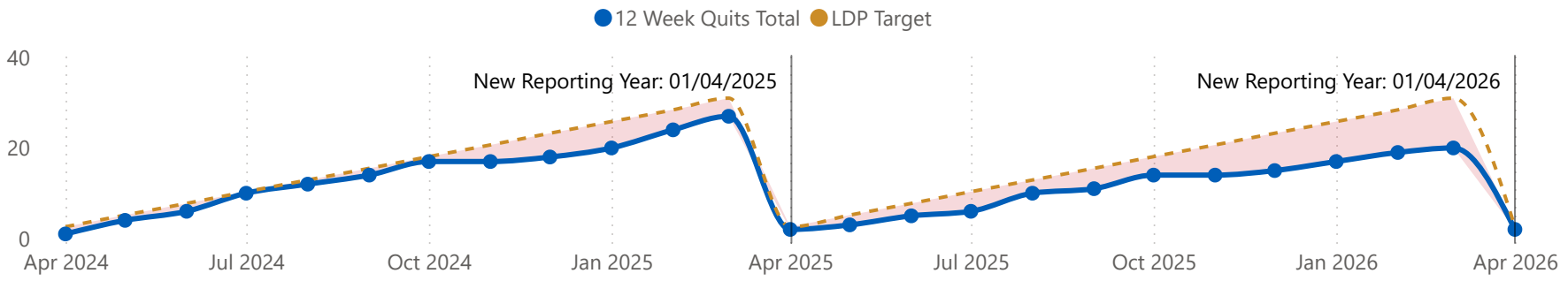
April 2026

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)	3	2	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	Completed
Continued delivery of a sustainable model for specialist stop smoking service (Quit Your Way Orkney)	01/10/2026	J Strawson	In Progress
Develop audit process which meets the needs of QYWO and has a sustainable delivery model.	01/10/2026	J Strawson	In Progress
Engagement work with wards	01/05/2026	J Strawson	Completed
Very brief intervention training delivered to staff groups in Orkney	01/06/2026	J Strawson	Completed
We will ensure public and professional awareness of stop smoking support locally and how to access this through development of communications plan which includes client and	31/03/2027	J Strawson	In Progress

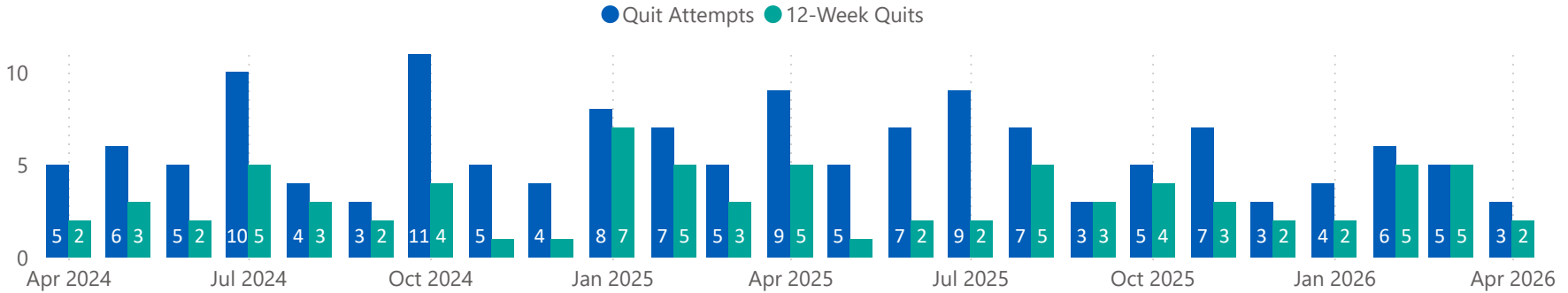
Smoking Cessation - 12-Week Quits vs. Local Delivery Plan (LDP)

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



Smoking Cessation - Total Quit Attempts & 12 Week Quits

Data Only Available 12 Weeks After Each Month End



Comments From Executive Lead

This target remains challenging. Both the Quit Your Way Orkney team and Community Pharmacies play a vital role in achieving this target. The Quit Your Way Orkney Team have been working to promote referrals to the service, including delivery of a session to the new resident doctors.

Dr. Louise Wilson, Director of Public Health



Population Health

Pregnancy Screening - Haemoglobinopathies

Data Source

Maternity Team

Latest Data

July 2026

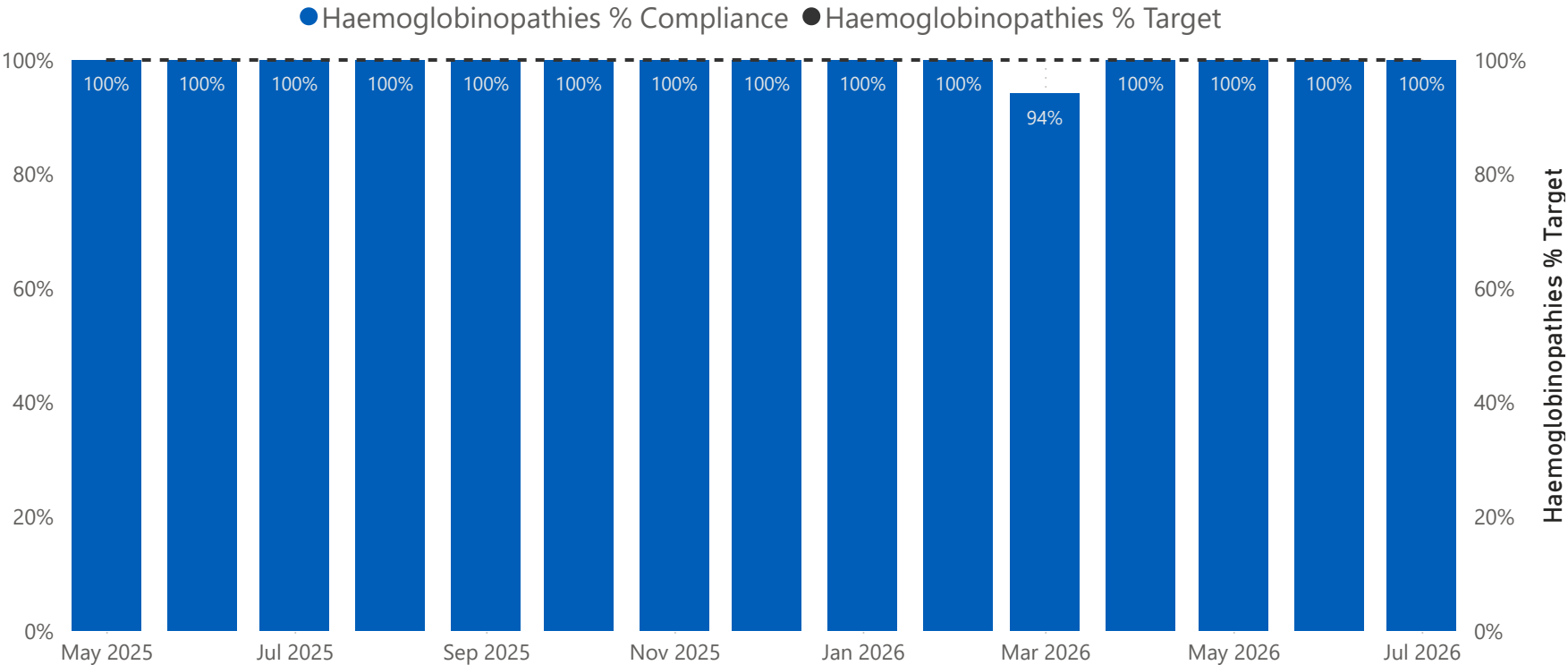
Compliance

KPI	Target	Actual	RAG Value
Pregnancy Screening - All eligible pregnant women are offered haemoglobinopathies screening.	100.0%	100.00%	Green

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

Pregnancy Screening - Haemoglobinopathies Screening Offered



Comments From Executive Lead

Uptake rates in Orkney fluctuate due to small population numbers. Performance is monitored routinely via Pregnancy and Newborn Screening Oversight Group

Dr. Louise Wilson, Director of Public Health



Population Health

Pregnancy Screening - Infectious Diseases

Data Source

Maternity Team

Latest Data

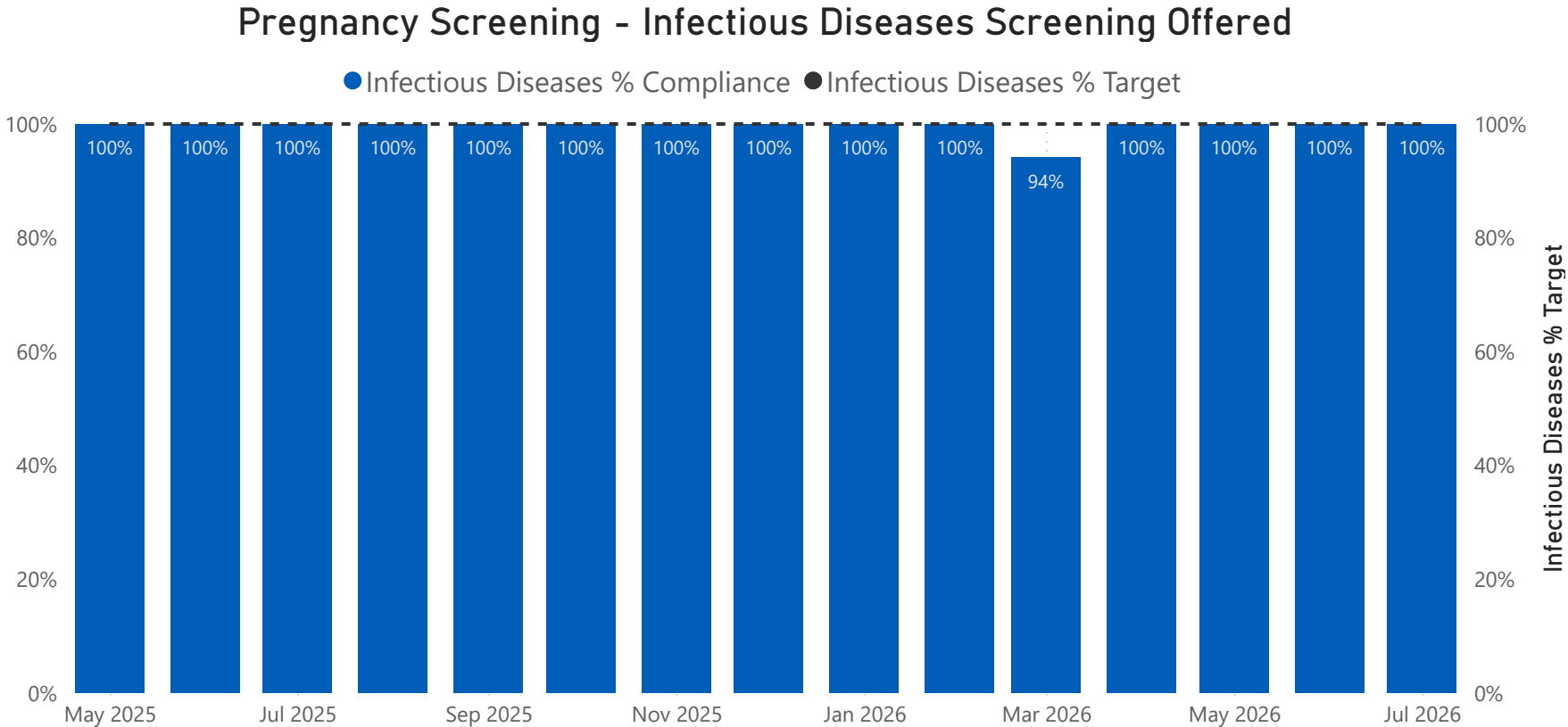
July 2026

Compliance

KPI	Target	Actual	RAG Value
Pregnancy Screening - All eligible pregnant women are offered infectious diseases screening	100.0%	100.00%	Green

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



Comments From Executive Lead

Uptake rates in Orkney fluctuate due to small population numbers. Performance is monitored routinely via Pregnancy and Newborn Screening Oversight Group

Dr. Louise Wilson, Director of Public Health



Population Health

Pregnancy Screening - Trisomy

Data Source

Maternity Team

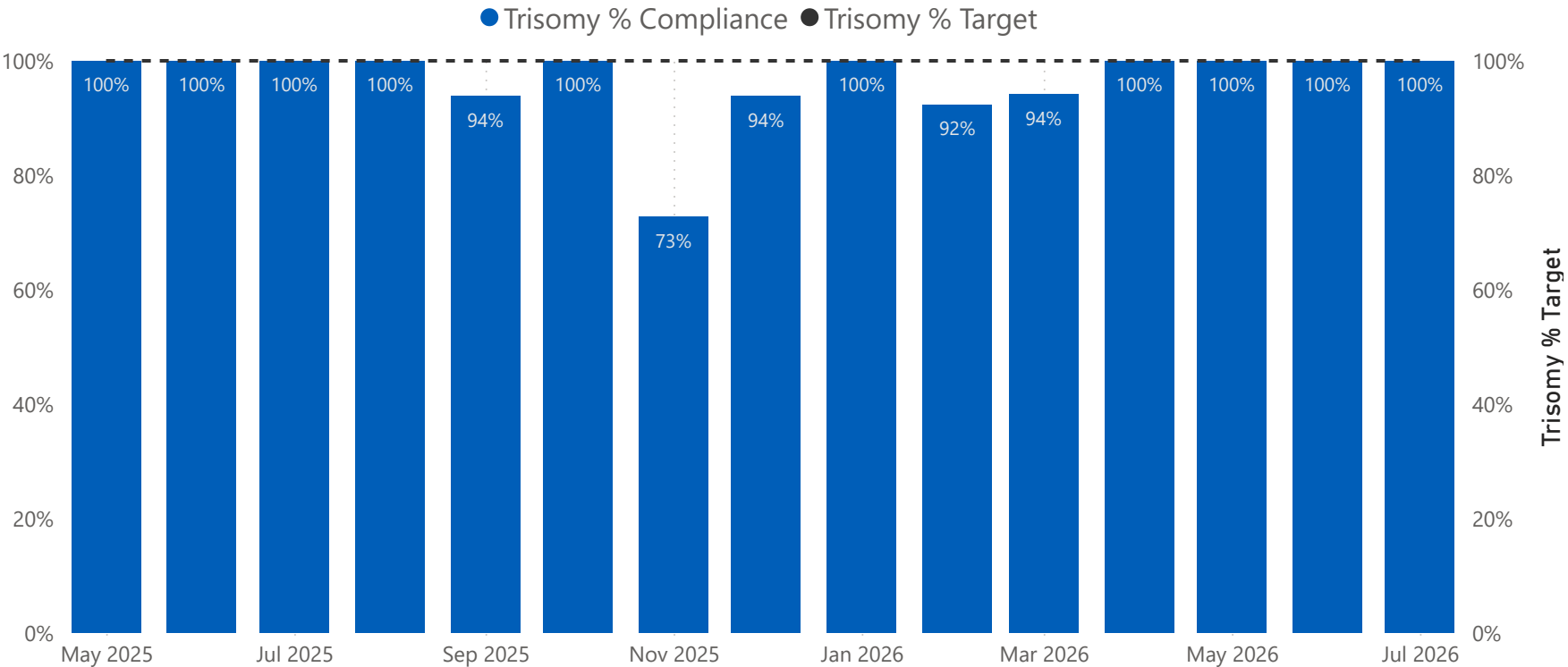
Latest Data

July 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%	100.00%	Green
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

Pregnancy Screening - Trisomy Screening Offered Within 20+0 Weeks



Comments From Executive Lead

Uptake rates in Orkney fluctuate due to small population numbers. Performance is monitored routinely via Pregnancy and Newborn Screening Oversight Group

Dr. Louise Wilson, Director of Public Health



Population Health

Blood Spot Screening Compliance

Data Source

Maternity Team

Latest Data

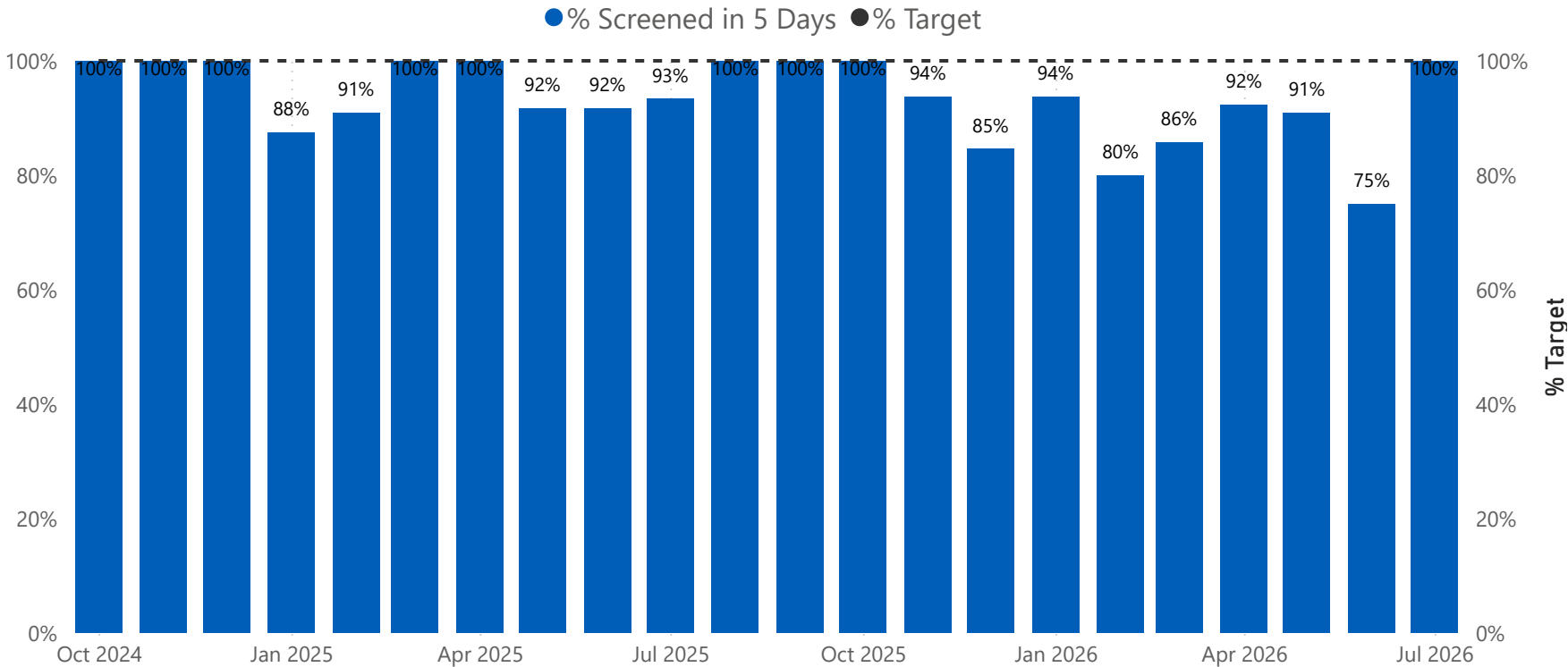
July 2026

Compliance

KPI	Target	Actual	RAG Value
Bloodspot Screening - 100% of newborn babies have bloodspot Screening completed by day 5	100.0%	100.00%	Green

Action	Target Date	Owner	Status
Detailed review of bloodspot screening compliance to be carried out so appropriate actions can be identified, agreed and implemented			
Pregnancy & Newborn Screening Oversight Group to review variance in this KPI and implement actions as appropriate.	30/04/2026	E Garcia	In Progress

Blood Spot Screening Completed by Day 5



Comments From Executive Lead

Uptake rates in Orkney fluctuate due to small population numbers. Performance is monitored routinely via Pregnancy and Newborn Screening Oversight Group

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's Services continue to deliver support across the organisation. There has been increased support to enable departments to review their service delivery, which has started some organisational change processes. The department is engaged with the Business Systems Programme nationally where there are currently some system reviews underway, as well as work to understand what future work/rollout will involve. Re-engagement of the Eroster system throughout the organisation continues to follow the engagement plan. It is evident that teams are making progress, but further work is needed to ensure that it will be fully implemented by the deadline. Additional Occupational Health continues with the implementation of their new system, leading to improvements in service delivery.

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

During the first two months of 26/27, there has been a significant increase in absence, with April and May recording over 7% each month. The team continue to support managers in training to enable colleagues to return to work and to ensure they have access to occupational health advice and support. Results across the organisation remain below the level expected for Appraisals. These conversations continue within the operational people group and at the performance review meetings to understand the plan managers have to achieve the required level.

People & Culture
NHS Orkney Sickness Absence

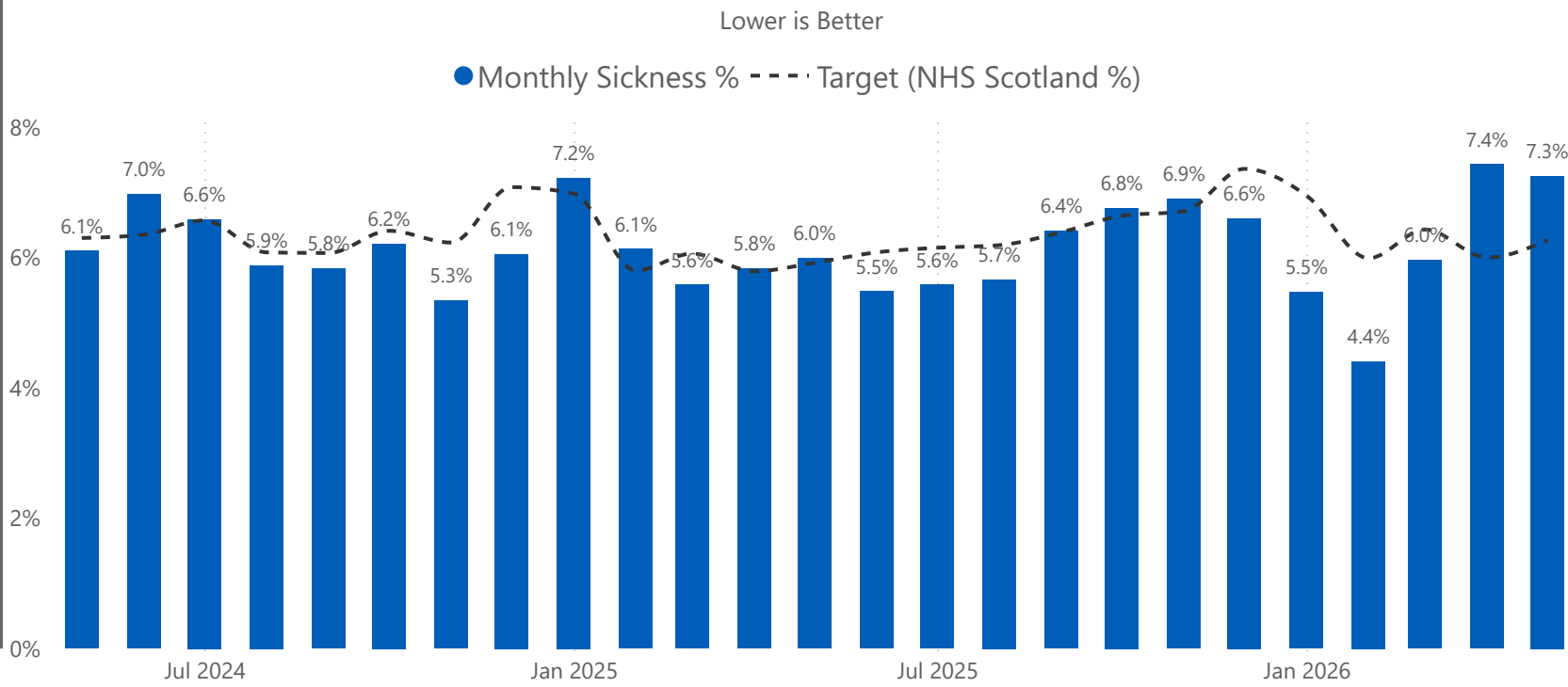
Data Source: SSTS/eESS National
Latest Data: May 2026

Compliance

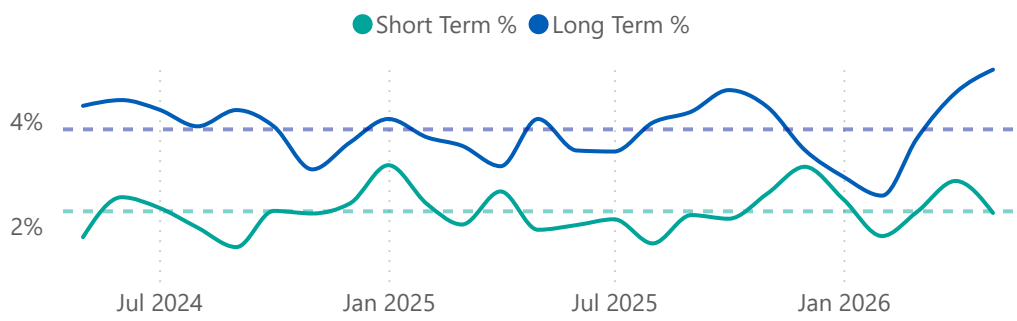
Table with 4 columns: KPI, Target, Actual, RAG Value. Row 1: Monthly sickness absence rates below national average, 6.27%, 7.25%, Red.

Table with 4 columns: Action, Target Date, Owner, Status. Rows detailing improvement actions for sickness absence rates.

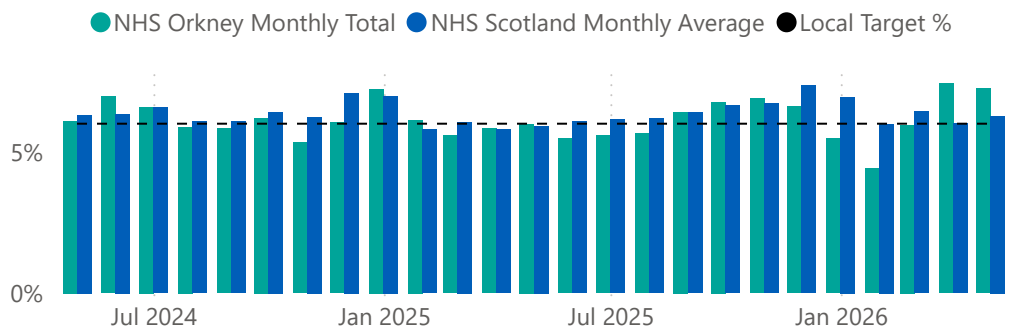
Monthly Sickness Absence



Monthly Sickness Absence - Long vs. Short Term Split



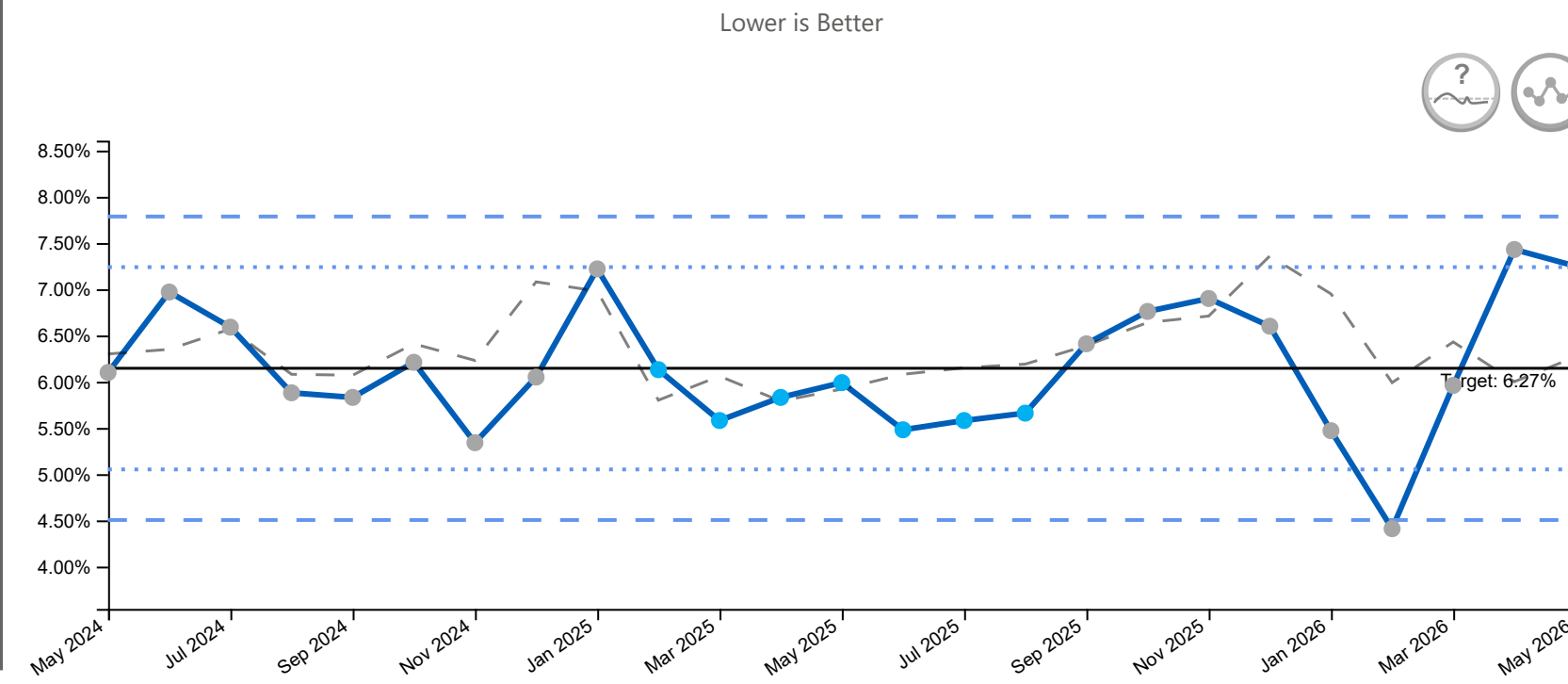
Monthly Sickness Absence - NHS Orkney vs. National Average



Statistical Process Control

Statistical Process Control table with columns: Date, Value, Target, Alt. Target, LL 99%, UL 99%, LL 95%, UL 95%, Shift. Rows from 01/05/2024 to 01/05/2026.

Monthly Sickness Absence



Comments From Executive Lead

Sickness absence has increased in the first 2 months of 26/27 to over 7% each month. This is the highest level in the last 12 Months for the organisation.

The People and Culture team continue to support managers across the organisation with sickness management, in line with the Once for Scotland Workforce Policy. The Occupational Health team has been engaging with managers to help individuals return to work.

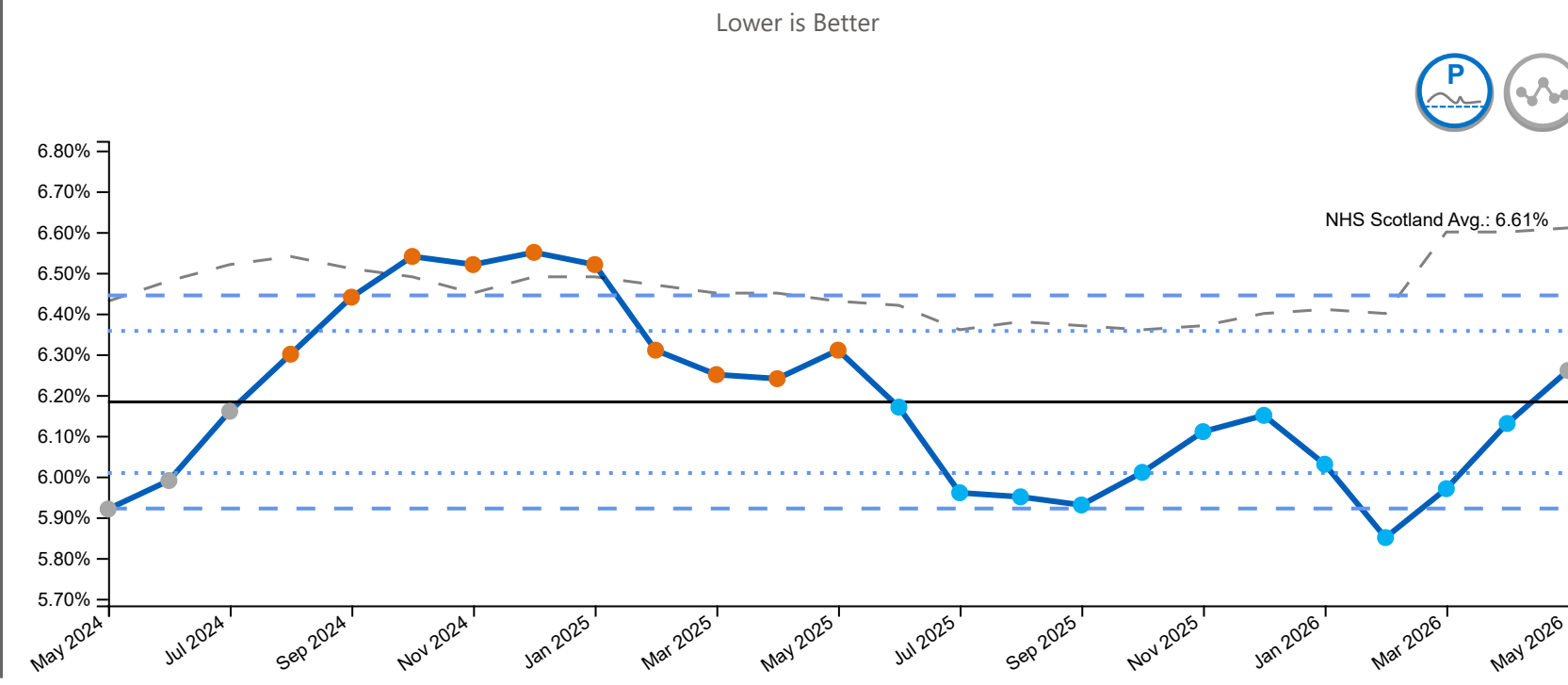
Dave Harris, Director of People and Culture



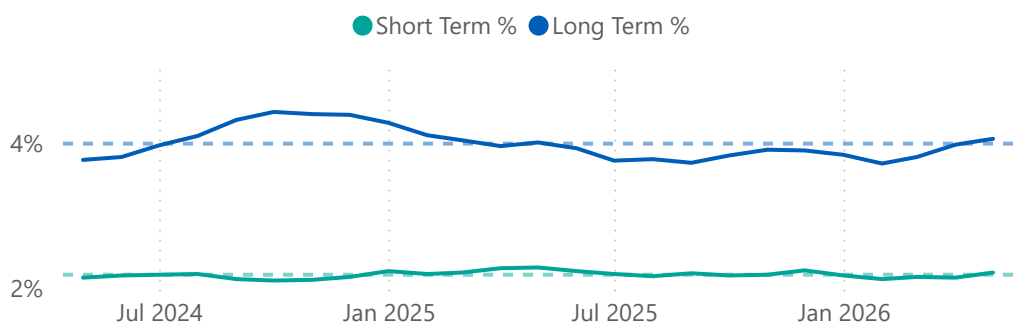
Statistical Process Control

Statistical Process Control table with columns: Date, Value, Target, Alt. Target, LL 99%, UL 99%, LL 95%, UL 95%, Shift. Rows from 01/05/2024 to 01/05/2026.

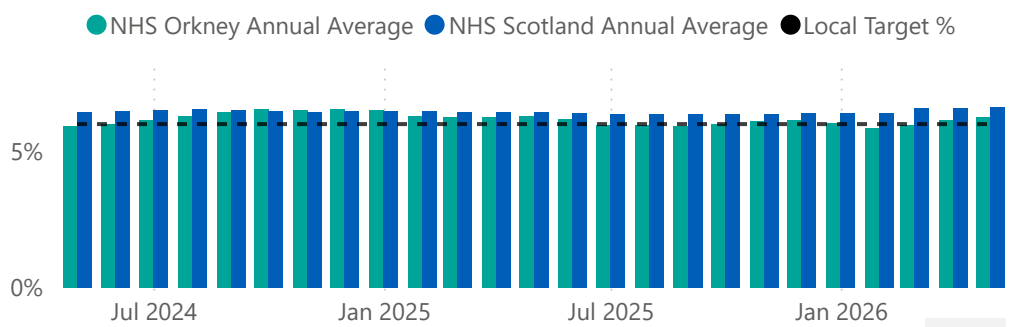
Annual Sickness Absence



Annual Sickness Absence - Long vs. Short Term Split



Annual Sickness Absence - NHS Orkney vs. National Average



People & Culture

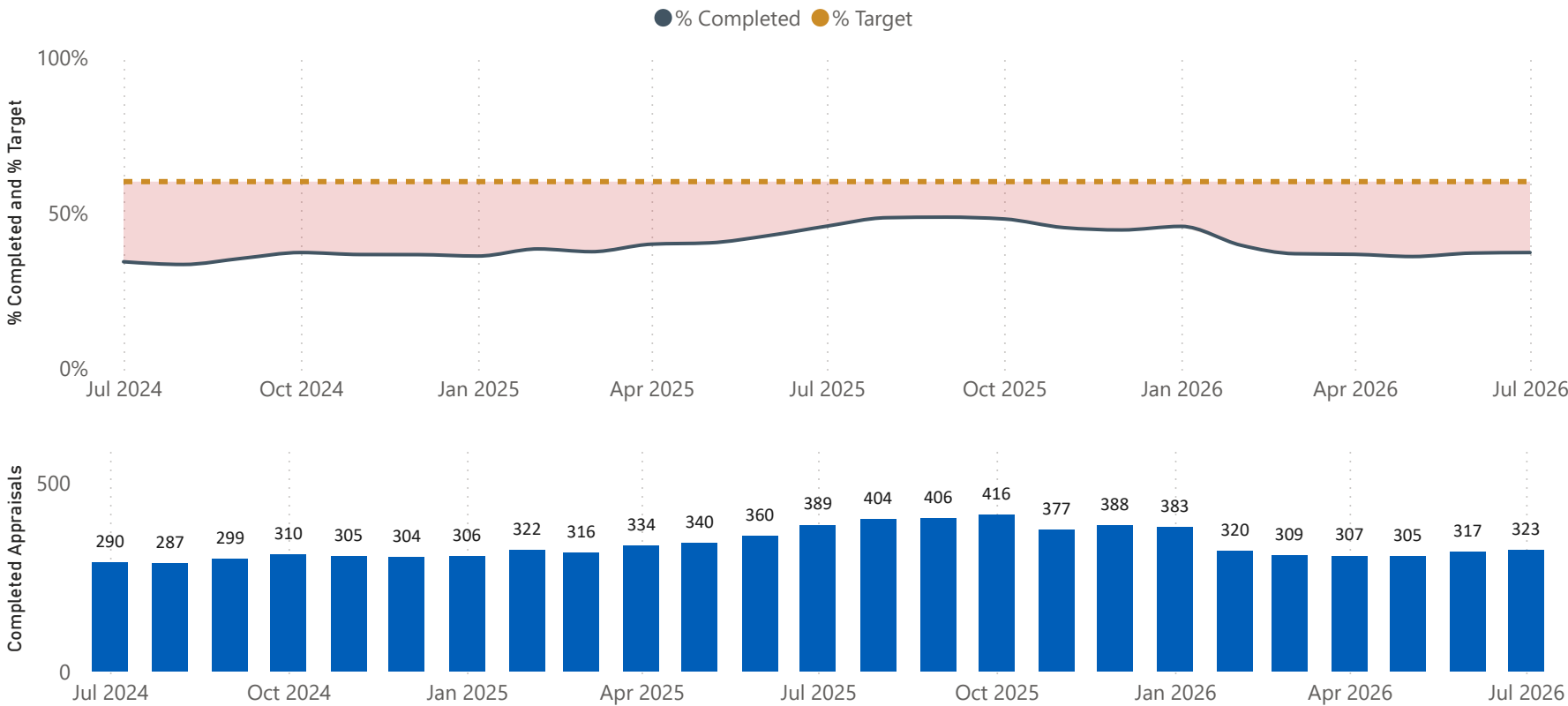
NHS Orkney Appraisal Rates

Compliance

KPI	Target	Actual	RAG Value
Appraisal compliance rate over the previous 12 months	60.00%	37.17%	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	Completed
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.	30/09/2026	Heads of Service	In Progress
PDPR process will be discussed at the Operational People Group prior to being shared across the organisation. Any further actions required will be discussed at the same forum	30/10/2026	Head of People and Culture	In Progress

Completed Appraisal Rates



Comments From Executive Lead

Performance is not where the organisation expects it to be, and there have been discussions across the organisation to progress a step change in the number of reviews undertaken. This has been discussed at the people operations group as well as the performance review meetings to seek assurance of the progress that. A PDPR process is being presented at the next operational people group to support the approach of the appraisal process for AfC colleagues.

Executive directors continue to be held accountable for appraisal rates within their directorates as part of their own appraisal objectives.

Dave Harris, Director of People and Culture



People & Culture

NHS Orkney Statutory/Mandatory eLearning Compliance

Data Source

Workforce Systems

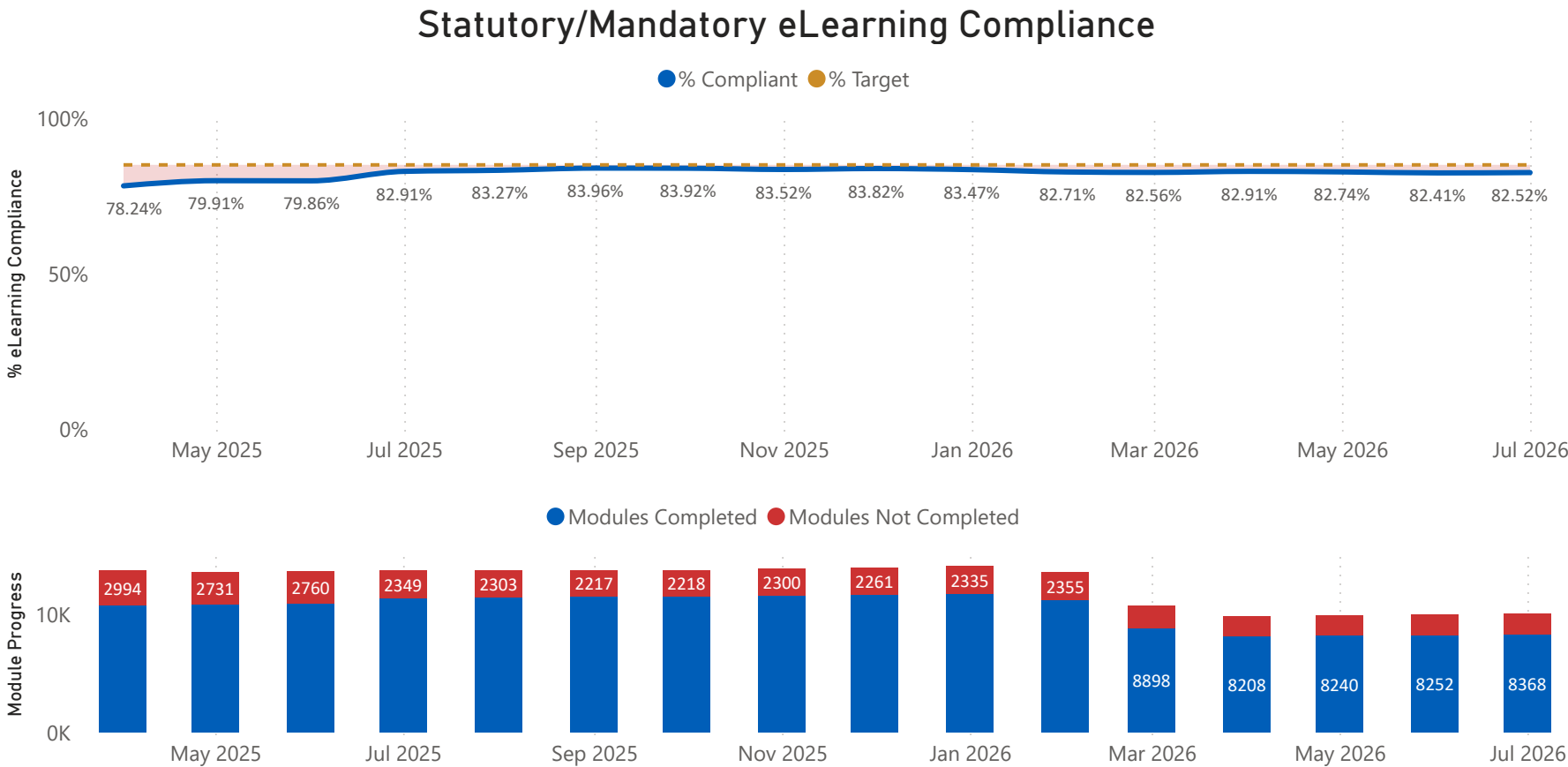
Latest Data

July 2026

Compliance

KPI	Target	Actual	RAG Value
Statutory/Mandatory eLearning Compliance	85.00%	82.52%	Amber

Action	Target Date	Owner	Status
Heads of Service will be held accountable for eLearning compliance rates at the Performance Review Meetings and, where relevant, asked to provide details on improvement actions.	30/09/2026	Heads of Service	In Progress



Comments From Executive Lead

A draft policy for statutory and mandatory learning is being presented at the operational people group to support the improvement of learning compliance and awareness.

Dave Harris, Director of People and Culture



People & Culture

Agency Hours Utilised

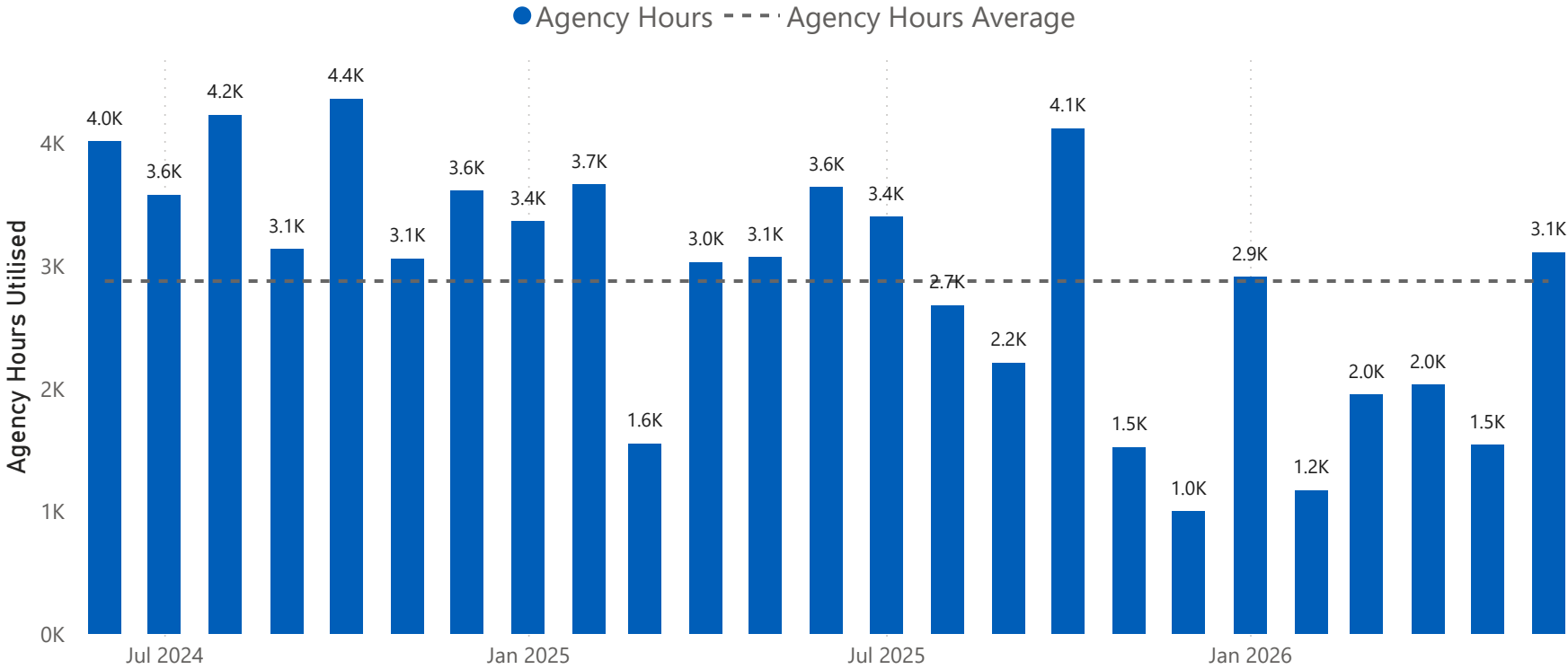
Compliance

KPI	Target	Actual	RAG Value
Agency hours used vs. average.		3110	Grey

Action	Target Date	Owner	Status
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All current actions completed/closed.

Hours Utilised - Agency Hours



Comments From Executive Lead

Dave Harris, Director of People and Culture



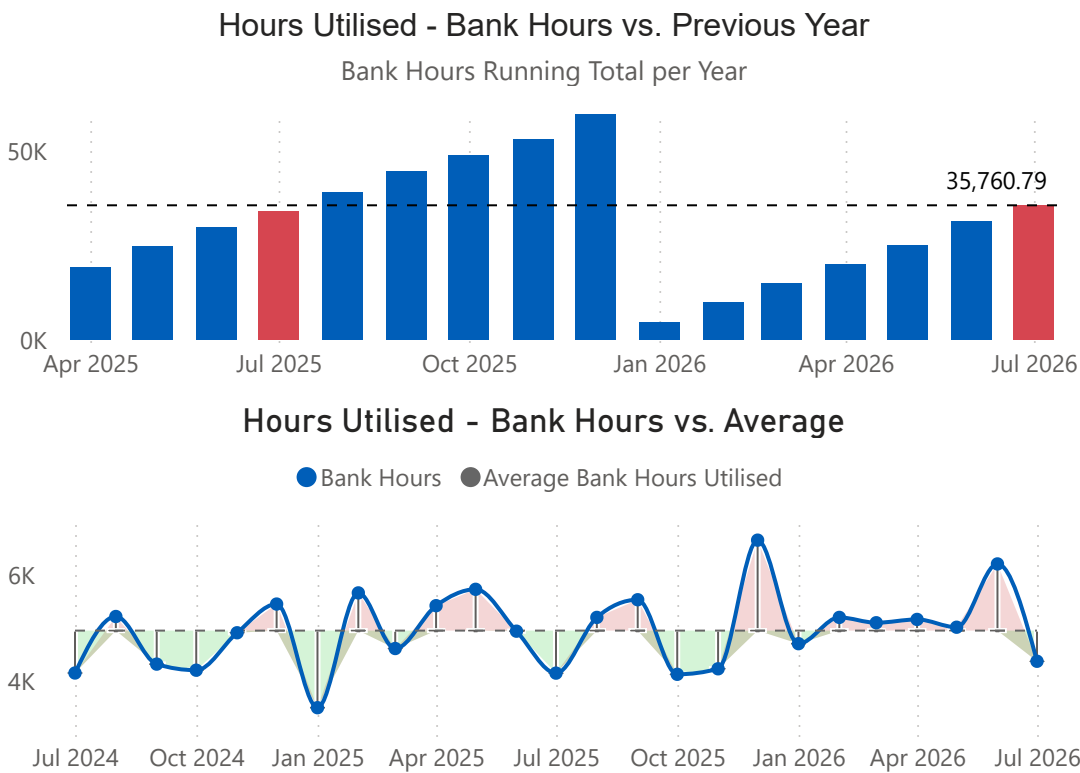
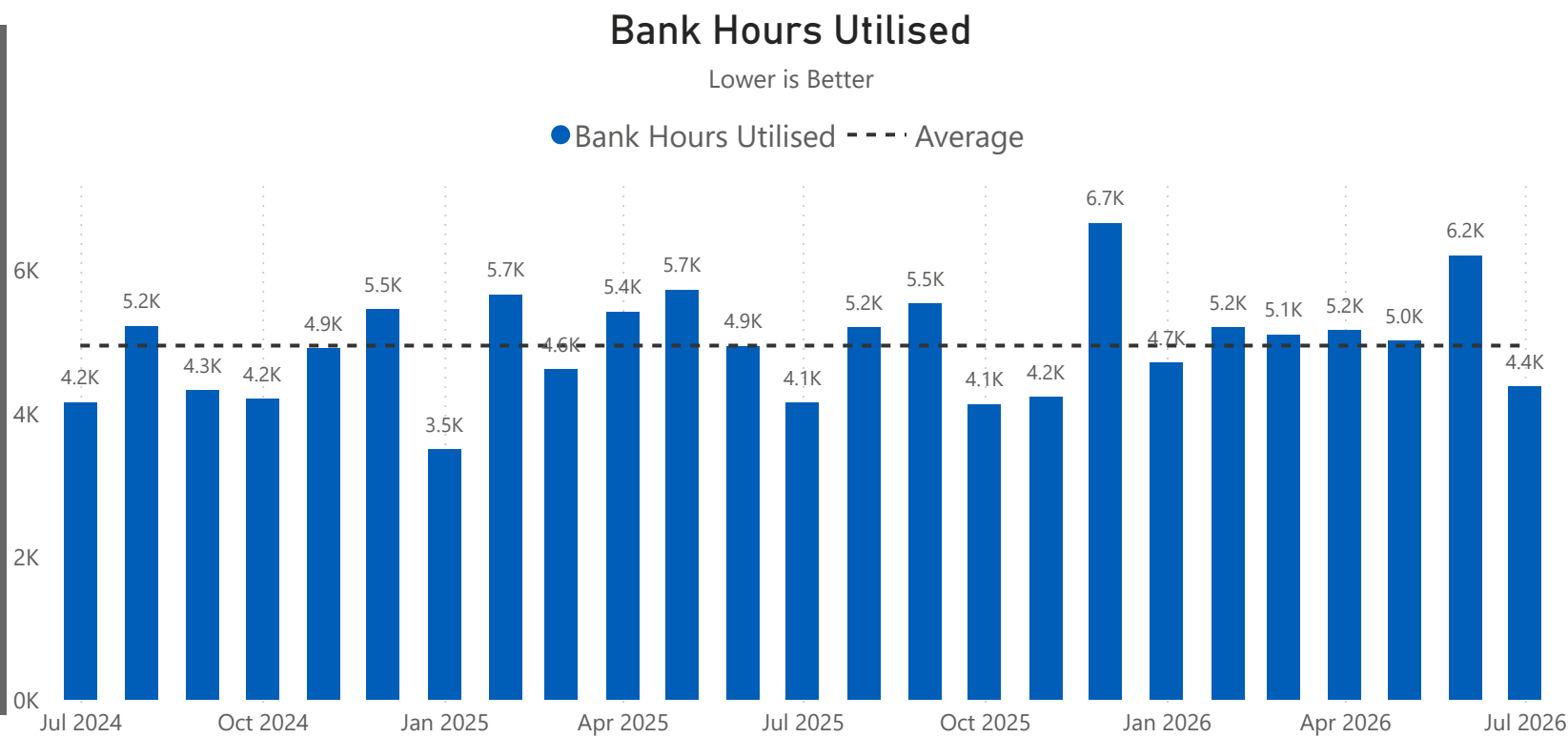
People & Culture
Bank Hours Utilised

Data Source
Latest Data
Workforce Systems
July 2026

Compliance

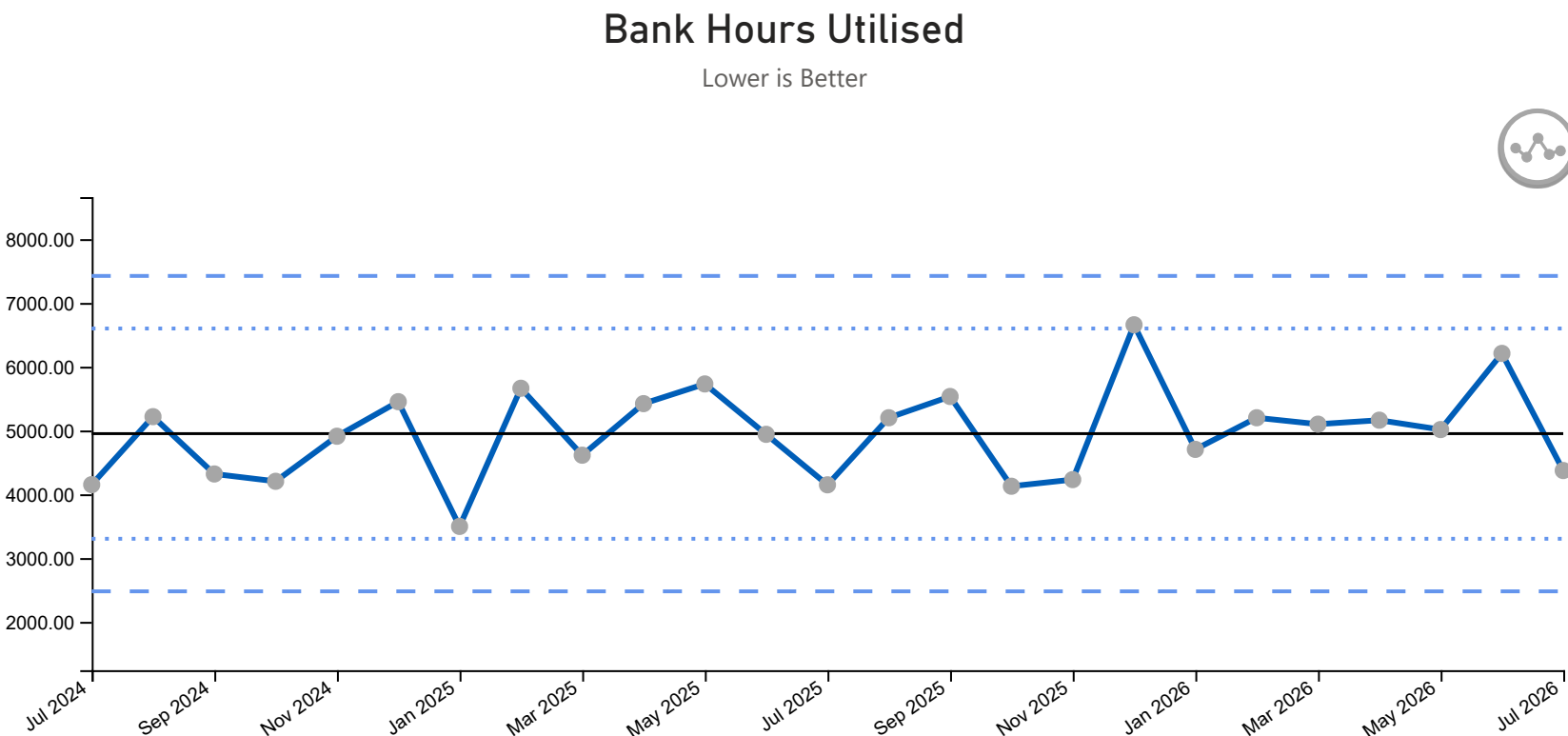
Table with 4 columns: KPI, Target, Actual, RAG Value. Row 1: Bank hours used vs. average., 4372, Grey.

Table with 4 columns: Action, Target Date, Owner, Status. Row 1: No target set, actions and target to be updated.



Statistical Process Control

Table with 8 columns: Date, Value, Target, LL 99%, UL 99%, LL 95%, UL 95%, Shift. Contains 40 rows of data from 01/07/2024 to 01/07/2026.



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

Compliance

KPI	Target	Actual	RAG Value
Overtime hours used vs. average.		388	Grey

Action

Target Date

Owner

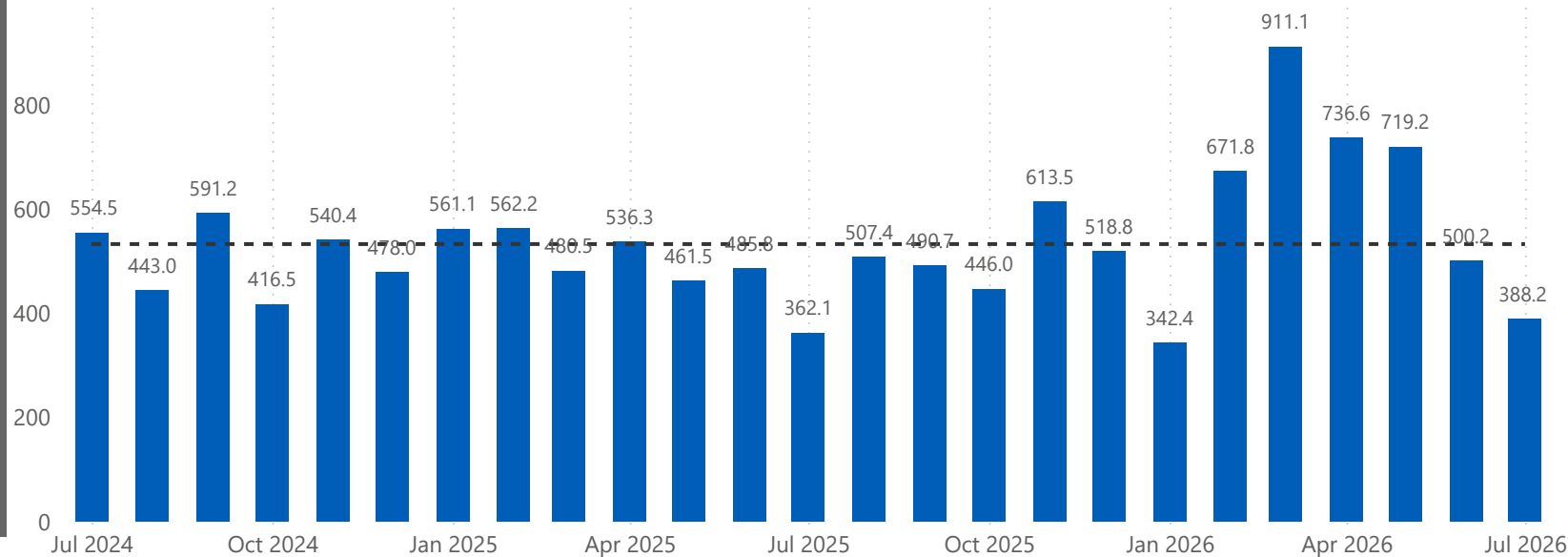
Status

No target set, actions and target to be updated.

Overtime Hours Utilised

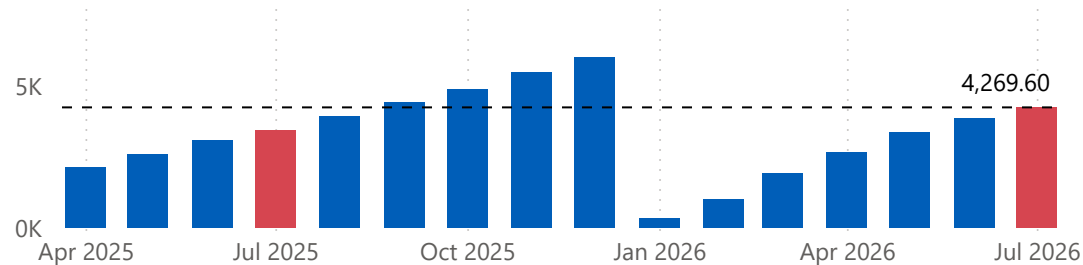
Lower is Better

Overtime Hours Utilised - - - - Average



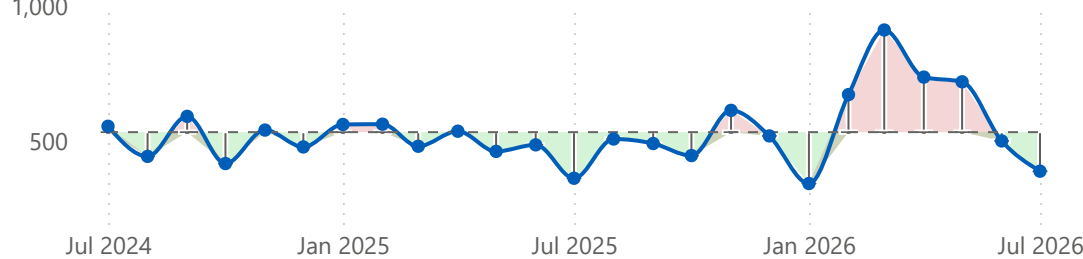
Hours Utilised - Overtime Hours vs. Previous Year

Overtime Hours Running Total per Year



Hours Utilised - Overtime Hours

Overtime Hours - Average Bank Hours Utilised

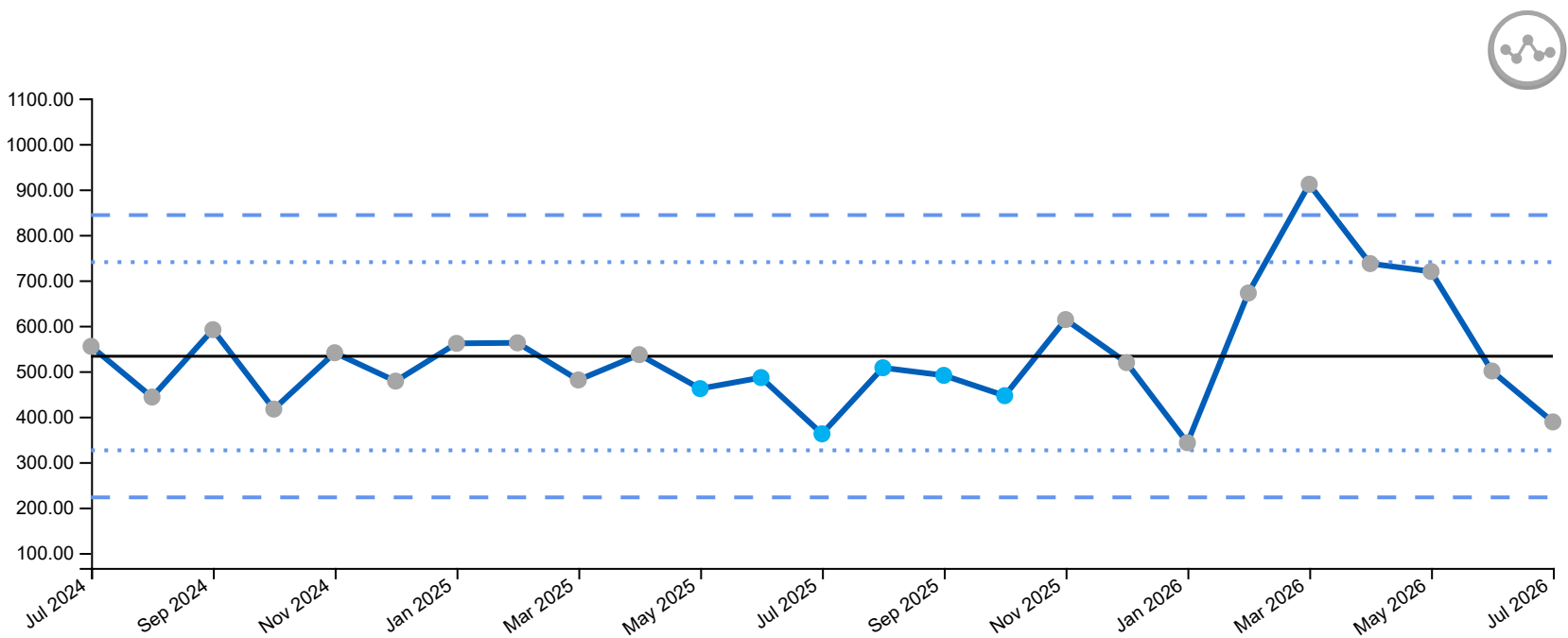


Statistical Process Control

Date	Value	Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	554.54	532.76	222.25	843.28	325.76	739.77	None
01/08/2024	443.00	532.76	222.25	843.28	325.76	739.77	None
01/09/2024	591.23	532.76	222.25	843.28	325.76	739.77	None
01/10/2024	416.50	532.76	222.25	843.28	325.76	739.77	None
01/11/2024	540.44	532.76	222.25	843.28	325.76	739.77	None
01/12/2024	478.00	532.76	222.25	843.28	325.76	739.77	None
01/01/2025	561.09	532.76	222.25	843.28	325.76	739.77	None
01/02/2025	562.24	532.76	222.25	843.28	325.76	739.77	None
01/03/2025	480.50	532.76	222.25	843.28	325.76	739.77	None
01/04/2025	536.28	532.76	222.25	843.28	325.76	739.77	None
01/05/2025	461.51	532.76	222.25	843.28	325.76	739.77	Improvement
01/06/2025	485.75	532.76	222.25	843.28	325.76	739.77	Improvement
01/07/2025	362.08	532.76	222.25	843.28	325.76	739.77	Improvement
01/08/2025	507.42	532.76	222.25	843.28	325.76	739.77	Improvement
01/09/2025	490.67	532.76	222.25	843.28	325.76	739.77	Improvement
01/10/2025	446.00	532.76	222.25	843.28	325.76	739.77	Improvement
01/11/2025	613.46	532.76	222.25	843.28	325.76	739.77	None
01/12/2025	518.80	532.76	222.25	843.28	325.76	739.77	None
01/01/2026	342.44	532.76	222.25	843.28	325.76	739.77	None
01/02/2026	671.82	532.76	222.25	843.28	325.76	739.77	None
01/03/2026	911.09	532.76	222.25	843.28	325.76	739.77	None
01/04/2026	736.59	532.76	222.25	843.28	325.76	739.77	None
01/05/2026	719.20	532.76	222.25	843.28	325.76	739.77	None
01/06/2026	500.23	532.76	222.25	843.28	325.76	739.77	None
01/07/2026	388.23	532.76	222.25	843.28	325.76	739.77	None

Overtime Hours Utilised

Lower is Better



Comments From Executive Lead

Overtime has decreased in the last quarter; however, this remains higher than the same time last year.

Dave Harris, Director of People and Culture



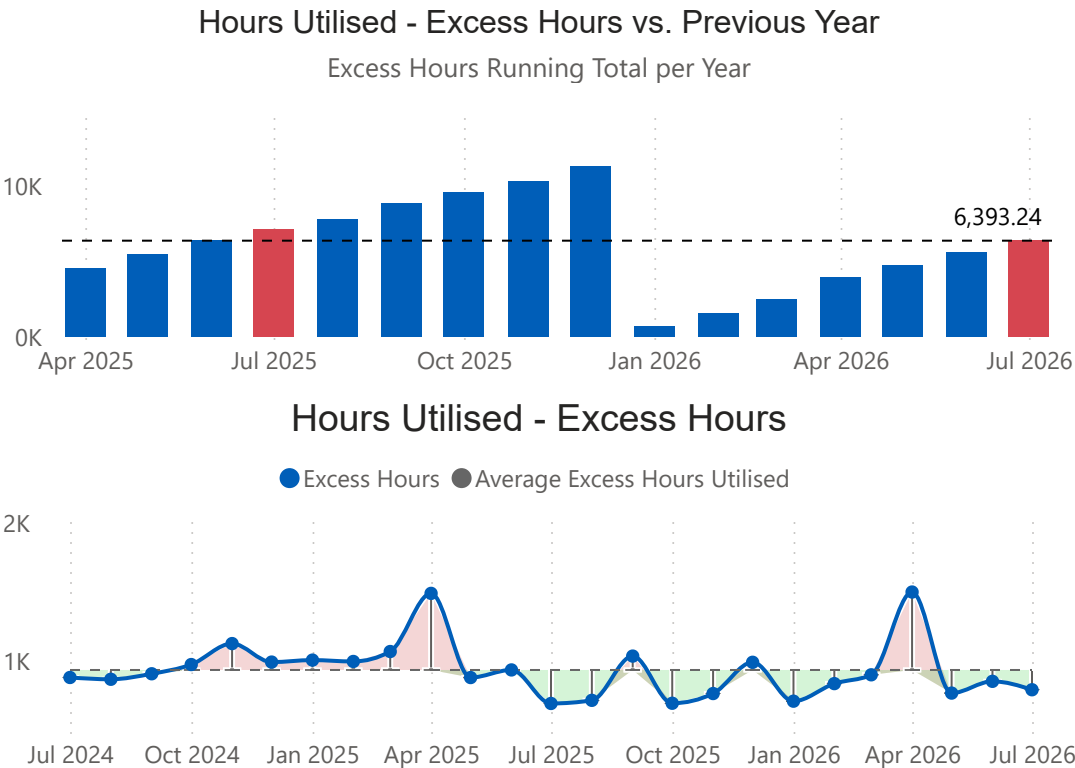
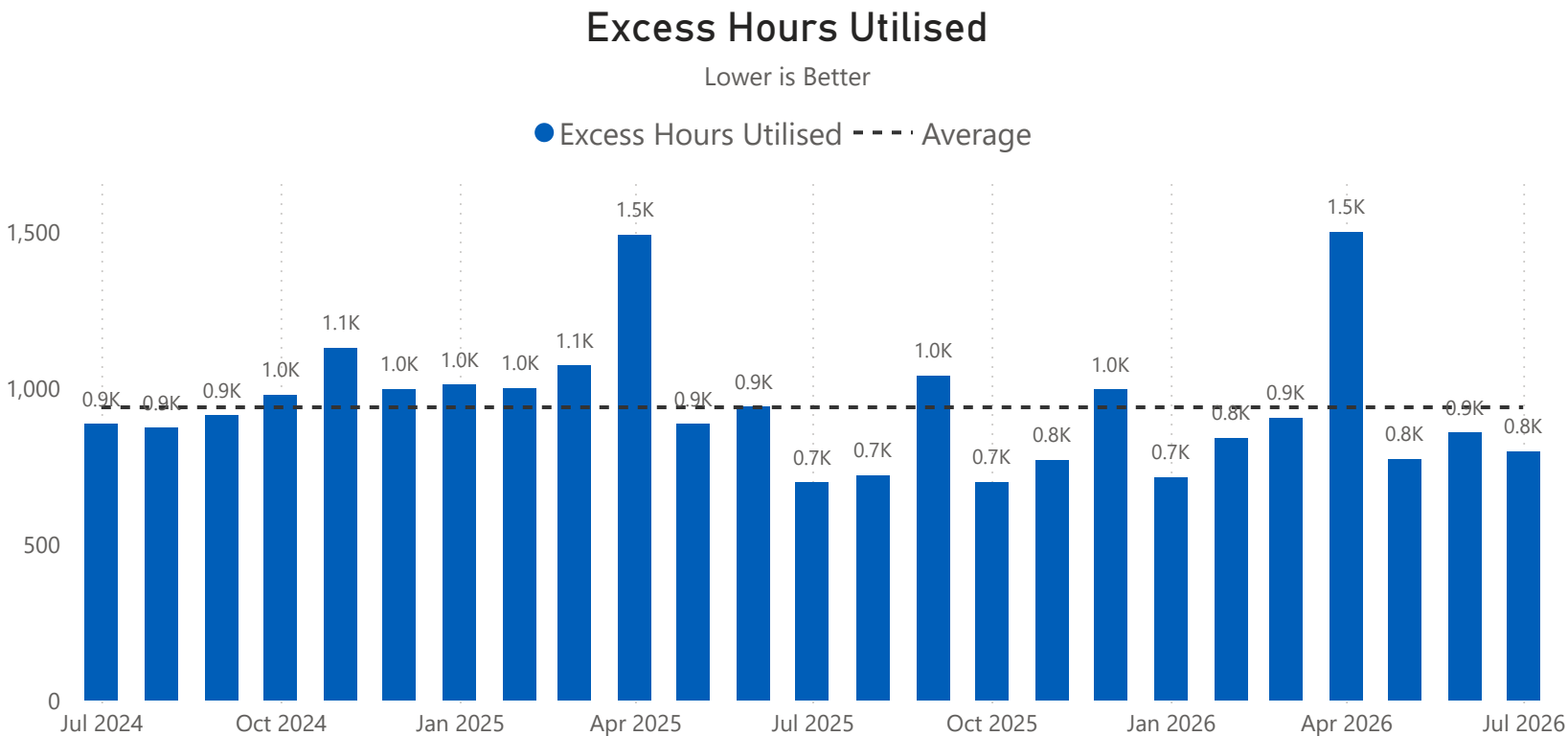
People & Culture

Excess Hours Utilised

Compliance

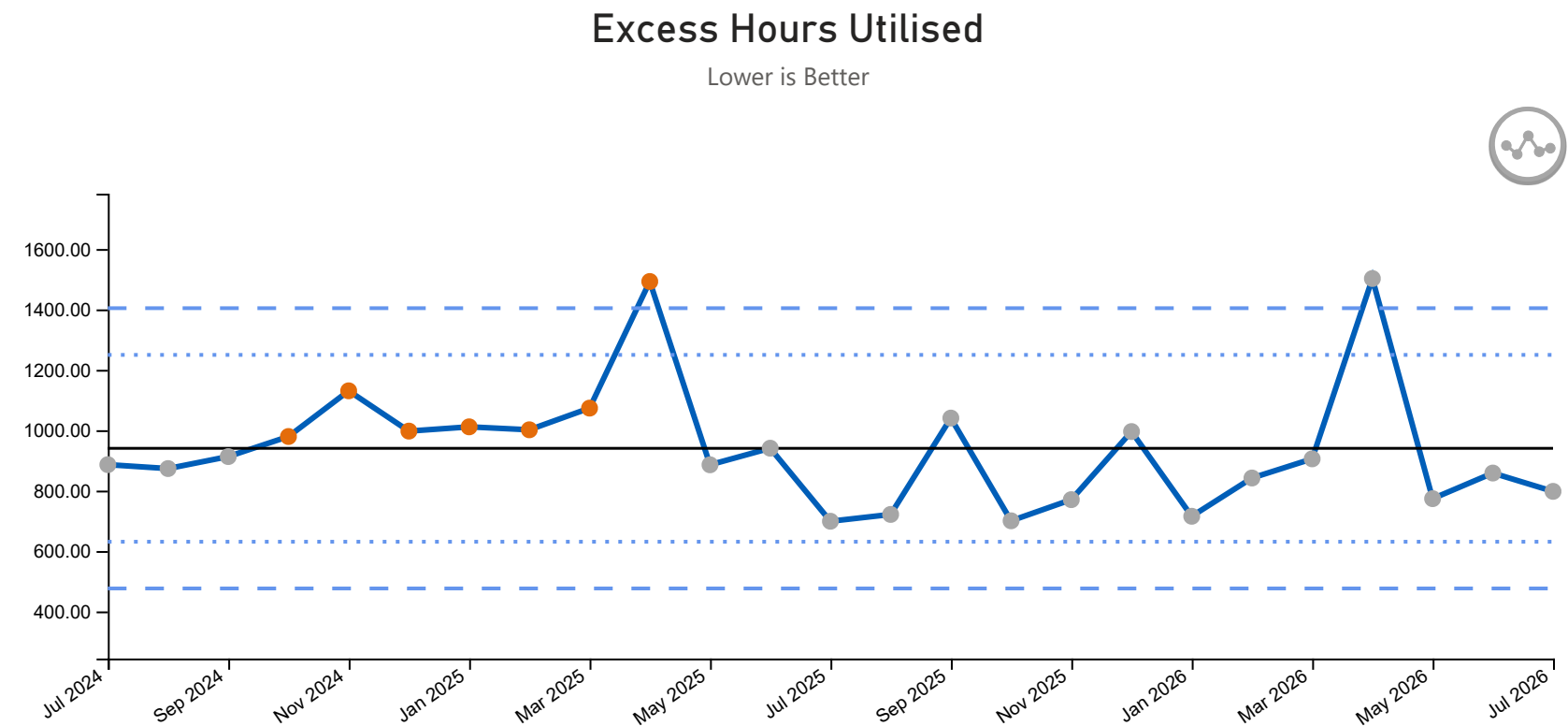
KPI	Target	Actual	RAG Value
Excess hours used vs. average.		798	Grey

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
01/07/2024	885.97	940.04	476.06	1404.02	630.72	1249.36	None
01/08/2024	873.00	940.04	476.06	1404.02	630.72	1249.36	None
01/09/2024	912.73	940.04	476.06	1404.02	630.72	1249.36	None
01/10/2024	979.15	940.04	476.06	1404.02	630.72	1249.36	Deterioration
01/11/2024	1130.39	940.04	476.06	1404.02	630.72	1249.36	Deterioration
01/12/2024	997.03	940.04	476.06	1404.02	630.72	1249.36	Deterioration
01/01/2025	1011.16	940.04	476.06	1404.02	630.72	1249.36	Deterioration
01/02/2025	1001.39	940.04	476.06	1404.02	630.72	1249.36	Deterioration
01/03/2025	1073.14	940.04	476.06	1404.02	630.72	1249.36	Deterioration
01/04/2025	1492.39	940.04	476.06	1404.02	630.72	1249.36	Deterioration
01/05/2025	885.48	940.04	476.06	1404.02	630.72	1249.36	None
01/06/2025	940.41	940.04	476.06	1404.02	630.72	1249.36	None
01/07/2025	698.58	940.04	476.06	1404.02	630.72	1249.36	None
01/08/2025	721.14	940.04	476.06	1404.02	630.72	1249.36	None
01/09/2025	1040.17	940.04	476.06	1404.02	630.72	1249.36	None
01/10/2025	700.06	940.04	476.06	1404.02	630.72	1249.36	None
01/11/2025	770.10	940.04	476.06	1404.02	630.72	1249.36	None
01/12/2025	995.52	940.04	476.06	1404.02	630.72	1249.36	None
01/01/2026	715.06	940.04	476.06	1404.02	630.72	1249.36	None
01/02/2026	841.75	940.04	476.06	1404.02	630.72	1249.36	None
01/03/2026	905.24	940.04	476.06	1404.02	630.72	1249.36	None
01/04/2026	1502.15	940.04	476.06	1404.02	630.72	1249.36	None
01/05/2026	773.36	940.04	476.06	1404.02	630.72	1249.36	None
01/06/2026	858.18	940.04	476.06	1404.02	630.72	1249.36	None
01/07/2026	797.50	940.04	476.06	1404.02	630.72	1249.36	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.

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.

There is risk to delivering elements of the efficiency schemes and there is a need to mitigate the risk by focusing on spend controls. The planned efficiency target has also not achieved the month three target delivery.

Overspend areas include medical and dental pay.

In September, NHS Orkney will begin to identify the efficiency plan for 2027/28 so that actions to deliver next year's plan can begin within the current year.

Finance

Financial Position Summary

Data Source
Finance Performance Report

Latest Data
June 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	-1,168	-137	-96	41	-320	-292	28
Other	-491	-95	-41	54	-279	-123	157
Primary Care Patient Charges	-431	-26	-31	-4	-135	-148	-13
Total Income	-2,090	-258	-168	91	-734	-563	171
Expenditure							
Pay							
Medical & Dental	9,672	940	807	-133	3,193	2,418	-775
Nursing & Midwifery	17,782	1,374	1,482	108	4,251	4,445	194
Other Staff Costs	27,545	2,110	2,299	190	6,308	6,888	579
Total Pay	54,999	4,424	4,589	164	13,753	13,751	-2
Non Pay							
Drugs - Primary Care	4,866	422	405	-16	1,205	1,216	12
Drugs - Secondary Care	3,645	292	304	11	767	911	144
General Dental Services	1,165	110	110	0	392	392	0
General Medical Services	5,157	484	430	-54	1,332	1,289	-43
General Ophthalmic Services	312	34	34	0	97	97	0
Medical Supplies	1,630	194	136	-58	539	407	-131
Other Expenditure	13,294	1,609	1,175	-434	4,243	3,338	-905
Pharmaceutical Services	1,057	89	88	0	240	263	23
Resource Transfer	2,334	186	195	9	651	584	-68
SLA's & UNPACs	10,084	831	840	9	2,753	2,521	-232
Total Non-Pay	43,544	4,251	3,717	-534	12,219	11,018	-1,201
Total	96,453	8,417	8,138	-279	25,238	24,206	-1,032

Figures shown in the above table represent £000s

Finance

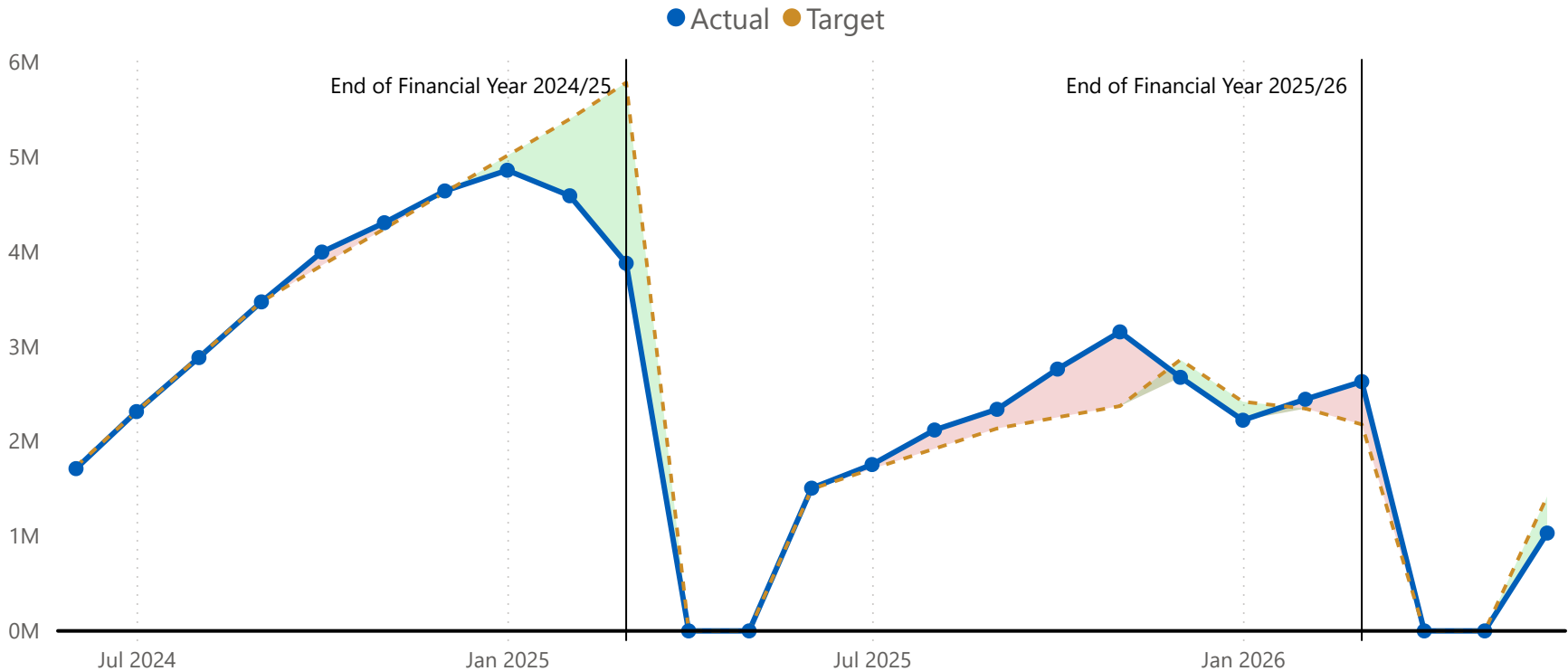
Financial Performance Against Plan

Compliance

KPI	Target	Actual	RAG Value
Financial performance against plan - YTD.	£1,417,000	£1,031,000	Green

Action	Target Date	Owner	Status
A training pack has been developed and is being trialed. If successful, this will be rolled out beyond the nursing team.		D Reid	In Progress
Ensure all outstanding budget holders undertake training in budget management	31/12/2026	M Barnes	In Progress

Financial Performance Against Plan



Comments From Executive Lead

The Month 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.

Damian Reid, Director of Finance

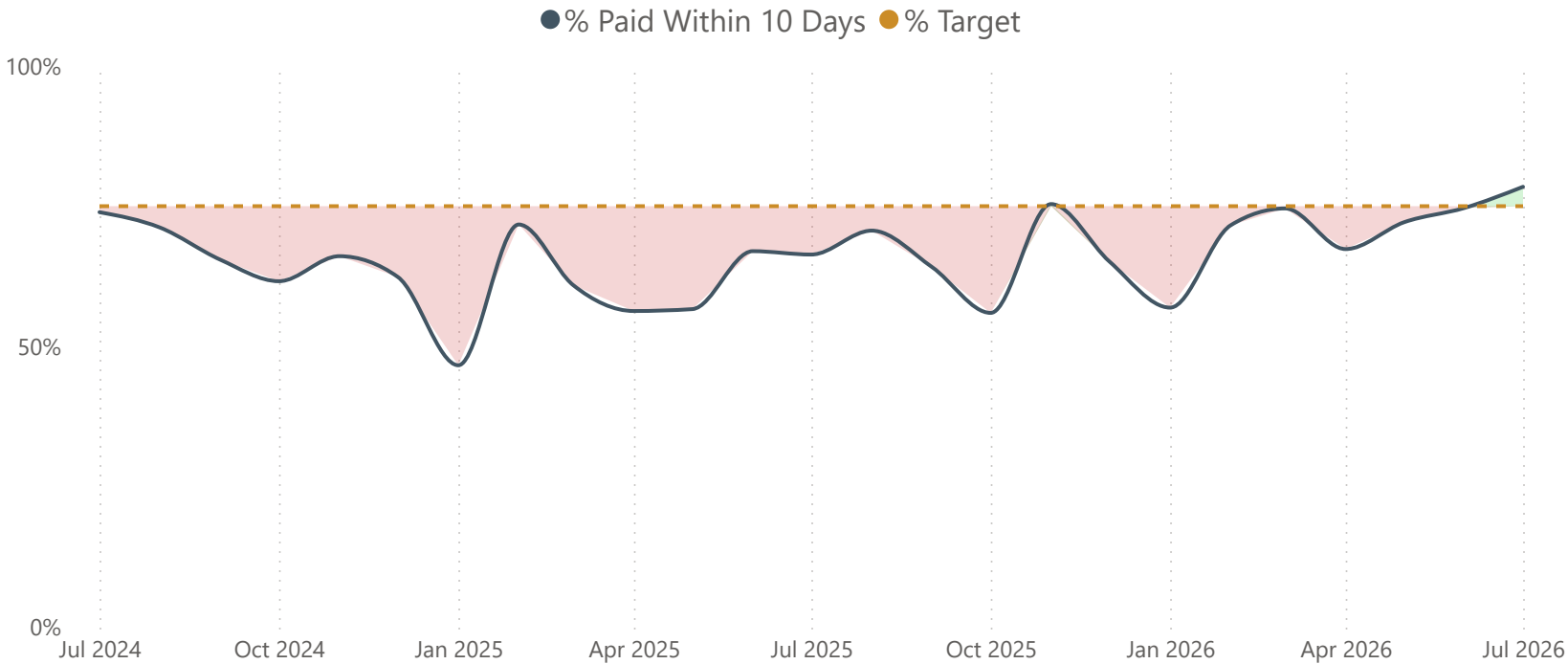


Finance
Accounts Payable 10-Day Performance

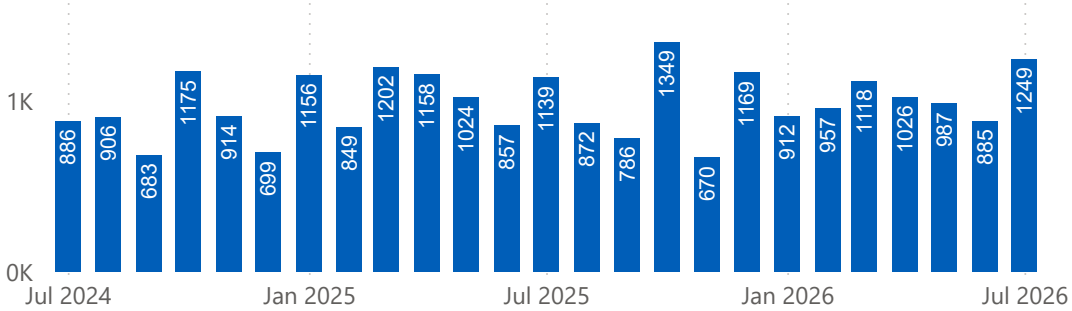
Compliance

Table with 4 columns: KPI, Target, Actual, RAG Value. Row 1: 75% of invoices to be paid within 10 days of receipt - local target, 75.00%, 78.46%, Green. Row 2: Action, Target Date, Owner, Status. Row 3: Ensure all outstanding budget holders undertake training in budget management, 31/12/2026, M Barnes, In Progress. Row 4: Continue to escalate issues with receipting of PO's and submission of invoices by departments to DoF, 31/03/2027, In Progress.

Accounts Payable - Invoices Paid Within 10 Days of Receipt



Accounts Payable - Invoices Received



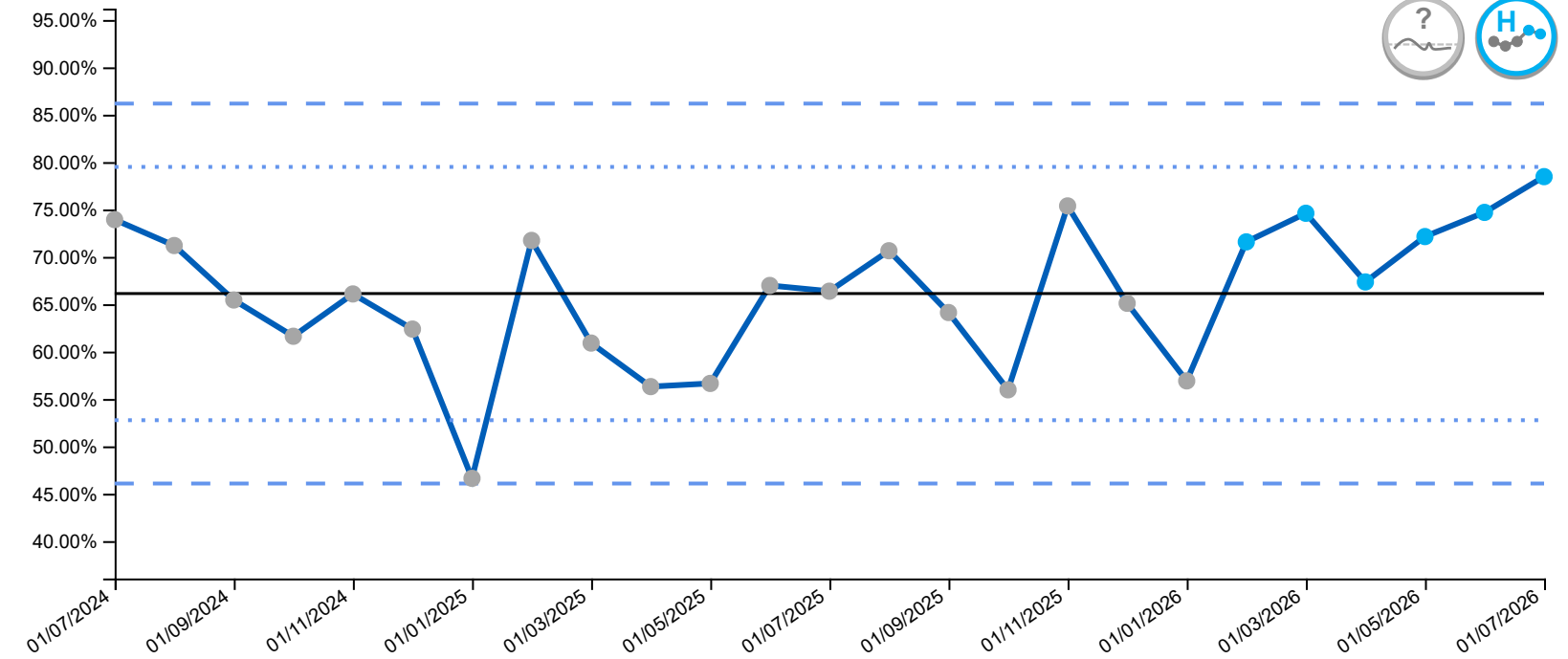
Accounts Payable 10-Day Target - Last 6 Months

Table with 6 columns: Month, Received, Paid <= 10 Days, % <= 10 Days, Target, RAG Value. Rows for February 2026 to July 2026.

Statistical Process Control

Table with 9 columns: Date, Value, Target, Alt. Target, LL 99%, UL 99%, LL 95%, UL 95%, Shift. Rows from 01/07/2024 to 01/07/2026.

Accounts Payable - Invoices Paid Within 10 Days of Receipt



Comments From Executive Lead

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

Damian Reid, Director of Finance



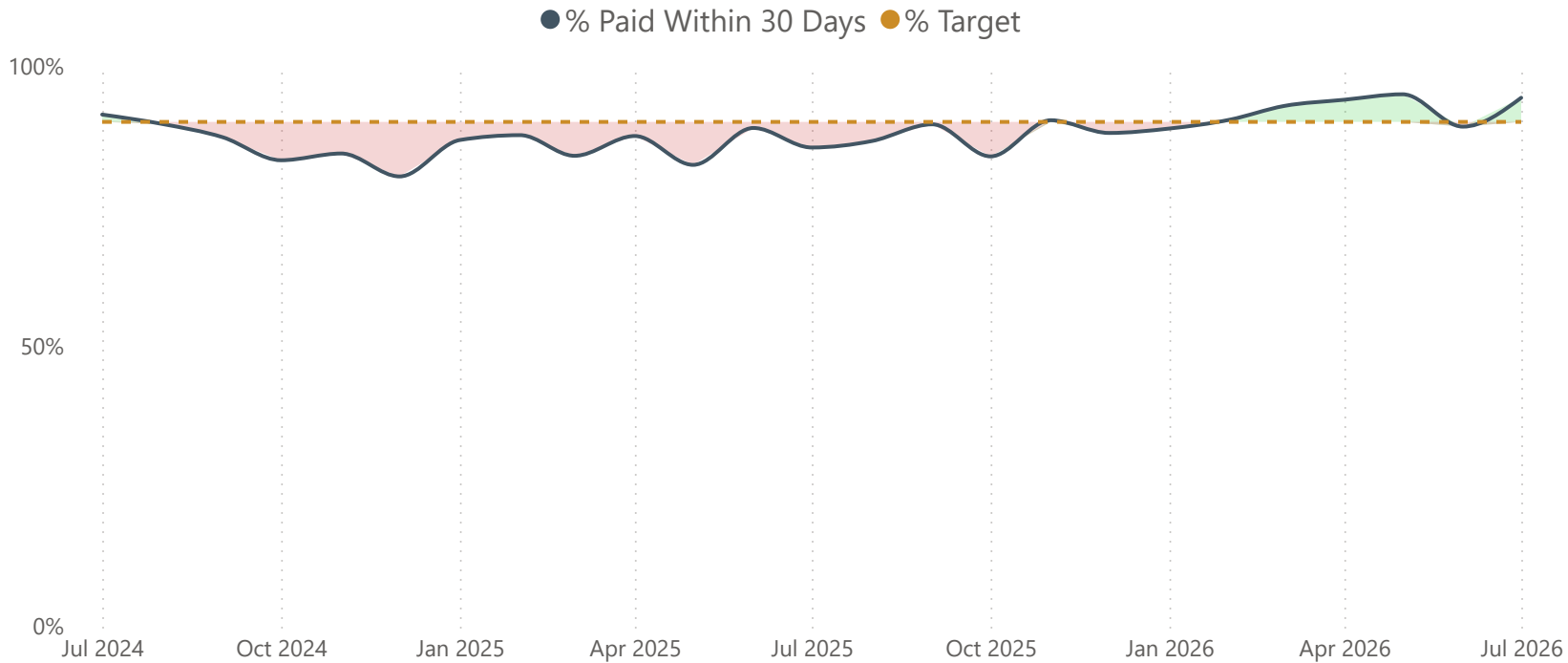
Finance

Accounts Payable 30-Day Performance

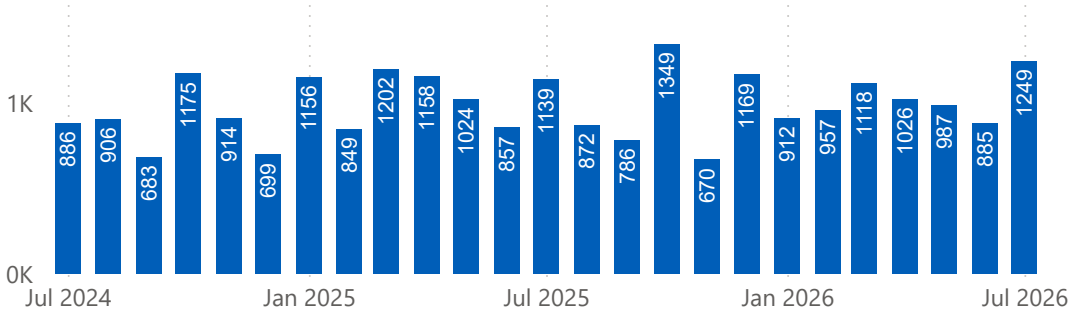
Compliance

KPI	Target	Actual	RAG Value
90% of invoices to be paid within 30 days of receipt - local target	90.00%	94.32%	Green
Action	Target Date	Owner	Status
Ensure all outstanding budget holders undertake training in budget management	31/12/2026	M Barnes	In Progress
Continue to escalate issues with receipting of PO's and submission of invoices by departments to DoF	31/03/2027		In Progress

Accounts Payable - Invoices Paid Within 30 Days of Receipt



Accounts Payable - Invoices Received



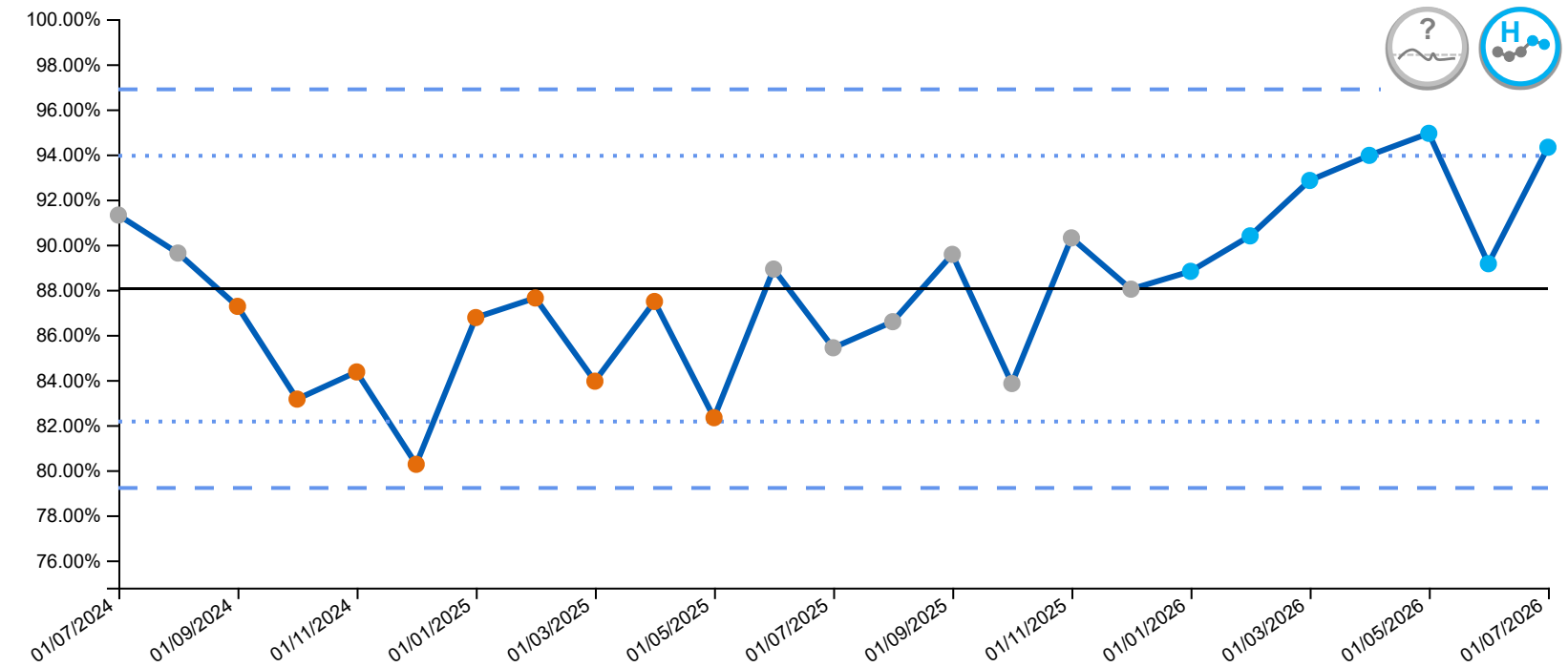
Accounts Payable 30-Day Target - Last 6 Months

Month	Received	Paid <=30 Days	% <=30 Days	Target	RAG Value
February 2026	957	865	90.39%	90.00%	Green
March 2026	1118	1038	92.84%	90.00%	Green
April 2026	1026	964	93.96%	90.00%	Green
May 2026	987	937	94.93%	90.00%	Green
June 2026	885	789	89.15%	90.00%	Red
July 2026	1249	1178	94.32%	90.00%	Green

Statistical Process Control

Date	Value	Target	Alt. Target	LL 99%	UL 99%	LL 95%	UL 95%	Shift
01/07/2024	91.31	88.05	90.00	79.21	96.88	82.15	93.94	None
01/08/2024	89.62	88.05	90.00	79.21	96.88	82.15	93.94	None
01/09/2024	87.26	88.05	90.00	79.21	96.88	82.15	93.94	Deterioration
01/10/2024	83.15	88.05	90.00	79.21	96.88	82.15	93.94	Deterioration
01/11/2024	84.35	88.05	90.00	79.21	96.88	82.15	93.94	Deterioration
01/12/2024	80.26	88.05	90.00	79.21	96.88	82.15	93.94	Deterioration
01/01/2025	86.76	88.05	90.00	79.21	96.88	82.15	93.94	Deterioration
01/02/2025	87.63	88.05	90.00	79.21	96.88	82.15	93.94	Deterioration
01/03/2025	83.94	88.05	90.00	79.21	96.88	82.15	93.94	Deterioration
01/04/2025	87.48	88.05	90.00	79.21	96.88	82.15	93.94	Deterioration
01/05/2025	82.32	88.05	90.00	79.21	96.88	82.15	93.94	Deterioration
01/06/2025	88.91	88.05	90.00	79.21	96.88	82.15	93.94	None
01/07/2025	85.43	88.05	90.00	79.21	96.88	82.15	93.94	None
01/08/2025	86.58	88.05	90.00	79.21	96.88	82.15	93.94	None
01/09/2025	89.57	88.05	90.00	79.21	96.88	82.15	93.94	None
01/10/2025	83.84	88.05	90.00	79.21	96.88	82.15	93.94	None
01/11/2025	90.30	88.05	90.00	79.21	96.88	82.15	93.94	None
01/12/2025	88.02	88.05	90.00	79.21	96.88	82.15	93.94	None
01/01/2026	88.82	88.05	90.00	79.21	96.88	82.15	93.94	Improvement
01/02/2026	90.39	88.05	90.00	79.21	96.88	82.15	93.94	Improvement
01/03/2026	92.84	88.05	90.00	79.21	96.88	82.15	93.94	Improvement
01/04/2026	93.96	88.05	90.00	79.21	96.88	82.15	93.94	Improvement
01/05/2026	94.93	88.05	90.00	79.21	96.88	82.15	93.94	Improvement
01/06/2026	89.15	88.05	90.00	79.21	96.88	82.15	93.94	Improvement
01/07/2026	94.32	88.05	90.00	79.21	96.88	82.15	93.94	Improvement

Accounts Payable - Invoices Paid Within 30 Days of Receipt



Comments From Executive Lead

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

Damian Reid, Director of Finance



ORKNEY NHS BOARD

Chair: Davie Campbell

Vice-Chairperson: Joanna Kenny

DRAFT GOVERNANCE STANDING COMMITTEES SEPTEMBER 2026

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

Joint Clinical and Care Governance Committee	Chair	Vice Chair	Non-executive Board Members	Lead Executive	Governance Lead
Three non-executive members one of whom must be the Area Clinical Forum Chair and a voting member of the Integration Joint Board.	Lynne Spence	Rona Gold (NHSO) Jean Stevenson (OIC)	Dr Kirsty Cole Ryan McLaughlin	Executive Nurse Director Chief Officer IJB	Rachel Ratter
Staff Governance Committee	Chair	Vice Chair	Non-executive Board Members	Lead Executive	Governance Lead
Four non-executive members including the Employee Director	Joanna Kenny	Ryan McLaughlin	Jason Taylor Dr Kirsty Cole Jean Stevenson	Director of People and Culture	Hazel Aim
Remuneration Committee	Chair	Vice Chair	Non-executive Board Members	Lead Executive	Governance Lead
Four non-executive members including the Chair of the Board and the Employee Director	Joanna Kenny	Hayley Green	Davie Campbell Ryan McLaughlin	Director of People and Culture	Debs Crohn
Endowment Fund Trustees	Chair	Vice-Chair	Non-executive Board Members	Lead Executive	Governance Lead
All members of the Board	Davie Campbell	Lynne Spence	Ryan McLaughlin Jason Taylor Rona Gold Hayley Green Jean Stevenson Kirsty Cole Fiona MacKay Joanna Kenny Michael Morrison	Director of Public Health	Hazel Aim
Orkney Alcohol and Drugs Partnership					
Michael Morrison					

Area Partnership Forum			Governance Lead
Ryan McLaughlin – Chair			Jade Rosie
Area Clinical Forum			Governance Lead
Dr Kirsty Cole – Chair			Gizelle Venteer
Orkney Partnership Board			
Davie Campbell			
Community Planning Partnership			
Davie Campbell Joanna Kenny			

Committee Membership 1 September 2026

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 2026
Responsible Executive/ Non-Executive	Davie Campbell, Board Chair
Report Author(s)	Debs Crohn, Associate Director Corporate Governance
Purpose of report	Decision - Reaching a conclusion considering options
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	- The Board is asked to approve the updated Governance Committee Membership, to take effect from 1 September 2026, following the recruitment of three new Non-Executive Board Members. - The proposed committee membership supports effective scrutiny, clear accountability, informed decision-making and alignment with committee Terms of Reference, including any required membership or exclusion criteria. - The changes are intended to balance Non-Executive Member commitments, make best use of skills and experience, address financial escalation risks and support succession planning for key roles, including the Board Chair and Integration Joint Board responsibilities.
Route to meeting	Direct to Board – 27 August 2026
Recommendation(s)	The Board is asked to <u>Approve</u> the reviewed and updated Governance Committee Membership from 1 September 2026 as set out in Appendix 1.

Committee Membership 1 September 2026

Debs Crohn, Associate Director Corporate Governance
30/07/2026

1. Situation

- 1.1 Effective governance committees are essential to ensure the Board fulfils its statutory responsibilities and delivers on its strategic objectives.
- 1.2 Following the successful recruitment of three Non-Executive Board Members, a review of committee membership has been undertaken. The Board is asked to consider and approve the proposed changes with effect from 1 September 2026.

2. Background

- 2.1 As set out in the Blueprint for Good Governance, robust committee structures enable clear lines of accountability, promote informed decision-making and support transparency throughout the organisation.
- 2.2 Such committees provide the necessary oversight, scrutiny, and assurance that key risks are managed, performance is monitored, and public resources are used efficiently and responsibly. In this way, they underpin the delivery of safe, effective, and person-centred care, fostering an environment of continuous improvement and public trust.
- 2.3 In determining committee membership, the Board must have due regard to each committee's purpose, role, remit and accountability requirements. Each Governance Committee of the Board must have a minimum number of Non-Executive Members, including those who are members by virtue of the office they hold.

3. Assessment

Committee membership 1 September 2026

- 3.1 A review of the Board's committee membership has been completed to ensure all Non-Executive Members can fulfil their responsibilities within their current time commitments. Appendix 1 details the proposed membership of each committee from 1 September 2026, in accordance with their Terms of Reference, highlighting any specific requirements or mandatory exclusions that must be observed.
- 3.2 These changes have been carefully considered to balance workload across committees, address risks associated with financial escalation, ensure Non-Executive Members' skills and experience are used effectively in support of the Board's strategic objectives, and support succession planning for key roles, including the Board Chair and the Integration Joint Board.

3.3 Impact Assessment

In developing this report, the following areas have been assessed for their impact on delivery of the 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	No impact
People	Workforce	Yes	No impact
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. Recommendation(s)

4.1 Decision - Reaching a conclusion considering options

4.2 The Board is asked to

- **Approve** the reviewed and updated Governance Committee Membership from 1 September 2026, as set out in Appendix 1.

5. List of appendices

5.1 **Appendix 1**, Proposed Committee Membership 1 September 2026 – March 2027.

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: 24 June 2026
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Fiona MacKay, Chair, Non-Executive Board Member	
Presented By:	Fiona MacKay, Chair, Non-Executive Board Member	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Performance Committee at its meeting on 24 June 2026		

Matters of Concern or Key Risks to Escalate		Major Actions Commissioned / Work Underway	
Month 2 financial performance – Committee noted that Month 2 performance was favourable against plan, while raising concerns about delivery of some efficiency schemes scheduled for later in the year. Committee agreed to recommend to the Risk Management Group an increase to the financial sustainability risk score to 16 recognising the Month 2 position. Transformation Priorities – Concerns were raised in relation to the pace of change in relation to the Isles Model of Care noting substantial savings and patient care attached to this workstream. Robertsons Facilities Management contract – Whilst some positive assurance was provided, Committee remained concerned in relation to Planned Maintenance at The Balfour. Mitigations against the risk are being managed by the Capital and Strategic Estates Group and the Corporate Risk Register.		Financial Sustainability Risk - Interim Director of Finance to present an updated risk jotter to the Risk Management Group July 2026. IPR Community standards – Committee noted the need for further data on MSK physiotherapy and Speech and Language services. The Chief Officer IJB will provide a more detailed update at the August 2026 meeting. IPR Delayed Transfers of Care – EDoNMAHP to discuss guardianship escalation through our MSP with the Chief Officer IJB and Head of Health and Community Care, with an update to be provided at the 25 August 2026 meeting. Month 2 Financial Position - Interim Director of Finance to meet with the Employee Director and staff-side colleagues to discuss the workforce implications of reducing run-rates across the organisation, with updates to be provided to the Area Partnership Forum. Transformational Priorities – Chief Officer IJB to bring an in-depth update and plan for the Isles Model of Care workstream to the July 2026 meeting Medical Staffing Model Workstream – Executive Management Team continue to work through the medical staffing model including benchmarking with other Health Boards. Robertsons Facilities Management – Interim Director of Finance to provide an overview of Performance Indicators (PIs) for inclusion in the next update to Committee. GP IT Re-provisioning – Committee noted that implementation of the new GP IT systems is underway, while recognising challenges arising from limited project management capacity.	
Positive Assurances to Provide		Decisions Made	
- Committee took assurance on the Integrated Performance Report aligned to the Finance and Performance Committee. - Positive progress was noted in relation to outpatient activity and waiting times, including the ultrasound service waiting list.		- Minutes and Chair's Assurance Report approved from meeting held 24 May 2026. - Reporting on the local efficiency programme will be covered in the monthly financial position, rather than being presented separately.	

3. Committee noted strong performance against the Emergency Department 4-hour target, with the Board consistently among the top three performing Boards in Scotland.
4. Committee noted that there had been an issue with how diagnostic performance was presented in the IPR which has now been resolved.
5. Assurance provided by the Executive Management Team that grip and control is in place in relation to discretionary costs and vacancy control run rates.
6. Committee took assurance on progress being made in relation to the Older Persons/Frailty and Out of Hours Transformational Priorities Workstreams.
7. Committee welcomed and took assurance on the planned care trajectories for 2026/27.
8. Assurance provided via Chair's Assurance Reports on the following
 - Improving Together Programme Board on our Efficiency Savings Programme 29 May 2026
 - Digital Information Operations Group (DIOG) on accelerating digital transformation 27 May 2026.
9. The Board is now live with the new national Child Health System which is a significant achievement

Comments on Effectiveness of the Meeting

- Apologies and the absence of some presenters limited the Committee's ability to take full assurance or make decisions on some items; further updates will be brought back where required.
- Members noted that some participants experienced technical difficulties associated with virtual meeting arrangements.

Finance and Performance Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Finance and Performance Committee	Date of Meeting: 28 July 2026
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Damian Reid, Interim Director Finance	
Presented By:	Fiona MacKay, Chair, Non-Executive Board Member	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Performance Committee at its meeting on 28 July 2026		

Matters of Concern or Key Risks to Escalate		Major Actions Commissioned / Work Underway	
Month 3 financial performance – Committee noted that Month 3 performance remains a challenge but remains on plan due to a focus on run rate controls, Concerns were raised in relation to delivery of efficiency schemes scheduled for later in the year. Transformational Priorities – Concerns were raised in relation to the pace of change in relation to the Isles Model of Care, Medical Staffing and Out of Hours noting substantial savings and improvements to patient care are associated to these workstreams. IJB reserves could be used as mitigation for non-delivery of the Isles Model of Care and Out of Hours workstreams.		Financial Sustainability Risk - Interim Director of Finance to present an updated risk jotter to the Risk Management Group July 2026. Month 3 Financial Position - Interim Director of Finance to deliver a session with Senior Leadership Team 5 August 2026 to support managers to better understand the budget-setting process and strengthen delivery of cost control measures Transformational Priorities – Deep dive of the 4 transformational priorities to be undertaken by the Improving Together Programme Board, update to be provided at next meeting. Isles Model of Care – Chief Officer IJB to present delivery and engagement plan to Committee 24 August 2026. Out of Hours Workstream – Medical Director and Interim Chief Operating Officer (COO) continue to align the workstream to sub-national planning and local target operating model. Medical Staffing Model Workstream – Medical Director to present an update on the current position on the medical staffing workstream to 25 August 2026 Meeting. Digital work is supporting efficiency and future service improvement Work is underway to identify cost-reduction and service improvement opportunities including roll out of Mycare app, and the SharePoint roll-out ahead of 'The Blog' becoming unsupported from January 2027.	
Positive Assurances to Provide		Decisions Made	
- Committee took assurance on the Corporate Risk Register aligned to Finance and Performance Committee. - Positive assurance provided on the litigation 6-monthly report noting an increase in the number of cases. - Positive assurance provided on management of the Robertsons contract in relation to Planned Maintenance at The Balfour. Key Performance Indicators (KPI's) will be presented to Committee in August 2026 to ensure performance is more effectively managed.		Minutes and Chair's Assurance Report approved from meeting held 24 June 2026.	

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| <ol style="list-style-type: none"> 4. Positive progress is being made across key digital programmes, good assurance on delivery, including reduced risk around the PACS/RIS roll-out, the planned go-live of GP IT re-provisioning at Stromness, and continued progress with the MORSE Community Electronic Patient Record roll-out across community services. 5. Assurance provided via Chair's Assurance Reports from the following <ul style="list-style-type: none"> • Digital Information Operations Group (DIOG) on accelerating digital transformation 22 June 2026. • Capital and Property Strategic Group 29 June 2026 • Improving Together Programme Board on our Efficiency Savings Programme 2 July 2026 | |
|--|--|

Comments on Effectiveness of the Meeting

- Frank, honest and open responses welcomed from the Executive Team.

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: 09 July 2026
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Dave Harris, Director of People and Culture	
Presented By:	Dave Harris, Director of People and Culture	
Purpose		
This report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on Tuesday 09 July 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. iMatter action planning – SLT agreed the following actions: - Director of People and Culture to develop “we said, we did” staff communications, outlining what actions SLT has agreed to take e.g. organisational, team and individual expectations, with a clear focus on speaking up, managing performance and visible leadership, and feeding back ideas arising from the iMatter survey. - Invite two to four members of staff to attend SLT each month. - Director of People and Culture and Head of Corporate Governance to agree the governance route for iMatter action plan. - Reset the approach to education, learning and development – this is a longer-term piece of work - Better use of TV screens and public spaces across the organisation to promote our work and our teams. - Explore the opportunity to train coaches and mentors through the endowment fund. - Create listening spaces where open discussions about complex issues can take place collectively / SLT to be tasked in future meetings to take complex/wicked problems back to their teams for ideas and solutions generation - Relaunch the Bright Ideas Scheme. 2. Population Health Organisation – SLT members to complete a Public Health Team surveys on the Population Health Organisation Improvement Plan, which will return to SLT in September 2026. 3. East of Scotland sub-regional planning – Head of Corporate Governance to explore how to ensure SLT is regularly kept informed of activities and planning with Scotland East region. 4. Long service awards – Director of People and Culture to clarify current policy and approach to long service awards.

Positive Assurances to provide	Decisions Made
1. SLT and clinical colleagues held positive, focused discussions on iMatter action planning, noting the positive feedback on visible leadership and team leadership set out in the HIS unannounced inspection reports. 2. SLT reflected on the positive impact of Board Walkarounds as a mechanism for receiving and acting on staff feedback. 3. Positive conversations took place in relation to moving to a Population Health Organisation. 4. Positive assurance was provided on the rollout of Optima (e-rostering), with the IP1 pilot complete and a service desk being established to manage support requests. SLT committed to ensuring their teams engage fully with the roll-out and understand the rationale and benefits. 5. SLT noted and welcomed the planned move from The Blog to SharePoint in 2027. 6. SLT discussed and welcomed the refreshed policy and procedure development framework, recognising it as a clear “we said, we did” response. 7. SLT noted the following key documents: • Record of Attendance 2026/27 • Timetable for papers 2026/27	1. Minutes and Chair’s Assurance Report approved from meeting held on 3 June 2026.
Feedback about the meeting - A wide range of constructive and imaginative contributions were made, and questions were raised and answered.	

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: 05 August 2026
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	James Goodyear, Interim CEO	
Presented By:	James Goodyear, Interim CEO	
Purpose		
This report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on 5 August 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. Supporting understanding of the budget-setting process and strengthening delivery of cost control measures – SLT agreed the following actions: • Clarify the current budget position for 2026/27. • Budget holders to review their budgets and confirm whether they can remain within allocation or exceed proposed savings targets. • Use peer support to identify and discuss opportunities. • Escalate any concerns about unintended consequences arising from savings targets.
Positive Assurances to provide		Decisions Made
1. SLT and clinical colleagues held positive, focused discussions on our budget setting processes and strengthening delivery of cost control measures. 2. SLT noted the following key documents: • Record of Attendance 2026/27 • Timetable for papers 2026/27		1. Minutes and Chair’s Assurance Report approved from meeting held on 9 July 2026.
Feedback about the meeting - SLT recognised shared responsibility and the importance of working collaboratively.		

Area Clinical Forum Chair's Assurance Report to Board

Title of Report:	Chair's Assurance Report from the Area Clinical Forum	Date of Meeting: 07 August 2026
Prepared By:	Hazel Aim, Senior Corporate Governance Officer	
Approved By:	Dr Kirsty Cole	
Presented By:	Dr Kirsty Cole	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Area Clinical Forum at its meeting on 7 August 2026		

Matters of Concern or Key Risks to Escalate		Major Actions Commissioned / Work Underway	
Area Dental Committee – NHSO continues to have no established ADC at present. eHealth – Members of both NAMAC and GPSub committees reported ongoing difficulties securing attendance from eHealth representatives at committee meetings. Concerns were raised regarding communication, understanding of operational impacts and the ability to collectively address system challenges. Further attempts at engagement are being pursued. Capacity assessments within vaccine services – concerns were raised relating to patients and carers being turned away from vaccine appointments when they were assessed to lack capacity to consent. Solutions being explored between GPSub Chair and Vaccine service lead. Waiting times for Psychiatry - Members discussed ongoing challenges within psychiatric services, particularly relating to extended waiting times for consultant psychiatry review. Reduced theatre utilisation - NAMAC reported underutilisation of theatre capacity resulting from reduced anaesthetic staffing availability. Reporting near misses - A requirement for consistent reporting of near misses was identified by NAMAC and this should be reviewed and actioned through appropriate governance processes.		Equality and Diversity Outcomes report - Steven Phillips attended the meeting to provide an update on the implementation of this report, which had recently been approved by the Board. It was recognised that, while progress had been made in establishing a working group to take the programme forward, clinical representation had not yet been secured. Clinical advisory groups will canvas their membership for interest in this role. Medical Director to work with pharmacy colleagues to develop and circulate professional guidance on private prescriptions. - Area Clinical Forum membership and distribution list to be updated.	
Positive Assurances to Provide		Decisions Made	
Hospital Sub Committee - Members were updated that a nomination has been received for the chair of the Hospital Sub Committee. Once re-established, this will pave the way for reconvening the Area Medical Committee. Restaurant queuing times – Members received an update following a meeting between the Chair and Catering services. Additional capacity		No decisions made	

and a staff only area of the restaurant are planned for August to ease waiting times and facilitate flow through the canteen for staff. 3. Document approval matrix – The medical director updated the committee on plans to provide a clear and consistent route for consultation, recommendation and approval of documents, reducing unnecessary duplication and repeated presentation of papers to multiple committees. 4. Regional/national pharmacy success • Nicola Tait has become NHS Highlands and Islands' very first Vocational Training Foundation Programme for Pharmacy Technicians (VTFPPT) completer. • The Committee also noted positive news regarding the successful approval of an Invest to Save funding bid relating to pharmacy-led medication review activity. It was recognised that the funding presented opportunities to further enhance clinical pharmacy support and medication optimisation work across primary care services. 5. Digital Dermatology Pilot - The digital dermatology photography pathway pilot had proved successful improving referral processes and image quality and is now being rolled out to all GP surgeries. 6. Clopidogrel pathway - The Committee noted successful implementation of clopidogrel pharmacogenetics testing pathways.	
Comments on Effectiveness of the Meeting	
• None noted	

Area Partnership Forum Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Area Partnership Forum	Date of Meeting: 21 st July 2026
Prepared By:	Jade Rosie	
Approved By:	Ryan McLaughlin, Employee Director	
Presented By:	Ryan McLaughlin, Employee Director	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Area Partnership Forum at its meeting on 21 st July 2026.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
Staff Side and Job Evaluation capacity: The reducing pool of trained Staff Side Job Evaluation practitioners is contributing to delays and placing pressure on individual representatives and their substantive services. This may affect recruitment, organisational change and effective partnership working. Work is underway to assess demand and capacity and review the existing Facilities Time Agreement. Staff bank governance: The Forum discussed the management and oversight of the staff bank, particularly within nursing. Concerns include the organisation of the bank, mandatory-training compliance and payment. Immediate payment issues are being investigated, with a wider review due to return to APF. Staffing establishments and safe staffing: APF has not yet been able to review the outputs of the common staffing method tool runs which are used to calculate the required staffing levels for clinical areas.	Facilities time and Job Evaluation capacity: Staff Side and People and Culture will assess current and unmet demand for trade union and Job Evaluation activity, compare this with available representative capacity and develop a more formal local Facilities Time Agreement or framework. Potential regional or national solutions, including shared Job Evaluation capacity, will also be explored. Staff bank arrangements: A substantive discussion on the future management of the staff bank will be scheduled for the September APF meeting. Exploratory discussions have already taken place regarding whether another NHS Board could provide a managed bank service. Immediate concerns relating to annual leave payments and payment for mandatory training are to be investigated separately and should not await the wider review. Staffing establishments and safe staffing: The incoming Interim Executive Director of Nursing, Midwifery and AHPs will work with relevant nursing, workforce and finance colleagues to collate and present the establishment-review outputs, including the methodology, evidence and safe staffing information supporting the current position. iMatter improvement work: The People Delivery Plan will be presented to APF and will incorporate relevant organisational actions arising from iMatter. The Director and Head of People and Culture will attend a Joint Staff meeting for more detailed discussion, and the Senior Leadership Team Chair's Assurance Report on iMatter will be shared with membe

	Public Service Reform and local collaboration: Work involving NHS Orkney and Orkney Islands Council will return to APF as proposals develop, allowing Staff Side representatives to contribute before formal decisions are taken through the respective Boards.
Positive Assurances to Provide	Decisions Made
• Strong staff participation in iMatter. The organisational response rate was 78%, demonstrating a high level of engagement. The Forum welcomed stronger iMatter results related to line management, clarity of roles, dignity and respect and teamwork. • Healthcare Improvement Scotland inspections of Acute and Maternity Services were positive. The reports recognised the quality of care being delivered and the patient- and family-centred culture within NHS Orkney. • Job Evaluation and the Band 5 Nursing Review continue to progress despite capacity pressures. The Forum noted the work undertaken through the STAC action plan and the continued use of a separate evaluator pool for Band 5 Nursing Review cases.	• Approved Extension to Sick Pay Procedure. • Approved Estates policies covering Asbestos Control, Management of Contractors, Confined Spaces, Electrical Safety and CDM, subject to agreed amendments. • Approved Health & Safety procedures covering COSHH, Violence & Aggression Training, Lone Working and Working in Isolation, and Lone Working Devices. • STAC Job Evaluation Action Plan approved. • Controlled pilot use of Microsoft Copilot within the Job Evaluation quality checking process approved. The pilot will retain oversight by two trained evaluators and is intended to support consistency and reduce administrative burden rather than replace panel decision-making. • The current School Nurse posts presented in the business plan are to be reviewed through Job Evaluation before the proposed organisational change progresses.
Comments on Effectiveness of the Meeting	
The Area Partnership Forum meeting was well attended, with constructive engagement from management and Staff Side representatives, supporting effective partnership working and open discussion across the agenda.	

Item 11.5

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: 2 July 2026
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Jean Stevenson, Vice-Chair and Non-Executive Board Member	
Presented By:	Jean Stevenson, 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 2 July 2026 .		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. There are no concerns or key risks to escalate to the Board.	1. Patient experience – the Head of Patient Safety, Quality and Risk advised that stage 2 complaints relate to communication. Complaint numbers will be monitored and reported to the Committee if themes emerge. 2. Serious Adverse Event Reviews – Medical Director to bring a report to Committee in October 2026 in relation to closing SAERs. 3. The Executive Director of Nursing, Midwifery and AHPs will provide a Public Protection Accountability Framework (PPAF) update to the Committee 4 February 2026. 4. Still awaiting confirmation of funding for the MRI Business case, noting this is an extensive for 12 months only.
Positive Assurances to Provide	Decisions Made
1. The Committee thanked Morag Linklater, NHS Orkney's first DAISY Award honouree, and noted her reflections on more than 34 years as a midwife in Orkney. 2. Assurance was provided that the ultrasound service currently has no waiting list. 3. Assurance was provided that processes are in place to respond to dental inspections, and the Committee recognised achievements across public and general dental services. 4. Assurance provided on the Corporate Risks aligned to Committee 5. Assurance provided from the Integrated Performance Report in particular safety, governance, complaints and population health.	1. Minute and Chairs Assurance Report of Meeting 8 April 2026 approved. 2. Healthcare Improvement Scotland (HIS) Inspection action plan (Maternity Services) approved. 3. NHS Orkney Patient Feedback Annual Report 2025/26 approved for onward submission to the Board August 2026. 4. Duty of Candour Annual Report 2025/26 approved for publication.

Item 11.5

6. Assurance taken from the Chairs Assurance Reports (CARs) for Area Drugs and Therapeutics Committee (10 June), Infection, Prevention and Control Committee (26 May), Social Work and Social Care Governance Board (& May), Clinical Governance Group (16 June).
7. Assurance provided from the Social Work and Social Care Service Annual User Experience report with positive examples of the work delivered across the service in the past 12 months.
8. Assurance provided through the Quality, Safety and Experience Quarterly Report.
9. Committee took assurance that significant progress has been made in embedding the Public Protection Accountability Framework (PFFAF), noting an annual report will be presented to Committee going forward.
10. Committee took assurance on the exceptionally positive Healthcare Improvement Scotland (HIS) inspection of Maternity Services.
11. Committee welcomed and took assurance on the Public Health Quarterly Report noting the roll out of MenB vaccination and the new Child Health IT system.
12. Assurance taken following the presentation of the Maternity external Peer Review Action Plan.
13. Committee noted the following documentation
 - Feedback Sottish Executive Nurse Directors (SEND)
 - Collaborative Community Care Group (CCCG) Chair's Assurance Reports 2 and 30 April 2026
 - Approved Infection Prevention Control Committee Terms of Reference - 2026-27

Comments on Effectiveness of the Meeting

- The Chair reflected on the quality of papers presented to Committee.

Public Sector Reform Update

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 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
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred • Sustainability
Key points for consideration	• A Public Sector Event was held on 8 June 2026 which was well received by those in attendance. • Adverts have gone live on two posts to help support work locally. • Initial meetings with services have commenced.
Route to meeting	• Not applicable.
Recommendation(s)	• Assurance - For members assurance only

Public Sector Reform Update

Stephen Brown, Chief Officer - IJB

18/08/2026

1. Situation

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

2. Background

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

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

3. Assessment

- 3.1 The Steering Group have continued to meet on a regular basis since the last highlight report to Board was provided. The frequency of these meetings has just recently increased from every three weeks to twice a month.
- 3.2 As Members will recall, the Public Sector Reform Event was held at the St Magnus Centre on 8 June 2026 which brought together NHS Orkney, Integration Joint Board and Elected Members along with senior leaders across both NHS Orkney and Orkney Islands Council. The day was facilitated by John Sturrock KC and had input from a range of local leaders as well as the Auditor General and Chair of the Accounts Commission. While some of those in attendance had reservations, feedback from the day was overwhelmingly positive with invitees being asked to make a pledge on what they will do to progress Public Sector Reform in Orkney.
- 3.3 One of the outputs from the Public Sector Reform Event was to draft an action plan. This has now been reviewed and honed with clear SMART target dates identified.
- 3.4 Adverts are now open for a Project Manager and Project Officer to support the work, and the Chief Executives of NHS Orkney and Orkney Islands Council alongside the Chief Officer are exploring what further leadership support will be required to accelerate progress.
- 3.5 Officer discussions with local leaders and Scottish Government continue monthly as Government prepares to announce its new Programme for Government in early September 2026.
- 3.6 The first Joint NHS Orkney and Orkney Islands Council Corporate Leadership Team/Executive Team Meeting was held on 13 July 2026 at the Harbour Authority Building. Further dates are organised to build on initial conversations.
- 3.7 On 12 August 2026, the Chief Officer met with the Head of Facilities, NHS Orkney, and the Service Manager (Fleet), Orkney Islands Council, to initiate discussion for potential collaboration within their remits.
- 3.8 Leaders across the organisations are looking at how to progress Public Sector Reform in Orkney such as organising meetings with NHS and Council staff where opportunities arise or where there are challenges being faced in one organisation where the other organisation may be able to assist.

- 3.9 The Steering Group have a scheduled facilitated session with John Sturrock on 4 September 2026 and a follow up session for November which is being organised at the time of writing this report.

3.10 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	No	There are no quality or patient care implications directly arising as a result of this report.
People	Workforce	No	There are no workforce implications directly arising from this report.
Performance	Finance	Yes	In the meantime, and subject to approval by the Scottish Government, the aforementioned funding from the Scottish Government will be applied to progress development of the proposed model of transition in Orkney. This will include the recruitment and employment of a Strategic Project Manager and a Strategic Project Officer to support the project. Their work will include undertaking the scoping and assessment work referred to in sections 7.3. and 8.1. and the design and development of revised operating structures where shared services are assessed as feasible. Resourcing of facilitation sessions between the NHS Orkney, Orkney Islands Council and other key stakeholders will also be necessary, as will be the arrangement of public engagement and consultation activities. There will also be a requirement to commission professional advice from external organisations, which may include legal, financial, communications and other professional advice. On 24 June 2025 the Scottish Government offered an additional £300,000 from its Invest to Save Fund to support with Orkney's public service reform work with the following conditions: • The funding is to enable the Project/Programme to be carried out. • The funding shall only be used for the purposes of the Project/Programme and for no other purpose whatsoever. • Bidders agree to provide 6 monthly updates on progress of the project using a bespoke reporting template. The first report is due on 12 December 2025. • Bidders engage, as required, with SG Officials to discuss any specific element of the bid or to provide information as required. • The final amount will be subject to the discussion with the local governance review

			team taking account of what other funding is available already to support some of the work and work already underway at a national level. - Any savings from the project can be retained to be reinvested into improving service delivery. - Significant analysis would be required to assess the financial impacts of the model of transition and those arising from any operating structures that may be agreed in the future.
Potential	Risk Management	No	There are no other risk implications directly arising as a result of this report.
	Digital	No	There are no digital implications directly arising as a result of this report.
Place	Equality and Diversity including health inequalities	No	There are no equality or diversity implications directly arising as a result of this report.
	Climate Change Sustainability	No	There are no climate change implications directly arising as a result of this report.

4.Recommendation(s)

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

Population Health Organisation Approach

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 2026
Responsible Executive/Non-Executive	• Dr Louise Wilson, Director of Public Health
Report Author(s)	• Hannah Casey, Public Health Manager NHS Orkney
Purpose of report	• Discussion
Contribution to Strategic ambition	• Corporate Strategy 2024/28 • Annual Operational Plan • Government policy/directive
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred • Sustainability
Key points for consideration	• The NHS needs to shift its focus from treatment to becoming an organisation focused on prevention- Population Health Organisation • A population health organisation assessment has been developed nationally with a maturity matrix which will allow the development of an improvement plan by 11 December 2026. • A collaborative approach is proposed, involving senior NHS Orkney leaders and Community Planning Partnership input, to support a robust and evidence-informed self-assessment. • The main risk is limited senior leadership engagement due to competing pressures, which could weaken the quality of the assessment and improvement plan. • A timeline has been developed to support NHS Orkney to develop and submit its PHO improvement priorities
Route to meeting	• Executive lead
Recommendation(s)	• Discussion - Consider the implications of a matter

Population Health Organisation Approach

Hannah Casey, Public Health Manager, NHS Orkney

21/07/2026

1. Situation

- 1.1 Through the Improving Population Health Group, NHS Chairs asked Directors of Public Health and Public Health Scotland to develop a Population Health Organisation (PHO) framework and a supporting self-assessment maturity matrix. The matrix was developed with support from the King's Fund and was agreed by NHS Chairs and Chief Executives.

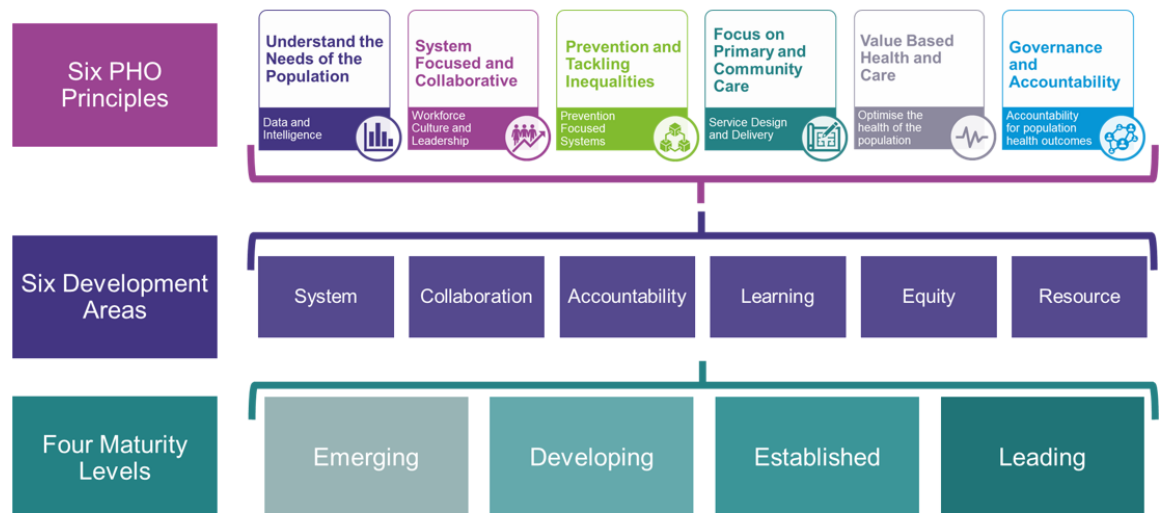
This matrix will help NHS Orkney Board to meet the 2026/27 operational priority to:

- assess progress in becoming a Population Health Organisation
- develop an improvement plan
- show progress with implementation

- 1.2 NHS Orkney's self-assessment of the maturity matrix and associated improvement plan are to be completed by **Friday the 11th of December 2026**.
- 1.3 This paper sets out the structured approach NHS Orkney is taking to implementation of the Population Health Organisation maturity matrix to provide assurance to Board on the quality and the timely delivery of this work. The planned approach is set out in Appendix A.

2. Background

- 2.1 There are six principles that have been identified as fundamental to a PHO, and six development areas relating to each of these principles. NHS Orkney will self-assess the organisation's position in relation to each of these 36 areas, identifying the level of maturity in which NHS Orkney is currently operating.



- 2.2 One of the key aims of using the Maturity Matrix assessment is to develop discussions within NHS Orkney and our partners on the organisations' readiness to deliver the Population Health Framework, Service Renewal Framework and wider reform. It is not designed to be a performance management tool.
- 2.3 There is flexibility in how NHS Orkney completes its assessment, as long as it is collaborative and deliberative. The options presented in the national guidance include an integrated assessment approach or separate sessions on each PHO principle.
- 2.4 The steps to completing the assessment are:
- Step 1: Prepare the system** - agreeing who is required to contribute.
 - Step 2: Build a shared evidence base** – contributors should draw on a common set of evidence as a shared reference point for discussion.
 - Step 3: Use the matrix to structure discussion** – to develop a shared understanding of how the system currently operates.
 - Step 4: Agree judgements and rationale** – Agree an indicative maturity level and record the key evidence and reasoning to support this judgment.
 - Step 5: Identify improvement priorities** – identify at least one priority area for improvement for each of the six PHO principles.
 - Step 6: Use the assessment for assurance and learning** – tracking progress over time as part of a continuous improvement cycle.

3. Assessment

3.1 Analysis

- 3.1.1 The current proposal engages senior leaders across the system in Orkney to discuss NHS Orkney's level of maturity as a Population Health Organisation.

This approach will identify evidence to support organisation level assessment, supporting the identification of strengths, gaps and improvement priorities for the organisation.

- 3.1.2 The proposal lays out a timeframe which allows for completion of the required assessment and improvement plan within the deadline.

3.2 Current Position

The approach set out in this paper will allow for the NHS Maturity Assessment to be based on discussions with partners as well as senior leaders across NHS Orkney. There is a risk of lack of engagement in the process due to leadership pressures, which would reduce the quality of the assessment, evidence base for the assessment and the proposed improvement plan.

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	Positive – becoming a population health organisation will support NHS Orkney to best use its resources to improve population health outcomes in Orkney. Negative – A proportionate response is required to ensure that quality patient care continues to be delivered as NHS Orkney moves to preventative activity.
People	Workforce	Yes	Negative – there is a time resource required from NHS Orkney staff to complete the self assessment, as well as develop, implement and evaluate the improvement plan.
Performance	Finance	Yes	Positive – As a population Health organisation, NHS Orkney will be required to move to preventative budgeting procedures.
Potential	Risk Management	Yes	Positive – If NHS Orkney does not move towards becoming a population health organisation, it risks not being able to reform its activities to focus on prevention, creating more pressures on the system in future.
	Digital	Yes	Positive – inclusive digital services are an aspect of moving towards a population health organisation.

Place	Equality and Diversity including health inequalities	Yes	Equality and diversity considerations, including developing services to reduce inequalities, are at the heart of becoming a Population Health Organisation.
	Climate Change Sustainability	No	

4. Recommendations

- Discussion on the approach to becoming a population health organisation

5. List of Appendices

5.1 The following appendices are included with this report

- I. **Appendix A**, NHS Orkney Planned Approach to Implementation of the Population Health Maturity Matrix.

Appendix A: NHS Orkney Planned Approach to Implementation of the Population Health Maturity Matrix.

Population Health Maturity Assessment Implementation Plan

Aim

The aim is to establish consensus of senior health, care and Community Planning Partnership leaders in Orkney on NHS Orkney's level of maturity as a Population Health Organisation, identifying evidence to support organisation level assessment. This information will be discussed at senior levels within NHS Orkney to identify strengths, gaps and improvement priorities for the organisation.

Approach

Surveys will be used to gather information from relevant senior leaders in NHS Orkney to facilitate information gathering from across the system. This will inform discussions as well as support the collation of evidence.

Engagement sessions in senior leadership meetings, will provide a format to discuss the maturity matrix. The Senior Leadership Team and the Board in NHS Orkney will be fora for Population Health Organisation discussions.

The Community Planning Partnership will be presented with NHS Orkney's senior leaders' assessment of the board's position in relation to outcomes relevant to its partnership working with the Community Planning Partnership. This will provide the opportunity for constructive feedback on our position from our partners.

NHS Orkney Board will be the governance body for the approval of the finalised improvement plan.

Timelines for Implementation

July 2026

Senior Leadership Team (09/07/26): COMPLETE

Agenda item (short presentation on PHO and the approach).

Follow up surveys circulated.

Expected outputs:

- Senior Leadership Team aware of Population Health Organisation assessment.

- Senior Leadership Team agree to completion of surveys.

Population Health Webinar (15/07/26) COMPLETE

Public Health Scotland webinar for Chairs and leads on the approach and the support available

Expected outputs:

Practical knowledge of approach to developing improvement plan

Board Development Session (23/07/26): COMPLETE

Deliver workshop.

Follow up surveys circulated.

Expected outputs:

- Develop initial maturity matrix levels.
- Gather evidence relating to Population Health Organisation matrix outcomes.

August 2026: In progress

Compile data and gather more evidence from leads in NHS Orkney and provide implementation approach paper to NHS Board on 27th August for assurance

September 2026

Senior Leadership Team (10/09/26):

Deliver Workshop.

Expected outputs:

- Agreement on levels/evidence to be proposed to Executive Team.
- Develop proposed improvement actions, including weighting for priority.

Community Planning Partnership (23/09/26):

Agenda item to discuss proposed NHS Orkney maturity level for Community Planning Partnership relevant outcomes.

Expected outputs:

- Critical challenge applied to NHS Orkney self-assessment by partners.

October 2026

Executive Leadership Team (12/10/26):

Agenda Item to agree maturity assessment and proposed improvement plan as well as discuss and agree governance arrangements for the improvement plan.

Expected Outputs:

- Finalise proposed matrix response and improvement plan for Board.
- Agree governance arrangements for improvement plan.

NHS Orkney Public Board (29/10/26):

- Agenda item to approve maturity matrix implementation plan and submission to Public Health Scotland.

Expected Outputs:

- Finalise matrix response and improvement plan.

November 2026

Maturity matrix self-assessment and associated improvement plan submitted to Public Health Scotland psh.strategicdevelopment@psh.scot to meet December deadline.

iMatter Health and Social Care Staff Experience Survey 2026

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 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	• Discussion
Contribution to Strategic ambition	• Corporate Strategy 2024/28 • NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	• Effective • Person-Centred
Key points for consideration	• NHS Orkney's 2026 iMatter results show a positive and stable overall position, with improved participation and staff engagement remaining within the Strive and Celebrate range. • The results highlight continued strengths across the Staff Governance Standard, with no Board-level Focus to Improve areas identified; however, some component scores have reduced compared with 2025. • The main areas for continued focus are confidence in organisational leadership, decision-making, performance management, and how concerns are followed up and responded to through meaningful team action planning.
Route to meeting	• Senior Leadership Team – 09 July 2026 • Area Partnership Forum – 21 July 2026 • Staff Governance Committee – 20 August 2026
Recommendation(s)	• Assurance - For members assurance only

iMatter Health and Social Care Staff Experience Survey 2026

1. Situation

1.1 The iMatter survey was open from Monday 11th May to Monday 1st June 2026. During this period, colleagues were encouraged to take part in the annual survey through multiple communication channels. The board, directorates, and teams received their results and were encouraged to undertake their action plans. To support managers in converting local outputs into meaningful actions by the following was offered:

- Conduct manager iMatter sessions to support the process.
- The iMatter lead provided assistance to managers and teams, including a toolbox for managers to use in creating action plans and following up with the team.
- Focus was on areas where one or two key actions would make a difference.
- Provided the organisation with regular updates on iMatter action planning and plan

2. Background

2.1 The iMatter questionnaire allows colleagues to share their personal experiences, provide feedback on team dynamics, and offer input about the organisation in real time. The results are reported at various levels - team, directorate, and organisation. Once the team receives the results, they work together to create an action plan within 8 weeks (closing date was 28 July 2026). Progress is monitored throughout the year. Teams gather to review the results, exchange ideas, and develop and implement action plans. The process is documented by sharing team stories, making it an integral part of the iMatter process. The iMatter program is monitored nationally, and a benchmarking report will be released later in the year.

3. Assessment

3.1 Analysis

The appendices attached detail the Board's outcome in relation to iMatter.

3.2 Current Position

3.2.1 The 2026 iMatter results show a broadly positive and stable position for NHS Orkney. Staff engagement remains within the Strive and Celebrate range, with

the Employee Engagement Index recorded at 75, a slight reduction from 76 in 2025 but still consistent with the positive five-year trend.

- 3.2.2 Participation improved significantly, with the response rate increasing from 69% in 2025 to 78% in 2026, representing the highest Board-level response rate across the five-year reporting period. This suggests stronger staff engagement with the survey process and provides a robust evidence base for organisational and team-level action planning. Early indications from Scottish Government colleagues creating the iMatter Health and Social Care Staff Experience Survey 2026 report suggest that this 9% increase in the response rate is the highest across all geographic boards. This has yet to be published; however, we expect it to be included in the national report, which will be published at the end of the year.
- 3.2.3 All five Staff Governance Standard strand scores remained within the Strive and Celebrate range. The strongest areas continue to relate to staff being well informed, appropriately trained and developed, treated with dignity and respect, and working within a safe and continuously improving environment. The overall staff experience score was 6.6 out of 10.
- 3.2.4 At the component level, 22 of the 28 iMatter scores were at or above the Strive and Celebrate threshold. However, compared with 2025, more component scores decreased than increased, with 8 scores improving, 4 remaining unchanged, and 16 decreasing.
- 3.2.5 The main areas identified for monitoring and further improvement relate to confidence in organisational leadership, governance and decision-making. These include staff confidence that performance is managed well, confidence and trust in Board members, involvement in decisions affecting the organisation, and accessibility of senior leaders. Positively, senior leader accessibility improved by 4 points, although it remains an area to monitor.
- 3.2.6 There were no Board-level “Focus to Improve” areas in 2026. At team level, 72 teams were in Strive and Celebrate, 13 teams were in Monitor to Further Improve, 1 team was in Improve to Monitor, and 6 teams had no report. This means 78.3% of teams were in Strive and Celebrate.
- 3.2.7 The Raising Concerns results show mixed confidence. Staff confidence in being able to safely raise concerns scored 73, while confidence that concerns will be followed up and responded to scored 65. This suggests that while many staff feel able to raise concerns, there is a need to strengthen confidence in how concerns are acted upon and responded to.
- 3.2.8 Overall, the 2026 performance remains positive, with strong participation, continued engagement, and no Board-level areas requiring focused improvement. The key priority is to ensure that action planning is completed and used meaningfully to address areas where confidence in organisational leadership, decision-making, performance management, and response to concerns can be strengthened.

3.2.9 Action planning for 2026 shows a significant improvement in completion within the required 8-week period. Teams across the organisation have achieved 78% completion of action plans, up from 66% in 2025 and the highest recorded Board position over the five-year reporting period. This represents a 12% improvement on the previous year and suggests stronger connection and follow-through in translating iMatter feedback into documented improvement actions.

3.2.10 This improvement suggests better engagement between managers and staff during the action planning stage of the iMatter process, beyond survey participation alone. However, 22% of action plans were not completed within the 8-week timeframe and continue to be recorded in the system. At the time of writing this paper, 82% of teams have an action plan recorded, which demonstrates that teams continue to work together. Whilst the action planning window of 8 weeks is in place for the national reporting window, teams continue to engage with the iMatter programme and record their action plans within the system.

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	iMatter is a valuable tool for continuous improvement that enhances patient care and improves colleagues experience when used appropriately.
People	Workforce	Yes	The iMatter tool is a national development utilised by all NHS Scotland Boards. Its purpose is to assist individuals, teams, Directorates, and Boards in understanding and improving colleague experience.
Performance	Finance	No	
Potential	Risk Management	No	No process-related issues have been identified. However, failing to engage in action planning may have negative consequences for colleagues in terms of a lack of positive change and disengagement if feedback is not seen to proactively drive change. National benchmarking may also generate risk and opportunities for NHS Orkney.
	Digital	No	
Place	Equality and Diversity including health inequalities	No	None identified – this is a nationally procured tool that has been impact assessed.
	Climate Change Sustainability	No	

4. Recommendations

- 4.1 Discussion - Consider the Implications of a matter

5. List of Appendices

- 5.1 The following appendices are included with this report

Appendix 1, iMatter 2026 overview. August

Appendix 2, Board Report 2026

Appendix 3, Board Yearly Components Reports

Appendix 4, Raising Concerns Report

Appendix 5, Yearly response rates

Appendix 6, Yearly EEI

Appendix 7, Action Plans 2026

Appendix 8, NHS Chair (Board Members) Action Plan 2026

iMatter 2026

The iMatter survey was circulated to NHS Orkney staff during 2026. The overarching Board report is attached at Appendix 2. The response rate for 2026 increased to 78%, with 664 respondents from 847 recipients.

There are a number of positives to take from the outputs:

- The employee engagement index has remained within the Strive and Celebrate range, moving from 76 in 2025 to 75 in 2026. The five-year trend is 72 (2022), 74 (2023), 75 (2024), 76 (2025) and 75 (2026) (Figure 1).
- The response rate increased from 69% in 2025 to 78% in 2026, representing the highest Board-level response rate in the five-year reporting period.
- Across the five Staff Governance Standards strand scores, all weighted index values remain within Strive and Celebrate: Well Informed 79, Appropriately Trained and Developed 76, Involved in Decisions 71, Treated Fairly and Consistently with Dignity and Respect 76, and Continuously Improving and Safe Working Environment 76.
- The overall experience score was 6.6 out of 10 in 2026 (Figure 2).

Figure 1

Yearly EEI

NHS Orkney

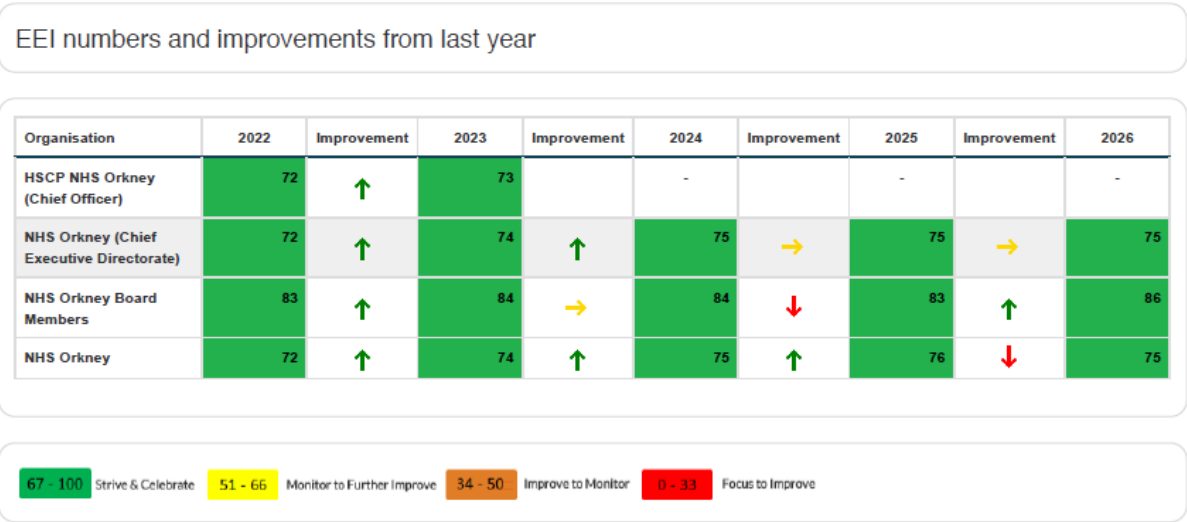
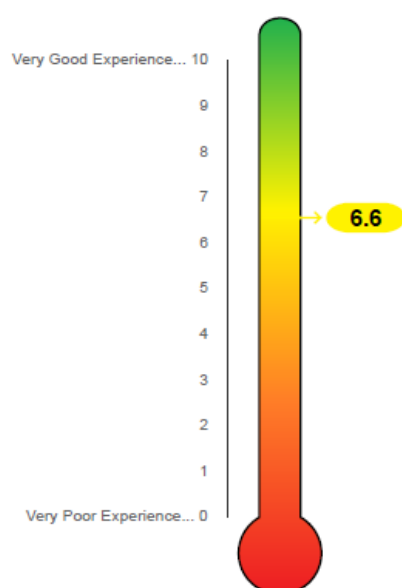


Figure 2



The majority of iMatter staff experience components remain within the Strive and Celebrate range. In 2026, 22 of the 28 component scores were 67 or above. Compared with 2025, 8 component scores increased, 4 remained unchanged and 16 decreased.

The areas highlighted from the organisation's feedback to 'monitor to further improve' are:

1. I am confident performance is managed well within my organisation – 58 (-2).
2. I have confidence and trust in Board members who are responsible for my organisation – 60 (-2).
3. I feel sufficiently involved in decisions relating to my organisation – 56 (-1).
4. I feel that Senior Leaders who are responsible for my organisation are sufficiently accessible – 65 (+4).

There were no 'focus to improve' areas at Board level. Team-level reporting shows 72 teams in Strive and Celebrate, 13 teams in Monitor to Further Improve, 1 team in Improve to Monitor, and 6 teams with no report. This means 78.3% of teams were in Strive and Celebrate, with 14.1% in Monitor to Further Improve. (See Figure 3)

Figure 3

EEI number for teams within the same Board

EEI Threshold	(67-100)	(51-66)	(34-50)	(0-33)	No report	Total
Number of Teams	72	13	1	0	6	92
Percentage of Teams	78.3%	14.1%	1.1%	0.0%	7%	100%

Raising Concerns

The 2026 Raising Concerns report for NHS Orkney recorded 648 total respondents, with 638 respondents answering the raising concerns statements. The average score was 73 for confidence in safely raising concerns about issues in the workplace, and 65 for confidence that concerns will be followed up and responded to.

- I am confident that I can safely raise concerns about issues in my workplace – average score 73.

Responses were:

- 57% Strongly Agree/Agree,
- 22% Slightly Agree,
- 7% Slightly Disagree
- 14% Disagree/Strongly Disagree.

- I am confident that my concerns will be followed up and responded to – average score 65.

Responses were:

- 42% Strongly Agree/Agree,
- 23% Slightly Agree,
- 14% Slightly Disagree
- 21% Disagree/Strongly Disagree.

Action Planning:

The action planning window opened on 2 June, when the reports were published, and the deadline for national reporting was 28 July 2026. This timeframe allowed managers to review their local results with teams and upload action plans into the system. Training and guidance are available to support managers with this process.

78% of teams have created and recorded an action plan within the 8-week timeframe. This demonstrates a 12% increase on 2025 performance and is the highest recorded rate since 2018.

Action plans completed within 8 weeks

Organisation	Action plan	Action plan		Action plan		Action plan		Action plan	
	2022	Improvement	2023	Improvement	2024	Improvement	2025	Improvement	2026
HSCP NHS Orkney (Chief Officer)	18%	↑	34%		-		-		-
NHS Orkney (Chief Executive Directorate)	48%	↑	68%	↑	69%	↓	66%	↑	78%
NHS Orkney Board Members	100%	→	100%	→	100%	→	100%	→	100%
NHS Orkney	39%	↑	58%	↑	69%	↓	66%	↑	78%

Summary

The 2026 iMatter Report highlights continued areas of strength alongside areas requiring focused improvement. The response rate increased to 78%, demonstrating stronger staff

participation than in 2025. The Employee Engagement Index remains within the Strive and Celebrate range at 75, although this represents a one-point reduction from 2025.

The strongest component scores continue to relate to direct line management, role clarity, dignity and respect, and team working. The areas requiring continued focus are organisational wellbeing, involvement in organisation-wide decisions, performance management within the organisation, and confidence and trust in Board members.

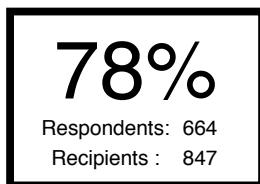
To maintain progress and address the areas highlighted in staff feedback, it is essential that teams continue to review their action plans and the agreed actions throughout the year to support meaningful improvement.

Board Report 2026

NHS Orkney

Total number of respondents: 664

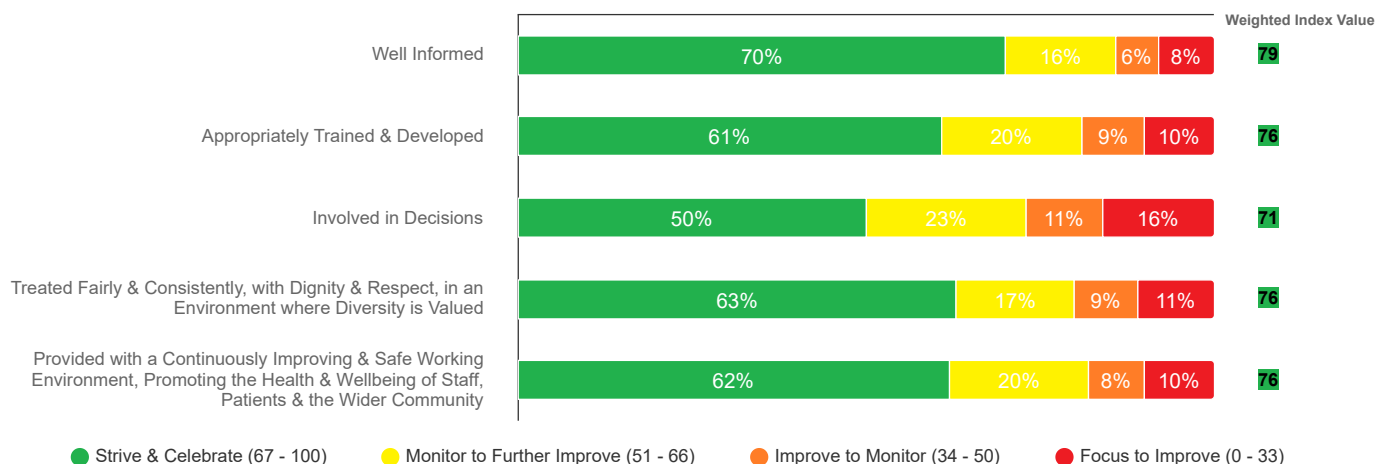
Response rate



EEI



Staff Governance Standards - Strand Score Index



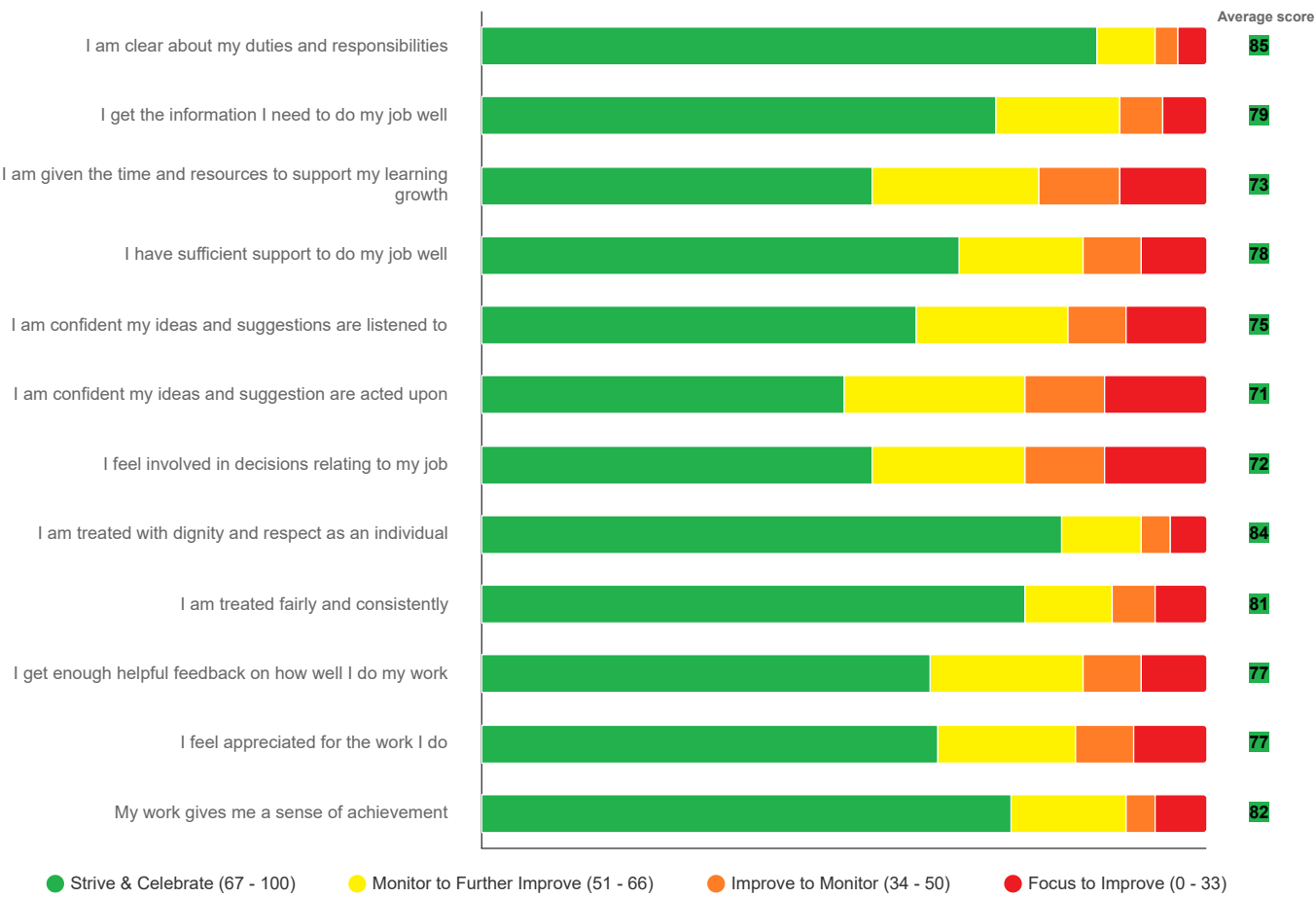
Calculating the Average Score

The number of responses for each point on the scale (Strongly Agree – Strongly Disagree) is multiplied by its number value (6-1) (see right). These scores are then added together and divided by the overall number of responses to the question.

6	Strongly Agree
5	Agree
4	Slightly Agree
3	Slightly Disagree
2	Disagree
1	Strongly Disagree

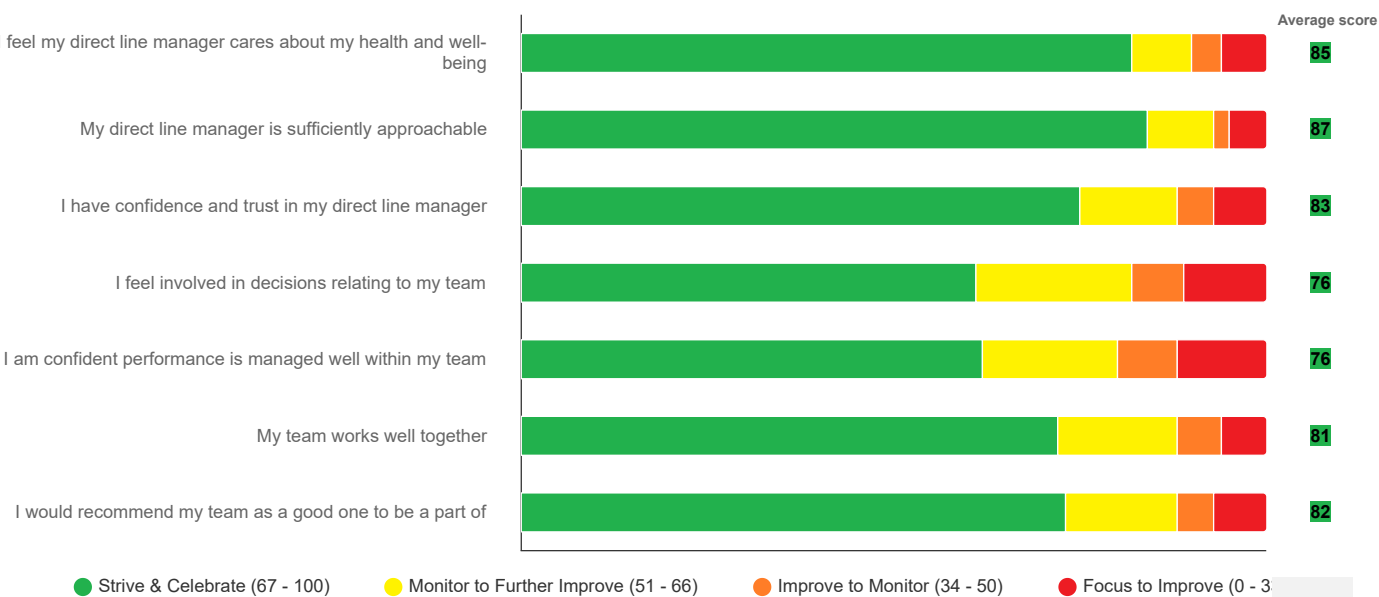
Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements:

Number of respondents: 664



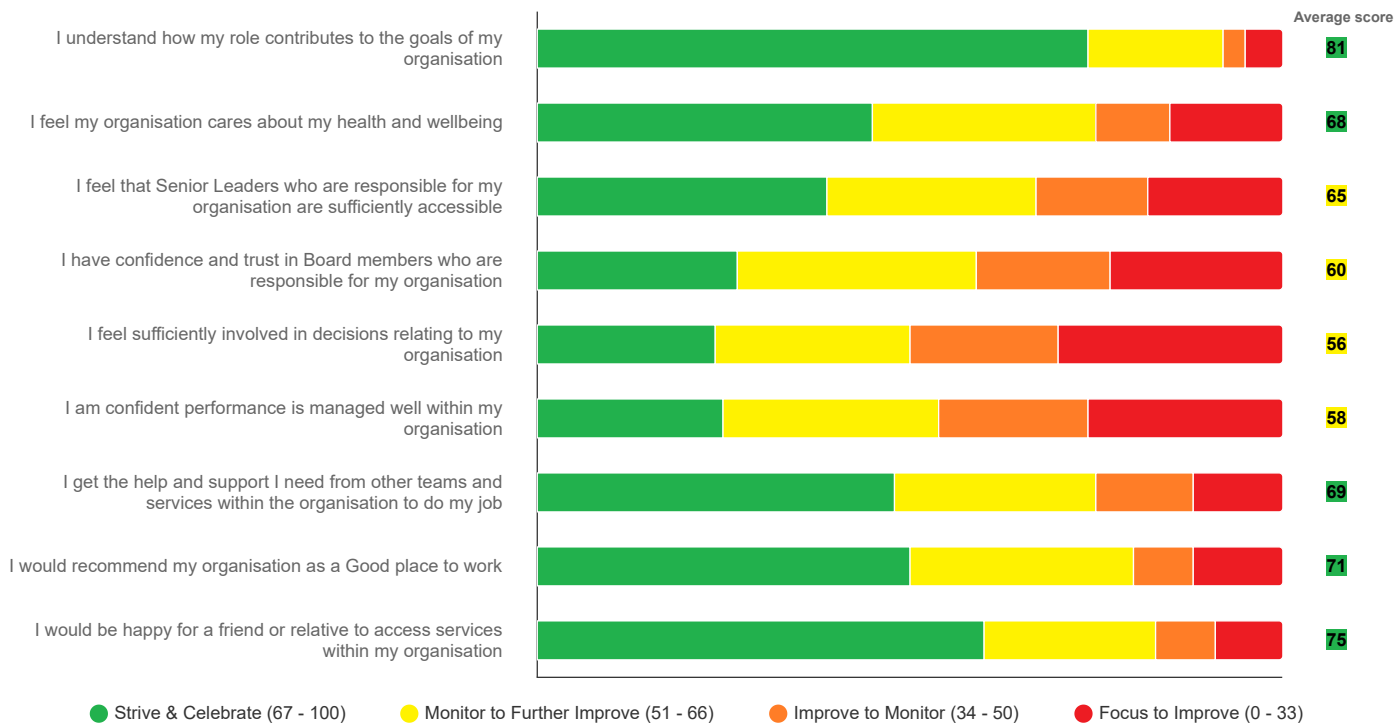
Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements relating to your team and direct line manager:

Number of respondents: 664



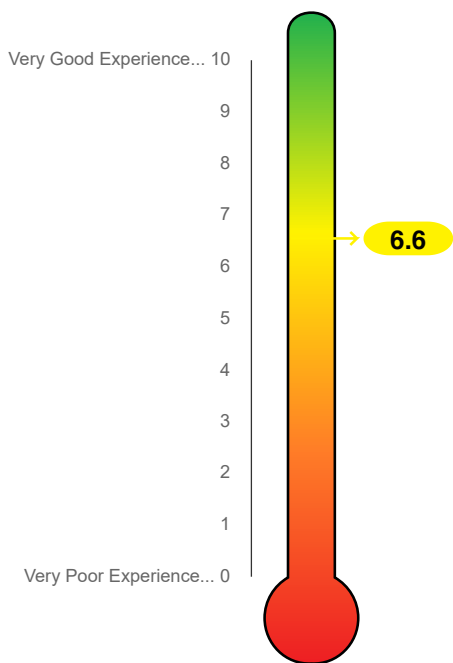
Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements relating to your Organisation:

Number of respondents: 664



Please tell us how you feel about your overall experience of working for your organisation from a scale of 0 to 10 (where 0 = very poor and 10 = very good):

Number of respondents: 664



EEl number for teams within the same Board

EEl Threshold	(67-100)	(51-66)	(34-50)	(0-33)	No report	Total
Number of Teams	72	13	1	0	6	92
Percentage of Teams	78.3%	14.1%	1.1%	0.0%	7%	100%

Total number of respondents: 664

iMatter Components

iMatter Questions	Staff Experience Employee Engagement Components	Average Response				
		2022	2023	2024	2025	2026
My direct line manager is sufficiently approachable	Visible and consistent leadership	83	84	86	87	87
I feel my direct line manager cares about my health and well-being	Assessing risk and monitoring work stress and workload	81	82	85	86	85
I am clear about my duties and responsibilities	Role Clarity	84	85	85	85	85
I am treated with dignity and respect as an individual	Valued as an individual	80	82	83	83	84
I have confidence and trust in my direct line manager	Confidence and trust in management	80	80	83	84	83
I would recommend my team as a good one to be a part of	Additional Question	80	81	82	83	82
My work gives me a sense of achievement	Job satisfaction	81	82	81	81	82
I am treated fairly and consistently	Consistent application of employment policies and procedures	77	80	81	81	81
My team works well together	Effective team working	80	80	82	82	81
I understand how my role contributes to the goals of my organisation	Sense of vision, purpose and values	80	81	80	81	81
I get the information I need to do my job well	Clear, appropriate and timeously communication	76	78	79	80	79
I have sufficient support to do my job well	Access to time and resources	74	76	76	77	78
I get enough helpful feedback on how well I do my work	Performance development and review	71	74	74	76	77
I feel appreciated for the work I do	Recognition and reward	72	75	75	77	77
I feel involved in decisions relating to my team	Empowered to influence	73	75	75	77	76
I am confident performance is managed well within my team	Performance management	72	74	76	77	76
I would be happy for a friend or relative to access services within my organisation	Additional Question	73	72	74	76	75
I am confident my ideas and suggestions are listened to	Listened to and acted upon	73	75	74	75	75
I am given the time and resources to support my learning growth	Learning & growth	71	72	72	72	73
I feel involved in decisions relating to my job	Empowered to influence	68	71	70	71	72
I would recommend my organisation as a Good place to work	Additional Question	69	70	71	72	71
I am confident my ideas and suggestion are acted upon	Listened to and acted upon	68	71	69	71	71
I get the help and support I need from other teams and services within the organisation to do my job	Appropriate behaviours and supportive relationships	67	69	70	70	69
I feel my organisation cares about my health and wellbeing	Health and wellbeing support	67	69	70	71	68
I feel that Senior Leaders who are responsible for my organisation are sufficiently accessible	Visible and consistent leadership	52	53	61	61	65
I have confidence and trust in Board members who are responsible for my organisation	Confidence and trust in management	57	57	61	62	60
I am confident performance is managed well within my organisation	Performance management	57	58	59	60	58
I feel sufficiently involved in decisions relating to my organisation	Partnership working	53	54	58	57	56

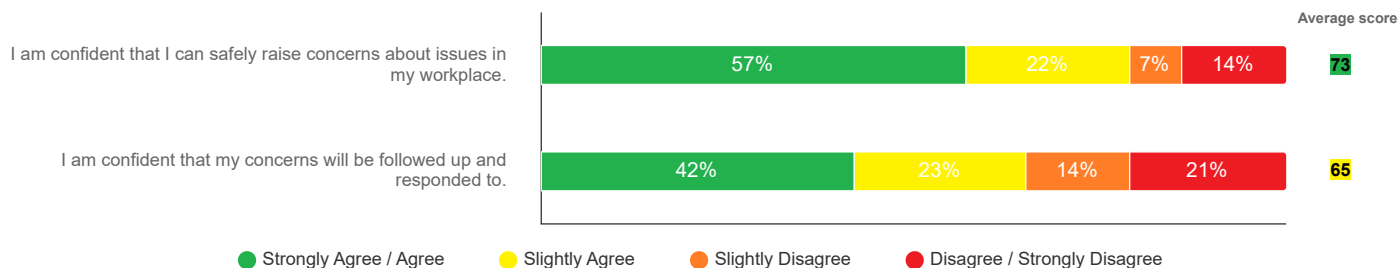
Raising Concerns Report

NHS Orkney (Chief Executive Directorate)

Total number of respondents: 648

Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements:

Number of respondents: 638



Yearly Response Rates

NHS Orkney

	Response rate	Response rate		Response rate		Response rate		Response rate	
Organisation	2022	Improvement	2023	Improvement	2024	Improvement	2025	Improvement	2026
HSCP NHS Orkney (Chief Officer)	47%	→	47%		-		-		-
NHS Orkney (Chief Executive Directorate)	66%	↑	70%	↓	69%	→	69%	↑	78%
NHS Orkney Board Members	82%	↑	89%	↑	93%	↓	87%	↑	100%
NHS Orkney	58%	↑	59%	↑	69%	→	69%	↑	78%

Yearly EEI

NHS Orkney

EEI numbers and improvements from last year

Organisation	2022	Improvement	2023	Improvement	2024	Improvement	2025	Improvement	2026
HSCP NHS Orkney (Chief Officer)	72	↑	73		-		-		-
NHS Orkney (Chief Executive Directorate)	72	↑	74	↑	75	→	75	→	75
NHS Orkney Board Members	83	↑	84	→	84	↓	83	↑	86
NHS Orkney	72	↑	74	↑	75	↑	76	↓	75

67 - 100 Strive & Celebrate 51 - 66 Monitor to Further Improve 34 - 50 Improve to Monitor 0 - 33 Focus to Improve

NHS Orkney

Total number of respondents: 664

Action plans completed within 8 weeks

Organisation	Action plan	Action plan		Action plan		Action plan		Action plan	
	2022	Improvement	2023	Improvement	2024	Improvement	2025	Improvement	2026
HSCP NHS Orkney (Chief Officer)	18%	↑	34%		-		-		-
NHS Orkney (Chief Executive Directorate)	48%	↑	68%	↑	69%	↓	66%	↑	78%
NHS Orkney Board Members	100%	→	100%	→	100%	→	100%	→	100%
NHS Orkney	39%	↑	58%	↑	69%	↓	66%	↑	78%

Storyboard

NHS Orkney Chair (Board Members)

What we do well

What we do well: We are a strong team who communicate well with each other.

Staff Experience Improvement Journey

Desired Outcome: Strengthen Board Development and Relationships

Action: Provide protected learning time for Non-Executive Directors, develop Board appraisal arrangements, and create opportunities for stronger relationships and engagement between Executive and Non-Executive Directors.

Desired Outcome: Enhance Board Culture, Equality and Meeting Effectiveness

Action: Embed Equality and Equity into Board discussions and assurance processes, strengthen reflection on Board behaviours and meeting effectiveness, and promote an inclusive culture where all voices are heard and respected

Desired Outcome: Improve Assurance, Insight and Communication

Action: Review iMatter feedback in greater depth, strengthen the Chair's Assurance Report process, improve how performance concerns are escalated and monitored, and enhance communication of Board outcomes to staff.

NHS Orkney Chair (Board Members)

86

Employee Engagement Index

Overall, working within my organisation is a

Number of respondents: 16

Very good experience... 10

9

8

7

6

5

4

3

2

1

Very Poor Experience... 0

8.13