

Themes from Board Walkarounds June - August 2026

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 2026
Responsible Executive/ Non-Executive	- Davie Campbell, Board Chair - James Goodyear, Interim Chief Executive
Report Author(s)	Hazel Aim, Senior Corporate Governance Officer
Purpose of report	Discussion
Contribution to Strategic ambition	- Corporate Strategy 2024-2028 - People - Operational Improvement Plan - Annual Delivery Plan - Local Policy - NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	- Safe - Effective - Quality - Person Centred
Key points for consideration	- Board Walkarounds remain an important mechanism for strengthening Board visibility, supporting direct engagement with staff, and providing insight into the operational realities, strengths and pressures experienced across services. - Since the previous update in April 2026, three Board Walkarounds have taken place across Daisy Villa GP Surgery, Speech and Language Therapy and Flotta GP Surgery, reflecting continued engagement across community, island and specialist services. - Feedback from Daisy Villa GP Surgery provides assurance on consistent GP provision, positive patient care and effective Pharmacy support. Staff also highlighted areas requiring ongoing support and assurance, particularly in relation to IT issues, implementation of the Vision GP IT system, prescribing arrangements, stock-take requirements, staff capacity, energy costs and winter resilience. - An action plan has been developed to ensure feedback is reviewed, assigned to the appropriate executive lead and progressed through service-level and governance routes, with feedback from Speech and Language Therapy and Flotta GP Surgery to follow at a future Board meeting.
Route to meeting	Executive Management Team – 17 August 2026
Recommendation(s)	Discussion

Themes from Board Walkarounds

June - August 2026

Hazel Aim, Senior Corporate Governance Officer
27 August 2026

1. Situation

- 1.1 Board Walkarounds are an established mechanism to support the visibility of Board members and enable direct engagement with staff across NHS Orkney.
- 1.2 This paper provides a summary of the feedback received from the Daisy Villa Surgery walkaround. Feedback from the Speech and Language Therapy Service and Flotta GP Surgery will be presented to a future Board meeting, reflecting the timing of the visits and paper preparation cycle.
- 1.3 The feedback provides Board members with further insight into the experience of staff working in remote and island-based services, including the practical impact of digital change, infrastructure pressures and the requirement to maintain continuity of care within small teams. While the feedback from Daisy Villa Surgery was generally positive, the issues raised highlight the importance of ensuring that local operational challenges are visible, understood and responded to through appropriate executive and service-level action.

2. Background

- 2.1 Board Walkarounds involve Executive Directors and Non-Executive Directors visiting teams and departments across NHS Orkney to listen to staff experiences and understand local opportunities and challenges.
- 2.2 Walkarounds provide an opportunity for Board members to build relationships, hear what staff are proud of and understand the challenges affecting day-to-day service delivery. This supports the Board's wider role in seeking assurance on staff experience, patient safety and organisational culture.
- 2.3 Walkaround discussions are structured around the following core questions:
 - 1) What is going well in your team/service at the moment?
 - What are you most proud of working in this area?
 - 2) What do you consider to be the main challenges you face on a daily basis?
 - What feedback do people using this service give you?
 - If you could change one thing, what would it be?
 - What do you wish you had more time to do?
 - 3) How can the Board help?
 - Is there anything that you would find helpful to raise to the Board?
 - 4) What does patient safety look like in your area? (new question added in 2024/25 in Year 2 of our Board walkarounds)
 - Do you feel confident in reporting incidents or near misses?
 - Do you get enough feedback when you report incidents/near misses?

- Do you feel there is enough support for you if you are involved in a patient safety incident?

5) Staff wellbeing: are colleagues aware of support available and have they been able to access that for staff as necessary?

3. Assessment

3.1 Main themes from Board Walkarounds: June–August 2026

Three Board Walkarounds took place between June and August 2026 as follows

Service	Date	Non- Executive Board	Executive Board Member
Daisy Villa GP Surgery	9 June 2026	Rona Gold Fiona Mackay	NA
Speech and Language Therapy	22 June 2026	Joanna Kenny	Dr Anna Lamont (Medical Director)
Flotta GP Surgery	04 August 2026	Joanna Kenny	Dave Harris (Director of People and Culture)

3.1.1 Strengths highlighted by staff Daisy Villa GP Surgery

At the meeting with staff at the Daisy Villa GP Surgery 9 June 2026 staff highlighted several positive areas which provide assurance on the stability and quality of service provision. At the meeting staff described confidence in the quality of care provided to patients, and the value of consistent GP input and Pharmacy support in sustaining day-to-day service delivery.

Consistency in GP provision was highlighted as an important strength, supporting continuity of care and helping to maintain confidence within the practice team and local community.

Staff highlighted the positive working relationship with Pharmacy, noting that this support contributes to safe and effective service delivery.

3.1.2 Areas of concern raised by staff

Staff raised concerns about ongoing IT issues and the reliance on workarounds to maintain day-to-day service delivery. Particular concerns were raised in relation to the transition to the Vision GP IT system, including prescribing arrangements, the workload associated with stock-taking and inventory inputting, and the capacity of the team to support this work alongside routine service pressures.

Staff highlighted that the practice's remote location can create access challenges during winter, particularly when barriers are not passable.

Staff noted that energy costs remain high despite recent energy efficiency measures having been implemented.

Staff feedback also demonstrates the cumulative impact that IT issues, implementation requirements and environmental factors can have on small teams, particularly where services are operating in remote settings with limited capacity to absorb additional workload.

An action plan has been developed to respond to the feedback received from staff following the Board Walkaround at the Daisy Villa GP Practice and is provided at Appendix 1.

3.2 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 People	Quality/Patient Care	Yes	Board Walkarounds provide an opportunity for Board members to hear directly from staff about service strengths, operational pressures and issues that may affect staff experience, patient safety and service delivery. Following each walkaround, feedback is reviewed and actions are identified to support resolution, escalation or further assurance where required.
	Workforce	Yes	
Performance	Finance	No	No impact.
Potential	Risk Management	Yes	Potential impact where matters raised by staff require escalation, mitigation or ongoing monitoring through established governance routes.
	Digital	Yes	Potential impact where digital systems, implementation support or IT-related risks affect service delivery.
Place	Equality and Diversity including health inequalities	No	No impact.
	Climate Change Sustainability	No	No impact.

4. Recommendation(s)

- 4.1 This paper is presented for discussion, enabling the Board to consider the themes and implications arising from recent Board Walkarounds.
- 4.2 The Executive Team is asked to:
 - discuss the feedback received from the Board Walkaround; and note the feedback action plan provided at Appendix 1.

5. List of appendices

- i. **Appendix 1** Feedback Action Plan – Daisy Villa GP Surgery

Appendix 1 – Board Walkaround Feedback Action Plan

Service	Staff Feedback	Executive Lead(s)	Action(s) taken since walkaround	Status
Daisy Villa GP Practice	Staff raised concerns about ongoing IT issues and the reliance on workarounds to maintain day-to-day service delivery. These concerns related to the transition to the Vision GP IT system, prescribing arrangements, stock-taking and inventory inputting requirements, and the capacity of the team to support this work alongside routine service pressures.	Interim Director of Finance/Chief Officer IJB	IT and Digital Services have continued to work with staff at Daisy Villa GP Practice to review the issues identified and put in place short-term support to reduce reliance on operational workarounds. A focused implementation meeting has taken place with the practice team, Digital Services, Pharmacy and the Vision project team to confirm the timeline, responsibilities, training requirements and support available before and after go-live. Daisy Villa GP Practice is now live with the Vision GP IT system. Any residual issues will continue to be monitored through the agreed support arrangements.	Actions complete
	High energy costs despite recent energy measures implemented.	Interim Director of Finance	Estates and Finance have been asked to review current utility costs, assess whether recent energy efficiency measures have delivered the intended benefits, and identify any further practical actions that may help reduce costs during the winter period.	In progress

Healthcare Associated Infection Reporting Template (HIART) update

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 2026
Responsible Executive/Non-Executive	• Lesley Thomson, Executive Nurse Director (Interim)
Report Author(s)	• Sarah Walker, Head of Infection Prevention • Catherine Edwards, Infection Prevention Nurse Specialist
Purpose of report	• Assurance
Contribution to Strategic ambition	• Government policy/directive
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred
Key points for consideration	• Healthcare Improvement Scotland Balfour Hospital - Safe Delivery of Care Inspection report found "Infection prevention practices were consistently of a good standard. Care environments were clean and well maintained, supported by effective teamwork and appositve ward culture". No infection prevention recommendations have been made, which is such an achievement for all teams. • Changes to Transmission Based Precautions updated within the National Infection prevention and Control Manual -DL (2026) 08 No updated LDP Standards have been received to date, a recent communication in June reported that ARHAI Scotland are currently assessing the final standards position before submitting this to Scottish Government for recommendations on the future priorities for national surveillance. • All fifteen general practices have received their annual infection prevention team visit with improvement plans received for all bar one to date. Following last year's visits upgrades have been completed to four clinical hand wash sinks and carpets have been removed from clinical and waiting rooms in two mainland practices.

	• HCID PPE training has commenced, with 23 staff members receiving the initial PPE training. Staff are yet to present for competency sign off.
Route to meeting	• Nil: this is a mandatory Board report
Recommendation(s)	• Assurance - For members assurance only

Healthcare Associated Infection Reporting Template (HIART) Update

Sarah Walker, Head of Infection Prevention
14/08/2026

1. Situation

1.1 HIS Inspection

The Healthcare Associated Infection Reporting Template (HAIRT) report is presented to the Board to provide oversight, assurance and scrutiny of healthcare associated infection (HAI) performance.

During March 2026, The Balfour hospital received an unannounced Healthcare Improvement Scotland Safe Delivery of Care Inspection report found “infection prevention practices were consistently of a good standard. Care environments were clean and well maintained, supported by effective teamwork and appositive ward culture”.

No infection prevention recommendations have been made, which is such an achievement for all teams.

1.2 Transmission Based Precautions (TBPs)

The National Infection Prevention and Control Manual has been updated with changes to TBPs. An Extraordinary Work Group has been in meeting for the past two years to ensure all subject experts were involved in the changes, which focus on changes for respiratory transmitted pathogens. The changes have primarily been made following an increase in evidence following the pandemic and TBPs have now been updated to contact and Air Transmission. This now requires risk assessment by clinical staff to assess the level of respiratory PPE required, dependent on the suspected/known pathogen, level of transmissibility, vaccines available and the staff members vulnerability to infection. This is currently under review by the team.

1.3 National Standards

Correspondence received NSS ARHAIdatateam, confirmed that the current national HAI standards concluded on 31 March 2026. These standards required that there should be no increase in the number of new healthcare associated infection cases of *Clostridioides difficile* infection (CDI),

Escherichia coli bacteraemia (ECB) and *Staphylococcus aureus* bacteraemia (SAB) when compared with the baseline period of April 2023 to March 2024.

ARHAI Scotland is currently reviewing the future direction of national HAI standards and is engaged in discussions with the Scottish Government. In the interim, the previous standards remain in place while ARHAI Scotland awaits further direction regarding recommendations for future national surveillance priorities.

- 1.4 High Consequence Infectious Disease (HCID) training has commenced with 23 staff members across multiple departments receiving the initial PEE donning and doffing training, including Emergency Department, HIn (IP2), Theatre and Day Unit. However, these staff are yet to request competency assessment, which is a requirement prior to caring for a patient with a suspected HCID .

2. Background

- 2.1 This report provides an overview of the changes since the last report two months ago, and highlights areas that require mandatory reporting as well as local data capture.

3. Assessment

3.1 Analysis

The Healthcare Associated Infection Reporting Template (HAIRT) report is provided in **Appendix 1**. As updated Local Delivery Standards have not yet been issued, the previous year's targets have been carried forward for reporting purposes.

3.2 Current Position

3.2.1 Mandatory National Surveillance

Quarter 1 surveillance data have been submitted to Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) Scotland.

- **Staphylococcus aureus bacteraemia (SAB):** One healthcare-associated infection was reported during April to June against a Local Delivery Standard target of zero. Two additional cases are currently under review.
- **Clostridioides difficile infection (CDI):** One healthcare-associated infection was declared during April to June. One further case is under review for this reporting period.
- **Escherichia coli bacteraemia (ECB):** One healthcare-associated infection was declared during April to June. One additional case remains under review.

3.2.2 Domestic Services and Estates Monitoring

Both Domestic Services and Estates achieved the required compliance target of **90%**. Domestic Services recorded compliance rates of **96%** in June and **93%** in July, while Estates achieved **100%** compliance in both months.

Built Environment

Work is nearing completion for a reduction in the splash risk to patients.

3.1 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	Robust management of investigation is undertaken for <i>Staphylococcus aureus</i> and <i>E.Coli</i> bacteraemia's and CDI cases. Reduction of risk to patients from splash zones. Where this cannot be achieved then a risk remains on the corporate register.
People	Workforce	No	
Performance	Finance	Yes	Meeting the IPC guidance across all healthcare settings would result in extensive financial impact to meet current recommendations.
Potential	Risk Management	Yes	Effectively addressing some of the current IPC risks to patients.
	Digital	No	
Place	Equality and Diversity including health inequalities	No	
	Climate Change Sustainability	Yes	Reduction in water usage will be achieved with the reduction in hand wash sinks.

4 Recommendations

4.1 The Board are asked to review and scrutinise the information shared and raise any questions or clarification required.

4.2 Assurance - For members assurance only

5 List of Appendices

5.1 The following appendices are included with this report

- i. **Appendix 1, HAIRT Report**

Healthcare Associated Infection Reporting Template

Mandatory National Surveillance

Local Delivery Plan (LDP) Standard for quarter 1 have been submitted to ARHAI Scotland.

***Staphylococcus aureus* bacteraemia (SAB)**

LDP Standard Target Quarters for LDP standard year 2026-27	Community Case	Healthcare Associated Cases (HCAI)	Hospital Cases (HCAI)
Q1 – Apr - Jun	0	1	0
Q2 – Jul - Sep			
Q3 – Oct - Dec			
Q4 – Jan - Mar			

***Clostridioides difficile* Infection (CDI)**

LDP Standard Target Quarters for LDP standard year 2026-27	Community Cases	Healthcare Associated Cases (HCAI)	Hospital Cases (HCAI)
Q1 – Apr - Jun	0	1	0
Q2 – Jul - Sep			
Q3 – Oct - Dec			
Q4 – Jan - Mar			

***Escherichia Coli* Bacteraemia (ECB)**

LDP Standard Target Quarters for LDP standard year 2026-27	Community Cases	Healthcare Associated Cases (HCAI)	Hospital Cases (HCAI)
Q1 – Apr - Jun	1	1	0
Q2 – Jul - Sep			
Q3 – Oct - Dec			
Q4 – Jan – Mar			

Multi Drug Resistant Organism (MDRO) Clinical Risk Assessment National Screening – Quarter 1 received (calendar quarter)

MRSA Uptake	2025 Q2	2025 Q3	2025 Q4	2026 Q1
Orkney	86.7%	90.0%	86.7%	100.0%
Scotland	83.0%	84.8%	81.1%	81.7%

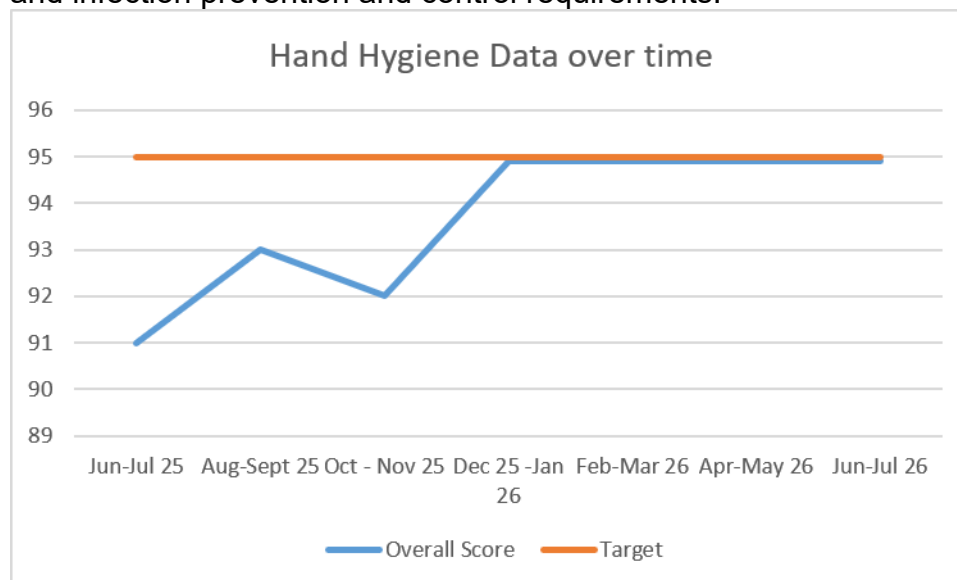
CPE Uptake	2025 Q2	2025 Q3	2025 Q4	2026 Q1
Orkney	100.0%	100.0%	100.0%	100.0%
Scotland	85.4%	87.2%	85.7%	86.9%

At the time of reporting, no further updates relating to the MRSA and CPE Clinical Risk Assessment KPI had been received.

Hand Hygiene

The hand hygiene compliance score for June to July 2026 was **95%**, achieving the national target. Compliance has remained consistently at or above target since December 2025, demonstrating sustained improvement in hand hygiene practices.

Opportunities for improvement were identified in relation to hand hygiene practices associated with PPE donning and doffing, as well as appropriate glove use. These areas will remain a focus for ongoing education, observation, and feedback to further strengthen compliance with best practice and infection prevention and control requirements.



Local Domestic and Estates Monitoring

Both Domestic and Estates monitoring tool remains above target within The Balfour.

Annual Months	Domestics % score	Estates % score
Jul-25	95%	100%
Aug-25	96%	100%
Sep-25	95%	100%
Oct-25	97%	100%
Nov-25	97%	100%
Dec- 25	95%	100%
Jan-26	96%	100%
Feb -26	97%	100%
Mar-26	94%	99%
Apr -26	97%	99%
May-26	96%	100%
Jun-26	96%	100%
Jul-26	93%	100%

IPC Team Update

HIS Inspection

A positive Healthcare Improvement Scotland (HIS) inspection report highlighted strong infection prevention and control practices and recognised the effective collaborative working relationships across teams.

The Infection Prevention Team's clear allocation of individual areas of responsibility, strengthens team effectiveness and supports a cohesive approach to service delivery. Team members are regarded as integral members of the multidisciplinary team.

The report confirmed that good infection prevention and control practice is embedded throughout the organisation and sustained through ongoing engagement, support and monitoring. Maintaining a visible and accessible Infection Prevention Team presence within clinical and non-clinical areas remains fundamental to promoting best practice, supporting staff, and ensuring continuous quality improvement.

TBPs

New guidance for TBPs have been issued with a DL (2026) 08 on the 10th August. Work around implementation is ongoing.

Splash Risk Mitigation

The work around the clinical hand wash basin to reduce risk of water splash is nearing completion. Robertson's Facilities Management are working collaboratively to progress this work.

High Consequence Infectious Diseases Preparedness (PPE)

The implementation date for the updated PPE ensemble and Board preparedness for High Consequence Infectious Disease has been pushed back to March 2027. This will enable the Board to purchase the relevant PPE required, which has been on back order nationally. 23 staff members across Theatre, Emergency Department, Day Unit and Hilyn Ward (IP2) have presented for the initial training, which is a huge step forward. However, to date there is still some improvement to be made around presenting for PPE competency sign off.

The Infection Prevention Nurse Specialist continues to set up training sessions within departments to aid staff presentation.

Community

Primary Care Infection Prevention Quality Assurance Audits 2026/27

The Infection Prevention Practitioner has now completed the 2026/27 General Practice Quality Assurance Audit Programme. The annual audits were conducted during May and June 2026 and included all fifteen island and community GP practices.

The audits are undertaken to assess progress, monitor improvement activity, and provide assurance of ongoing compliance with Standard Infection Control Precautions (SICPs). Practices are expected to achieve a minimum compliance rate of 90% across all ten SICPs.

To date, fourteen of the fifteen practices have submitted completed improvement plans. An additional follow-up visit was required for one practice to provide further support with the development of an action plan.

Recommendations arising from the previous year's audits that were shared with Estates colleagues have now been completed. This has resulted in improvements to compliant clinical hand-wash facilities in four practices and the removal of carpeting from clinical and waiting areas in two mainland practices.

Following completion of the 2026/27 audits, areas identified as requiring Facilities or Estates input have again been shared with relevant colleagues to support ongoing improvement and ensure compliance with infection prevention and control standards.

Exception Reporting to ARHAI and Scottish Government.

No exception reporting

Healthcare Improvement Scotland (HIS) Inspection Update

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 2026
Responsible Executive/Non-Executive	Lesley Thomson, Executive Nurse Director (Interim)
Report Author(s)	Lesley Thomson, Executive Nurse Director (Interim)
Purpose of report	Assurance
Contribution to Strategic ambition	- Emerging Issue - Government policy/directive - Legal requirement
Alignment to NHS Scotland quality ambition(s)	- Safe - Effective - Quality - Person Centred
Key points for consideration	- HIS Acute and maternity inspections identified common organisational themes relating to governance, workforce capability, leadership capacity, adverse event management and staffing governance. - Progress is evident across all improvement domains; however a number of actions remain in implementation and require sustained organisational focus. - The inspection findings support revising assurance against the Health and Care (Staffing) (Scotland) Act 2019 from Substantial Assurance to Limited Assurance pending full implementation and embedding of improvement actions.
Route to meeting	Report direct to Board, however inspection findings have been discussed in multiple forums
Recommendation(s)	Assurance - For members assurance only

Healthcare Improvement Scotland (HIS) Inspection Update

11/08/2026

Lesley Thomson, Executive Nurse Director (Interim)

1. Situation

- 1.1 Healthcare Improvement Scotland (HIS) undertook two unannounced inspections, one for Acute services and the second for Maternity Services at The Balfour Hospital in March 2026. Improvement Action Plans were developed in response to all requirements and recommendations. This report provides an integrated progress update and assesses implications for NHS Orkney and statutory staffing assurance.

2. Background

- 2.1 The Acute inspection generated seven mandatory requirements focused on paediatric life support, governance, training, adverse event management, Paediatric Early Warning Score (PEWS), leadership time and staffing governance. The Maternity inspection generated ten requirements and two recommendations focused on VTE compliance, documentation, training, leadership, staffing methodologies, appraisal compliance and trauma informed practice. Both plans are now monitored through NHS Orkney governance arrangements. Improvement plans were agreed between NHS Orkney and HIS with responses to requirements needed by November 2026

3. Assessment

- 3.1 Areas of good practice identified by inspectors included committed and compassionate staff, strong multidisciplinary working, engagement with improvement and a clear focus on patient centred care. Comparison of both action plans demonstrates considerable overlap. Governance and policy management requirements were raised, in addition to adverse event management.
- 3.2 Furthermore several aspects of health and care staffing/staff governance were highlighted in both inspections including compliance with staff training, safe staffing, compliance with common staffing method and time to lead. As these were themes across both inspections this will result in some actions being considered on a system wide basis rather than service specific.
- 3.3 Acute services uniquely require sustainable Advanced Paediatric Life Support (APLS) capability in the Emergency Department. Maternity services uniquely require strengthened Venous Thromboembolism (VTE) compliance and Maternity Early Warning Score (MEWS) documentation. Plans are underway

across the organization to address the requirements. Workforce capacity remains the principal risk to sustainable delivery.

3.2 Impact Assessment

3.2.1 Strategic Alignment

The inspection improvement plans directly support NHS Orkney Corporate Strategy 2024-2028. Governance improvements strengthen quality and patient safety. Workforce development and appraisal improvements support the People agenda. SafeCare implementation and staffing governance actions support sustainable and resilient services. As such, the plans should be viewed as supporting delivery of NHS Orkney's strategic Objectives in addition to providing regulatory compliance actions.

There are no immediate adverse financial implications beyond existing workforce and training investment requirements. The principal residual risk relates to workforce availability and the ability to protect learning and leadership time while maintaining service delivery.

3.3.2 Health and Care Staffing Act Assurance

Findings in both inspections regarding staff governance including leadership capacity, workforce training and education, SafeCare utilization and workforce planning methods indicate NHS Orkney cannot yet evidence full compliance with all expectations of the Health and Care (Staffing) (Scotland) Act 2019. While progress is evident such as the roll out of SafeCare, many controls remain in implementation. Accordingly, assurance will move from Substantial Assurance to Limited Assurance until improvements are embedded and evidenced through routine governance.

3.3.3 Overall Assurance

Moderate Assurance can be provided in relation to delivery of the HIS Improvement Plans. Governance arrangements, executive ownership and progress tracking mechanisms are being developed. However, Limited Assurance is recommended regarding compliance with the Health and Care (Scotland) Act 2019 due to recurring findings across both inspections concerning time to lead real time staffing and use of common staffing method as part of wider workforce planning.

3.4 Impact Assessment

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	The inspections highlighted several areas of positive practice in terms of quality of patient care and highlighted areas for improvement including assessment and documentation, training including APLS and VTE processes
People	Workforce	Yes	Change in assurance level from substantial to limited for Health Care Staffing Act given areas

			highlighted in the inspections including time to lead, real time staffing and escalation and use of common staffing method.
Performance	Finance	Yes	Some financial investment will be required to support training and potentially link to staffing. Whether this can be absorbed in existing budgets or requires further investment still requires assessment.
Potential	Risk Management	Yes	The inspections note requirements in NHS Orkneys current adverse event reporting and response timelines.
	Digital	Yes	Implementation of systems including eRoster and SafeCare are in progress however full utilisation of the systems and data reporting still under development.
Place	Equality and Diversity including health inequalities	No	N/A
	Climate Change Sustainability	No	N/A

4. Recommendations

4.1 The Board is asked to

- Note progress against the Healthcare Improvement Scotland Acute and Maternity Improvement Action Plans.
- Take assurance that appropriate governance arrangements are being progressed to oversee delivery.
- Note the Executive Nurse Director assessment that assurance against the Health and Care (Staffing) (Scotland) Act 2019 should move from Substantial Assurance to Limited Assurance.
- Endorse continued organisational focus on governance, workforce capability, leadership capacity, organisational learning and staffing assurance.
- Receive a further progress update through the established governance cycle.

5. List of Appendices

5.1 The following appendices are included with this report

- Appendix 1 - HIS Maternity Inspection report
- Appendix 2 – HIS maternity improvement plan
- Appendix 3 – HIS acute Inspection report
- Appendix 4 – HIS Acute improvement plan

i.

Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Balfour Hospital

NHS Orkney

23 – 24 March 2026

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About our inspection

Background

In November 2021 the Cabinet Secretary for Health and Social Care approved Healthcare Improvement Scotland inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. Taking account of the changing risk considerations and sustained service pressures the methodology was adapted to minimise the impact of our inspections on staff delivering care to women, birthing people and families. Our inspection teams are carrying out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records.

From April 2023 our inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland [Quality Assurance Framework](#). Further information about the methodology for acute hospital safe delivery of care inspections can be found on our [website](#).

The Healthcare Improvement Scotland (HIS) Maternity Care Standards, published on 23 March 2026, set out national expectations for the delivery of safe, effective and person-centred maternity care across all settings, including midwifery units, community and home settings, hospitals, primary care and prisons. In March 2026, the Chief Operating Officer (COO) formally advised all health boards that the Maternity Care Standards will be incorporated into HIS inspection activity from Monday, 21 September 2026 onwards. More information can be found [here](#).

Our Focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

Whilst this report uses the term 'women' the inspection team acknowledge the importance of including all people who give birth.

About the hospital we inspected

The Balfour is situated near the centre of Kirkwall. It is a small rural hospital with 48 beds containing an emergency department, inpatient and day wards and an integrated maternity and women's health service as well as several outpatient services such as physiotherapy, audiology and radiography. Patients requiring specialist treatment may be transferred to the Scottish mainland. In 2025, there was 100 births recorded at NHS Orkney.

About this inspection

We carried out an unannounced maternity services inspection in conjunction with an acute safe delivery of care inspection to Balfour Hospital, NHS Orkney on Monday 23 March and Tuesday 24 March 2026 using our safe delivery of care inspection methodology. An inspection report for the acute inspection will be published on our website. During the maternity inspection, we inspected the following areas:

- Combined antenatal, labour suite and postnatal ward.

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with women and birthing people, such as during mealtimes
- spoke with women, birthing people, visitors and ward staff and
- accessed women and birthing peoples health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Orkney to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Orkney and in particular all staff at maternity services for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection.'

Throughout our inspection we observed staff providing person-centred, compassionate and responsive care to women and their families.

Good teamwork was evident throughout the inspection between obstetricians, midwives and the health care support team. The senior midwifery and senior obstetric leadership teams were visible with respectful, friendly and supportive interactions observed. Staff described being supported by senior managers and felt able to raise concerns.

Staff were actively engaged with their own learning and development with plans in place to ensure they all complete their mandatory training.

Women and their families were complimentary of their care and would recommend NHS Orkney to friends and family.

During inspection, some areas of improvement were identified. These included the improved oversight and governance of the review of policies, guidelines and procedures.

Further improvements are required to ensure timescales of adverse events are achieved. This includes feedback to staff to support and improve the safe delivery of care.

NHS Orkney must ensure that clinical leaders have protected time to lead to fulfil their leadership roles.

Improvement in the completion of the electronic staffing tools was also identified to ensure the service is safe to start and that mitigations to ensure patient safety are consistently recorded.

What action we expect the NHS board to take after our inspection

This inspection resulted in 12 areas of good practice, two recommendations and nine requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on women, birthing people and families using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Orkney to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website:

<http://www.healthcareimprovementscotland.org>

Areas of good practice

The unannounced inspection to Balfour Hospital resulted in 12 areas of good practice.

Domain 1	
1	Staff were observed to provide responsive, compassionate and family-centred care (see page 11).
2	NHS Orkney has implemented a dedicated 'red phone' system within maternity triage to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff (see page 11).
3	The maternity ward was clean, organised and maintained to a high standard (see page 11).

Domain 2	
4	We observed an open and transparent culture with respectful, multidisciplinary team communication (see page 14).

5	Staff reported feeling well supported and able to escalate concerns to senior managers including the use of QR codes (see page 14).
6	NHS Orkney has introduced the Daisy Award programme to celebrate and recognise staff (see page 14).
7	A trigger list was available to all staff to aid and encourage the submission of incident report forms following an adverse event (see page 14).
8	NHS Orkney is engaging with and responding to, feedback from service users (see page 14).

Domain 4.1

9	We observed the implementation of a local newborn ultrasound screening programme for neonatal hip dysplasia to reduce carbon emissions from travel to mainland health boards as well as reduce the travel burden on families (see page 19).
10	All equipment examined was clean and stored safely ready for use (see page 19).

Domain 6

11	Women, families and visitors that we spoke with were highly complementary of the multidisciplinary team and the care provided (see page 23).
12	Women and families were supported by staff to build confidence in their infant feeding choice and supported to develop close and loving parent-infant relationships (see page 23).

Recommendations

The unannounced inspection to Balfour Hospital resulted in two recommendations.

Domain 4.1

1	NHS Orkney should consider introducing a structured communication format such as an SBAR (Situation, Background, Assessment, Recommendation) during handovers and at times of escalations (see page 19).
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Domain 6

2	NHS Orkney should consider improving trauma informed training compliance rates for all staff (see page 23).
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Requirements

The unannounced inspection to Balfour Hospital resulted in nine requirements.

Domain 1

1	NHS Orkney must ensure governance and oversight to ensure venous thromboembolism risk assessment compliance (see page 11). This will support compliance with: The Quality Assurance Framework (2022) criteria 2.6.
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Domain 2

- 2 NHS Orkney must ensure timescales of adverse events are achieved. This includes feedback to staff and action plans to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland's National Framework (see page 14).

This will support compliance with: Healthcare Improvement Scotland A national framework for reviewing and learning from adverse events in NHS Scotland and Healthcare Improvement Scotland Quality Framework (2018) criteria 2.5 and 2.6.

Domain 4.1

- 3 NHS Orkney must ensure effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use (see page 19).

This will support: Quality Assurance System: Quality Assurance Framework (2022) criterion 2.5 and 2.6.

- 4 NHS Orkney must ensure an effective system is in place to record patient documentation. This includes but is not limited to:

- i. The maternity early warning score is accurately completed to support the safe delivery of care (see page 19).

This is to comply with Nursing and Midwifery Council (NMC) The code (2018) and NHS Scotland and Healthcare Improvement Scotland Quality Assurance Framework (2022) criteria 2.6.

- 5 NHS Orkney must ensure that employees receive time and resources to undertake training which is essential to their role (see page 19).

This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

- 6 NHS Orkney must ensure that all staff complete statutory fire safety training (see page 19).

This will support: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3 and Fire Safety (Scotland) Regulations (2006).

Domain 4.3

- 7 NHS Orkney must ensure senior charge midwives have appropriate and protected leadership time to fulfil their leadership and management responsibilities. This will include but is not limited to:

- i. Staff appraisals

This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls (see page 21).

This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Health and Social Care Standards (2017) criteria 3.14, 3.15 and 3.19.

8	NHS Orkney must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real-time staffing risk across all clinical professional groups within maternity services. This is to support consistent management of any identified staffing risks which should include, but is not limited to: i. Recording any escalation, mitigation and/or inability to mitigate and communication of outcomes to all relevant teams ii. A record of any disagreements with decisions made (see page 22). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
9	NHS Orkney must ensure that there are processes in place to support the consistent application of the common staffing method. This includes, but is not limited to: i. The application of the mandated staffing level and professional judgement tools ii. A reporting template demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement (see page 22). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We observed good multidisciplinary team work to provide prompt, responsive and compassionate care. The service supported a family-centred approach, recognising the importance of encouraging fathers, co-parents, partners and family members to be partners in care.

NHS Orkney provides maternity services to women and their families across Orkney in Balfour Hospital, Kirkwall. The maternity ward is situated on the first floor and is clearly signposted from the main entrance. The department delivers an integrated maternity and women's health service to its community which amongst others covers antenatal, intrapartum and postnatal care. The maternity ward provides midwifery led care supported by onsite consultant obstetricians.

The maternity service supports the continuity of care model described within Scottish Governments 2017 vision for maternity services; The Best Start: A five-year forward plan for maternity and neonatal care in Scotland recommending parents and babies are offered truly family-centred and compassionate care. NHS Orkney provides a team midwifery model where women are allocated to a small team of midwives who provide their care. We observed no restrictions to visiting and the service supported a family-centred approach, recognising the importance of encouraging fathers, co-parents, partners and family members to be partners in care. Women and families who we spoke with told inspectors that they were provided with appropriate information relating to their care, had time to ask questions and felt actively

involved in their care plans. They described that their wishes were heard and respected and felt like they were partners in care.

The maternity service is accessible 24 hours a day, seven days a week following a telephone assessment carried out by midwives, allowing maternity staff oversight of women attending. Staff document calls on a standard maternity electronic patient communication log developed to record telephone conversations. Women who require to attend the maternity service are reviewed promptly upon their arrival. This is consistently achieved due to low acuity within the department.

NHS Orkney supports both scheduled and unscheduled care within the maternity unit with staff able to support this. During inspection, inspectors observed that calls were answered promptly and there were no delays observed. Staff and senior managers did not describe any delays to prioritising triage calls or care. We asked NHS Orkney to provide all incident reports submitted by staff for the six months prior to our inspection in relation to patient safety. From review of submitted reports we observed no incidents related to delays to prioritising triage or care.

The maternity ward has recently implemented a dedicated 'red phone' system to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff. The availability of a 'red phone' was raised as a recommendation following a recent fatal accident inquiry within another NHS board. This system facilitates timely, clear and prioritised communication during critical information sharing, supporting safer and more effective coordination of patient care. Due to a small staffing model, the senior management team confirmed that the midwife on shift always carries the maternity phone when away from the desk ensuring uninterrupted access to maternity staff. This arrangement mitigates any potential safety risk and aligns with their local escalation procedure.

Within the maternity ward there are two spacious birth rooms, one with a birthing pool. There are a further two side rooms that are flexibly used for antenatal or postnatal care depending on requirements. Staff highlighted that these rooms, at times of high acuity within the wider hospital, may be used as surge beds with staff from the acute ward continuing to care for their patients. Should this be required, the maternity unit can be reconfigured with a set of closed doors to protect safety. There are further consultation rooms which have multipurpose usage such as triage, clinical appointments as well as ultrasound services. Throughout our inspection, the maternity ward was clean, organised and maintained to a high standard.

During the onsite inspection, the unit was busy but calm and we did not observe any delays to care. Women were reviewed immediately and call bells were answered promptly. We observed staff providing responsive and person-centred care. Senior managers informed us that although delays occasionally occur, these are rare. As a mitigation and particularly during out of hours where only one midwife is on duty within the unit, there is an agreed on-call model to ensure the availability of a second midwife when required. NHS Orkney was able to provide a policy which supports the escalation of staffing risk concerns to support the safe delivery of patient care. Data relating to delays to care, including delays to induction of labour and if medical staff were unavailable to attend a patient, would be captured through the incident reporting system. Through the review of evidence submitted, there were no reported incidents of delays to care observed in the six months prior to our inspection.

Obstetric emergencies and concerns over the wellbeing of the unborn baby are time sensitive, requiring a systematic approach which identifies women of the highest clinical priority to improve outcomes. The appropriate equipment to manage these situations should be readily available. An emergency trolley provides immediate access to critical equipment and medications during an obstetric emergency. Essential medications which would be used during obstetric emergencies were observed to be stored safely and appropriately. During the onsite inspection, we noted that emergency trolleys were placed appropriately within the maternity ward. They were clean, organised and accessible to all staff for their prompt use.

In the event of an unwell or unexpected premature newborn baby who needs enhanced support at birth, it is fundamental that staff have the required skills to respond effectively. Maternity staff described undertaking enhanced learning in emergency skills and stabilisation of the newborn baby. Stabilisation of the newborn is a process where midwives, neonatologists and paediatricians are involved in providing care to a baby who requires increased support whilst awaiting the attendance of a neonatal transport team. ScotSTAR is a national service for the safe and effective transport and retrieval of newborn babies as well as critically ill children throughout Scotland. In NHS Orkney midwives are required to stabilise newborn babies as there are no neonatologist or paediatricians on site but the anaesthetic team are available to support where required. During the antenatal care, women are made aware that if their baby requires immediate support, midwives and the medical teams will provide the initial support but that an emergency transfer to the most appropriate neonatal unit may be required. Midwives consistently described respectful partnerships with medical teams from mainland health boards when they required support or guidance to ensure that immediate neonatal care is initiated to provide safe delivery of care. In evidence submitted by NHS Orkney, we observed 94% of midwifery staff had undertaken the Scottish Neonatal Resuscitation Course (SNRC) with the remaining two midwives scheduled for attendance. Obstetric consultants had a 67% compliance rate, reflecting one new member of staff recently commencing in post.

If any concerns are identified regarding the wellbeing of the mother or her baby, staff may in collaboration with mainland health boards, arrange for a transfer to ensure the continued safe delivery of care. In evidence submitted, we noted that due to Orkney's geographical location, urgent transfers to the mainland are facilitated by air, though this is determined by the availability of aircraft, crew and weather conditions. In evidence reviewed, we observed a reduction in local births from 145 in 2020 to 100 in 2025. However, the service has observed a rise in transfers from 45 in 2020 to 54 in 2025. The increase in transfers is linked to an increase in maternal complexity which is consistent with national trends. Of overall transfers during 2025, 39% were classified as emergency maternal transfers and 6% were neonatal transfers to mainland health boards.

Mother and babies: reducing risk through audits and confidential enquiries across the UK ([MBRRACE-UK](#)) aim to improve outcomes for women and babies through learning from national audit. The 2024 report demonstrated the leading cause for maternal death in the UK being attributed to venous thromboembolism. Learning from the report highlighted a need for continuous evidence-based risk assessment throughout pregnancy and following birth. In evidence submitted by NHS Orkney, we observed that 95% of inpatients had their risk assessments done. However, only 78% of antenatal and 87% of postnatal risk assessments were completed. Patient safety incident reports submitted did not highlight any submissions or concerns relating to thromboprophylaxis being omitted. A requirement has been given to

support further improvement in the consistent completion of venous thromboembolism assessments.

The National Bereavement Care Pathway Scotland is a project funded and developed by Scottish Government in partnership with Sands, the stillbirth and neonatal death charity, with the aim of standardising and improving the quality of bereavement care for the families of Scotland. Further information can be found [here](#). During our inspection we observed that bereaved families would be allocated a room in the maternity ward due to the limitations of the ward and hospital environment. Staff raised some concerns regarding the location of caring for bereaved families in the maternity ward and were conscious of the emotional and mental challenges this might cause women and their families. Staff spoke with empathy and compassion of providing holistic and compassionate care ensuring women and families were empowered to create memories as part of their Memory Box. Within the maternity services the role of the bereavement lead is undertaken by a midwife. Evidence reviewed demonstrate that learning and development sessions are offered to all staff. This is in line with Key Action 32 of the National Bereavement Care Pathway Scotland which highlights that all staff who are caring for bereaved families should be supported to access learning opportunities. In 2025, 88% of midwives, 100% of health care support workers and 67% of obstetric consultants had attended bereavement training, the lower rate among obstetric consultants reflected one new member of staff recently commencing in post.

Areas of good practice

Domain 1	
1	Staff were observed to provide responsive, compassionate and family-centred care.
2	NHS Orkney has implemented a dedicated ‘red phone’ system within maternity triage to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff.
3	The maternity ward was clean, organised and maintained to a high standard.

Requirements

Domain 1	
1	NHS Orkney must ensure governance and oversight to ensure venous thromboembolism risk assessment compliance.

Domain 2 – Leadership and culture	
Quality indicator 2.1 – shared values	

We observed an open and transparent culture where senior midwifery managers and obstetric consultants were visible, aiding support and care provision. We observed areas for improvement in the timely review of incident reports and consistent feedback.

Inspectors observed respectful and inclusive multidisciplinary team communication during inspection. The Nursing and Midwifery Council and General Medical Council emphasise the importance of effective team working and communication to provide good and safe patient care within their ‘Good teamwork means better maternity care’ document. Further information can be found [here](#). Communication and effective multidisciplinary working are key

in all clinical areas where there may be multiple issues that require prioritisation and planning. Throughout the inspection, midwives and obstetricians were noted to be working closely together and shared good oversight of how and when they would contact other teams including anaesthetists, theatre teams and senior managers if the need should arise during an emergency to ensure the safe delivery of care. Staff told inspectors that they felt well supported when they escalated issues such as understaffing and increased acuity to the senior management team. Within evidence received, NHS Orkney was able to provide the escalation policy which supports staff in and out of hours to escalate any staffing concerns to senior managers.

A positive working culture and psychological safety is essential to the safe delivery of care and has been evidenced within the reviews into maternity services by [Kirkup \(2015\)](#) and [Ockenden \(2022\)](#). Psychological safety is the ability of all staff groups to feel free to speak up, ask questions, report errors, raise concerns and ask for feedback without fear of consequences or being judged. During our inspection staff described a positive and supportive workplace culture. Staff told inspectors that they felt well supported by senior managers when they escalated issues such as staffing and increased acuity. During the inspection, we observed posters that provided staff with an option to use a Quick Response (QR) barcode displayed within the maternity unit to raise their concern anonymously if they wished.

In evidence submitted by NHS Orkney, we reviewed the 2025 iMatter Health and Social Care Staff Experience Survey for maternity services. The survey is structured around key enablers of staff engagement, allowing teams and health boards across health and social care to reflect on their progress against the five strands of the Staff Governance Standard. This standard supports staff to feel well informed, appropriately trained, involved in decisions, treated fairly and working in an environment that promotes their health and wellbeing. More information can be found [here](#). The survey results demonstrate that 100% of maternity staff participated in the survey which is a considerable increase from 58% responding in 2023. The 2025 results show a high Employee Engagement Index of 86 across the five Staff Governance Standards. Staff particularly rated being appropriately trained and developed as well as being treated fairly and consistently with dignity and respect. These results enable the maternity service to recognise and celebrate their achievements and for the board to explore opportunities for continuous improvement where staff have identified areas where this is needed.

Staff described a positive culture where staff wellbeing was promoted. The maternity team has weekly team meetings which staff spoke highly of as a time to come together, learn and consider suggestions for improvements. Staff who inspectors spoke with during the onsite inspection highlighted high levels of support and psychological safety through these meetings. Senior staff demonstrated commitment and awareness to role model respectful, compassionate communication and through their leadership improving workplace culture, individual and team performance and in doing so, improving patient care.

The maternity service has introduced the Daisy Award which is a programme to celebrate and recognise staff for the care and kindness they have provided. Staff may collect nominations from women, families and their peers. During the inspection, we observed several posters and Daisy nomination cards that could be submitted into a nomination box, or nominees could use the QR barcodes that were displayed. Maternity staff spoke of the positive impact the Daisy Award has on acknowledging their colleagues, receiving nominations from peers or from the women and families they have cared for.

The national perinatal mortality review tool (PMRT) is a national tool designed to standardise the review and identify learning following stillbirths and neonatal deaths. NHS Orkney uses the national review tool and includes the experiences of families involved. NHS Orkney submits all data in relation to perinatal deaths and uses the PMRT to support adverse events reviews.

The learning from adverse events national framework highlights that all adverse incidents should be reviewed. The level of the review will be determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. Further information on the adverse event framework can be found [here](#). A trigger list was available to all staff to aid and encourage the submission of incident report forms following an adverse event.

A significant adverse event is an event which caused or could have caused significant harm. Significant adverse event reviews are essential to ensure key learning and reduce the risk of future harm. Through the review process, NHS Orkney ensures patients and families are informed, involved and supported throughout the review and allocates a named contact who may answer their questions. Patients and families are offered the opportunity to contribute through face to face or virtual meetings to ensure their perspectives, concerns and experiences form part of the review process. The most serious adverse events are categorised as level one, requiring a significant adverse event review which should be completed within 140 working days. In evidence provided, we observed that the maternity service commissioned and completed the review within the expected timeframe in line with national and local processes, however delays were noted within the wider hospital setting. The maternity service developed an action plan to address the recommendations outlined in the review. These actions were agreed through clinical governance processes with most of the improvements implemented. The final action is expected to be concluded at the end of May 2026.

During the inspection, we spoke with staff who described feeling able to submit incident reports without concern. However, some staff told us that they do not report all incidents mostly due to long delays before feedback is provided, or in some cases that they did not receive feedback. Inconsistent incident reporting might have an impact on learning from adverse events thus reducing opportunities to understand what went wrong, why it happened and improve safety within the system. In the national framework for reviewing and learning from adverse events level two incidents require a review completed within 30 working days whilst level three incidents should be completed within 10 working days. In review of evidence, we observed that the maternity service at NHS Orkney has a delay of up to four months in reviewing some incidents. This delay limits timely improvement, feedback and learning. In discussion with senior managers, they described good oversight, governance and system progress to improve their compliance in accordance with the national framework however, the delay to complete the review of these adverse events remains. This was also highlighted in the acute inspection and a requirement has therefore been given to support further improvement in this area.

In [Healthcare Improvement Scotland National Framework for Reviewing and Learning from Adverse Events](#), it outlines that NHS boards should ensure immediate access to support for staff involved in adverse events. Staff at NHS Orkney spoke highly of their peers for support whilst recognising other support options such as occupational health and NHS Scotland wellbeing and mental health support services, should they prefer. Staff described the use of the hot debrief technique to support and promote psychological safety following an adverse

event. Initiating a hot debrief or discussion immediately following the event is an important element of staff support and opportunity to ensure there are no immediate patient safety risks. Facilitating this acknowledges what has happened and ensures staff receive proportionate support in a timely and person-centred manner. Senior staff acknowledged the emotional and professional impact adverse events might have and discussed reaching out to staff involved to ensure their wellbeing. Staff told the inspection team that they felt well supported without fear of blame. Staff articulated that they viewed adverse events as an opportunity of learning and to improve future care displaying a culture of continuous learning as integral to delivering safe, effective and compassionate care to the community.

Listening to service users is a key component in a quality management system and in improving the quality of services. As part of the inspection, we noted multiple thank you cards displayed within the maternity unit and observed several posters with QR codes encouraging and welcoming feedback from service users. In discussion with staff and senior managers as well as in the evidence received from NHS Orkney, there was an acknowledgement of receiving limited feedback through Care Opinion. This is an anonymous platform where patients can share their experiences which are passed on to the health service in an aim to improve care and experiences. Senior managers highlighted that patient experiences and feedback reported to the board are shared through the monthly Clinical Quality Group providing oversight and supporting the use of service users' experiences to inform service improvement. In evidence received, we observed that the maternity service had developed a postnatal questionnaire in 2025 to obtain feedback and suggestions for improvements from mothers. The survey responses demonstrated few suggestions for change, with respondents praising the person-centred care, compassion and outstanding support they had received throughout their care journey.

Areas of good practice

Domain 2	
4	We observed an open and transparent culture with respectful, multidisciplinary team communication.
5	Staff reported feeling well supported and able to escalate concerns to senior managers including the use of QR codes.
6	NHS Orkney has introduced the Daisy Award programme to celebrate and recognise staff.
7	A trigger list was available to all staff to aid and encourage the submission of incident report forms following an adverse event.
8	NHS Orkney is engaging with and responding to, feedback from service users.

Requirements

Domain 2	
2	NHS Orkney must ensure timescales of adverse events are achieved. This includes feedback to staff and action plans to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland's National Framework.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

All areas inspected were calm and well organised with staff working hard to support the safe delivery of care. However, during inspection we observed that many clinical policies and guidelines were overdue their review date.

Quality improvement in maternity care aims to make a difference to women by improving safety, effectiveness and experience of care. We asked for evidence of data oversight and quality improvement initiatives to improve patient safety and experiences within the maternity services. In discussion with inspectors, staff described being aware of ongoing quality improvement projects. We observed a list of improvement ideas that everyone was encouraged to add their suggestions to. This enables staff to become actively involved with quality improvements and advance a culture of continuous learning within their workplace. We were told of innovation to support quality improvement. This includes the Green Maternity Challenge initiative focusing on sustainable maternity care. The proposal included the implementation of a local newborn ultrasound screening programme for neonatal hip dysplasia to reduce carbon emissions from travel to mainland health boards as well as reduce the travel burden on families. The project has now been implemented and maternity staff described how this environmentally sustainable model has had a positive impact on families, reducing stress from travelling whilst enhancing efficiency, care and experiences within a more environmentally sustainable care model.

Evidence-based clinical guidelines, policies and procedures are used to assist clinicians in decision making regarding treatment and care in specific circumstances. Guidelines are a resource within clinical practice to improve communication between patients and health professionals and help patients make informed decisions. Ensuring clinical guidelines are consistent with evidenced based practice requires oversight and a system of review to ensure they remain relevant.

Many of the clinical guidelines within maternity services which should be available to support and guide staff in clinical practice were overdue their review date, for example, the Emergency In-Utero Transfer standard operating procedure and the Additional Support Pathway for Women with Vulnerabilities. Some policies had been developed in other health boards or were national guidance documents including the Accessing Neonatal Advice and Pathways for Transfers of Newborn Infants without clear oversight and governance for their implementation in NHS Orkney. There appeared to be no maternity section noted on the intranet for staff to locate policies and guidelines and whilst a folder with guidelines was available, some staff we spoke with were not sure of where to find these. We asked senior managers about what processes are in place for the oversight of policies and procedures. They advised us that in May 2025 they had developed a document to provide oversight and prioritisation of policies required to be reviewed, developed or were requiring approval by clinical governance processes. Senior leaders told us that the maternity clinical governance group had recently been set up and would, amongst others, review and approve process documents for maternity services and to provide formal oversight. In discussion with senior leaders, it was evident that whilst there was acknowledgement of the delay to renewing and developing policies, the timely review process was, in part, also delayed due to limited senior leadership capacity which may compromise the safe delivery of care. Whilst we recognise the initial steps taken to

improve governance and oversight, a requirement has been given to support improvement in this area.

The Scottish Patient Safety Programme (SPSP) is a national quality improvement programme which aims to improve the safety and reliability of care and reduce harm. Through its perinatal programme, boards submit quarterly progress updates which form the basis of coaching conversations between teams and Healthcare Improvement Scotland. This identifies any improvement support required to meet the aims and objectives set. In evidence submitted by NHS Orkney, we observed the maternity service aims and progress updates between April and December 2025, such as to implement the continuity of carer model. The progress report outlines that where obstetric care is required, women now have a named primary consultant obstetrician. The service anticipates developments in compliance with the continuity of carer by the woman's primary or buddy midwife. NHS Orkney's published Integrated Performance Report from February 2026 demonstrate good oversight of performance in relation to national and local reporting requirements and includes performance updates in relation to the continuity of carer model. The report highlights that 67% of intrapartum care was provided by the woman's primary or buddy midwife which is exceeding NHS Orkney's target of 50%. Following some staff changes, 59% of women now receive scheduled antenatal care by their primary or buddy midwife demonstrating progress towards their target of 75%. However, only 26% of postnatal care was provided by the primary or buddy midwife which remains below NHS Orkney's target of 75%. As a result, postnatal continuity of care has now been recognised as a key priority area for improvement with a new dedicated postnatal team identified as a test of change.

The Maternity Early Warning Score (MEWS) is a bedside screening tool which supports observation of physiological parameters such as blood pressure and heart rate. The aim of this is to improve the recognition of pregnant and postnatal women at risk of clinical deterioration, facilitating early intervention to improve outcomes. In evidence submitted, we observed monthly MEWS audits of compliance with appropriate completion and escalation showing progress from 75% in September 2025 to 100% in February 2026 with the service working towards demonstrating a sustained improvement over time. However, the small sample size may impact the reliability of the results. Staff advised us that they use a hybrid approach to MEWS documentation where electronic patient care records and paper-based documentation are both used. A hybrid documentation approach may increase potential risks to patient safety due to, but not limited to, loss of information from other records, duplication of records and a non-standard approach and inconsistency in escalation parameters across different documentation formats. Staff told us that the hybrid approach to MEWS documentation was based on individual preference, though for some due to their proficiency of the implemented electronic records system. A requirement has been given to support improvement in this area.

Effective communication is acknowledged as one of the most crucial elements to ensure the delivery of quality assured healthcare services. The SBAR tool refers to a structured communication framework used widely in healthcare and the maternity services to improve clarity, efficiency and safety of the exchange of all relevant information between healthcare professionals, such as at shift handovers or when escalating concerns. Within the maternity services at NHS Orkney, staff told us that they do not utilise the electronic SBAR communication tool or a paper-based version but are instead relying on verbal handovers. This

approach may increase the risk of ineffective communication, omissions of information and unclear responsibilities with the potential to compromise patient safety and contribute to adverse events. A recommendation has been given to support improvement in this area.

Staff we spoke with told us they were encouraged and supported to undertake regular training, including mandatory training and that senior staff were working hard to accommodate these requirements. Core mandatory training requirements for midwives and obstetricians in Scotland were published by Scottish Government in 2018. This required each NHS board to establish training around fetal (unborn baby) heart monitoring, obstetric emergencies and neonatal resuscitation. Wider national reports on the provision of safe maternity care over the last decade such as [Ockenden \(2022\)](#) and Each baby counts ([RCOG 2019](#)) have highlighted the essential safety feature of teams working and training together to improve outcomes for patients. Evidence received from NHS Orkney demonstrated that as of 31st August 2025, varying rates of compliance were noted within the maternity services. 65% of midwives and 33% of obstetric consultants had undertaken the practical Scottish Core Obstetric Teaching and Training in Emergencies (SCOTTIE) course with future course dates planned for staff requiring updates and for new colleagues. This course is designed to train the multidisciplinary team in the management of obstetric emergencies. Cardiotocography (CTG) and intermittent auscultation are used to record and interpret the fetal heart rate in pregnancy and during labour. It is an important tool used in conjunction with clinical assessment to determine fetal wellbeing. NHS Orkney provided evidence that 94% of midwives had completed the yearly fetal heart monitoring training and 88% had completed the two-yearly requirement. An additional 94% of midwives attended a CTG masterclass in 2024. 100% of obstetric staff had undertaken the yearly fetal monitoring training and 67% the two-yearly learning package. Senior managers told us that they have recently recruited to a vacant consultant obstetric post and some midwives were on maternity leave impacting their overall compliance. However, the service demonstrated oversight and had taken a proactive approach to facilitate multidisciplinary and cross-departmental training as well as ensuring staff who were required and available to attend training were booked on upcoming courses. Whilst we recognise this, a requirement has been given to support improvement in this area

Some midwives within NHS Orkney have taken on further roles through the development of their skills and competencies to support and enhance the local service provision. Additional roles include sonographer training to enable more pregnancy scans to be performed within the service, as well as the newborn ultrasound screening programme for neonatal hip dysplasia. One midwife has an education focused role to strengthen the oversight and development of a robust core mandatory update programme and the identification of training needs through audit and incident reviews. Others are instructors for emergency scenario training, lead midwife for bereavement services, hypnobirthing, aqua natal instructors or aromatherapy. Staff spoke of their pride in taking on these roles to facilitate the best care and service to women, babies and families.

We were provided with evidence of health care support workers and maternity care assistants who have further training to provide support and assistance to the midwife and wider multidisciplinary team to deliver safe care. Health care support workers and maternity care assistants are non-registered health care staff working under the guidance of the midwife within a hospital or community setting. They provide important support to staff and women across the maternity journey. Healthcare assistants who inspectors spoke with felt they had

good opportunities to carry out their role with women and families and understood how to escalate their concerns to midwifery staff. Respectful and engaging relationships were noted between support staff and families.

We observed fire risk assessments were completed in October 2025. NHS Scotland Fire code SHTM 86: 'Fire Risk Assessment' states that hospitals and other healthcare premises with sleeping accommodation should have a yearly fire safety review. A fire risk assessment within the maternity unit was noted. Fire escape routes and exits were clear, well signposted and unobstructed. All staff must be aware of fire evacuation processes and maintain up to date fire safety training modules. Staff e-learning training compliance for fire safety submitted by NHS Orkney demonstrated that 82% of midwifery staff had attended the mandatory fire safety training in the last 12 months whilst 67% of consultant obstetricians had attended. A requirement has been given to support improvement in this area.

During the inspection, all equipment examined was stored safely, clean and ready for use. Storerooms were tidy and well organised.

During onsite inspection, medicines were observed stored in locked cupboards inside an appropriately locked preparation room which was pass controlled. Medicines for each patient are stored in locked bedside cabinets and dispensed from there. Medicines required to treat obstetric emergencies were appropriately stored in the preparation room and were able to be accessed if needed. Medication fridges were secure and only accessible to appropriate staff within the maternity unit.

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 stipulate that chlorine-based cleaning products must be stored securely and kept in a secure area such as a locked cupboard. We observed chlorine-based cleaning products stored safely in an access restricted sluice.

Hand hygiene is an important part of standard infection control precautions to reduce the risk of infection as outlined in the National Infection and Control Manual. In evidence submitted, the service demonstrates a 100% compliance with hand hygiene procedures in the three months prior to inspection. During the onsite inspection, we observed good compliance with hand hygiene and that no opportunities to perform hand hygiene were missed.

Personal protective equipment such as gloves and aprons was readily available at the point of care. Inspectors observed the appropriate use of personal protective equipment.

Inspectors observed safe sharps management compliance with sharps boxes labelled as per guidelines and having temporary closures in use. The use of the temporary closure prevents needles or other sharp objects protruding from the boxes or falling out of the container if they are dropped. Inspectors also observed sharps boxes stored appropriately when not in use.

Linen trolleys were placed and stored appropriately with the correct covering. This is in line with the national infection prevention control manual. Used linen, which was potentially contaminated with blood or suspected to be infectious, was managed and disposed of correctly.

Mealtimes were well organised. Staff highlighted that it was easy to obtain specialist meals for women with differing requirements. Women were able to have snacks such as tea, toast and sandwiches as they wished.

NHS boards are required to have water safety systems in place for the control and management of risks posed by waterborne organisms that may cause disease. Evidence submitted by NHS Orkney demonstrate compliance with water flushing regimes in the area inspected.

Areas of good practice

Domain 4.1	
9	We observed the implementation of a local newborn ultrasound screening programme for neonatal hip dysplasia to reduce carbon emissions from travel to mainland health boards as well as reduce the travel burden on families.
10	All equipment examined was clean and stored safely ready for use.

Recommendations

Domain 4.1	
1	NHS Orkney should consider introducing a structured communication format such as an SBAR (Situation, Background, Assessment, Recommendation) during handovers and at times of escalations.

Requirements

Domain 4.1	
3	NHS Orkney must ensure effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use.
4	NHS Orkney must ensure an effective system is in place to record patient documentation. This includes but is not limited to: i. The maternity early warning score is accurately completed to support the safe delivery of care.
5	NHS Orkney must ensure that employees receive time and resources to undertake training which is essential to their role.
6	NHS Orkney must ensure that all staff complete statutory fire safety training.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Staff we spoke with described a supportive and responsive leadership at all levels if they required to raise concerns. However, we observed senior midwives did not always have protected time to lead.

Workforce pressures including recruitment and retention of staff continue to be experienced throughout NHS Scotland. Senior managers were able to discuss the ongoing challenge of recruitment within midwifery and obstetrics in NHS Orkney, though a recent recruitment to an obstetric consultant post had been completed. This is contributed to by the fact that island communities are more remote and includes a requirement to work on-call across day and night. The consultant obstetric team currently work a one in two on-call rota pattern with the requirement to cover on-call extending during periods of annual leave. During discussion with the senior obstetric team, we asked regarding the opportunity for middle grade obstetric

training within the unit to support both the quality of the service and as an opportunity for succession planning and attracting new recruitment and retention to the unit. Whilst the senior team highlighted the potential limitations to middle grade obstetric training within the service regarding the number of service users and potential exposure to learning they acknowledged its essential nature for succession planning, recruitment and retention.

In the workforce data reviewed from NHS Orkney, it demonstrated a 19% shortfall in the Band 8b Lead Midwife role which is currently undertaken on a part time basis and incorporates dual responsibilities as a Deputy Nurse Director whilst the senior charge midwifery role had a 28% shortfall. We consider a shortfall of 10% vacancy as high. Whilst it was evident that both roles were delivered with significant commitment and goodwill, it was noticeable that due to ongoing and competing demands for the senior charge midwife such as management duties, leading on a variety of quality improvement initiatives and supporting the clinical workload, time to lead was, at times, compromised. Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019) to ensure clinical leaders have protected time and adequate resource to facilitate appropriate staffing alongside other professional duties to lead the delivery of safe, high-quality and person-centred healthcare. A requirement has been given to support improvement in this area.

In evidence received, we observed that all consultant obstetricians had their appraisals undertaken within the last 12 months. In the same timeframe, 63% of midwives had received an appraisal by their line manager. Whilst a small number of staff were only recently due an appraisal, 21% of midwives had not had an appraisal since 2024. Staff appraisals are essential to support and enable staff to feel valued and support their individual development. Inspectors discussed this with senior midwives during inspection, who acknowledged that competing demands and capacity was making it challenging to complete in a timely manner. A requirement has been given to support improvement in this area.

Midwives work a day, back and night shift pattern that incorporates an on-call model. Inspectors explored the on-call commitment with staff and senior managers who highlighted that the on-call model is to ensure a second midwife is always available to support the safe provision of intrapartum care during the day and throughout the night where one midwife and one clinical support worker is rostered to work within the unit. Staff spoke of having a low threshold to call in the on-call midwife or escalate any clinical care concerns to the senior midwifery and obstetric team. Midwifery staff consistently spoke very positively of the support they would receive from the multidisciplinary team when concerns occurred or when they required advice. We asked how shortfalls within the shift rota and on-call would be managed. Senior managers were able to describe that covering these were, at times, challenging due to staff currently on maternity leave. Any shortfall across shifts and the on-call rota were supported by staff and senior managers who would cover any gaps. In discussion with senior managers, they demonstrated monitoring and oversight of all on-call activity to ensure staff wellbeing and adequate rest periods are facilitated in line with local policy.

The Health and Care (Staffing) (Scotland) Act 2019 requires all NHS boards ensure they have a real-time staffing assessment in place to capture risk caused by staffing levels to the health and safety of patients. We were able to attend the different safety huddles which support the safe delivery of care and occurred at different points throughout the day. The purpose of a safety huddle is to provide situational awareness, understand patient flow and raise issues such as patient safety concerns, review staffing and identify wards or areas at risk due to reduced

staffing levels. We were able to observe how maternity services fed into the site safety and capacity huddle during which staffing was discussed and collective solutions found where required. We observed maternity services form an active part of the huddle ensuring that NHS Orkney senior managers had oversight of real-time staffing, acuity and safety concerns within maternity services. Whilst inspectors observed this overview as part of the wider hospital huddles, it was unclear which process the maternity service undertook to achieve this oversight. The evidence provided by NHS Orkney did not indicate how decisions about staffing are captured, where this is recorded and where staff can record within the system their feedback on decisions made. It is also unclear how this data is captured over time to feed into service improvement. In discussion with senior managers, they acknowledged this as an area for improvement and informed us of the intention to implement SafeCare in May 2026. A requirement has been given to support improvement in this area.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024 and requires all NHS boards ensure appropriate staffing for the provision of safe and high-quality care. NHS boards have a duty to apply the Common Staffing Method (CSM). The CSM triangulates and analyses all relevant service specific data, evidence and intelligence to support clinical leaders understand staffing requirements for a given area. As part of common staffing methodology, it is mandated that the given areas undertake a staffing level tool and professional judgement tool run concurrently over a two week period once a year. In review of evidence, NHS Orkney did not provide the CSM report, instead providing a BOXI report which is capturing inpatient and triage activity only. The service explains this rationale with the complexity of accurately capturing the full scope of their activities within the CSM as they are providing an integrated maternity and women's health service within the maternity unit. However, the service is preparing to transition to the maternity staffing level tools within SafeCare from May 2026. A requirement has been given to support improvement in this area.

A plan to develop a robust system of workforce support, nurturing leadership to prepare staff to take on senior leadership roles, including a focus on succession planning is outlined within the National Workforce Strategy for Health and Social Care in Scotland. More information can be found [here](#). Staff we spoke with highlighted good opportunities for development within their current banding. In evidence reviewed, NHS Orkney is introducing a clinical leadership programme for nurses and midwives at agenda for change bands 6 and 7 with the first cohort commencing in April 2026. This investment in its existing workforce, supports career progression whilst reducing leadership fragility in a remote and rural health board.

Requirements

Domain 4.3

- 7 NHS Orkney must ensure senior charge midwives have appropriate and protected leadership time to fulfil their leadership and management responsibilities. This will include but is not limited to:

- i. Staff appraisals

This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls.

8	NHS Orkney must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real-time staffing risk across all clinical professional groups within maternity services. This is to support consistent management of any identified staffing risks which should include but is not limited to: i. Recording any escalation, mitigation and/or inability to mitigate and communication of outcomes to all relevant teams ii. A record of any disagreements with decisions made.
9	NHS Orkney must ensure that there are processes in place to support the consistent application of the common staffing method. This includes, but is not limited to: i. The application of the mandated staffing level and professional judgement tools ii. A reporting template demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement.

Domain 6 – Dignity and respect

Quality 6.2 – Dignity and respect

We observed women and their families being treated with compassion, dignity and respect and supported to develop close and loving parent-infant relationships.

Inspectors observed staff providing holistic and person-centred care. Women and families who we spoke with were complementary of their care from the multidisciplinary team with many highlighting that all staff went above and beyond, respecting their preferences and choices.

Inspectors observed staff taking time to answer questions and ensuring women and families had time to seek clarifications and to ask further questions. All interactions observed between staff and women, babies and families were compassionate and respectful. Women described staff as being responsive to their needs and spoke highly of the staff and the care provided, including receiving assistance and receiving analgesia when needed.

The Scottish Trauma-Informed Leaders Transformation (STILT) programme is a national leadership webinar delivered by NHS Education for Scotland to support senior and emerging leaders to understand their role in creating trauma-informed systems, cultures and ways of working. The programme provided a shared framework, resources and a clear roadmap for leading trauma-informed change across services, emphasising that sustainable impact requires leadership alignment rather than isolated training. Members of the senior leadership team recently participated in STILT together with Orkney Islands Council. This collaboration plans the implementation on how trauma-informed training and development can be embedded across both organisations as a co-ordinated joint approach, supporting consistent practice, shared language and collaborative system-wide change across health and local authority services. Staff across the organisation have access to trauma informed modules which will be signposted as recommended training with no compliance rates yet available. A recommendation has been given to support improvement in this area.

UNICEF Baby Friendly Initiative supports families with evidence-based advice relating to infant feeding and developing close and loving parent-infant relationships. NHS Orkney is UNICEF Baby Friendly Initiative joint maternity and health visiting Gold accredited and has demonstrated commitment to continuous learning and improvements in the four pillars around leadership, culture, monitoring and progression. The most recent UNICEF annual board response letter to NHS Orkney highlights the commitment by the service and the positive outcomes being achieved as a result, such as the introduction of a peer support service. In a recent audit by the infant feeding team submitted to UNICEF, 100% of women audited reported being very happy with their overall care and 100% thought staff were always kind and considerate. Women we spoke with described staff as compassionate and responsive providing person-centred care as well as supporting building confidence in their infant feeding choice.

During the onsite inspection, we observed information displayed regarding the Patient Charter. The charter of patient rights and responsibilities outlines the right to safe, effective person-centred and sustainable care and treatment which should be provided at the right time, in the right place and by the most appropriate person. This applies to anyone using NHS services ensuring their care is delivered with dignity, respect and fairness. Throughout our maternity inspection within NHS Orkney, we observed these principles implemented in practice.

Areas of good practice

Domain 6	
11	Women, families and visitors that we spoke with were highly complementary of the multidisciplinary team and the care provided.
12	Women and families were supported by staff to build confidence in their infant feeding choice and supported to develop close and loving parent-infant relationships.

Recommendations

Domain 6	
2	NHS Orkney should consider improving trauma informed training compliance rates for all staff.

Appendix 1 - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- [Allied Health Professions \(AHP\) Standards](#) (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- [Antenatal care](#) (NICE, August 2021)
- [CMO\(2018\)18 - Core mandatory update training for midwives and obstetricians](#) (Scottish Government, December 2018)
- [Delivering Together for a Stronger Nursing & Midwifery Workforce](#) (Scottish Government, March 2025)
- [Fire \(Scotland\) Act 2005](#) (Fire Scotland Act, Acts of the Scottish Parliament, 2005)
- [Food Fluid and Nutritional Care Standards](#) (Healthcare Improvement Scotland, November 2014)
- [Generic Medical Records Keeping Standards](#) (Royal College of Physicians, October 2015)
- [Guidance — NHS Scotland Staff Governance](#) (NHS Scotland, June 2024)
- [Health and Care \(Staffing\) \(Scotland\) Act](#) (Acts of the Scottish Parliament, 2019)
- [Health and Social Care Standards](#) (Scottish Government, June 2017)
- [Infection prevention and control standards](#) (Healthcare Improvement Scotland, 2022)
- [Intrapartum care](#) (NICE guideline, September 2023)
- [Maternity Triage](#) (RCOG Maternity Triage good practice paper, December 2023)
- [MBRRACE-UK](#) (Maternal, Newborn and Infant Clinical Outcome Review Programme, 2025)
- [National Infection Prevention and Control Manual](#) (NHS National Services Scotland, June 2023)
- [NMC Record keeping: Guidance for nurses and midwives](#) (NMC, August 2012)
- [Operating Framework: Healthcare Improvement Scotland and Scottish Government:](#) (Healthcare Improvement Scotland, November 2022)
- [Person-centred care - NMC](#) (The Nursing and Midwifery Council, December 2020)
- [Prevention and management of pressure ulcers standards](#) (Healthcare Improvement Scotland, October 2020)
- [Professional Guidance on the Administration of Medicines in Healthcare Settings](#) (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- [Professional Guidance on the Administration of Medicines in Healthcare Settings](#) (Royal Pharmaceutical Society and Royal College of Nursing, January 2024)
- [Recommendations | Postnatal care | Guidance | NICE](#) (NICE, April 2021)
- [Scottish Patient Safety Programme \(SPSP\)](#) (Healthcare Improvement Scotland)
- [The best start: five-year plan for maternity and neonatal care - gov.scot](#) (Scottish Government, January 2017)

- [The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives](#) (Nursing & Midwifery Council, October 2018)
- [The UNCRC Act - UNCRC \(Incorporation\) \(Scotland\) Act 2024](#) (Scottish Government, September 2024)
- [The Quality Assurance System \(healthcareimprovementscotland.org\)](#) (Healthcare Improvement Scotland, September 2022)

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Please contact our Equality and Diversity Advisor on 0141 225 6999

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Improvement Action Plan

Healthcare Improvement Scotland: Unannounced Maternity Services safe delivery of care inspection

Balfour Hospital, NHS Orkney

23 – 24 March 2026

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature:

Full Name: David Campbell

Date: 19 June 2026

NHS board Chief Executive

Signature:

Full Name: James Goodyear

Date: 19 June 2026

File Name: 2026-05-20 MaternityHIS_LAP_MAT_BH_ORK_JUN26 Balfour Hospital, NHS Orkney v1.0	Version: 1.0	Date: 23/06/2026
Produced by: HIS/NHS Orkney	Page: Page 1 of 9	Review Date: 05/11/
Circulation type (internal/external): Internal and external		

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
Recommendations					
Domain 1 – Clear vision and purpose					
1	NHS Orkney should consider introducing a structured communication format such as an SBAR (Situation, Background, Assessment, Recommendation) during handovers and at times of escalations. NHS Orkney uses SBAR for transfer of information and escalation across the organisation. An SBAR is available for use within the clinical record, and targeted training will be put in place to support maternity staff in using the SBAR approach consistently.	31/08/2026	Lead Midwife Senior Charge Midwife	June 2026 – Discussions have commenced within the Maternity service to revise the way handovers are currently conducted. Training is being planned and integrated into the current training schedule.	
Domain 6 – Dignity and Respect					
2	NHS Orkney should consider improving trauma informed training compliance rates for all staff. Work is underway across NHS Orkney to strengthen trauma-informed practice, supported by implementation of the TURAS trauma-informed training programme and a target of achieving 80% compliance within maternity services. Training uptake will be monitored and reported through the clinical governance structure, of which the Maternity Clinical Governance Group forms part. This work is being taken forward in conjunction with partner agencies, including Orkney Islands Council, to support a joined-up approach. It includes senior leadership participation in the Scottish Trauma-Informed Leaders Transformation (STILT) programme and planned bereavement care training, within which trauma-	31/12/2026	Executive Director of Nursing, Midwifery & Allied Health Professionals and Chief Officer for Acute Services Lead Midwife Senior Charge Midwife	June 2026 – STILT was completed in March 2026 by members of the Senior Leadership team. Joint planning with OIC commenced in April 2026 to support a conjoined approach. A baseline of compliance for Maternity services was completed in June 2026 with a plan to support staff to complete TURAS training.	
File Name: 2026-05-20 MaternityHIS_LAP_MAT_BH_ORK_JUN26 Balfour Hospital, NHS Orkney v1.0				Version: 1.0	Date: 23/06/2026
Produced by: HIS/NHS Orkney				Page: Page 2 of 9	Review Date: 05/11/
Circulation type (internal/external): Internal and external					

	informed practice is embedded, to support consistent application and system-wide improvement.			Trauma-informed practice now embedded within the planned bereavement care training.	
Requirements					
Domain 1 – Clear vision and purpose					
1	NHS Orkney must ensure governance and oversight to ensure venous thromboembolism (VTE) risk assessment compliance. NHS Orkney will implement a standardised VTE approach across the maternity pathway through revision and ratification of the Minimum Maternity Care Pathway and the VTE prevention Standard Operating Procedure (SOP). Compliance will be monitored through inclusion of VTE metrics within the maternity audit programme, including trend analysis and escalation where required, with the Maternity Clinical Governance Group having ownership for this, and sustained improvement assured through the clinical governance processes including Performance Review Meetings and quarterly reporting to the NHSO Clinical Governance Group.	30/09/2026	Lead Midwife Senior Charge Midwife	June 2026 – The pathway and SOP are currently in draft and out for consultation with ratification expected by the end of August 2026. Audit reporting now in place as part of the maternity audit plan.	
Domain 2 – Leadership and Culture					
2	NHS Orkney must ensure timescales of adverse events are achieved. This includes feedback to staff and action plans to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland's National Framework. NHS Orkney will strengthen the organisation-wide management of adverse events through review of current processes and revision and ratification of adverse event management guidance, aligned to Healthcare Improvement Scotland's national framework. This will	31/10/2026	Medical Director Head of Patient Safety, Quality and Risk.	June 2026 – Processes are in place for scrutiny of Category 1 adverse event reviews, with escalation through clinical governance structures to Board. Additional reviewers are being trained to improve resilience.	

	support consistent review timeframes, clear action planning, timely feedback to staff and shared learning across services. The adverse event reporting system will be reviewed to support robust and clear action plans, documented feedback and improved tracking of completion. Compliance with expected review timeframes will be monitored through audit and routine reporting, with strengthened oversight through clinical governance processes, including performance review meetings and escalation through the clinical governance structure to Board where required.			The Adverse Event Management Guidance is being updated in line with HIS national framework, with consultation planned ahead of ratification by end July 2026. Work is also underway to strengthen reporting systems to improve action planning, feedback and tracking. Within maternity, multidisciplinary collaborative reviews commenced in March 2026 and are now supported through dedicated time. Oversight is being strengthened through the Maternity Clinical Governance Group, with regular sharing of learning at weekly service meetings.	
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Domain 4.1 – Pathways, procedures and policies

3	NHS Orkney must ensure effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use.	30/11/2026	Head of Patient Safety, Quality and Risk	June 2026 – The draft consultation and ratification process is complete and is currently being used as a test	
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	NHS Orkney will revise the Corporate Policy and Procedure Development Framework to clarify and ensure that all clinical standard operating procedures, guidelines, pathways and policies are developed and managed through a uniform organisation-wide process. This will set clear expectations for document development, consultation, approval, review timeframes and ratification. The existing document tracker will be highlighted to all staff, alongside a process to ensure that all organisation-wide and service-held documents are captured centrally. This will provide full organisational oversight of current documents, review dates and approval status. Maternity services will be supported to transition to this process, strengthening oversight and ensuring alignment with the wider clinical governance arrangements.		Head of Corporate Governance	of change. Collation of guidance documents has commenced on a service-by-service basis to support central oversight of organisation-wide and service-held documents. Maternity services are reviewing their process documents and are partially through the review of the out-of-date documents.	
4	NHS Orkney must ensure an effective system is in place to record patient documentation. This includes but is not limited to: i. The maternity early warning score is accurately completed to support the safe delivery of care. NHS Orkney will strengthen maternity documentation by moving to a single process and documentation approach for maternity early warning score (MEWS) completion, escalation and recording. This will support consistent practice across maternity services and reduce variation between documentation routes. To support this, and the move to the Once for Scotland approach to MEWS, NHS Orkney is actively engaging in the Scottish Patient Safety Programme (SPSP) MEWS work to implement the new chart and support staff	01/09/2026	Lead Midwife Senior Charge Midwife Obstetric Lead Head of Patient Safety, Quality and Risk	June 2026 – NHS Orkney actively participating in the MEWS SPSP programme with implementation plan agreed.	

	training as part of the national implementation programme. Compliance will be monitored through audit and reported via SPSP and the Maternity Clinical Governance Group, with learning and improvement actions escalated through wider clinical governance processes.				
5	NHS Orkney must ensure that employees receive time and resources to undertake training which is essential to their role. NHS Orkney will ensure all staff are supported to meet statutory, mandatory and core maternity training requirements through prioritisation of protected learning time within duty rosters and proactive monitoring of compliance. Training needs will be identified through annual appraisal and departmental Training Needs Analysis. Compliance, including uptake of protected learning time (target 80% via e-Roster), will be routinely audited and reported through governance structures, with gaps escalated to line managers. Access to key national programmes (including K2 and SMMDP) will be supported, with multidisciplinary participation to strengthen team-based learning and coordination across the maternity pathway.	30/09/2026	Executive Director of Nursing, Midwifery & Allied Health Professionals and Chief Officer for Acute Services Lead Midwife Senior Charge Midwife	June 2026 – SMMDP courses are booked for 2026/2027. Training dates are now live for quarterly CTG review sessions on the ward. Staff are rostered protected time via eRoster to ensure completion and training compliance reporting established organisation wide through governance processes including performance review meetings.	
6	NHS Orkney must ensure that all staff complete statutory fire safety training. NHS Orkney will strengthen compliance with statutory fire safety training across maternity services through proactive monitoring, escalation of non-compliance and prioritisation of protected time for staff to attend training. Compliance will be routinely reported through	31/07/2026	Lead Midwife Senior Charge Midwife	June 2026 – Current compliance levels reviewed and gaps identified. With staff made aware and rostered to complete training. Training reviewed through governance	

	the Maternity Clinical Governance Group to provide oversight and assurance.			processes including the performance review meetings.	
Domain 4.3 – Workforce planning					
7	NHS Orkney must ensure senior charge midwives have appropriate and protected leadership time to fulfil their leadership and management responsibilities. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls. NHS Orkney will ensure protected leadership time for the Senior Charge Midwife and Interim Deputy Director of Nursing/Lead Midwife to support delivery of managerial, professional, governance and strategic responsibilities. Rosters will be structured to prioritise leadership time, with proactive planning to minimise redeployment. Compliance and impact will be reviewed through the Maternity Clinical Governance Group and wider governance structures to provide oversight, assurance and escalation where required.	01/08/2026	Executive Director of Nursing, Midwifery & Allied Health Professionals and Chief Officer for Acute Services Lead Midwife Senior Charge Midwife	June 2026 – Review of current Senior Charge Midwife workload and leadership allocation undertaken. Initial steps taken to reflect protected leadership time within rosters. SafeCare in place within Maternity and staff undergoing training to fully implement the system.	
8	NHS Orkney must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real-time staffing risk across all clinical professional groups within maternity services. NHS Orkney will standardise the use of SafeCare as the single system for real-time assessment, recording escalation of staffing risk across all maternity staff groups. This will include clear expectations for use, targeted training and implementation of a consistent	01/08/2026	Executive Director of Nursing, Midwifery & Allied Health Professionals and Chief Officer for Acute Services Lead Midwife Senior Charge Midwife	June 2026 – SafeCare in place within Maternity and staff undergoing training to fully implement the system.	

	process for completion at defined points within each shift. All staffing risks, escalations, mitigation actions and any unresolved risks or disagreements will be documented within SafeCare to support transparency and shared decision-making. Data will be routinely reviewed through SafeCare reporting and monitored via the Maternity Clinical Governance Group and wider governance structures to identify themes, inform workforce planning and provide assurance, with escalation of risks where required.				
9	NHS Orkney must ensure that there are processes in place to support the consistent application of the common staffing method. CSM tool runs will be undertaken in line with national expectations, with outputs formally reported, reviewed and used to inform workforce planning and service improvement. Compliance will be monitored through governance structures, with findings reported to the Maternity Clinical Governance Group to provide oversight, assurance and escalation of any gaps or risks.	01/08/2026	Lead Midwife Senior Charge Midwife	June 2026 – Organisation wide SOPs in place. Maternity supported to implement and embed these. Maternity Staffing level tool has been completed May/June 2026.	
10	NHS Orkney must ensure that clear and robust systems and processes are in place to ensure that all staff can engage and complete the appraisal process. NHS Orkney will strengthen appraisal compliance through proactive monitoring, regular reporting and escalation of non-compliance to line managers to ensure timely completion. Individual development will be identified through annual appraisal processes and aligned to service requirements.	31/08/2026	Lead Midwife Senior Charge Midwife	June 2026 – Current compliance levels have been reviewed and gaps identified with outstanding appraisals scheduled.	

	Appraisal compliance will be routinely reviewed through governance structures, including the Maternity Clinical Governance Group, to provide oversight, assurance and targeted action where gaps are identified.				
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Unannounced Inspection Report

Acute Hospital Safe Delivery of Care Inspection

Balfour Hospital

NHS Orkney

23-24 March 2026

Healthcare Improvement Scotland 2026
Published July 2026

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About our inspection

Background

In November 2021 the Cabinet Secretary for Health and Social Care approved Healthcare Improvement Scotland inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. Taking account of the changing risk considerations and sustained service pressures, the methodology was adapted to minimise the impact of our inspections on staff delivering care to patients. Our inspection teams are carrying out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records.

From April 2023 our inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland [Quality Assurance Framework](#). Further information about the methodology for acute hospital safe delivery of care inspections can be found on our [website](#).

Our Focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

About the hospital we inspected

The Balfour is situated near the centre of Kirkwall. It is a small rural general hospital with 48 beds. As well as inpatient units, day units, emergency department and maternity and women's health services, the Balfour has both a physiotherapy department and an occupational therapy department. It also has outpatients departments, audiology, radiography (X-Ray), a pharmacy, the laboratory, medical records, and a central decontamination unit.

Patients requiring specialist treatment may be transferred to the Scottish mainland, usually Aberdeen.

About this inspection

We carried out an unannounced hospital inspection in conjunction with a maternity services inspection to Balfour Hospital, NHS Orkney on Monday 23 and Tuesday 24 March 2026 using our safe delivery of care inspection methodology. An inspection report for the maternity inspection is published on our website. We inspected the following areas during the hospital inspection:

- emergency department
- Eir Acute Ward (Acute Care Inpatient 1) and,
- Hlin Assessment and Rehabilitation Ward (Inpatient 2).

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with patients, such as during patient mealtimes
- spoke with patients, visitors and ward staff, and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Orkney to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Orkney and in particular all staff at Balfour Hospital for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection.'

We observed that wards were calm and well organised, with clear leadership, effective communication, and multidisciplinary teamwork. Patients we spoke with described receiving good, responsive care. We observed staff interacting with patients with compassion, dignity and respect.

Site wide hospital huddles were inclusive, well attended and supported staff to identify potential staffing risks.

Domestic staff were visible throughout the hospital and the hospital environment, including communal areas, which appeared clean and well maintained. All areas inspected were tidy and uncluttered.

Student nurses described positive learning experiences during their placements. In evidence submitted to us we can see NHS Orkney has developed a structured pathway to support newly qualified nurses as they move from training into practice.

Internationally recruited nurses also reported positive experiences of support and inclusion within NHS Orkney. Evidence demonstrated a structured approach to recruitment, development and pastoral support, with nurses describing feeling welcomed, safe and respected.

Areas for improvement identified include the strengthening and oversight of governance arrangements for the review of policies, guidelines and procedures.

Improvements are required in the completion of electronic staffing tools, and in assuring that clinical leaders are provided with protected time to fulfil their leadership responsibilities, including completion of staff appraisals.

Further improvement is required to ensure that timescales for the review of adverse events and significant adverse events are consistently met and that compliance with key mandatory training, including, fire safety, paediatric life support and mental health training is improved.

What action we expect the NHS board to take after our inspection

This inspection resulted in eight areas of good practice and seven requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Orkney to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: <http://www.healthcareimprovementscotland.scot/>

Areas of good practice

The unannounced inspection to Balfour Hospital resulted in eight areas of good practice.

Domain 2

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| 1 | We observed an open and supportive culture with the majority of staff reporting that the hospital was a good place to work (see page 19). |
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Domain 4.1

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| 2 | All areas inspected were calm and well organised (see page 22). |
| 3 | Domestic staff were visible throughout the hospital and all areas visited were tidy and cleaned to a high standard. Equipment was clean and stored safely ready for use (see page 22). |
| 4 | Medications were stored securely in all areas inspected (see page 22). |

Domain 4.3

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| 5 | We observed that the hospital safety huddles were well managed, open, transparent, and focused on patient care, with all disciplines attending and contributing (see page 27). |
| 6 | Initiatives to support student and newly qualified nurses transition from training into practice (see page 27). |
| 7 | Structured and supportive approach to the recruitment and retention of internationally recruited nurses (see page 27). |

Domain 6

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| 8 | All observed interactions were professional, friendly and respectful. Patients and carers spoke positively about the care they received (see page 28). |
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Requirements

The unannounced inspection to Balfour Hospital resulted in seven requirements.

Domain 1

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| 1 | NHS Orkney must ensure there is one member of staff on duty in the emergency department at all times who has advanced paediatric life support training or equivalent (see page 16).

This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and The Royal College of Paediatrics and Child Health standards 'Facing the Future: Standards for children in emergency care settings 2025. |
| 2 | NHS Orkney must ensure effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use (see page 16). |

This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criterion 2.5 and 2.6.

- 3** NHS Orkney must ensure that all staff are suitably trained, qualified and competent to safely carry out their role. This includes completion of statutory and role-specific training including:
- Paediatric basic life support
 - Paediatric immediate life support
 - Fire safety
 - Prevention and Management of violence and aggression, including breakaway and restraint techniques
 - Mental health training, including relevant legislation (see page 16).

This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006) and Health and Care (Staffing) (Scotland) Act (2019) and relevant codes of practice of regulated healthcare professions.

Domain 2

- 4** NHS Orkney must ensure timescales of adverse events and significant adverse event reviews are achieved, including feedback to staff and action plans to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland National Framework (see page 19).

This will support compliance with: Healthcare Improvement Scotland A national framework for reviewing and learning from adverse events in NHS Scotland (2025) and the Quality Assurance Framework (2022) criteria 2.5 and 2.6.

Domain 4.1

- 5** NHS Orkney must ensure that all relevant staff complete Paediatric Early Warning Score (PEWS) training to support the accurate and consistent completion of PEWS documentation (see page 22).

This will support compliance with: Nursing and Midwifery Council (NMC) The code (2018) and NHS Scotland and the Quality Assurance Framework (2022) criteria 2.6 and 4.4.

Domain 4.3

- 6** NHS Orkney must ensure that senior charge nurses have sufficient protected leadership time to fulfil their leadership and management responsibilities,

including the completion of staff appraisals and support for staff development. This should include consistent monitoring and recording of when and why leadership time is compromised as part of mitigation for staffing shortfalls (see page 27).

This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Health and Social Care Standards (2017) criteria 3.14, 3.15 and 3.19 and the Quality Assurance Framework (2022) criteria 2.6 and 4.4.

- 7** NHS Orkney must ensure consistent use of the electronic staffing tool to effectively identify, record and manage staffing risks (see page 27).

This will support compliance with: Health and Social Care Standards (2017) criteria 4.11, 4.14, 4.19 and 4.23 and the Health and Care (Staffing) (Scotland) Act 2019 and the Quality Assurance Framework criteria 2.5, 2.6 and 4.3.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

During our inspection the emergency department was operating within capacity, supported by effective patient flow processes, timely ambulance handovers and established patient pathways. While care was well organised, improvements are required in workforce training, paediatric life support training and the review of clinical guidance.

The national target for accident and emergency waiting times is 95% of patients should wait no longer than four hours from arrival at the emergency department before admission, discharge or transfer for other treatment. During the week of our onsite inspection, across NHS Scotland 67.5 % of patients were seen within the four-hour target, whilst 97% of patients were seen within four hours at Balfour hospital. During the week of the onsite inspection, no patients at Balfour Hospital's emergency department waited longer than eight hours or 12 hours before being admitted, discharged, or transferred.

The emergency department comprises five individual patient bays and two resuscitation bays. Despite pressures on hospital capacity the department was operating within capacity with all patients cared for in designated areas.

We observed that the longest wait for transfer to an inpatient bed was 4.27 hours on the morning of the first day of inspection. In evidence received, we can see that there were no adverse events raised in the six months prior to this inspection due to delayed patients' admissions from the emergency department.

Patient flow and capacity within the emergency department are supported by pre alert arrangements with the Scottish Ambulance Service, with crews providing advance notification of patients being transported to the department, enabling staff to prepare appropriately for their arrival. This allows staff time to create capacity by moving patients out of the department where required. Inspectors were told that staff select the most clinically appropriate patients for discharge or admission to support safe patient flow. Staff in the emergency department described feeling well supported by senior managers and ward teams, with ward areas opening additional contingency beds on a short term basis to accommodate suitable patients during periods of increased demand.

During these periods of increased demand in acute services, inspectors were advised that additional surge capacity is created through the use of two designated single rooms within the maternity unit. Patients accommodated in these rooms are cared for and easily accessible to nursing staff from inpatient 1, with call bells redirected to that ward. When these rooms are utilised for acute patients, access between the rooms and the maternity unit is restricted. The rooms are situated between two sets of double fire doors; the doors on the maternity side are kept locked to prevent access into the maternity ward, while the doors on the inpatient ward side remain open to allow patients to enter and leave the rooms. Access to the maternity area itself remains controlled via security pass operated doors. In evidence received, we did not observe any incident reports relating to the use of these additional surge beds.

During our inspection, we did not observe any delays in ambulance turnaround times. Staff in the emergency department advised that delays in ambulance crews being able to transfer patients straight into the department were unusual. Available national data shows that for the week of the 23 March 2026, the median ambulance turnaround time at Balfour Hospital was 24.59 minutes. The national average for the same time was 52.08 minutes. We did not see any incident reports submitted in the six months prior to our inspection relating to delays in ambulance turnaround times.

Scottish Government emergency signposting guidance seeks to ensure patients receive care in the most appropriate setting while helping to improve waiting times and delays in emergency departments and acute admission units. Further information can be found [here](#). Balfour Hospital does not have an acute admission unit and all patients who require admission are transferred directly from the emergency department to an inpatient ward. All referrals from general practitioners are assessed within the emergency department, typically by a doctor or emergency nurse practitioner within a designated treatment room. Inspectors were told that, while these attendances can contribute to overall activity within the department, they do not routinely impact adversely on patient flow or capacity. The department also supports returning patients for planned interventions, such as dressing changes. Inspectors were told that transport arrangements have, on occasion, presented challenges, resulting in some patients being admitted to hospital following attendance due to the unavailability of suitable transport.

Staff described previous challenges in securing timely wheelchair accessible transport, to support discharge particularly during out of hours periods. We can see from the evidence provided, NHS Orkney outlined how it has responded to these issues through a range of actions, including the award of a new patient transport contract providing 24 hour wheelchair accessible provision and strengthened collaboration with the Scottish Ambulance Service. These measures are intended to reduce the risk of avoidable overnight hospital stays and improve the reliability of discharge arrangements. As several of these actions have only been in place since April 2026, it is too early to determine their full effectiveness. NHS Orkney state in evidence, however, they will continue to monitor progress through patient feedback and established governance processes.

Patients self-presenting to the emergency department are triaged by a doctor or nurse. Triage is the process of quickly assessing a patient's condition on arrival to determine how urgent their needs are and what the most appropriate next step in their care should be. Following triage, patients that are assessed as not requiring further investigation or treatment in the department, are given written information and guidance to support redirection to the most appropriate service such as general practice, dental services, optometry or community pharmacy. In evidence received, we did not observe any incident reports relating to patients who have been redirected following attendance to the emergency department.

Staff triage training is aligned with NHS Grampian practice. NHS Orkney follows NHS Grampian's redirection and triage pathways, with Aberdeen Royal Infirmary supporting delivery of Manchester Triage training locally. The Manchester Triage System is a structured clinical tool used in emergency departments to prioritise patients based on the urgency of their condition, assigning a category that determines how quickly they should be seen. At the time of inspection, 79% of emergency department staff were trained in Manchester Triage, including both senior charge nurses, 5 of 7 emergency nurse practitioners, and 8 of 10 nurses, with remaining staff in newly appointed or development posts not yet due for training. An emergency nurse practitioner is a registered nurse with advanced clinical training who is able to assess, diagnose, treat, and discharge patients presenting with a range of minor injuries and illnesses.

NHS Orkney demonstrated established pathways to support people presenting with a mental health need, including arrangements for timely assessment, access to specialist advice and onward referral where required. In the absence of an on island specialist psychological service, emergency department and inpatient teams are supported by real-time access to consultant psychiatrist advice through NHS Grampian. This operates alongside local clinical assessment, Community Mental Health Team input and Mental Health Officer involvement where required, including during out of hours periods.

The emergency department includes a dedicated emergency mental health transfer room, designed to support the safe management of patients experiencing mental

health distress while awaiting transfer to specialist services. The room provides a ligature reduced environment, including an adjoining ligature reduced bathroom, and allows for safe observation with access to a nearby staff observation space and enclosed private outdoor courtyard. Its use is underpinned by individualised risk assessment, including assessment of ligature risk, legal status and clinical presentation. Legal status refers to the patient's position under relevant mental health and capacity legislation, including whether they are subject to detention, voluntary admission, or other statutory measures that influence their care, observation, and rights. Observation levels, including continuous intervention where required, are determined proportionately to the assessed level of risk. Continuous intervention refers to a heightened level of observation in which a staff member maintains uninterrupted, direct engagement with the patient to ensure their immediate safety and respond promptly to any escalation in risk.

Inspectors observed that the emergency mental health transfer room was equipped with a hospital bed rather than an emergency department trolley to support patient comfort. Staff reported that patients receiving care within the emergency department for extended periods, including those in the emergency mental health transfer room, are offered hot meals in addition to standard provision.

Direct care for patients presenting with mental health needs is provided by Community Psychiatric Nurses within the emergency department and inpatient wards. This ensures that patients are supported by staff with the appropriate skills and knowledge to meet their needs.

Inspectors were told that patients requiring inpatient care who do not require transfer to specialist mental health services are admitted to Balfour Hospital wards. In these instances, ligature risk is managed through environmental risk reduction measures and enhanced observation, with patients prioritised for areas that optimise visibility and safety. Patients presenting with higher levels of risk, or where a safe management plan cannot be sustained locally, are escalated appropriately, including transfer to specialist inpatient services under established pathways.

Once a decision to transfer has been made, coordinated processes are in place to support safe and timely transfer. Patients are accommodated within the emergency mental health transfer room for short stays prior to transfer, supported by the community mental health team, including ongoing risk assessment, therapeutic engagement and coordination of transfer arrangements.

NHS Orkney reported that all emergency detention certificates are completed with appropriate statutory oversight by a Mental Health Officer, ensuring compliance with the Mental Health (Care and Treatment) (Scotland) Act (2003). An emergency detention certificate is a legal authority under the Mental Health (Care and Treatment) (Scotland) Act 2003 that allows a doctor to detain a person in hospital for up to 72 hours for assessment and care where there are urgent concerns about their mental health. No patients were subject to an emergency detention certificate during the inspection.

Evidence provided showed no reported incidents involving physical restraint, rapid tranquillisation or other restrictive interventions within the emergency mental health transfer room in the six months prior to our inspection. Physical restraint refers to the use of direct physical contact to restrict a person's movement to prevent harm to themselves or others. Rapid tranquillisation involves the use of medication to quickly reduce severe agitation or distress; both are only used as a last resort when other de-escalation measures have not been effective.

NHS Orkney provided evidence of recent developments to strengthen local mental health support within unscheduled care. This includes the introduction of a nurse-led psychiatric liaison service for patients of all ages, which at the time of inspection was operating in an interim model while recruitment continues. Although not yet fully established and operating within defined hours, this service enhances local specialist input to risk assessment, including the identification and management of self-harm and ligature risks, and supports clinical decision-making alongside existing escalation and transfer arrangements. Senior managers informed inspectors that the service is expected to be fully established by September 2026.

Additionally, senior managers reported that training on mental health legislation and the management of mental health presentations is being introduced for resident doctors. This training, developed by the community mental health team and delivered by senior mental health leads, is scheduled to commence from August 2026 as part of the resident doctor induction programme. This training is designed to replace the previous information sessions delivered by the mental health team.

Additionally, compliance with training in the Prevention and Management of Violence and Aggression, including restraint, was variable across clinical areas. Prevention and Management of Violence and Aggression courses support staff with the knowledge and practical skills to anticipate, de-escalate and safely manage incidents of violence or aggression, including the use of safe restraint techniques where necessary to protect patients and staff. Foundation level compliance ranged from 60% to 85%, while advanced and emergency training ranged from 50% to 85%. In the emergency department, 16 of 23 staff (70%) had completed advanced training, with a further four staff booked to complete the course by June 2026. This would increase compliance in the emergency department to 87%, and 82% overall throughout the hospital. Senior managers advised that gaps were partly due to staff absence. A requirement has been given to support improvement in this area.

NHS Orkney does not have any paediatricians onsite. Evidence provided includes the Standard Operating Procedure for Paediatric Care in the Balfour Hospital. This documents the process for escalation, senior clinical oversight and decision-making in the absence of any onsite paediatric specialists. The procedure outlines that care is led by the clinician with the most appropriate skills available such as consultant physician, surgeon, anaesthetist, obstetrician, general practitioner or midwife. This is supported by early consultant to consultant discussion and specialist advice from NHS Grampian. Local care is focused on emergency assessment, short term

stabilisation and observation, with transfer to mainland specialist services where ongoing or intensive care is required.

Although the emergency department assesses, diagnoses and treats both adult and paediatric patients, all nurses working in the department are registered adult nurses. Where paediatric patients are conveyed to the emergency department by ambulance, pre-alert calls are made by the Scottish Ambulance Service, enabling advance preparation and escalation of support. Senior managers described how this allows for early involvement of senior clinical decision-makers, including surgical, medical and anaesthetic consultants. Additional specialist advice can be sought via telephone support from the on-call paediatric consultant in NHS Grampian. Inspectors were advised that although the on-call anaesthetist is not resident onsite overnight, they are called in alongside the on-call theatre team to provide additional support when required. For paediatric patients requiring a higher level of care, arrangements are made to transfer the patient off island to NHS Grampian as soon as practicable.

Where children require intensive care support, senior nursing staff and managers told inspectors that transfer is coordinated through ScotSTAR, the national retrieval service. Similar arrangements apply to adults requiring intensive care, with patients supported locally by an anaesthetic doctor and operating department practitioner while awaiting retrieval. An operating department practitioner is a registered healthcare professional who works primarily in operating theatres and other perioperative settings, such as recovery areas, critical care and, in some hospitals, emergency departments.

The Royal College of Paediatrics and Child Health standards Facing the Future: Standards for children in emergency care settings state that every emergency department treating children must have staff trained in infant and child basic life support, with at least one member of staff on duty at all times who has advanced paediatric life support (or equivalent training). Advanced paediatric life support training provides in-depth knowledge and skills to lead paediatric resuscitation and builds upon those developed through paediatric immediate life support. While 66% of consultant medical staff based in the wider hospital have completed advanced paediatric life support training, no medical staff based within the emergency department hold this qualification. However, inspectors were advised that, in the event of an unwell child, support is provided by anaesthetic, surgical or medical consultants who have completed advanced paediatric life support and can attend to support care as required.

NHS Orkney also advised that a resident doctor within the emergency department is scheduled to undertake advanced paediatric life support training by the end of June 2026. Further information provided showed that 60% of registered nurses in the emergency department have completed paediatric immediate life support training. A requirement has been given to support improvement in this area.

Staff explained paediatric patients presenting to the emergency department who require inpatient care are admitted to inpatient 1 ward either for ongoing care or while awaiting transfer off island. Senior nursing staff described that paediatric patients are cared for within designated assessment rooms on the ward, enabling close observation and appropriate monitoring. Compliance with paediatric immediate life support training was reported as 100% for registered nurses in this area. No nursing staff working in the ward have completed advanced paediatric life support training.

Within evidence received we observed healthcare support workers caring for paediatric patients have access to, and have completed, paediatric basic life support training appropriate to their role. However, compliance rates were variable at 90% within the emergency department and 29% within inpatient 1 ward. A requirement has been given to support improvement in this area.

Inspectors observed one paediatric admission during the inspection period, where a clear plan was in place for continued assessment, review and potential transfer depending on the child's clinical condition.

We asked NHS Orkney to provide evidence of any incidents or adverse events reported through the incident reporting system in the six months prior to our inspection. Within these reports, we did not observe any adverse events relating to the care of paediatric patients awaiting transfer to a specialist paediatric unit. We discuss adverse event reporting further on page 16.

During the time of our onsite inspection there were 11 delayed transfers of care between the two wards. A delayed transfer of care occurs when a patient who is medically fit to be discharged from hospital cannot leave the hospital due to a lack of care, support or suitable accommodation such as a nursing home placement. Some patients were awaiting care home placements or care packages to facilitate a safe discharge. Quality improvement work and initiatives to address the issues surrounding delayed transfers of care are discussed in more detail in domain 2.

Throughout the inspection, medical and nursing staff described clinical support provided to NHS Orkney, primarily by NHS Grampian. Staff highlighted that a number of services, including the emergency department, outpatient oncology and maternity services, benefit from established and supportive collaborative arrangements between the two boards. Senior managers confirmed that these arrangements operate through an Obligate Network agreement, supporting the delivery and sustainability of services for the local population.

Obligate Networks were introduced following the Scottish Government policy Delivering for Remote and Rural Healthcare (2008). The policy recognised that formal collaboration between NHS boards is essential to deliver safe, effective and sustainable services for people living in remote and rural communities. Obligated arrangements require NHS boards to work together to maintain local services and to ensure access to specialist care that is not routinely available in Rural General

Hospitals. This includes agreed access to services such as child health, mental health, radiology and laboratory services. The approach reflects a system wide focus on equity of access, shared responsibility and continuous improvement across NHS Scotland.

While these collaborative arrangements provide important clinical support and access to specialist expertise, inspectors also reviewed supporting documentation, including clinical pathways and standard operating procedures, which underpin the delivery of care across NHS Orkney. During this review, inspectors noted that a number of pathways and standard operating procedures were past their renewal date, including NHS Grampian's triage guidance for pregnant women presenting to the emergency department (review date 2022) and Safe Handling, Disposal and Management of Systemic Anticancer Therapy (SACT) Spillage (review date 2022).

Whilst these documents are developed and maintained by NHS Grampian, inspectors noted that NHS Orkney has a responsibility to ensure that any guidance adopted for local use is current, appropriate and aligned with practice. Out-of-date documentation presents a potential risk to the consistency and safety of care and requires appropriate oversight across both organisations to ensure it remains up to date and fit for purpose. A requirement has been given to support improvement in this area.

NHS Orkney was able to provide evidence that 84.55% of staff had completed mandatory fire training. We were also provided with the Fire Risk Assessments for clinical areas inspected including the emergency department. Fire folders were observed at the entrances to ward areas with fire evacuation maps displayed on the wall. Fire log checklists within the fire folders contained checklists of daily, weekly and monthly checks required to ensure fire safety. Staff are required to carry out a walk round daily to ensure fire escapes are clear and that all self-closing doors are fully functioning, closed and not wedged open.

All checklists reviewed were up to date with no gaps in completion observed. All staff spoken to were aware of fire evacuation process and which of the patients in their care that would require assistance to safely evacuate. All corridors were free of clutter with fire doors unobstructed and closed as appropriate.

Child Protection and Adult Support and Protection training form a core element of workforce assurance within NHS Scotland. From January 2026 this training has been combined into one online course titled: Once for Scotland: Child Protection and Adult Support and Protection. Completion of this training provides assurance that frontline staff have the knowledge and skills to recognise risk, respond appropriately to concerns, and escalate public protection issues in line with national guidance. Monitoring compliance with mandatory public protection training supports the NHS board's assurance that its workforce is competent, supported, and able to deliver safe care to children and adults at risk. Evidence submitted by NHS Orkney shows that only one clinical area has not achieved a compliance rate of 91% or above due to staff long term absence.

Requirements

Domain 1

1	NHS Orkney must ensure there is one member of staff on duty in the emergency department at all times who has advanced paediatric life support training or equivalent.
2	NHS Orkney must ensure effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use.
3	NHS Orkney must ensure that all staff are suitably trained, qualified and competent to safely carry out their role. This includes completion of statutory and role-specific training, including: • Paediatric basic life support • Paediatric immediate life support • Fire safety • Prevention and Management of violence and aggression, including breakaway and restraint techniques • Mental health training, including relevant legislation.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

Inspectors observed a supportive leadership culture, with effective communication through safety huddles and clear escalation routes. Multidisciplinary working was well established. System pressures, including delayed transfers of care and workforce constraints, were recognised with a plan to address these through service redesign and pathway improvements. However, requirements were identified to strengthen adverse event review timescales, improve reporting processes, and increase workforce training compliance.

All areas inspectors visited were calm and well led. All staff we spoke with described senior leadership as supportive and approachable, and reported feeling encouraged to raise concerns when required.

Safety huddles support situational awareness through regular review of patient flow, staffing levels and emerging risks. They provide a forum to raise patient safety concerns and identify wards or areas at increased risk due to reduced staffing. We attended hospital wide safety huddles held throughout the day. The huddles observed were multidisciplinary, inclusive and supported staff to identify and respond to potential staffing risks. Attendees included nursing, allied health professionals and members of domestic services.

Within both inpatient wards, ward based safety huddles were carried out following each shift handover. Although inspectors did not observe these huddles, staff told us these were used to discuss patient safety concerns, including falls risks and staffing

issues. Inspectors reviewed completed safety brief templates from one ward, which recorded attendance by ward-based nursing staff and the issues discussed, including patients requiring referral to a dietician and those with infection prevention and control precautions in place.

In both ward areas, inspectors were told that a multi-disciplinary meeting was held in the morning and attended by nursing, medical and allied health professional staff. This meeting enabled discussion of changes in patient's care and highlighted key information from the earlier hospital huddle or ward safety brief.

During our inspection we observed pressures across the hospital relating to patient flow, including unplanned admissions and delayed discharges, which were discussed through site safety huddles. Inspectors noted that delays in transfer of care were influenced by a range of system factors rather than isolated service issues. including the timing of access to assessment, availability of community-based support and challenges in accessing suitable transport.

In response to these challenges NHS Orkney has commenced a programme of systemwide service redesign to improve patient flow and address the impact of an ageing population, increasing frailty and workforce pressures. Following an externally commissioned clinical services review completed in June 2025, a number of priority recommendations were agreed and progressed through six workstreams, these include Older Persons and Acute/Front Door. These workstreams focus on strengthening early identification and management of frailty, improving coordination across services, and reducing avoidable admissions and delayed transfers of care.

While core allied healthcare professionals services operate during weekday hours in line with local demand and workforce sustainability, urgent and time critical needs are met by the intermediate care team, weekend rehabilitation support and access to on call respiratory physiotherapy. Evidence from previous testing of extended allied healthcare professionals hours demonstrated low out of hours referral demand and no measurable impact on emergency department flow or patient outcomes. Senior managers explained that further work is underway to implement a single access and triage model for Occupational Therapy, Physiotherapy and Intermediate Care referrals, aimed at improving prioritisation, reducing duplication and strengthening system flow.

NHS Orkney's current guidance for learning from adverse events, was introduced in October 2025. The guidance aligns with national requirements, including the revised [National Framework for Reviewing and Learning from Adverse Events in NHS Scotland \(2025\)](#) and the updated Organisational Duty of Candour guidance. It sets out defined arrangements for the reporting, review and learning from adverse events, including expected timescales and escalation routes. The aim of the guidance is to support a consistent and transparent approach to learning, with a focus on openness and the involvement of patients, families and staff. A trigger list was also available to all staff to aid and encourage the submission of incident reports following an adverse event.

Staff described being encouraged to speak openly about incidents and learning, with senior managers and line managers taking an active role in checking on staff wellbeing following events. This includes signposting to a range of support options, local debriefs, peer support and access to occupational health and wellbeing services, with ongoing support available where required.

While staff told inspectors that they felt able and supported to complete incident reports, some explained not all potentially reportable incidents were submitted, explaining that perceived delays or lack of feedback were contributory factors. Review of evidence submitted by NHS Orkney showed that, despite the introduction of updated guidance, a number of incident reports remained under review more than six months after submission. Delays in review and feedback may limit opportunities for timely organisational learning, reduce staff confidence in the reporting process, and impact the board's ability to identify trends and implement preventative improvements. This was also highlighted in the maternity inspection as an area for improvement.

At the time of inspection, NHS Orkney had two outstanding significant adverse event reviews. Evidence provided showed that both of these had exceeded the 140 working day timescale for completion. A significant adverse event is an event which caused or could have caused significant harm. Significant adverse event reviews are essential to ensure key learning and reduce the risk of future harm. The most serious adverse events are categorised as level one, requiring a significant adverse event review which should be completed within 140 working days. Senior managers advised that the need for specialist clinical input from external clinicians has contributed to delays in meeting event review timeframes, with progress dependent on the availability of this support from other NHS boards. A requirement has been issued to support improvement in this area.

During our inspection, emergency department staff identified the absence of a designated clinical lead as a potential governance and oversight concern. During our initial feedback session inspectors raised this with senior managers. In response evidence was provided by NHS Orkney describing a distributed leadership model in place to maintain clinical oversight, including visible senior nursing and medical presence within the department. Access to senior clinical advice is supported through established regional and national pathways.

Beyond day-to-day operational leadership, senior managers informed inspectors that oversight of safety, quality and performance within the emergency department is supported through structured governance arrangements. This includes routine monitoring of risks and key performance indicators through operational processes and formal governance committees. Additional assurance is provided through participation in national and regional benchmarking and NHS Orkney governance processes and oversight arrangements to enable external scrutiny and shared learning. During our onsite inspection, staff demonstrated awareness of escalation

procedures and governance processes. A review of evidence found no recorded incidents related to escalation processes in the past six months.

NHS Orkney also provided a self-assessment against the NHS Greater Glasgow and Clyde Emergency Department Review published in March 2025. This was undertaken to consider the relevance of the findings and recommendations within their own local context. Inspectors noted that this exercise focused on key themes, including patient flow, workforce pressures and leadership capacity. Through this NHS Orkney identified areas of relative strength alongside ongoing system pressures. Performance information reviewed during the inspection indicated that key access and flow measures, including ambulance turnaround times and time to first assessment, compared favourably at a national level.

Senior managers we spoke with regarding this self-assessment recognised continuing challenges and pressures associated with delayed transfers of care, including escalation of surge arrangements. Lack of clinical nursing leadership capacity within the emergency department due to current vacancy of clinical nurse manager was also identified as a contributing factor. To address these issues, we were provided with evidence of the introduction of defined support arrangements, including 24 hour senior managers and executive cover, alongside annual review of acute site escalation and surge plans.

Engagement with service users forms a core part of quality assurance and continuous improvement. Inspectors observed several posters located across the hospital containing QR codes, providing service users with accessible opportunities to share feedback on their experience of care.

Areas of good practice

Domain 2

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| 1 | We observed an open and supportive culture with the majority of staff reporting that the hospital was a good place to work. |
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Requirements

Domain 2

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| 4 | NHS Orkney must ensure timescales of adverse events and significant adverse event reviews are achieved, including feedback to staff and action plans to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland's National Framework. |
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Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

Inspectors observed that both inpatient wards and the emergency department were calm, organised and delivering responsive care. Documentation standards,

medicines management and infection prevention practices were consistently of a good standard. Care environments were clean and well maintained, supported by effective teamwork and a positive ward culture.

We observed a supportive ward culture, with good teamwork evident across all areas. Patients spoke positively about the care they received, and call bells were answered promptly. Patients described staff as responsive, attentive and supportive of their needs.

Paediatric Early Warning Score (PEWS) charts are used across NHS Scotland to record a child's physiological observations, such as breathing, heart rate and behaviour, and supports the early recognition and escalation of deterioration. As outlined in domain 1, paediatric patients may receive care within the emergency department and inpatient 1 ward.

We were provided with information regarding a quality improvement project to increase compliance with PEWS completion. Baseline initial audits identified gaps in the completion of the PEWS such as incomplete observations, inconsistent recording and omissions that risked delayed recognition of a deteriorating child. An improvement plan introduced in August 2025 focused on targeted education, simulation and senior nursing oversight, with audits showing progress and compliance rising from 59% to 95% by February 2026 (19 of 20 charts).

Senior managers reported that PEWS compliance continues to be monitored through audit and training. Since December 2025, 55% of staff in key areas and 40% of staff across the board have completed training sessions as part of the ongoing programme. Inspectors reviewed one completed PEWS chart during inspection, noting improvements; however, a requirement has been issued to ensure progress is sustained through further training.

All patient care documentation, including risk assessments such as Malnutrition Universal Screening Tool (MUST), Peripheral Venous Catheter (PVC) bundles and falls risk assessments, were completed to a good standard. Risk assessments were updated appropriately where changes in patient care were identified, for example falls risk assessments updated following a fall or where patients were reweighed due to weight loss.

Inspectors observed an Adults with Incapacity Section 47 Certificate was in place for one patient at the time of inspection. This was completed correctly and clearly documented within care planning. An Adults with Incapacity Section 47 Certificate is a legal document which assist patients, their families and staff to make decisions regarding a patient's care and treatment when the patient is unable to make the decision independently

During our onsite inspection, senior managers and a senior charge nurse highlighted a high number of patient falls within one clinical area. This was supported by evidence submitted, which showed a high number of incident reports relating to falls. Discussions with hospital managers identified that these were associated with a

small number of individuals receiving care. During the inspection, we observed that appropriate measures were in place to support patient's safety, with all relevant risk assessments and documentation up to date.

We were also provided with evidence regarding ongoing quality improvement activity aimed at reducing falls across the hospital, including work aligned with the Scottish Patient Safety Programme (SPSP) Acute Adult Programme, specifically the Falls Reduction and Excellence in Care workstreams. NHS Orkney also acknowledged the challenges associated with an increasingly frail and ageing patient population, as well as the limitations posed by the hospital's single-room accommodation, which restricts the ability to cohort patients identified as being at increased risk of falls. We were advised that all falls are recorded using an incident reporting system, with each incident reviewed within 24 hours and discussed at daily ward safety huddles to support shared learning and continuous improvement.

We observed mealtimes in both inpatient wards during the inspection, these were well organised, with meals served promptly and appropriate assistance provided to patients when required. Patients were offered hand hygiene prior to their meal and told us that the quality of the food was good.

Throughout our inspection, we observed that medicines were stored securely within locked cupboards located in a locked, pass controlled clean utility room. Patient's own medicines were kept in locked bedside cabinets and administered from these. There were no unattended medicines visible on bedside cabinets or tables during our inspection.

Standard infection control precautions should be used by all staff at all times to minimise the risk of cross infection. Standard infection control precautions include patient placement, hand hygiene, the use of personal protective equipment (PPE) such as aprons and gloves, management of patient care equipment and the care environment, as well as safe management of blood and fluid spillages.

Hand hygiene is an important part of standard infection control precautions to reduce the risk of infection as outlined in the National Infection and Control Manual. In all areas inspected, we observed good compliance with hand hygiene and the provision of and use of PPE and hand hygiene across all staff groups. Alcohol based hand rub was available throughout the hospital.

Signage was observed on doors for patients under Infection Prevention and Control precautions, with doors kept closed.

Other standard infection control precautions include the safe management of waste including linen and sharps. We observed good compliance with sharps and used linen management, with sharps boxes labelled and managed as per guidelines. Linen trolleys were placed and stored appropriately with the correct covering, while used linen was managed and disposed of correctly.

Contaminated care equipment can present a risk of infection if not cleaned effectively. During the inspection, all equipment reviewed appeared clean and stored appropriately, ready for use.

All areas of the hospital we visited including general corridors and reception were clean, tidy and uncluttered including patient bed areas. Domestic staff were visible throughout the hospital with the environment appearing to be in a good state of repair.

We observed chlorine-based cleaning products were stored securely in line with the Control of Substances Hazardous to Health (COSHH) Regulations 2002.

Areas of good practice

Domain 4.1	
2	All areas inspected were calm and well organised.
3	Domestic staff were visible throughout the hospital and all areas visited were tidy and cleaned to a high standard. Equipment was clean and stored safely ready for use.
4	Medications were stored securely in all areas inspected.

Requirements

Domain 4.1	
5	NHS Orkney must ensure that all relevant staff complete Paediatric Early Warning Score (PEWS) training to support the accurate and consistent completion of PEWS documentation.

Domain 4.3 – Workforce planning
Quality 4.3 – Workforce planning

Inspectors observed visible leadership, with staff reporting good support and clear escalation routes. Student nurses described positive learning experiences during their placements. Workforce challenges and recruitment pressures were recognised, with initiatives in place to support the development and retention of newly qualified and internationally recruited nurses.

While staffing and governance arrangements were generally well managed, there was variation in appraisal completion rates across staff groups and clinical areas. Alongside limited protected time for leadership roles and inconsistent use of workforce systems, this was identified as an area for further improvement.

Senior charge nurses were visible and actively present across most clinical areas. Staff reported that they felt supported by senior colleagues and were confident in escalating concerns, including those relating to staffing pressures. Site safety huddles were inclusive of all departments and provided a whole-system overview of staffing, patient flow and risk in real time.

Workforce pressures and recruitment challenges continue to impact NHS Scotland. Senior managers reported that the remote and rural location of Balfour Hospital presents additional challenges in recruiting to vacant posts. Workforce data showed 2.5 vacancies in Band 5 and Band 6 registered nursing roles at the time of inspection, alongside a vacant Band 8A Clinical Nurse Manager post. Senior managers advised that this vacancy has impacted leadership capacity, including oversight of adverse event review processes.

Student nurses inspectors spoke with described positive learning experiences during their placements. In evidence submitted to us we can see NHS Orkney has developed a structured pathway to support newly qualified nurses as they move from training into practice. The programme is designed for the rural and island context and offers planned rotations across different clinical settings over a two-year period, followed by a consolidation post. This approach helps nurses build confidence and competence while gaining a broad range of experience and becoming part of the NHS Orkney workforce.

The pathway is supported by clear development expectations, dedicated preceptorship and regular clinical supervision, with a focus on wellbeing and professional support. Senior managers described strong interest in the programme, with high numbers of applicants and successful recruitment to all posts. Early feedback from participants has been positive, highlighting increased confidence, job satisfaction and readiness for practice. Overall, the pathway aims to support recruitment and retention, help develop a flexible nursing workforce and contribute to the long-term sustainability of services in a rural setting.

NHS Orkney has also put in place a structured and supportive approach to the recruitment and retention of internationally recruited nurses. Nurses joining from overseas receive preparation and ongoing support to help them meet professional requirements, alongside access to education, supervision and pastoral support. This includes input from the Practice Education Team, senior nursing staff and the international recruitment team, helping nurses to settle into their roles and the wider organisation.

Senior managers told inspectors that internationally recruited nurses have regular opportunities for professional development and access to clinical supervision that supports wellbeing and confidence. At the time of the inspection, 10 internationally recruited nurses were in post with some moving into further training and development. Nurses spoke positively to inspectors about their experiences of living and working in Orkney, describing feeling welcomed, safe and respected within the community and their teams. This focus on pastoral care and inclusion supports workforce stability and aligns with national expectations for international recruitment, contributing to the long-term sustainability of NHS Orkney's workforce. This focus on inclusion, staff wellbeing and long term workforce sustainability was recognised in May 2024 when NHS Orkney, in partnership North of Scotland Boards, received an International Recruitment Pastoral Care Quality Award.

Building on this focus on staff wellbeing, inclusion and long-term workforce sustainability, NHS Orkney also described actions to strengthen leadership capacity and support career progression within its nursing and midwifery workforce. As part of this approach, NHS Orkney has developed a Clinical Leadership Programme for nurses and midwives at Agenda for Change Bands 6 and 7, aimed at supporting staff who hold, or aspire to, clinical leadership roles and strengthening internal succession planning. Delivery takes place over a six-month period on a rolling basis, with an initial cohort of 18 nurses and midwives scheduled to begin in April 2026. NHS Orkney indicated that this forms part of a wider approach to improving leadership resilience and retention within a remote and rural context.

This leadership development offer includes a range of sessions focused on leadership behaviours, team culture, quality improvement, governance and staff wellbeing, drawing on expertise from across the organisation.

Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019). This is intended to ensure clinical leaders have protected time and resources to oversee appropriate staffing alongside their professional responsibilities and support the delivery of safe, high-quality and person-centred care. The Senior Charge Nurse role includes key leadership responsibilities such as oversight of quality and safety and the development of their teams, including the completion of annual appraisals. Staff appraisals are essential to enable staff to feel valued, support their development and promote a positive workplace culture.

Senior managers acknowledged the challenges associated with releasing protected leadership time and described systems in place to monitor and escalate where this cannot be achieved, including a dedicated Standard Operating Procedure (Adequate time given to clinical leaders (Time to Lead)). However, senior charge nurses across all three clinical areas told inspectors that accessing protected leadership time remains challenging due to service demand and staffing pressures, and that they did not feel they consistently had sufficient time to fulfil their leadership responsibilities in practice. Evidence provided by NHS Orkney demonstrated variation in the proportion of time senior charge nurses are able to allocate to leadership duties, ranging from approximately 6.4% in some clinical areas to up to 24.4% in others.

NHS Orkney provided data showing variation in appraisal completion rates for registered nursing staff, healthcare support workers and Allied Health Professionals across clinical areas, with compliance ranging from 0% to 100%.

We were provided with evidence that appraisal performance is monitored through performance review meetings alongside other workforce indicators, such as sickness absence and mandatory training compliance, with areas of low compliance discussed with senior leaders and expectations for improvement reinforced. We can also see appraisal data is reported through formal staff governance arrangements, including the Staff Governance Committee. Evidence provided, outlined a range of targeted actions to support improvement, including reinforcing line manager accountability,

providing practical support to managers to prioritise appraisal activity, and exploring changes to appraisal cycles to improve completion rates, with ongoing support from the NHS Orkney People and Culture Team. A requirement has been issued to support improvement in this area.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024. It stipulates that NHS boards have a duty to follow the Common Staffing Method (CSM). The application of the common staffing method supports NHS boards to ensure appropriate staffing and the provision of safe and high-quality care. From 1 April 2024, NHS boards are required to demonstrate that they are complying with the duties as cited in the legislation. Inspectors observed that clinical areas that were inspected were calm and well organised, with no staffing shortages reported during hospital wide huddles while we were onsite.

Inspectors reviewed NHS Orkney's application of the Common Staffing Method as part of its arrangements to support safe staffing and workforce planning. Evidence reviewed showed that staffing level tool outputs are considered alongside professional judgement, local knowledge and wider service specific quality and workforce information, in line with local procedures. Inspectors noted that Common Staffing Method activity has informed a wider review of nursing establishments across inpatient wards, the High Dependency Unit, the emergency department and Macmillan services. Where staffing pressure or variance has been identified, establishment changes have been agreed through governance routes, which has supported the recruitment of substantive staff and strengthening leadership capacity, skill mix and patient safety.

Senior managers explained limitations in how national staffing tools reflect the realities of providing care in a small remote hospital. In some inpatient areas, staff care for patients with a range of different needs at the same time, including medical, surgical and palliative care, which can increase workload and complexity. Wards made up entirely of single rooms may also reduce how easily staff can keep sight of patients and increase the time spent moving between rooms. These challenges are greater in a small remote service, where even small changes in patient needs can place added pressure on staffing and there is less flexibility to adjust resources at short notice. As a result, staffing tool outputs are considered alongside professional judgement and service specific information as part of Common Staffing Method to ensure staffing arrangements remain safe and appropriate.

Senior managers acknowledged that staffing tool use has been inconsistent to date, reflecting the early stage of implementation and variable staff familiarity with the tools. To strengthen assurance over time, senior managers informed inspectors that there is a renewed focus on improving consistency, with agreed plans to complete additional staffing tool runs across all departments. Inspectors were assured that, in the interim, staffing decisions continue to be reviewed through senior nursing oversight, incorporating patient acuity, workforce data, quality indicators and incident information. Governance of the Common Staffing Method process was

found to be supported through established operational, staff governance and board level routes, providing organisational oversight of staffing risks and mitigations.

Alongside staffing assurance through the Common Staffing Method, inspectors also reviewed NHS Orkney's arrangements for real-time identification and escalation of staffing risk to support safe and timely decision making in practice. This includes the use of an electronic staffing system to support real-time monitoring and escalation of staffing pressures, in line with the Health and Care (Staffing) (Scotland) Act. Senior managers described how the system was introduced across the organisation in 2023 to provide a consistent digital approach to recording staffing risk. Inspectors noted that use of the system has not yet been fully embedded across all acute services, with variable confidence and application across teams. Senior managers described a coordinated improvement approach aimed at reinforcing the system as the primary tool for day-to-day staffing risk assessment. This will be supported by a refresher training programme for all teams within NHS Orkney, which began in January 2026 and aims to improve data accuracy and ensure its appropriate use.

Evidence received showed that targeted improvement activity has been undertaken within higher acuity areas to improve the quality and timeliness of data entry, support consistent use of professional judgement and strengthen links between system outputs, operational huddles and escalation decisions. Inspectors were told that learning from this work is informing a phased approach to further rollout across services, taking account of workforce capacity and prioritising areas of higher clinical risk. Pending full embedding, additional controls are in place, including senior-led operational and safety huddles supported by structured documentation to record staffing levels, patient demand, mitigating actions and escalation. These measures support oversight of staffing risk while further improvement work continues.

Inspectors also reviewed NHS Orkney's Standard Operating Procedure for real-time staffing assessment and risk escalation. This Standard Operating Procedure sets out clear roles, responsibilities and escalation processes to support compliance with the Health and Care (Staffing) (Scotland) Act (2019), and provides a consistent framework for identifying, recording and responding to staffing risks in practice. The Standard Operating Procedure supports the use of the electronic staffing system for real-time monitoring and complements the Common Staffing Method by ensuring that staffing concerns, including severe or recurring risks, are escalated, mitigated and reviewed through established governance arrangements. While recognising the improvement work already underway, NHS Orkney must ensure the consistent and effective use of the electronic staffing system across clinical areas. This includes providing appropriate support and training for staff to embed the system into routine practice, so that it reliably supports oversight and informs decision-making, including as part of existing processes such as safety huddles. A requirement has been given to support further improvement in this area.

Areas of good practice

Domain 4.3

- | | |
|---|--|
| 5 | We observed that the hospital safety huddles were well managed, open, transparent, and focused on patient care, with all disciplines attending and contributing. |
| 6 | Initiatives to support student and newly qualified nurses transition from training into practice. |
| 7 | Structured and supportive approach to the recruitment and retention of internationally recruited nurses |

Requirements

Domain 4.3

- | | |
|---|--|
| 6 | NHS Orkney must ensure that senior charge nurses have sufficient protected leadership time to fulfil their leadership and management responsibilities, including the completion of staff appraisals and support for staff development. This should include consistent monitoring and recording of when and why leadership time is compromised as part of mitigation for staffing shortfalls. |
| 7 | NHS Orkney must ensure consistent use of the electronic staffing tool to effectively identify, record and manage staffing risks. |

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

Inspectors observed consistently respectful, compassionate and person-centred care. Patients spoke highly of staff, describing care as kind and responsive, and described clear communication and support. Privacy, dignity and independence were well supported through single room accommodation and attentive care.

Inspectors observed that interactions between staff and patients were consistently professional, courteous and respectful. Patients and carers spoke positively about the care they received. All patients were accommodated in single rooms with access to a shower and toilet. Privacy was supported through the availability of blinds between the door and bed area when required.

The majority of patients were dressed in their own clothes and were sitting out at the bedside, supporting independence and wellbeing.

Inspectors observed staff delivering care in a kind and compassionate manner, taking time to support patients and explain treatments. Patients described care as person-centred, dignified and respectful and reported being kept informed about their care and treatment with regular updates provided to both patients and their families. Feedback from patients was overwhelmingly positive, with care described as “kind” and “exceptional”, staff praised for “going above and beyond” and that they

“couldn’t do enough for them”. One patient who had previously been transferred off island for surgery told inspectors they “couldn’t wait to get back to the Balfour”.

Nursing staff within both wards spoke positively about the support and availability of allied healthcare professionals colleagues such as physiotherapists, occupational therapists and dieticians. Patients also spoke highly of the support provided by allied healthcare professionals teams. Allied healthcare professionals staff were visible in both wards.

Areas of good practice

Domain 6	
8	All observed interactions were professional, friendly and respectful. Patients and carers spoke positively about the care they received.

Appendix 1 - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- [Allied Health Professions \(AHP\) Standards](#) (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- [Ageing and frailty standards – Healthcare Improvement Scotland](#) (Healthcare Improvement Scotland, November 2024)
- [Delivering Together for a Stronger Nursing & Midwifery Workforce](#) (Scottish Government, March 2025)
- [Fire Scotland Act](#) (Acts of the Scottish Parliament, 2005)
- [Food, fluid and nutritional care standards – Healthcare Improvement Scotland](#) (Healthcare Improvement Scotland, October 2014)
- [Generic Medical Record Keeping Standards](#) (Royal College of Physicians, November 2009)
- [Health and Care \(Staffing\) \(Scotland\) Act](#) (Acts of the Scottish Parliament, 2019)
- [Health and Social Care Standards](#) (Scottish Government, June 2017)
- [Infection prevention and control standards – Healthcare Improvement Scotland](#) (Healthcare Improvement Scotland, May 2022)
- [National Infection Prevention and Control Manual](#) (NHS National Services Scotland, January 2024)
- [Healthcare Improvement Scotland and Scottish Government: operating framework](#) (Healthcare Improvement Scotland, November 2022)
- [Prevention and Management of Pressure Ulcers - Standards](#) (Healthcare Improvement Scotland, October 2020)
- [Professional Guidance on the Administration of Medicines in Healthcare Settings](#) (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- [The quality assurance system and framework – Healthcare Improvement Scotland](#) (Healthcare Improvement Scotland, September 2022)
- [Staff governance COVID-19 guidance for staff and managers](#) (NHS Scotland, August 2023)
- [The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives](#) (Nursing & Midwifery Council, October 2018)

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Improvement Action Plan

Healthcare Improvement Scotland: Unannounced acute hospital safe delivery of care inspection

Balfour Hospital, NHS Orkney

23 – 24 March 2026

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: _____

Full Name: David Campbell

Date: _____01 July 2026_____

NHS board Chief Executive

Signature: _____

Full Name: James Goodyear

Date: _____01 July 2026_____

File Name: 2026-07-16_HIS_LAP_BALFOUR_ORKNEY_v1.0	Version: 1.0	Date: 08/07/2026
Produced by: HIS/NHS Orkney	Page: Page 1 of 6	Review Date:
Circulation type (internal/external): Internal and external		

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
Requirements					
Domain 1 – Clear vision and purpose					
1	NHS Orkney must ensure there is one member of staff on duty in the emergency department at all times who has advanced paediatric life support training or equivalent. NHS Orkney will ensure that all Emergency Department (ED) shifts are staffed with at least one clinician who holds current Advanced Paediatric Life Support (APLS) certification or equivalent competency. Staff will be prioritised for APLS training and revalidation. A sustainable training plan will be developed to maintain compliance and resilience, including forward planning for expiry and refresher requirements.	31/03/2027	Director of Nursing, Midwifery & Allied Health Professionals and Chief Officer for Acute Services	June 2026 – Current compliance levels reviewed and gaps identified.	
2	NHS Orkney must ensure effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use. NHS Orkney will revise the Corporate Policy and Procedure Development Framework to clarify and ensure that all clinical standard operating procedures, guidelines, pathways and policies are developed and managed through a uniform organisation-wide process. This will set clear expectations for document development, consultation, approval, review timeframes and ratification. The existing document tracker will be highlighted to all staff, alongside a process to ensure that all organisation-wide and service-held documents are captured centrally. This will provide full organisational oversight of current documents, review dates and approval status	30/11/2026	Head of Patient Safety, Quality and Risk Head of Corporate Governance	June 2026 – The draft consultation and ratification process is complete and is currently being used as a test of change. Collation of guidance documents has commenced on a service-by-service basis to support central oversight of organisation-wide and service-held documents.	

3	NHS Orkney must ensure that all staff are suitably trained, qualified and competent to safely carry out their role. This includes completion of statutory and role-specific training including: • Paediatric basic life support • Paediatric immediate life support • Fire safety • Prevention and Management of violence and aggression, including breakaway and restraint techniques • Mental health training, including relevant legislation Orkney will ensure all staff are supported to meet statutory, mandatory and core training requirements through prioritisation of protected learning time within duty rosters and proactive monitoring of compliance. Training needs will be identified through annual appraisal and departmental Training Needs Analysis. NHS Orkney will strengthen appraisal compliance through proactive monitoring, regular reporting and escalation of non-compliance to line managers to ensure timely completion. Individual development will be identified through annual appraisal processes and aligned to service requirements. Compliance, including uptake of protected learning time (target 80% via e-Roster), will be routinely audited and reported through governance structures, with gaps escalated to line managers.	30/010/2026	Executive Director of Nursing, Midwifery & Allied Health Professionals and Chief Officer for Acute Services Clinical Nurse Manager Acute Services Senior Charge Nurses / Midwife	June 2026 – Current compliance levels reviewed and gaps identified. Staff made aware and rostered to complete training. Training reviewed through governance processes including the performance review meetings.	
Domain 2 – Leadership and Culture					
4	NHS Orkney must ensure timescales of adverse events and significant adverse event reviews are achieved, including feedback to staff and action plans to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland National Framework.	31/10/2026	Medical Director		

	NHS Orkney will strengthen the organisation-wide management of adverse events through review of current processes and revision and ratification of adverse event management guidance, aligned to Healthcare Improvement Scotland's national framework. This will support consistent review timeframes, clear action planning, timely feedback to staff and shared learning across services. The adverse event reporting system will be reviewed to support robust and clear action plans, documented feedback and improved tracking of completion. Compliance with expected review timeframes will be monitored through audit and routine reporting, with strengthened oversight through clinical governance processes, including performance review meetings and escalation through the clinical governance structure to Board where required.		Head of Patient Safety, Quality and Risk. Clinical Nurse Manager Senior Charge Nurses / Midwife	June 2026 – Processes are in place for scrutiny of Category 1 adverse event reviews, with escalation through clinical governance structures to Board. Additional reviewers are being trained to improve resilience. The Adverse Event Management Guidance is being updated in line with HIS national framework, with consultation planned ahead of ratification by end July 2026. Work is also underway to strengthen reporting systems to improve action planning, feedback and tracking.	
Domain 4.1 – Pathways, procedures and policies					
5	NHS Orkney must ensure that all relevant staff complete Paediatric Early Warning Score (PEWS) training to support the accurate and consistent completion of PEWS documentation. NHS Orkney will ensure that all relevant clinical staff are trained and competent in the use of the Paediatric Early Warning Score (PEWS) system to support accurate recognition and escalation of the deteriorating child. Standardised PEWS documentation and guidance will be reinforced to ensure consistent completion and escalation. Compliance with PEWS completion will be monitored through documentation audit and clinical governance processes.	30/11/2026	Executive Director of Nursing, Midwifery & Allied Health Professionals and Chief Officer for Acute Services Clinical Nurse Manager Acute Services	June 2026 – Current compliance levels reviewed and gaps identified. Staff made aware and rostered to complete training.	

	Learning from audits and incidents will be used to further strengthen training and practice.				
Domain 4.3 – Workforce Planning					
6	NHS Orkney must ensure that senior charge nurses have sufficient protected leadership time to fulfil their leadership and management responsibilities, including the completion of staff appraisals and support for staff development. This should include consistent monitoring and recording of when and why leadership time is compromised as part of mitigation for staffing shortfalls. NHS Orkney will ensure protected leadership time for the Senior Charge Nurses / Midwife to support delivery of managerial, professional and governance responsibilities. Rosters will be structured to prioritise leadership time, with proactive planning to minimise redeployment. Compliance and impact will be reviewed through the performance review meetings and wider governance structures to provide oversight, assurance and escalation where required.	30/11/2026	Executive Director of Nursing, Midwifery & Allied Health Professionals and Chief Officer for Acute Services Clinical Nurse Manager Acute Services	June 2026 – Review of current Senior Charge Nurse / Midwife workload and leadership allocation undertaken. Initial steps taken to reflect protected leadership time within rosters. SafeCare in place within Eir Ward (Inpatients one) and Hlin Ward (Inpatients 2), the Emergency Department and Maternity service with staff undergoing training to fully implement the system.	
7	NHS Orkney must ensure consistent use of the electronic staffing tool to effectively identify, record and manage staffing risks. NHS Orkney will standardise the use of SafeCare as the single system for real-time assessment, recording escalation of staffing risk across all staff groups. This will include clear expectations for use, targeted training and implementation of a consistent process for completion at defined points within each shift.	30/11/2026	Executive Director of Nursing, Midwifery & Allied Health Professionals and Chief Officer for Acute Services	June 2026 - SafeCare in place within Eir Ward (Inpatients one) and Hlin Ward (Inpatients two), Emergency Department and Maternity service, with staff undergoing training to fully implement the system.	

	All staffing risks, escalations, mitigation actions and any unresolved risks or disagreements will be documented within SafeCare to support transparency and shared decision-making. Data will be routinely reviewed through SafeCare reporting and monitored via governance structures to identify themes, inform workforce planning and provide assurance, with escalation of risks where required.		Clinical Nurse Manager Acute Services Senior Charge Nurses / Midwife		
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Patient Experience Feedback Annual Report – 2025-2026

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 2026
Responsible Executive/ Non-Executive	• Dr Anna Lamont, Medical Director
Report Author(s)	• Julie Tait, Patient Experience Officer
Purpose of report	• Decision For Approval
Contribution to Strategic ambition	• Government policy/directive • Legal requirement • Local policy
Alignment to NHS Scotland quality ambition(s)	• Safe • Effective • Quality • Person Centred
Key points for consideration	• The Patient Feedback Annual Report 2025-2026 is presented to the NHS Orkney Board prior to submission to the Scottish Government as part of the annual requirements of the Complaints Handling Policy and Procedure • To provide data and information on the feedback received by NHS Orkney throughout the year.
Route to meeting	• Joint Clinical and Care Governance Committee – July 2027
Recommendation(s)	• Decision - Reaching a conclusion considering the options

Patient Experience Feedback Annual Report – 2025-2026

Julie Tait, Patient Experience Officer
24/06/2026

1. Situation

- 1.1 The Patient Feedback Annual Report 2025-2026 is presented prior to submission to the Scottish Government as part of the annual requirements of the Complaints Handling Policy and Procedure.
- 1.2 Members are asked to approve the report.

2. Background

- 2.1 The Patient Rights (Scotland) Act 2011 and supporting legislation, provides a specific right for people to make complaints, raise concerns, make comments and give feedback. The Act also places a duty on NHS Boards to thoroughly investigate and respond to any concerns raised, to take improvement actions where appropriate and to share learning from the views they receive.
- 2.2 The Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Amendment Directions 2024, sets out in legislation that each NHS Boards is required to submit its complaints reports annually, within 6 months of the year end to which the details relate, in an appropriate format to allow collation and publication of national complaints statistics.

3. Assessment

- 3.1 The report provides data and information on the feedback received by the organisation throughout the year and the actions taken in response to this.
- 3.2 Patients generally provide feedback because something has gone wrong, they want to share their experience, or they wish to complement our services. Feedback offers NHS Orkney the opportunity to listen, learn and take action to ensure we are provided safe, effective and person-centred care.
- 3.3 Stage one complaints reduced as the year progressed however, the more complex Stage two complaints rose.
- 3.4 Yearly comparisons over the last five years show a reduction in complaint numbers overall.

3.5 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	Learning from complaints and feedback as a result of patient experiences has a positive impact.
People	Workforce	Yes	Capacity to conduct investigations can be challenging. Staff who are the subject of complaints can find the process upsetting and this can negatively impact services and staff.
Performance	Finance	No	
Potential	Risk Management	No	
	Digital	No	
Place	Equality and Diversity including health inequalities	No	
	Climate Change Sustainability	No	

4. Recommendation(s)

- 4.1 Review the attached annual report and approve the report for submission to the Scottish Government.
 - i **Assurance** – For Members’ assurance only.
 - ii **Decision** – Reaching a conclusion after the consideration of options.
 - iii **Discussion** – Examine and consider the implications of a matter.

5. List of appendices

- 5.1 The following appendices are included with this report:
 - i **Appendix No**, Patient Feedback Annual Report – 2025-2026

Notes on use of the template

The first page is the cover page, the main body of your report should follow from page 2.

Where a separate report is attached as the main report, complete the impact assessment and recommendations (sections 3 and 4)

The markers <.....> indicate what should be completed, do not include the <> markers.

The numbering of each section is automatic, use tab, and shift tab to move ahead and back a numbering level.

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Brough of Birsay, Orkney – June 2025

NHS Orkney Patient Feedback

Annual Report 2025-2026

Foreword

This year's Patient Feedback Annual Report sets out how NHS Orkney has received, responded to, and learned from the feedback, concerns, complaints and compliments shared with us by patients, carers and families during 2025/26.

It is worth saying at the outset what a report of this kind is for. The figures that follow are not, in themselves, a measure of how well or how poorly we are performing. They are a measure of something I consider more fundamental: whether the people who use our services feel able to tell us about their experience, and whether we are organised to hear them, respond to them, and act. The value of this report lies as much in the openness of the channels it describes as in any individual figure it contains. That principle of transparency, alongside our willingness to publish the picture in full, is itself part of what good clinical governance looks like.

On that measure, 2025/26 has been a year of real and visible progress.

Care Opinion submissions have more than doubled, with every story received this year positive in tone. Compliments continue to arrive in significant numbers across our wards and services, and a selection is included in the pages that follow. Two cases referred to the Scottish Public Services Ombudsman were closed without further investigation, with the Ombudsman finding our handling reasonable in both. Our longer-term trend in Stage 1 complaints continues downward and now sits closer to pre-pandemic levels, which we take as a sign that staff are resolving concerns confidently at the point of care. The Patient Experience Service has expanded the ways people can give us feedback, including a revised form aligned with the principles of Realistic Medicine.

Tangible service changes have also followed directly from feedback this year. These include a new protocol for recording and supporting patients with sensory impairment, structured planning for patients with learning disabilities in acute care, and renewed staff focus on clear communication with patients and families before procedures. Each of these began with a patient or family telling us that something needed to be better.

There are areas where we want to do more. A rise in Stage 2 complaints in the final quarter of the year, and pressure on our response times at investigation stage, both reflect the complexity of cases that cross services and the capacity demands placed on clinical investigators. We are working on both: strengthening investigator capacity and supporting earlier resolution where that is the right outcome for the patient. I would rather present this candidly here than have it surface elsewhere, and the report describes our planned response in more detail.

Looking ahead, our focus is on continuing to make it easy to speak to us, faster to respond to what we hear, and clearer to demonstrate what has changed as a result. This work sits squarely within our new Corporate Strategy and within my own commitment, as Executive Medical Director, to a culture in which feedback of every kind is genuinely welcomed.

My thanks go to the patients, families and staff who have contributed feedback during the year, and to the Patient Experience team and clinical colleagues whose work makes it possible to listen, respond and improve.

Anna Lamont
Medical Director
NHS Orkney

Section 1

1.1 Encouraging and Gathering Feedback

- 1.1.1 NHS Orkney collects feedback in the form of complaints, comments, concerns and compliments. We welcome, encourage and value all feedback and use this to learn from people's experience and to inform improvements and change.
- 1.1.2 We know from the compliments and positive feedback we get throughout the year that generally our patients and their carers or families are very pleased with the care they receive. But we are also very aware that we could sometimes do better and therefore the feedback we gather is invaluable in letting us know where improvements can be made.
- 1.1.3 We have again this year focused our efforts on reviewing complaints promptly and responding at Stage 1 wherever possible. This approach ensures that patients are listened to quickly and effectively and has proven to work well. We can evidence this through the very small number of complaints that have escalated during the year.
- 1.1.4 The following methods are means by which our patients and their families can provide us with feedback on our services:
- Complaints – Early Resolution and Investigation stages. These can be made in writing, by email or over the telephone to the Patient Experience Officer or any other member of staff at the point of care. Our Feedback team offers a single point of contact to support patients and families to provide feedback and make complaints.
 - We will also arrange face-to-face meetings for anyone who wishes to discuss their complaint in person, although most patients prefer to make contact by telephone or email.
 - NHS Orkney's website includes a dedicated feedback and involvement section, allowing patients to leave suggestions, compliments or feedback, submit a complaint, or express an interest in becoming involved.
 - Our comments boxes and feedback leaflets are available throughout our health care locations on our Welcome Boards. We have renewed posters with details of how to contact us electronically, a QR code to directly signpost to Care Opinion and feedback leaflets available so that patients can feedback on their experiences whilst in the hospital.
 - Patient Satisfaction Surveys are also undertaken locally at a service level and also as part of national survey programmes.
 - We post on NHS Orkney's social media platforms to encourage patients to tell us of their experiences.
- 1.1.5 All feedback, whether good or bad, is acknowledged and responded to. Patients have taken the time to provide us with information on their experiences and we ensure they know we are very thankful for this. Staff are encouraged to resolve

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issues at the point of contact wherever possible, and our data continues to show a higher number of Stage 1 complaints compared to Stage 2 complaints.

- 1.1.6 Information about advice and support available from the Patient Advice and Support Service (PASS) at the Citizens Advice Bureau is shared with staff across our hospital and healthcare services. Staff are encouraged to signpost patients to PASS when it may be considered helpful. Details of PASS are included in the information provided to patients at the initial stages of a complaint, on our website, and within our acknowledgement letters.

Section 2

2.1 Hospital and Community Services:

- 2.1.1 Our Complaints Handling Procedure (CHP) aims to provide a quick, simple and streamlined process for resolving complaints early and locally by capable, well-trained staff. Our complaints process provides two opportunities to resolve complaints internally:
- Early resolution (Stage 1) - aims to resolve straightforward complaints that require little or no investigation at the earliest opportunity. This should be as close to the point of service delivery as possible.
 - Investigation (Stage 2) - not all complaints are suitable for early resolution and not all complaints will be satisfactorily resolved at that stage. Complaints handled at the investigation stage of the complaints handling procedure are typically serious or complex and require a detailed examination before we can state our position.

2.2 Early Resolution and Investigation Complaints

Performance Indicator Four

Number of complaints <u>received</u> by the NHS Orkney Complaints and Feedback Team	82
Number of complaints received by NHS Orkney Primary Care Service Contractors	54
Total number of complaints received	136

NHS Board Managed Primary Care services:	
General Practitioner	2
Dental	N/A
Ophthalmic	N/A
Pharmacy	N/A
Independent Contractors - Primary Care services:	
General Practitioner	51
Dental	1
Ophthalmic	0
Pharmacy	2
Total of Primary Care Services complaints	56

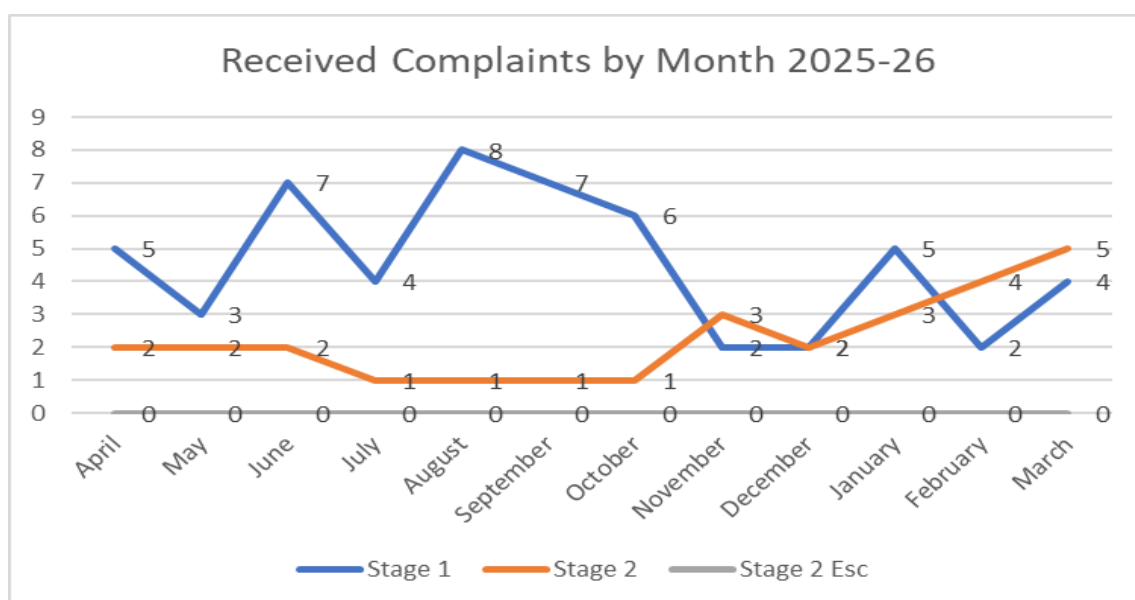
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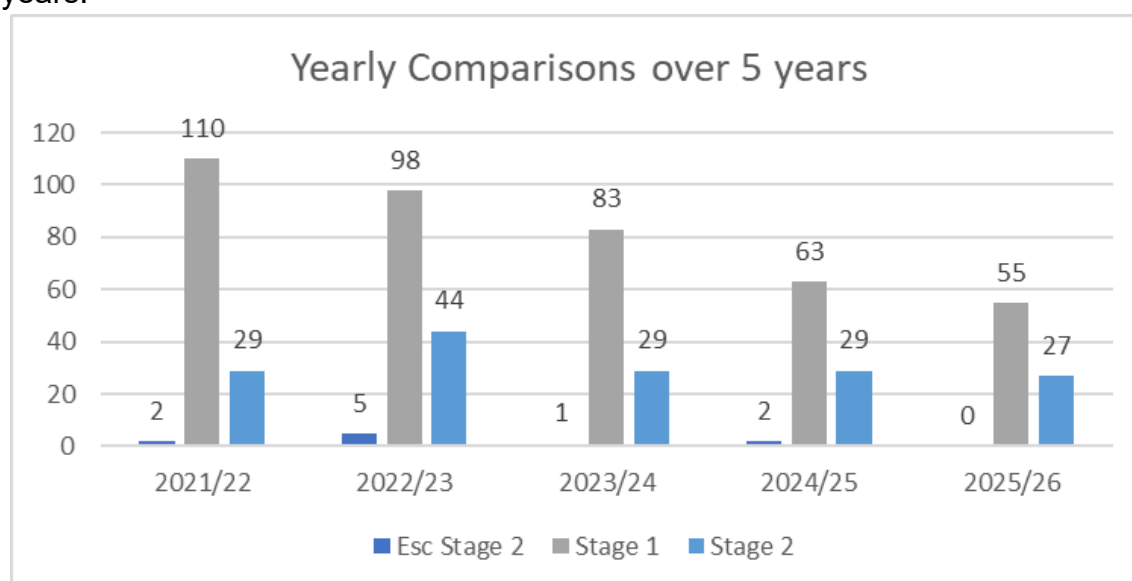
Performance Indicator Five

Number of complaints <u>closed</u> at each stage	Number	As a % of all Board complaints closed (not contractors)
5a. Stage One	52	66%
5b. Stage two – non escalated	27	44%
5c. Stage two - escalated	0	0%
5d. Total complaints closed by NHS Orkney	79	100%

- 2.2.1 During 2025–26, more Stage 1 complaints were received in the first half of the year than in the second half. Stage 2 complaints rose in the final quarter, more than doubling by March 2026. In February and March 2026, NHS Orkney registered more Stage 2 complaints than Stage 1 complaints, a trend rarely seen during the year except for a similar occurrence in November 2025.

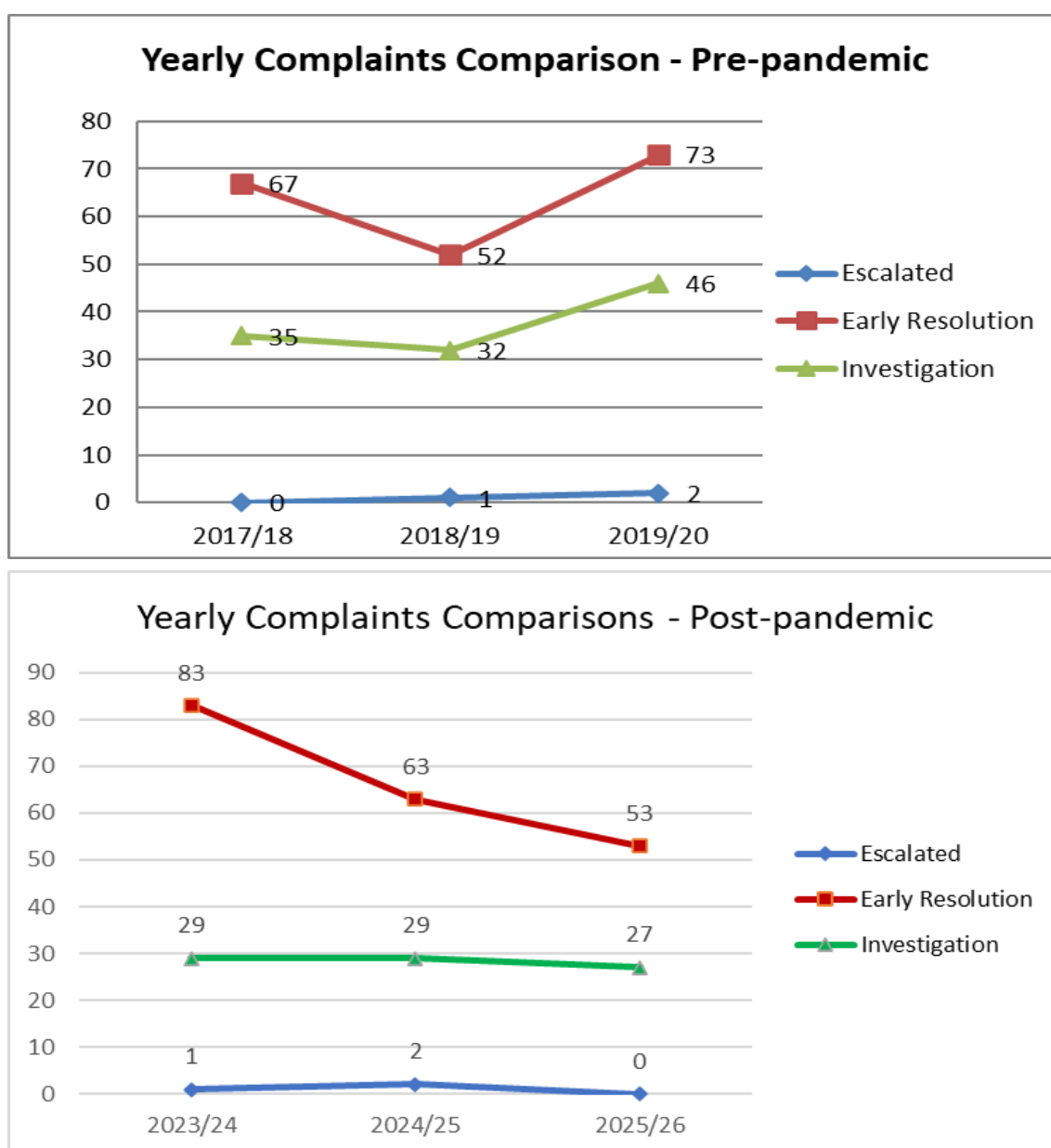


- 2.2.2 The following chart shows comparisons between our complaints over the last five years.



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- 2.2.3 There has been a continued decrease in Stage 1 complaints over the past two years, whereas Stage 2 complaints have remained largely consistent, with only a slight decline observed in the current financial year. This is highly likely to be due to staff awareness of responding to concerns at the point of contact and managing these to patient's satisfaction.
- 2.2.4 The Feedback Team at NHS Orkney collaborates with various departments and services to facilitate prompt resolution of complaints at the point of care. This approach has proven effective, as demonstrated by the consistently low rate of Stage 2 complaints.
- 2.2.5 2025/26 Stage 1 complaints continue to reduce in numbers to more in line with the numbers received pre-pandemic. Apart from the spike in 2022/23, Stage 2 complaints continue to be fairly consistent in the upper twenty's. This is slightly lower than pre-pandemic.



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2.3 Outcome Decision - Complaints upheld, partially upheld and not upheld:

Performance Indicator Six

Early Resolution complaints

	Number	As a % of all complaints closed at stage one
Number of complaints upheld at stage one	21	40%
Number of complaints not upheld at stage one	17	33%
Number of complaints partially upheld at stage one	14	27%
Total stage one complaints outcomes	52	100%

Investigation complaints

Non-escalated complaints	Number	As a % of all complaints closed at stage two
Number of non-escalated complaints upheld at stage two	2	7%
Number of non-escalated complaints not upheld at stage two	16	59%
Number of non-escalated complaints partially upheld at stage two	9	33%
Total stage two, non-escalated complaints outcomes	27	100%

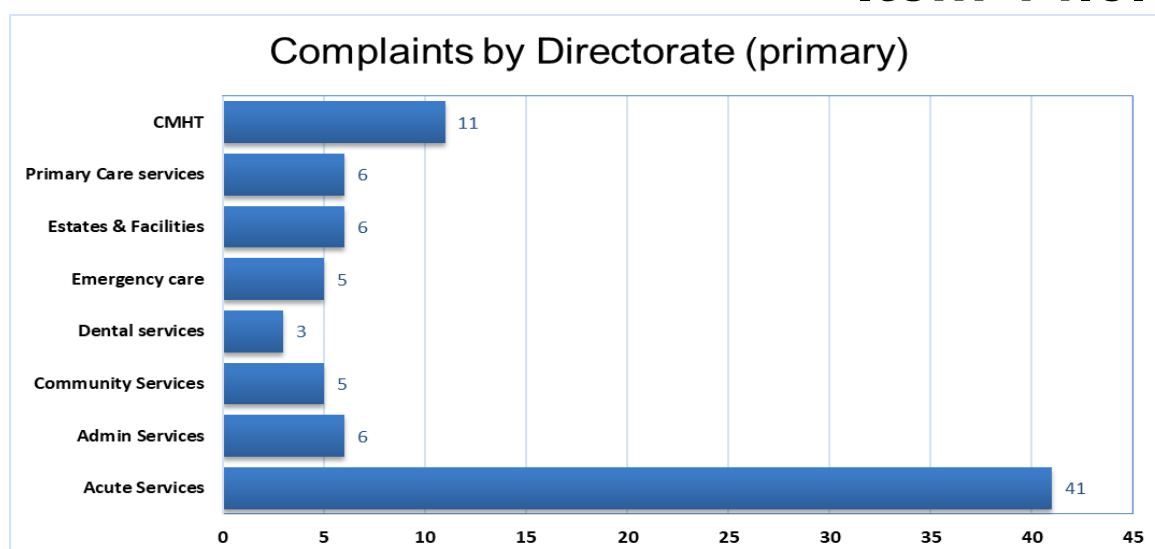
Escalated complaints

Escalated complaints	Number	As a % of all escalated complaints closed at stage two
Number of escalated complaints upheld at stage two	0	0
Number of escalated complaints not upheld at stage two	0	0
Number of escalated complaints partially upheld at stage two	0	0
Total stage two escalated complaints outcomes	0	0%

2.4 Service Areas:

- 2.4.1 NHS Orkney receives complaints across many services, most commonly in Acute Services. These include inpatient, outpatient, waiting times, and both clinical and non-clinical hospital complaints. GP/Primary Care complaints relate to Board Administered Practices, while Community Services complaints include areas such as community nursing, specialist nursing, Physiotherapy and Dietetics.
- 2.4.2 Acute Services recorded the highest number of complaints, reflecting the wide range of inpatient, outpatient, unscheduled care and specialty services provided.

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2.5 Response Times:

- 2.5.1 Early Resolution complaints must be responded to within 5 working days, Investigation stage complaints have response timescales of 20 working days. Boards are required to report response times as one of the key performance indicators of the CHP.
- 2.5.2 Stage 1 complaints remain the focus for NHS Orkney. We consider each complaint on receipt to ensure patients receive a response as quickly as possible. This has the best outcome for the patient in a more person-centred way. Some complaints, however, are more complex.
- 2.5.3 We have found again this year that the more complex complaints cross services and organisations and this has resulted in more complicated investigations with more staff involved in the process. With the added complexity, timescales have failed at times.
- 2.5.4 For information the breakdown quarterly for response times is as follows:

Closed within Timescales	Q1	Q2	Q3	Q4
Total Number of Complaints closed in full at Stage 1	7	10	5	7
% closed within timescale of 5 working days	47%	53%	56%	78%
Total Number of Complaints closed in full at Stage 2	1	2	5	10
% closed within timescale of 20 working days	17%	66%	83%	83%
Total Number of Escalated complaints closed	0	0	0	0
% closed within timescales of 20 working days	-	-	-	-

Performance Indicator Eight

	Number	As a % of complaints closed at each stage
Number of complaints closed at stage one within 5 working days.	29	56%
Number of non-escalated complaints closed at stage two within 20 working days	18	67%

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Number of escalated complaints closed at stage two within 20 working days	0	0
Total number of complaints closed within timescales	47	59%

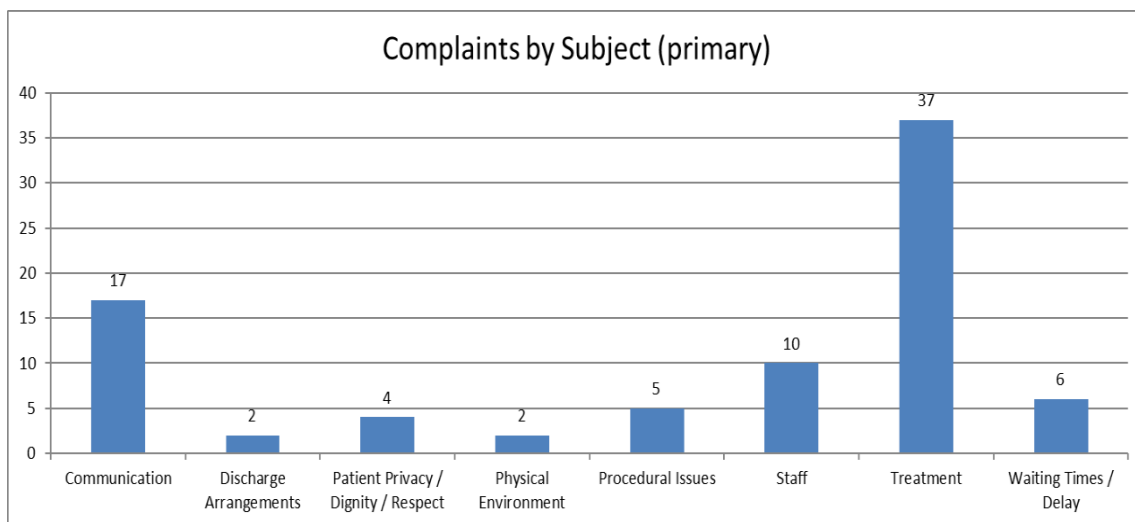
Performance Indicator Nine

	Number	As a % of complaints closed at each stage
Number of complaints closed at stage one where extension was authorised	29	56%
Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	18	67%
Total number of extensions authorised	47	59%

- 2.5.5 In 2025/26 47 of 79 complaints were closed within timescales in line with national guidelines which compares to 53 of 94 in 2024/2025.
- 2.5.6 Response rates improved from last year (38%), with 67% of Stage 2 complaints closed within timescales during the year. The main reason for this was delays within the investigation process. Complaints can be complex, cross services and at times cross organisations and result in delays. Additionally, as in previous years, capacity issues at investigation stage, ie, a lack of available clinical managers to carry out investigations coupled with their ability to carry out complaint investigations alongside clinical duties, also cause deadlines to pass.
- 2.5.7 This year 56% of Stage 1 complaints were responded to within 5 working days and staff should be commended for resolving complaints quickly and early. Managers, who were responding to these alongside their day-to-day duties, were very responsive and quick to manage the majority of concerns at this level. This is however slightly poorer than 2024/2025 when we responded to 67% of Stage 1 complaints within the target time. Patients much prefer this approach and whilst timescales are not met, complaints are resolved and closed with a positive outcome for the complainant.

2.6 Trends and Emerging Themes:

- 2.6.1 NHS Orkney complaints are wide ranging and cross a diverse range of services, making it difficult to identify trends. In 2025/26 themes of care and treatment, communication and staff issues are identified as the main issues within Investigation and Early Resolution complaints. This is identical to previous years, although a slight drop in waiting time complaints, and similar to other Boards themes over the last few years.



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2.7 Alternative Dispute Resolution:

- 2.7.1 There were no complaints during the year which met the need for Alternative Dispute Resolution. NHS Orkney is aware of the services provided by the Scottish Mediation Service and has used it in the past.

2.8 Engagement with Complainants Policy

- 2.8.1 At times NHS Orkney must review a complainant in line with the Engagement with Complainants policy. This happens when it is considered that there is nothing further that can reasonably be done to assist complainants or to rectify a real or perceived problem. Where this is the case and further communications would place inappropriate demands on NHS staff and resources, consideration may need to be given to classify the person, behaviours or actions as unacceptable.
- 2.8.2 There were no occasions where NHS Orkney had to refer and act in line with the policy during this complaints year.

2.9 Complaint process experience

- 2.9.1 NHS Orkney surveyed a random sample of 20 (25%) complainants who had completed the complaints process at both Stage 1 and Stage 2. A response rate of 50% indicated reasonable engagement with the experience survey.
- 2.9.2 Overall satisfaction ratings tended to be negative, which is not unexpected. Respondents who choose to complete the survey often feel their complaint has not been upheld and, in some cases, appear to confuse feedback on the complaints handling process with dissatisfaction regarding the outcome or subject matter of their complaint. Several comments suggested that responses related more to the issues raised within the complaint itself rather than the process of submitting and managing a complaint.
- 2.9.3 Positively, complainants consistently reported that it was easy to submit a complaint and that information on how to do so was accessible. Many also felt that an apology had been appropriately offered as part of the process. While apologies were frequently achieved, there remained notable gaps between complainants' expectations and perceived outcomes, particularly in relation to receiving clear explanations, feeling fairly treated, and seeing evidence of actions taken to prevent recurrence.

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- 2.9.4 The Patient Experience Service is committed to ensuring that all patients feel listened to, supported and well-informed throughout the complaints process. Feedback from this survey will be carefully reviewed to identify opportunities to improve both communication and responses. Achieving this relies on services providing thorough investigation reports and demonstrating clear ownership of learning, improvements, and service changes arising from complaints.

2.10 Family Health Services (not including salaried GPs/Dentists)

NHS Board Managed Primary Care services;	
General Practitioner	2
Dental	N/A
Ophthalmic	N/A
Pharmacy	N/A
Independent Contractors - Primary Care services;	
General Practitioner	51
Dental	1
Ophthalmic	0
Pharmacy	2
Total of Primary Care Services complaints	56

- 2.10.1 Primary Care Services received more complaints in the current reporting year, 54, compared to 37 in 2024/2025.
- 2.10.2 NHS Orkney handle complaints made about the Salaried GP's and Board Administered Practices. Our figures show only two complaints were made during the year.

2.11 MSP / MP - Constituents' Concerns Raised

- 2.11.1 There are occasions when patients contact their MSP/MP in the first instance to make a complaint, raise a concern or enquiry. During the period 1st April 2025 – 31st March 2026, the Chief Executive received many written expressions of concern or complaint which sought address through a MSP. Patients are more frequently raising issues through their MSP. Issues regularly include waiting times for appointments, care and treatment or enquiries regarding patient travel.
- 2.11.2 NHS Orkney Feedback Service responded to 47 MSP/MP requests during the year.

2.12 Care Opinion

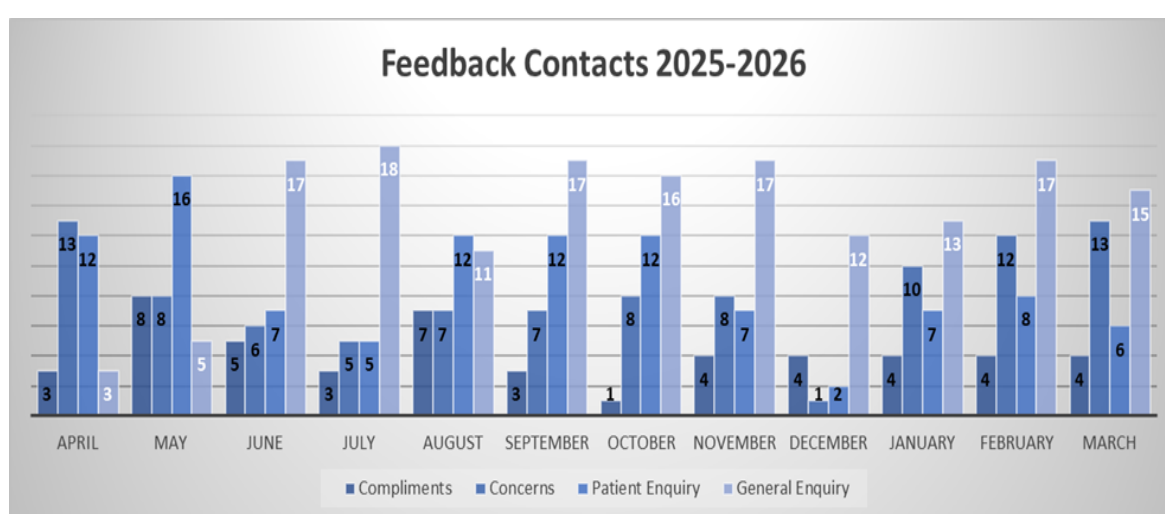
- 2.12.1 Since entering into the full subscription with Care Opinion in 24/25, NHS Orkney Patient Experience staff have been committed to promoting the online feedback platform with our staff and patients.
- 2.12.2 We have increased promotional information around the hospital, including new posters with "direct ask" QR codes on all Welcome Boards. We have provided promotional material to interested services. In March 2026, we held a staff awareness event in the main hub where we shared information and materials with some services to promote use with their patients.

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- 2.12.3 We have met with Care Opinion representatives, attended both live and recorded webinars and shared these with staff.
- 2.12.4 We received nine notifications of feedback submitted on the Care Opinion website between 1 April 2026 and 31 March 2026. This is an increase compared to last year where four stories were received. 100% of this year's feedback was positive.
- 2.12.5 We intend to hold a patient awareness event in the main reception area in the coming year.

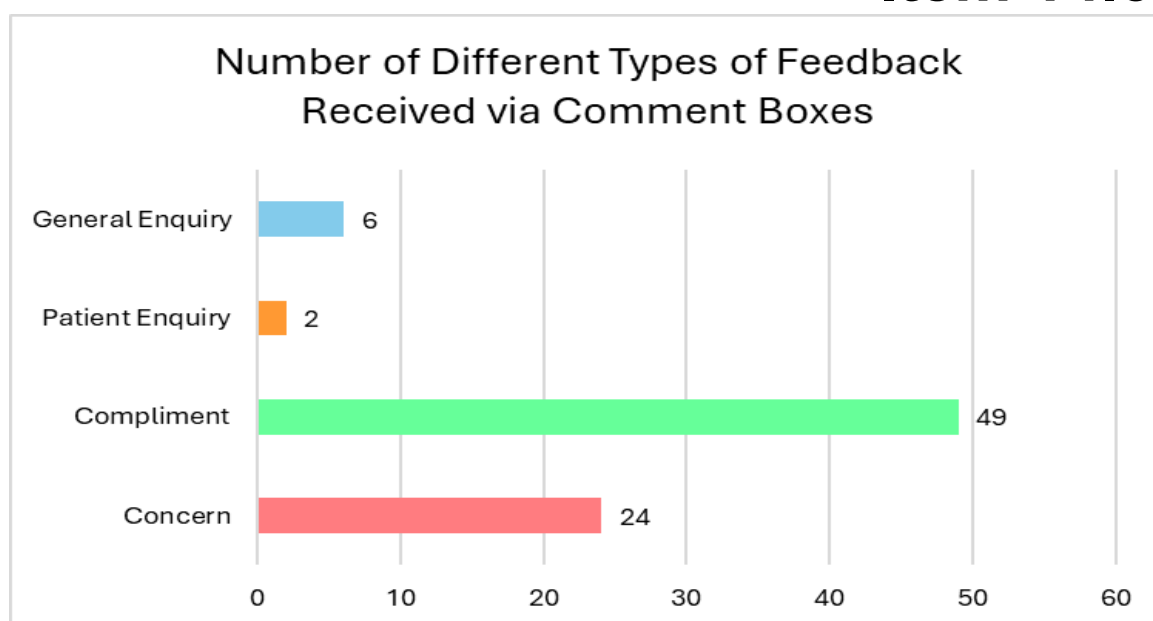
2.13 Feedback and Comment Boxes

- 2.13.1 Informal feedback and concerns are logged and recorded by the Feedback service and are reported quarterly to the Clinical Quality Group. We received in excess of 470 recorded patient contacts requiring response during 2025/26.



- 2.13.2 The table above summarises feedback received by email, telephone and face-to-face.
- 2.13.3 Patients are also encouraged to share their views using our feedback forms, which are available on the welcome board alongside information about Care Opinion.
- 2.13.4 In February 2026, the feedback form was updated to include questions which aligned with the principles of Realistic Medicine. This was developed in collaboration with the Realistic Medicine Lead and introduced six new, simple questions designed to encourage completion. Early responses have been positive, and completed forms are being received.
- 2.13.5 The following chart shows information about the feedback we have received on our feedback forms:

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Your Feedback Matters



Your information helps us to make sure we are doing things well and if you tell us we are not, we can make improvements and changes.

Thinking about your visit to the hospital today, please tell us about your experience:

Please rate each statement below, where **1 = Poor** and **5 = Excellent**

1. **Today, options around my healthcare were clearly explained:**
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
2. **I felt I had time to ask questions and was listened to:**
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
3. **I felt involved in decisions about my healthcare:**
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
4. **I was treated with dignity and respect:**
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
5. **Today, the healthcare I received met my expectations:**
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
6. **How was your overall experience in the hospital today?**
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

- 2.13.6 Patients most frequently raised concerns about waiting environments and accessibility, car parking, and privacy within clinical areas. Compliments highlighted staff kindness, efficient care, and high standards of professionalism and clinical expertise.
- 2.13.7 Our new form seems to be well received and once enough useable data has been received, we will be able to use this to identify areas to celebrate.

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2.14 Patient Advice and Support Service (PASS)

2.14.1 PASS offer advice and support for all NHS users and can help patients if they have any comments or complaints about any aspect of the health service. The Patient Experience Officer provides information on the service to complainants so that they may use the service if they feel unable to raise concerns themselves.

2.14.2 Unfortunately, the number of clients and contacts supported by PASS during 2025/26 is not available at the time of writing this report. We can report that we did not receive any complaints from the service on behalf of patients.

2.14.3 However, a number of patients have been signposted to the service and requests for advice have been received from the PASS Officer.

2.15 Scottish Public Services Ombudsman (SPSO):

2.15.1 During the year 2025/26, The Scottish Public Services Ombudsman received two complaints from Orkney patients who were unhappy with the response received from NHS Orkney.

	Complaint	Outcome
Case 1	Family of patient complained information was not shared from the hospital to the GP in a timely manner.	Not considered for further investigation - NHS Orkney's complaint investigation and response was reasonable.
Case 2	Patient complained follow up actions were not taken following their complaint and they were not informed of this in a timely manner.	Not considered for further investigation – nothing more could be achieved from their investigation.

2.16 Compliments

2.16.1 As with previous years, NHS Orkney receives a significant number of compliments. These are predominantly sent to our wards and departments in the forms of letters, cards, flowers, chocolates and biscuits.

2.16.2 NHS Orkney do receive a number of compliments directly which we record and send on to the relevant staff members or area.

2.16.3 Here's a selection of what our patients have told us:



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"The care we received by the team at the Balfour maternity prior to and following the birth of our daughter was amazing. We were treated with care and respect and equipped to look after our baby with confidence."

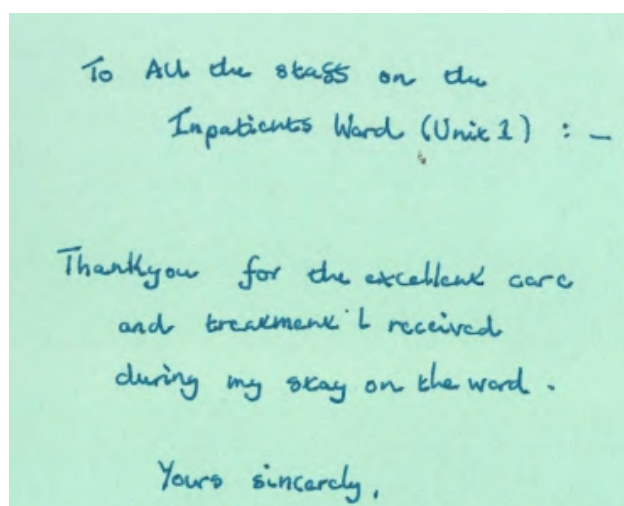
I must say that I was dealt with by your colleagues and your dentist very professionally and quickly and was very pleased with the service provided and outcome especially more so as a tourist visitor.

"Both the radiographer and nurse were just so supportive, kind and so clear in all explanations about what was happening and when, and although very overwhelmed, I managed to get through the appointment."



"They wanted the catering staff to know how much their dad appreciated the meals he had whilst on dialysis. He thought the Balfour kitchen was amazing!"

"The nurses were so kind and patient with him as they carried out their checks and were also able to have a bit of banter with him, which made all the difference."



Section 3

3.1 The culture, including staff training and development

- 3.1.1 At NHS Orkney we pride ourselves in delivering high quality care and we will ensure all our patients are treated with dignity and respect whilst ensuring we deliver excellence and professionalism in all that we do.
- 3.1.2 Our patients can expect:
- to be treated with dignity and respect
 - for us to show compassion by taking the time to listen, to talk and do the things that matter to them
 - to receive high quality patient care and when they don't, we will listen and act on feedback so we can learn, improve and do better next time
 - for us to be consistent and reliable and do what we say we will
 - us to work with patients and their family (carers) and our colleagues so that we put their needs first
 - for us to communicate (as individuals, teams and as an organisation) effectively, keeping them informed and involved and providing explanation if something has not happened
- 3.1.3 Although no recorded cases have been received this financial year, it is considered the continuing good relationship between PASS and NHS Orkney is vital to ensuring patients are given as much advice and support as possible in a cohesive, co-ordinated fashion whilst remaining aware that PASS is an independent service.
- 3.1.4 Our online training is now hosted fully by Turas and the Patient Experience Officer has encouraged those who express an interest, to undertake the non-mandatory training. This can be found in the Clinical Governance section of the Turas learning platform.
- 3.1.5 The Patient Experience Officer is available to carry out informal training for any team who wishes help with complaint handling, investigating or learning from complaints.
- 3.1.6 The following table indicates the number of staff who have completed the online training modules during this financial year. It should be noted that these modules are not mandatory required training and therefore numbers are low:

Module	Staff Completion Numbers
Module 1 - Value of feedback	3
Module 2 - Encouraging effective feedback	1
Module 3 - Complaints and feedback process	2
Module 4 - The Value of Apology	2
Module 5 - Managing difficult behaviour	1
Complaints investigation skills	2

Section 4

4.1 Improvements to Services

4.1.1 When any aspect of a complaint is upheld, the service identifies what improvements can be made. We continue to use our Complaints Reporting Template which provides an opportunity for staff to clearly identify actions, improvements and recommendations.

4.1.2 The following are some examples of improvements made over the last year:

Issue Raised	Findings	Outcome
Patient with sensory impairment experienced challenges due to lack of staff awareness	No guidance in place to record patients with sensory impairment needs	Protocol developed and introduced in inpatient areas.
Patient's family did not feel included in decisions	Communication with the family was not as expected.	Delivery of training in best practice for communicating with patients and families
Patient not given information before procedure	Communication with the patient had not clearly described the procedure and that sedation would not be administered	Highlighted with staff and team to ensure communication is improved and explanations are clear
Family were concerned that the needs of a patient with learning disabilities were not recognised	Challenges were recognised both for the patient and staff	NHS Orkney's Learning Disability and Autism Spectrum Disorder will provide support and create training plans for staff in acute care.

4.1.3 As mentioned above, all complaints are reported at the Clinical Quality Group as part of the Safety, Quality and Experience Report which ensures the Clinical Directors are sighted on incidents, complaints and emerging issues.

4.1.4 Any improvements, actions or changes that are identified through the complaints process, either formally or informally, are shared with the complainant in our response. An apology is given regardless of the outcome.

Section 5

5.1 Accountability and Governance

5.1.1 NHS Orkney report complaint performance to the Clinical Quality Group as part of their quarterly Safety, Quality and Experience Performance Report. This includes information on incidents and Significant Adverse Event Reviews (SAERs), allowing correlation of incidents, SAERs and complaints where appropriate.

5.1.2 NHS Orkney Board members receive updates through the Joint Clinical and Care Governance Chairs report and receive the Annual Report. Quarterly reporting on KPI's for complaints is also included as part of the Integrated Performance Report

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to the NHS Orkney Board and to the Joint Clinical and Care Governance Committee.

- 5.1.3 A complaints update is shared with Executive Directors on a weekly basis and has recently changed to an “at a glance” report which also provides information on incidents, SAERs and all other feedback.
- 5.1.4 Complaint investigations are undertaken by Lead Officers, supported by their direct manager on the Senior Management Team. Once complete, investigations are reviewed and signed off by the Medical Director or Director of Nursing, AHP’s and Chief Officer for Acute Services before being submitted to the Chief Executive for final approval.

Section 6

6.1 Person-Centred Health and Care

- 6.1.1 Person-Centred Health and Care is at the heart of all our services within NHS Orkney. It is recognised that, to achieve this, we need to work at many different levels and with the wider community in which we live. The following are some examples of different work that has been carried out with involvement of, or by, NHS Orkney staff.
- 6.1.2 During National Smile Month, NHS Orkney’s Oral Health Team delivered fun, interactive activities aimed at encouraging healthy eating and good oral health habits among children and families. These sessions supported early prevention and promoted positive messages around dental health in an engaging way.



Childsmile Summer Snack Fun
At the Pool Viewing Gallery
The Pickaquoy Centre
14th June 2025, 10-11.30am

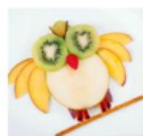
**Promoting Oral Health
During National Smile Month**



A fun session to create yourself a super smiley snack. Pop in and see us to make a tasty treat good enough to eat.



We will provide an assortment of fruit and vegetables to taste and try, and for you to create a super snack.



Children should be accompanied by a parent/carer.
Tea & coffee, milk and water will be available.



It's National Smile Month so please come and join the Childsmile Team for some healthy fruity fun.
It'll be a sweetie and fizzy free zone.
For more information, contact the Childsmile Team at ork.oralhealth@nhs.scot
This event is kindly supported by the Pickaquoy Centre and Tesco, Kirkwall.

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- 6.1.3 A local family generously donated new, easy-to-use televisions for inpatient wards at The Balfour. The televisions have been installed across the Macmillan Ward and Hlin Assessment and Rehabilitation Ward, helping to improve comfort and enjoyment for patients during their stay. Feedback from patients has been very positive, with many commenting on the improved experience.

Improving Patient Comfort Through Community Kindness



- 6.1.4 Pupils from Stenness Primary School took part in a Basic Life Support session delivered by NHS Orkney's Practice Education Team. The session focused on cardiopulmonary resuscitation and gave pupils the opportunity to learn vital life-saving skills in a practical and engaging way, supporting prevention and community education.



Teaching Life-Saving Skills in the Community

- 6.1.5 During the International Island Games, NHS Orkney's Radiology Team established a temporary on-site x-ray service within the event polyclinic. This allowed athletes to be assessed and treated locally, reducing the need for hospital visits and demonstrating flexible and innovative service delivery through partnership working.

Delivering Innovative Care at the Island Games



Item 14.3.1

- 6.1.6 Children across Orkney were invited to take part in a competition to rename NHS Orkney's inpatient wards. The winning names, Eir Acute Ward and Hlin Assessment and Rehabilitation Ward, reflect Orkney's Norse heritage and values of healing and comfort, highlighting the importance of community involvement.



Celebrating Community Involvement – Naming Our Wards

- 6.1.7 Quit Your Way Orkney continues to provide personalised support to people who want to stop smoking. The service has been recognised nationally for its positive outcomes, reflecting the commitment of staff and community pharmacy partners to improving health and reducing smoking-related harm across Orkney.

Helping People to Quit Smoking



- 6.1.8 The Improving the Cancer Journey service continues to support people affected by cancer by addressing non-clinical concerns alongside clinical care. An introduction event at The Balfour helped raise awareness of the service and reinforced NHS Orkney's commitment to holistic, person-centred support.

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Supporting People Affected by Cancer

6.1.9 As part of national awareness activity, NHS Orkney supported local efforts to raise awareness of pregnancy and baby loss and to ensure people across the community know where to access support. Community-based initiatives focused on sharing messages of kindness, connection and hope, reinforcing that support is available locally for anyone who may need it.

Supporting Families Through Pregnancy and Baby Loss Awareness



6.1.10 As part of wider Island Games celebrations, staff and patients enjoyed a visit from the official Games mascot. The visit helped bring a sense of fun and community spirit into NHS Orkney settings, contributing positively to the experience of those attending or working within services.

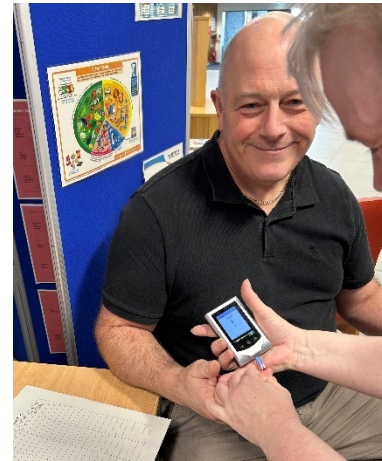


Celebrating the Island Games Mascot Visit

6.1.11 On World Diabetes Day, NHS Orkney staff and patients were offered the opportunity to take part in health checks and discussions focused on diabetes awareness and prevention. The activity supported early identification of risk factors and encouraged conversations about healthy lifestyles.

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**Raising Awareness on
World Diabetes Day**



Month 4 Finance & Improving Together (efficiency programme) progress report

Meeting	NHS Orkney Board
Meeting date	Thursday, 27 August 2026
Responsible Executive/Non-Executive	• Damian Reid, Interim Director of Finance
Report Author(s)	• Damian Reid, Interim Director of Finance
Purpose of report	• Discussion
Contribution to Strategic ambition	• Corporate Strategy 2024/28 • Annual Operational Plan • Government policy/directive • Legal requirement
Alignment to NHS Scotland quality ambition(s)	• Effective • Quality • Sustainability
Key points for consideration	•
Route to meeting	• Finance and Performance Committee 25 August 2026
Recommendation(s)	• Discussion - Consider the Implications of a matter

Month 4 Finance & Improving Together (efficiency programme) progress report

Damian Reid, Interim Director of Finance

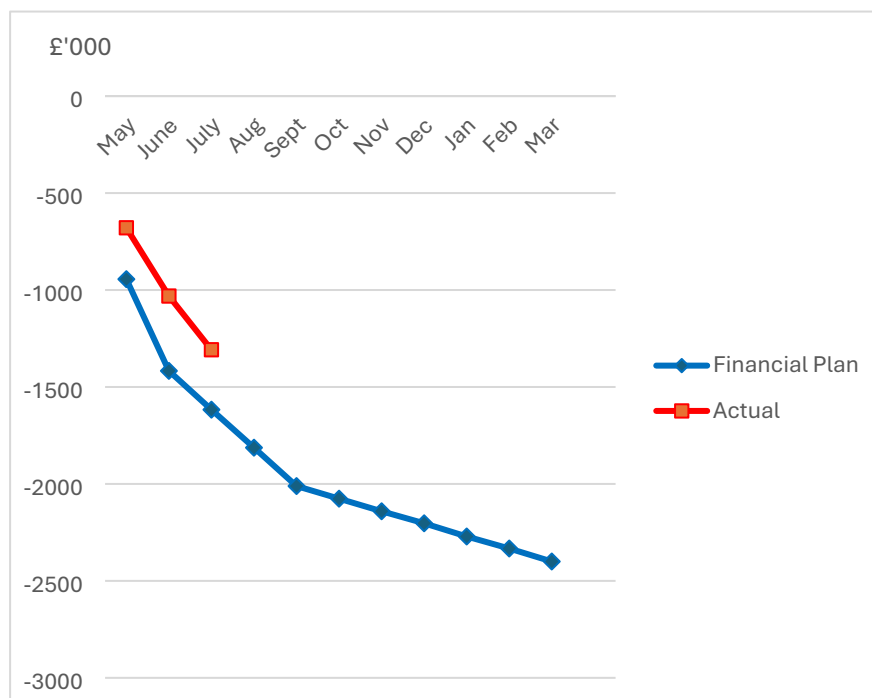
15/07/2026

1. Situation

- 1.1 NHS Orkney remains escalated to stage 3 of the NHS Scotland Support and Intervention Framework for finance. The Board has an approved financial plan for 2026/27 which projects a £2.4m overspend for the year

2. Background

- 2.1 At the end of Month 4, the reported financial position an overspend of **£1.308m**, which is **£309k** lower than the planned trajectory ant Month 4 of **£1.617m**. The achieved savings at Month 4 is **£0.202m adverse** to the YTD plan of **£0.821m**.
- 2.2 Whilst there is a slight improvement on the YTD position, compared to the financial plan, the year-end position still heavily relies on achieving the savings in the plan as well as identifying additional schemes.



- 2.2 If we fail to reach the forecasted position of £2.4m over spent then there is a risk that of risk of a Section 22 Qualification on our accounts for 2026/27.

3. Assessment

3.1 Analysis

SG have made it clear that they are expecting NHS Orkney to deliver as close to the approved financial plan as possible. The forecast deficit of £2.4m will require a continuing to review expenditure forecasts and savings schemes to help identify opportunities for reducing the year end deficit to as much as possible.

3.2 Current Position

At Month 2 we are still forecasting the £2.4m overspend at year end from the financial plan on the caveat that additional savings schemes can be identified between now and then

3.3 Impact Assessment

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

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	Successful delivery of transformation ensures improved clinical outcomes and patient experience. Quality Impact Assessments are a pre-requisite of any identified efficiency/ transformation scheme to ensure the best outcomes for patients as part of any scheme pursued in the delivery of the financial plan.
People	Workforce	Yes	Delivery of the Board's financial plan is challenging, and it is recognised that successful delivery will have an impact on workforce. As part of the financial performance and delivery of the financial plan, changes to WTE, skill mix and role redesign will be necessary, however, these will be subject to Quality Impact Assessments and rigorous engagement with teams prior to implementation and to mitigate adverse concerns.
Performance	Finance	Yes	Failure to deliver against the 2024/25 financial plan outturn will have a significant impact on the Board and the ability to de-escalate from level 3 of the NHS Scotland Support and Intervention Framework. Monthly reporting allows the position to be monitored closely and corrective action to be taken timeously as required.
Potential	Risk Management	Yes	Risk that the Board cannot deliver on its statutory responsibility to deliver a financial balance.

			Monthly reporting to the Scottish Government to ensure they are aware of the most up to date position.
	Digital	Yes	Investment in digital technology may be required in order to deliver against some of the transformational savings schemes to ensure the most effective and efficient processes are in place. Additional investment if not captured appropriately during financial planning can have a detrimental impact on delivery of the forecast financial outturn.
Place	Equality and Diversity including health inequalities	Yes	Financial planning and performance along with the ongoing improvement work and savings schemes to ensure delivery against the Board's financial responsibilities has fairness and equality at the heart of ongoing improvement work as captured the QIA and developing a culture of continuous improvement
	Climate Change Sustainability	Yes	Several of the ongoing improvement/ savings schemes in place to deliver against the Board's financial plan incorporate schemes to reduce travel to and from Orkney with a number of additional schemes that look to reduce waste and overall the environmental impact

4. Recommendations

- 4.1 Discuss the Month 4 Financial Position
- 4.2 Discussion - Consider the Implications of a matter

5. List of Appendices

- 5.1 The following appendices are included with this report
 - i. **Appendix 1**, Month 4 Financial Position

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NHS Orkney

Financial Position – Month 4 2026/27

Introduction

NHS Orkney was escalated to stage 3 of the NHS Scotland Support and Intervention Framework for finance in October 2023 and the Board is focused on reducing its deficit and returning to financial balance in a short a timescale as possible.

Funding for the NFI has been confirmed as recurrent funding for the year.

Year to Date Financial Position

After 4 months of the 2026/27 reporting period, the revenue position shows an **overspend of £1.308m**, which is **£0.309m lower** than the planned year-to-date overspend of **£1.617m**.

The achieved cash releasing savings at Month 3 is **£0.619m** and is **£0.202m adverse** to the year-to-date target of **£0.821m** from the planned savings. The trajectory of savings is geared towards the end of the financial year with **73.7%** planned to be delivered in the remaining 8 months.

Month 4 Financial Position

The following events had an impact on our position this month:

- The addition of full year (recurring) funding for the MRI resulted in a £62k favourable movement in the year to date position.
- The increased use of locums by Primary Care led to a £96k adverse movement in the month.

Graph 1 illustrates the financial plan trajectory compared to the actual monthly results for the 2025/26 financial year.

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Graph 1: Year to Date Run Rate vs Planned Run Rate

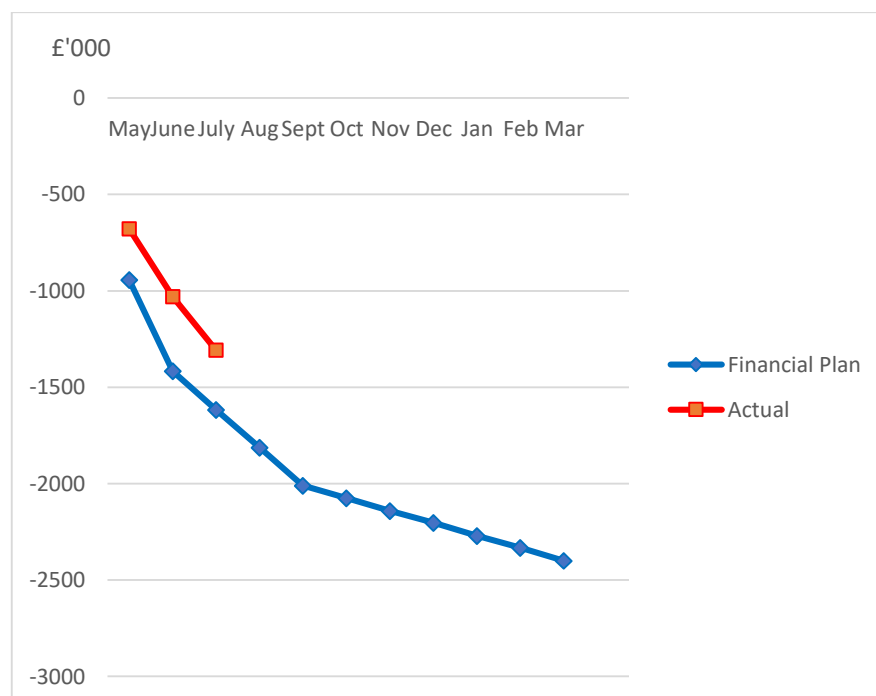


Table 1: Summary Month 4 Position

Level 4 Cost Category	Annual Budget	Period Actuals	Period Budget	Period Variance	YTD Actuals	YTD Budget	YTD Actuals	YTD Variance
<u>Income</u>								
Health Board Income	-1,168	-134	-98	36	-454	-390	-454	64
Other	-491	-117	-41	76	-396	-164	-396	233
Primary Care Patient Charges	-431	-34	-39	-5	-169	-187	-169	-18
Total Income	-2,090	-285	-177	108	-1,019	-740	-1,019	279
<u>Expenditure</u>								
<u>Pay</u>								
Medical & Dental	9,862	1,045	869	-176	4,238	3,287	4,238	-951
Nursing & Midwifery	17,824	1,392	1,510	118	5,643	5,956	5,643	312
Other Staff Costs	27,470	2,122	2,275	153	8,431	9,157	8,431	726
Total Pay	55,156	4,560	4,655	95	18,312	18,400	18,312	88
<u>Non-Pay</u>								
Drugs - Primary Care	5,341	419	564	145	1,624	1,780	1,624	156
Drugs - Secondary Care	4,009	240	425	185	1,007	1,336	1,007	329
General Dental Services	1,165	132	132	0	524	524	524	0
General Medical Services	5,157	414	430	16	1,746	1,719	1,746	-27
General Ophthalmic Services	312	34	34	-1	131	130	131	-0
Medical Supplies	1,658	162	145	-17	701	553	701	-149

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Other Expenditure	12,063	1,585	727	-858	5,828	4,007	5,828	-1,822
Pharmaceutical Services	1,057	91	95	4	331	358	331	27
Resource Transfer	2,334	213	195	-18	864	778	864	-86
SLA's & UNPACs	10,871	974	1,103	129	3,727	3,624	3,727	-103
Total Non-Pay	43,967	4,265	3,850	-415	16,483	14,809	16,483	-1,674
Total Expenditure	99,123	8,824	8,504	-320	34,796	33,209	34,796	-1,587
Total	97,033	8,539	8,327	-212	33,777	32,469	33,777	-1,308

Improvement Programme

NHS Orkney had an integrated improvement function which is responsible for driving savings delivery within the organisation. £3.865m of savings are required to be achieved during 2026/27 to deliver the £2.400m deficit plan (before Transitional Funding Support).

The Board has achieved **£0.619m** after 4 months against a planned trajectory of **£0.821m**.

At M4 the Improvement Programme is forecasting a delivery of **£3.009m** run-rate savings (from schemes currently in implementation) with additional pipeline schemes being scoped and progressed to implementation stage. **£1.333m** has been highlighted as medium or high risk to deliver.

Overview: Month 4 Financial Position (Core RRL)

The overview at Month 4 is summarised in Table 2, with further detail provided in Appendix 1.

Table 2 – Core RRL by Area

Directorate		Annual Budget	Period Actuals	Period Budget	Period Variance	YTD Actuals	YTD Budget	YTD Variance
Acute Services Directorate	Income	-120	-23	-10	13	-142	-40	102
	Pay	20,838	1,653	1,737	84	6,919	6,946	26
	Non Pay	1,404	179	148	-31	757	586	-171
Acute Services Directorate	Total	22,122	1,809	1,875	67	7,535	7,492	-43
Chief Executive Directorate	Income	0	3	0	-3	0	0	0
	Pay	2,492	198	204	6	837	862	24
	Non Pay	-53	14	-63	-77	42	-87	-129
Chief Executive Directorate	Total	2,438	215	141	-74	879	774	-105

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Chief Officer Integration Board	Income	-731	-63	-61	2	-228	-244	-16
	Pay	16,657	1,517	1,438	-79	5,763	5,567	-196
	Non Pay	17,938	1,558	1,661	103	6,199	6,241	42
Chief Officer Integration Board	Total	33,865	3,012	3,038	26	11,734	11,565	-170
Directorate of Human Resources	Income	-43	-7	-4	3	-28	-14	14
	Pay	1,172	96	98	2	374	391	17
	Non Pay	147	27	12	-15	95	49	-47
Directorate of Human Resources	Total	1,277	115	106	-9	441	425	-16
Finance, E&F and IT Directorate	Income	-572	-132	-48	85	-336	-191	145
	Pay	7,689	598	605	7	2,297	2,532	235
	Non Pay	4,812	668	-14	-682	2,777	1,389	-1,389
Finance E&F, IT Directorate	Total	11,929	1,134	543	-590	4,739	3,730	-1,009
Medical Directorate	Income	-261	-28	-22	6	-117	-87	30
	Pay	3,494	257	338	81	1,146	1,165	19
	Non Pay	17,253	1,567	1,850	283	5,598	5,641	44
Medical Directorate	Total	20,486	1,796	2,166	370	6,626	6,719	93
Performance And Transformation	Income	0	0	0	0	0	0	0
	Pay	1,681	146	140	-6	588	560	-27
	Non Pay	3	2	0	-2	9	2	-7
Performance And Transformation	Total	1,684	148	140	-8	597	562	-35
Public Health Directorate	Income	-66	-7	-6	1	-26	-22	4
	Pay	1,133	94	94	0	389	378	-11
	Non Pay	40	-2	3	5	31	13	-17
Public Health Directorate	Total	1,107	86	92	6	393	369	-24
		94,908	8,315	8,103	-212	32,944	31,636	-1,308

Appendix 1 provides high level performance detail of each area.

Significant Areas of Concern

Agency Spend & Bank

Agency spend in in the first 4 months of the year is in line with the average for 2025/26 but will need to reduce if we hope to achieve our financial target in 2026/27. Bank continues to be a key issue.

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Primary Care Prescribing

Primary Care prescribing costs have increased in M4 can be volatile so that may change as the year goes on.

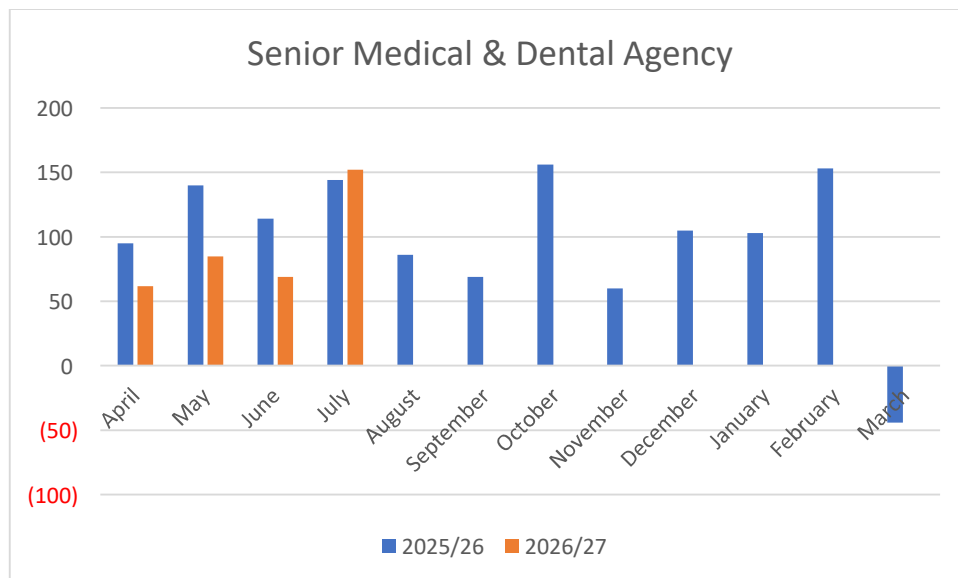
Other areas

The most significant risk to the Board's overall financial position is achievement of the savings target. Addressing the gap between the plan and those schemes in implementation must be a key organisational priority to ensure the financial plan outturn is achieved and to meet the conditions of the Transitional Funding Support agreement.

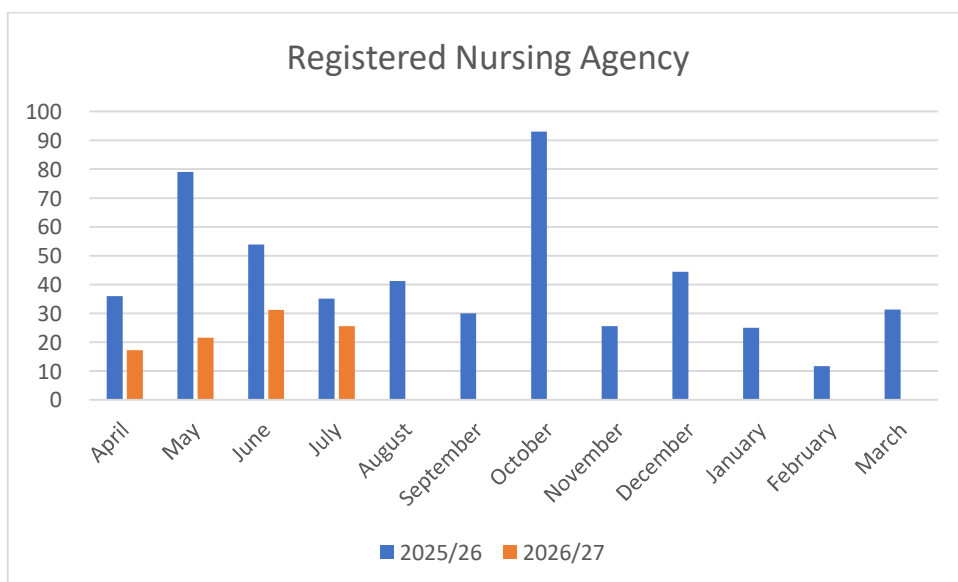
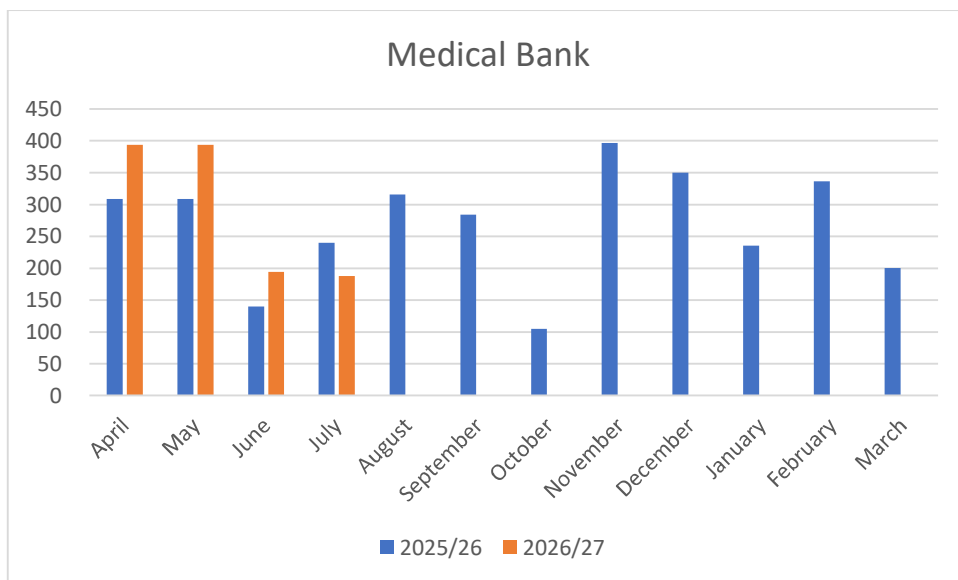
Key Costs - Spend

Pay

Agency costs continue to be a significant area of concern for the Board, with some reductions being seen in 2025/26 and into 2026/27 in AHPs and Healthcare Sciences. Community Nursing and Senior Medical, however, continue to rely on agency and usage remains high for the first 4 month of 2026/27:



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Directorate	Category	Average WTE	Current WTE	Variance
Acute Services Directorate	Medical & Dental	33.70	29.49	-4.21
	Nursing & Midwifery	156.41	152.59	-3.82
	Other Staff	42.23	42.87	0.64
Acute Services Directorate		232.34	224.95	-7.39

Chief Executive Directorate	Medical & Dental	2.00	2.00	
	Nursing & Midwifery			
	Other Staff	25.11	23.10	-2.01
Chief Executive Directorate		27.11	25.10	-2.01

Chief Officer Integration Board	Medical & Dental	19.46	23.83	4.38
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	Nursing & Midwifery	77.46	76.60	-0.86
	Other Staff	103.55	105.90	2.36
Chief Officer Integration Board		200.46	206.33	5.87

	Medical & Dental			
Directorate of Human Resources	Nursing & Midwifery	1.23	1.10	-0.13
	Other Staff	15.69	15.67	-0.02
Directorate of Human Resources		16.92	16.77	-0.15

	Medical & Dental			
Finance Directorate	Nursing & Midwifery			
	Other Staff	119.83	121.07	1.24
Finance Directorate		119.83	121.07	1.24

	Medical & Dental	3.81	2.60	-1.21
Medical Directorate	Nursing & Midwifery	0.75		-0.75
	Other Staff	38.12	37.71	-0.41
Medical Directorate		42.68	40.31	-2.37

	Nursing & Midwifery			
Performance And Transformation	Other Staff	30.96	31.50	0.54
Performance And Transformation		30.96	31.50	0.54

	Medical & Dental	1.03	1.00	-0.03
Public Health Directorate	Nursing & Midwifery	1.01	1.00	-0.00
	Other Staff	12.30	12.28	-0.02
Public Health Directorate		14.34	14.28	-0.06

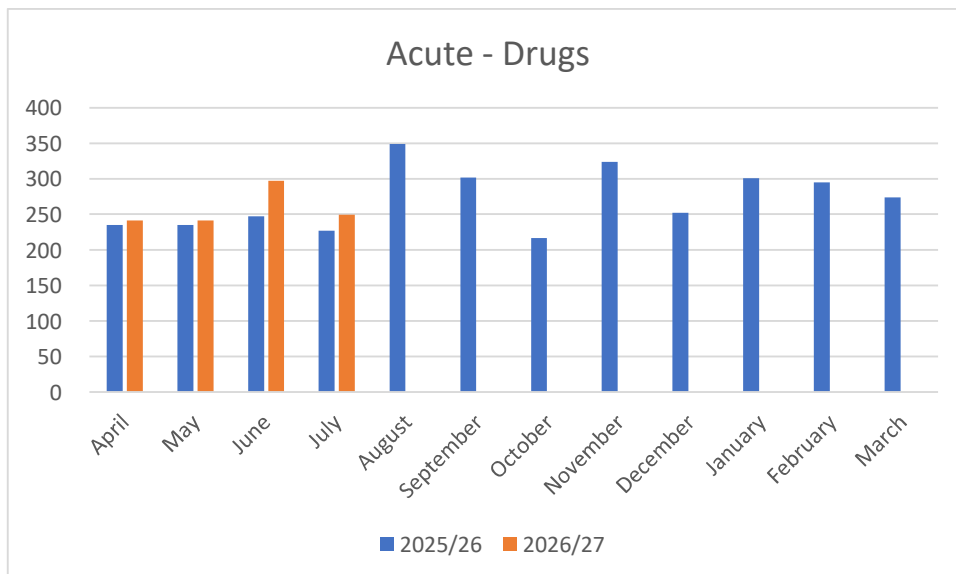
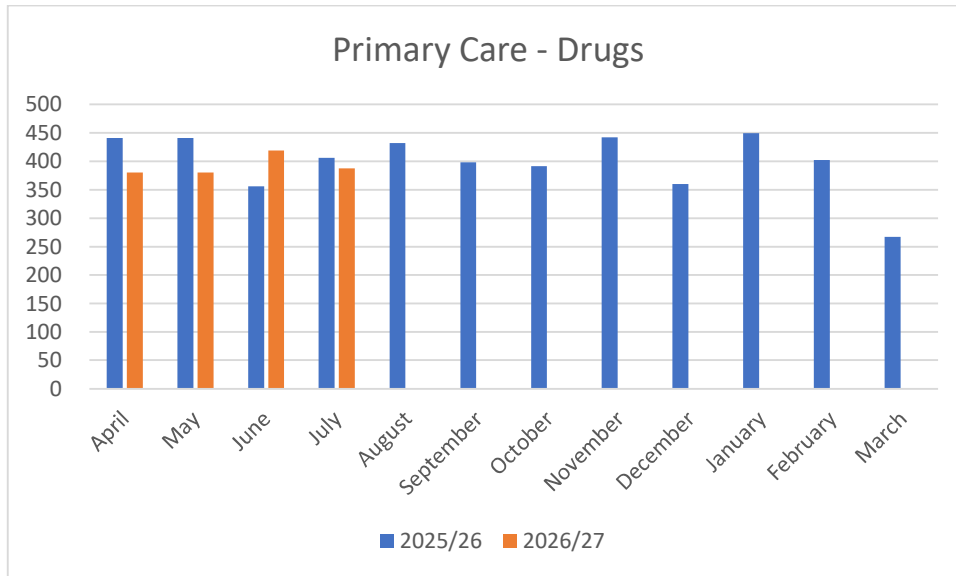
	Sum:	684.63	680.31	-4.31
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Non-Pay

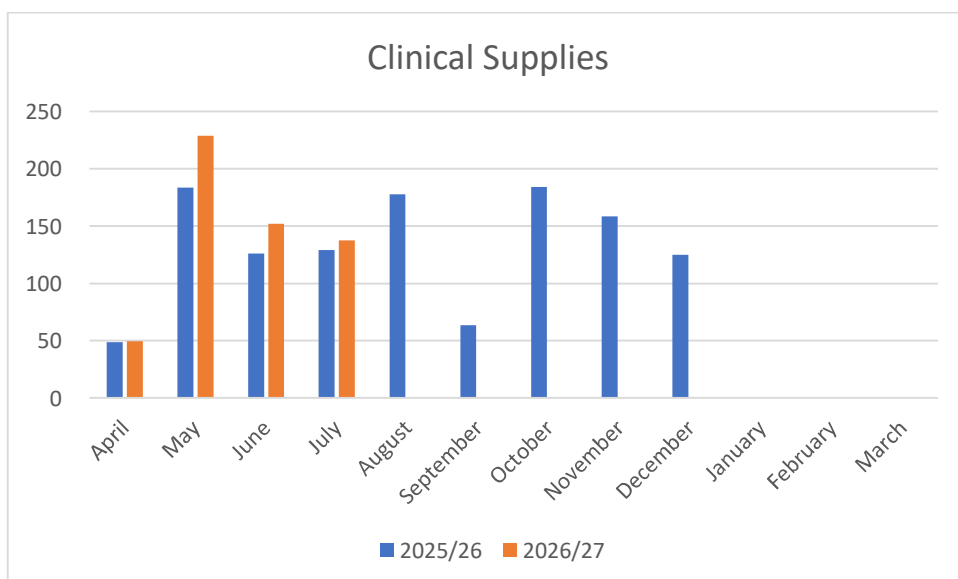
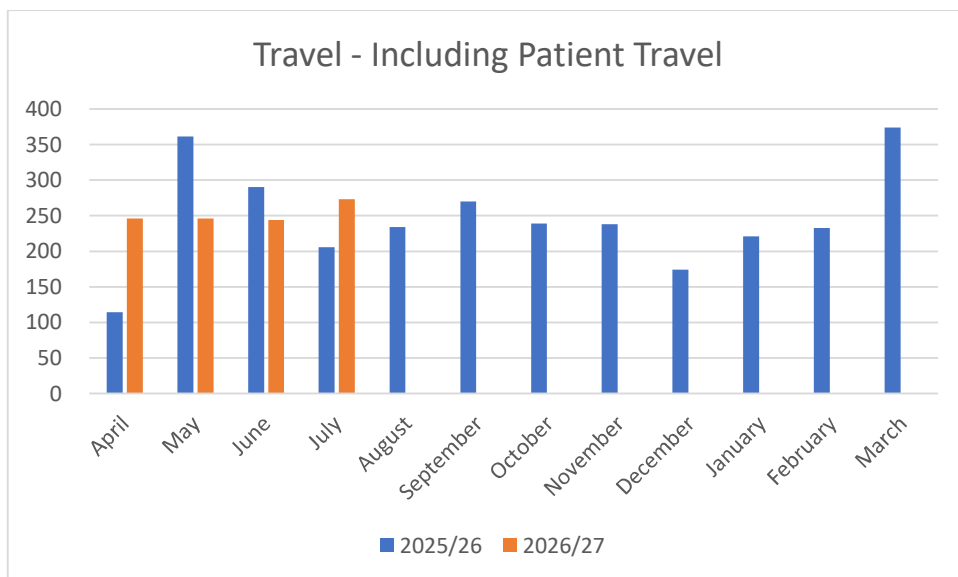
There are several high-spending non-pay areas that are monitored through the Improvement Programme for 2026/27 with targeted work via the Procurement, Diagnostics, Outpatient and Pharmacy Workstreams. There has been a reduction in spend across Primary Care Drugs compared with the same period last year. The key area of variance is other expenditure which is made up of £1.802m. Costs on this line

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including estate management fees and payments to OIC. The variance represents the need to reduce expenditure to stay within our income target.



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Capital

The Capital formula allocation for 2026/27 in the financial plan is £1.078m.

Capital Projects		Total Approved Budget	YTD Actual	Forecast Remaining Expenditure	Variance	Notes
		£'000	£'000	£'000	£'000	
Formula Capital Projects		1,078	97	981	0	
Earmarked Allocations	NIB Funding	0	0	0	0	
Unallocated Budget		0	0	0	0	

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Transfer to Revenue		0	0	0	0	
Capital Receipts						
Total		1,078	97	981	0	

Conclusion and Next Steps

The year-to-date financial position after the first 4 months of the 2026/27 financial year shows an adverse variance to plan, with a reported deficit of **£1.308m**, against the trajectory overspend of **£1.617m**, giving an overall favourable variance of **£0.309m** at the end of the reporting period.

The Board remains focused delivering its financial plan and returning to financial balance in a short a timescale as possible.

The significant work undertaken to review all schemes within the Improvement Programme and development of a robust expenditure forecast has highlighted that cash releasing savings of **£3.009m** will be delivered in this financial year.

Reduction of the run rate will be essential to achieving the planned year-end deficit of £2.400m and the Board is reviewing options to achieve that.

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Appendix 1 –Performance summary

Acute Services - £0.043m overspend

- *Hospital Medical Staff, £0.081m underspend*

Spend within Hospital Medical Staffing remains high however the agency spend to date is down compared to last year.

- *Ambulatory Nurse Manager, £0.015m overspend*

The main increase in costs in the first 4 months relates to Theatres (£18k) and is due to the cost of surgical supplies.

- *Clinical Nurse Manager, £0.048m overspend*

Inpatients 1 (£12k over), MacMillan Inpatient (£25k over) and ED (£33k over) are all reporting overspends compared to 2025/26 which is partly due to Band 6 arrears which will need to be dealt with.

- *Women's Health £0.035m overspend*

The main area of overspend is the Maternity Ward (£35k over) and most of it can be attributed to filling vacancies from 2025/26.

- *Laboratories, £0.067m overspend*

Laboratories increase in spend is mainly due to higher-than-average supplies costs related to the managed service contract.

Medical Director - £0.093m underspend

- *Pharmacy, £0.051m overspend*

The increase in Hospital Drug prices in 2026/27 as the estimate in the original Financial Plan at the start of the year which is the reason for the underspend to date. These costs are variable in nature and will be monitored as year progresses.

- *Radiology & Audiology £0.058m Overspend*

There is an overspend against Radiology pay which is mainly due to the use of Agency staff.

- *Head of Assurance and Improvement £0.186m underspend*

There is an underspend on Waiting Times (£179k) due to additional baseline funding. Work is being done to review the planned expenditure for 2026/27.

- *External Commissioning, £0.001m underspend*

External Commissioning including SLAs and visiting specialist has a combination of over and underspending areas. There is a need to review current SLA usage against charges which are based on a 2-3 average.

- *Unplanned Activity £0.003m overspend*

Unplanned Activity is variable by nature and is subject to significant potential movement from year to year.

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IJB – Delegated Services - £0.170m overspend

- *Community Nursing £0.087m overspend*

This is mainly due to the recruitment to vacancies with the East (£65k) and West (£17k) Nursing Teams.

- *Primary Care, £0.103m overspend*

This is mainly due to the use of locums to cover GP vacancies

- *Specialist Nurses £0.057m overspend*

The is mainly due to locum costs in Out of Hours (£38k) and Medical Equipment in Diabetes (£19k).

- *Health and Community Care, £0.092m overspend*

Mental Health Services has an increase in spend of £114k to non-recurring income that was received in 2025/26.

- *Primary Care Prescribing, £0.159m underspend*

The Prescribing Unified budget is showing an underspend of £122k. This is a volatile cost area and will continue to be closely monitored along with the accrual assumptions which are based on payments made 2-months in arrears. There is also an underspend on Vaccs & Imms (£36k) but that is due to the timing of the expenditure normally occurring over the winter months due to influenza.

Finance & IT - £0.653m overspend

Central target of £650K set to achieve efficiencies and offset risk of non-delivery of corporate schemes.

Focus on vacancy and grip and control measures.

Estates and Facilities - £0.356m overspend

The reason for the overspend is mainly due to an under accrual for oil in 2025/26 due to issues with invoicing from the supplier resulting in a YTD over spend of £186k. There is also a YTD overspend against rates and insurance of £68k, Catering £28k, Domestic £30k and Switchboard £26k. Further work will need to be done to investigate whether this is down to timing of expenditure or other cost pressures.

Chief Executive - £0.105m overspend

The increase in cost is the result of interim cover.

Public Health - £0.024m overspend

Overspend is mainly due to the cost of Public Health Consultant cover.

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Human Resources - £0.016m overspend

The increase in costs is down to an increase in external non-pay recruitment costs.

Performance and Transformation - £0.035m overspend

The increase in cost is the result of increased staffing costs.



Minute Audit and Risk Committee Tuesday 26 May 2026

Attendance

Rachel Ratter (Senior Corporate Governance Officer), Damian Reid (Interim Director of Finance), Suzanne Gray (Senior Financial Accountant), Issy Grieve (Non-Executive Board Member), Dr Anna Lamont (Medical Director), Ryan McLaughlin (Non-Executive Board Member/Employee Director), Tammy Sharp (Director of Performance, Transformation and Deputy CEO), Jason Taylor (Non-Executive Board Member – Chair), Debs Crohn (Head of Corporate Governance), James Goodyear (Interim Chief Executive), Rona Gold (Non-Executive Board Member).

Guests: Iain Gray, Information Governance Manager, David Miller, Resilience Officer

1. Cover page (Presenter: Chair)

To support the Board in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge.

2. Apologies (Presenter: Chair)

The Chair opened the meeting at 09.30 and welcomed members to the meeting.

Apologies were received from Kat Jenkin (Head of Patient Safety, Quality and Risk).

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

3. Declaration of Interest (Presenter: Chair)

There were no declarations of interest raised.

4. Minutes of meeting held 3 March 2026 (Presenter: Chair)

The Chair presented the minutes of Audit and Risk Committee meeting held on 3 March 2026.

Decision / Conclusion

The minutes of the Audit and Risk Committee were approved as an accurate record of the meeting.

4.1 Chairs Assurance Report from meeting on 3 March 2026 (Presenter: Chair)

The Chair presented the Chair's Assurance report from the meeting held on 3 March 2026.

Decision / Conclusion

The committee took assurance on the report.

5. ACTION LOG (Presenter: Chair)

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

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

The Medical Director presented the Corporate Risk and Assurance Report.

The committee were advised that there was one additional risk for the quarter in relation to the facilities maintenance contract, which had been reviewed at the Risk Management Group on 20 May 2026.

The Medical Director informed members risk descriptions and text would be presented as a summary update to provide a strengthened and concise overview.

The Chair acknowledged that, prompted through various committees, a general review of risks was being undertaken to ensure they remained relevant for 2026/27.

R Gold noted a trend throughout the risk register whereby not all risks had action updates against the risk. Members were reassured that certain risks had been re-written and all risks would include further clarification moving forward.

Decision / Conclusion

The Committee noted and took assurance on the management of the Corporate Risk Register, acknowledging the progress on operational risk management arrangements.

6.1 Emergency Planning Update (Presenter: Director of Public Health)

The Director of Public Health presented the Emergency Planning update, relating to Risk 233.

Progress on Exercise Foreland actions had been slower than anticipated due to staff absence and members were advised the live play exercise should have read 23 June 2025.

R Gold requested clarification regarding the action that had taken place regarding leadership training. The Director of Public Health advised that the training offered during quarter 3 was around general principles and training with partners in relation to emergency planning was aimed primarily at Gold Commander level. It had been identified that e-learning in terms of integrated emergency planning principles in general and the Jessup principles were again aimed at Gold Commander level and potentially the Senior Leadership Team cohort.

Members were also advised that the progress of the learning outcomes in relation to integrated emergency planning principles, work had taken place with the Resilience Officer to provide a time plan.

It was agreed the Director of Public Health would arrange Emergency Planning training for Executives, confirmation would be provided at the 1 December 2026 Audit and Risk committee meeting.

The Interim Chief Executive highlighted the requirement for a clear organisational view of the required level of competence and training support for staff.

Decision / Conclusion

The Committee took assurance on the report.

6.2 Risk Management Group Chairs Assurance Reports (Presenter: Head of Patient Safety, Quality and Risk)

The Medical Director presented the Risk Management Group Chair's Assurance Reports.

The Medical Director and Interim Director of Finance provided assurance on the new risk related to the Robertson contract, detailing mitigations such as fire damper checks, water tank replacement and improved defect management, with ongoing oversight by the Finance and Performance committee.

It was agreed a 6 monthly update would be brought to the 1 December 2026 Audit and Risk Committee meeting following the changes to the Risk Management Group.

Decision / Conclusion

The Committee noted the Chair's Assurance Reports from the Risk Management Group.

6.3 Senior Leadership Team Chair's Assurance Report (Presenter: Interim CEO)

The Interim CEO presented the Senior Leadership Team Chair's Assurance Reports from the meetings held on 1 April and 5 May 2026.

Due to the change in Risk Management processes, it was agreed the Senior Leadership Team Chair's Assurance reports would be submitted to the Audit and Risk committee for noting only.

Decision / Conclusion

The Committee noted the Chair's Assurance Reports from the Senior Leadership Team meeting.

7. AUDIT AND RISK COMMITTEE ANNUAL REPORT 2025/26 (Presenter: Chair)

The Chair presented the Audit and Risk Committee Annual Report 2025/26 for approval.

R Gold thanked the Chair for the informative report and suggested the word reform should not have a capital to not confuse with a political party. She also queried when it was predicted for half of Orkneys population to be over 65 as referenced in the report.

Decision/Conclusion

Committee approved the Audit and Risk Committee Annual Report 2025/26.

8. STRATEGIC – PERFORMANCE

8.1 Draft NHS Orkney Annual Report and Accounts for year ended 31 March 2026 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Draft NHS Orkney Annual Report and Accounts for year ended 31 March 2026 confirming statutory duties had been met with deficit support funds and highlighted the challenge of achieving financial sustainability over the next three years.

Decision / Conclusion

The Committee took assurance on the report.

8.2 Draft Audit and Risk Committee Governance Assurance Statement 2025/26 (Presenter: Chair)

The Chair presented the draft Audit and Risk Committee Governance Assurance Statement 2025/26.

Decision / Conclusion

The Committee took assurance on the Audit and Risk Committee Governance Assurance Statement 2025/26.

8.3 Draft Directors Subsidiary Assurance Statement and Internal Control Self-assessment 2025/26 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Draft Directors Subsidiary Assurance Statement and Internal Control Self-assessment 2025/26 for assurance.

The Chair noted the duplication of the statement provided by the Director of People and Culture.

Decision / Conclusion

The Committee took assurance on the Draft Directors Subsidiary Assurance Statement and Internal Control Self-assessment 2025/26.

8.4 Orkney Health Board Endowment Funds Sub Committee Annual Governance Statement 2025/26 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Orkney Health Board Endowment Funds Sub Committee Annual Governance Statement 2025/26.

Decision / Conclusion

The Committee took assurance on the Orkney Health Board Endowment Funds Sub Committee Annual Governance Statement 2025/26.

8.5 Governance Committee Annual Reports 2025-2026 2025/26 (Presenter: Chair)

The Chair presented the Board's Governance Committee Annual Reports 2025/26.

Decision / Conclusion

The Committee approved the following Annual Reports for inclusion in the Annual Report 2025/26

- Area Clinical Forum Annual Report 2025/26
- Area Partnership Forum Report 2025/26
- Finance and Performance Committee Annual Report - 2025/26
- Joint Clinical and Care Governance Committee - Annual Report 2025/26
- Remuneration Committee Annual Report 2025/26
- Staff Governance Committee Annual Report 2025/26

9. STRATEGIC OBJECTIVE – PLACE

9.1 Internal Audit

9.1.1 Internal Audit Quarter 4 progress report and tracker (Internal Auditor, Director of Performance and Transformation)

The Information Governance Manager presented the Internal Audit Recommendations Quarter 4 progress report and tracker, advising most actions from earlier audit years were complete or nearing completion, with remaining gaps largely due to external dependencies and wider improvement programmes, creating limited but continued risk.

Members were advised 2025/26 audits were underway with early progress in Information Governance, though full assurance was constrained by outstanding reports and the need for more consistent action tracking and timelines.

It was confirmed that there would be additional administrative support in place from July 2026.

Decision / Conclusion

The Committee took assurance on the Internal Audit Recommendations Quarter 4 progress report and tracker.

9.1.2 Health and Safety – Implementation Internal Audit Report (Internal Auditor)

The Internal Auditor presented the Health and Safety implementation Internal Audit Report which identified both good practices and areas for improvement, particularly in policy management, training, and cultural aspects of safety management.

The Chair welcomed the in-depth audit and acknowledged the usefulness of the extra time committed to the audit, as compared to previous years.

The Committee welcomed the Health and Safety – Implementation Internal Audit Report noting additional work was required with the Senior Leadership Team in relation to culture and ownership.

It was agreed the Head of Corporate Governance would share H&S Implementation Internal Audit Report with the Staff Governance Committee for cross Committee assurance. The Interim CEO committed to leading a workshop with Senior Leadership Team with an update brought to 1 September 2026 Committee meeting.

Decision / Conclusion

The Committee took assurance on the Health and Safety implementation Internal Audit Report.

9.1.3 Internal Audit Progress report 2025/26 (Internal Auditor)

The Internal Auditor presented the Internal Audit progress report 2025/26 which provided a summary of internal audit activity since the last meeting, confirming the completion of the 2025/26 plan.

Decision / Conclusion

The Committee took assurance on the Internal Audit progress report 2025/26.

9.1.4 NHS Orkney Internal Annual Audit Report 2025/26 (Internal Auditor)

The Internal Auditor presented the Internal Audit Report 2025/26 advising that the audit opinion was that NHS Orkney had a framework of governance, risk management and controls that provided reasonable assurance regarding the effective and efficient achievement of objectives, except in relation to aspects of payroll.

The Interim Director of Finance advised there had been a review of the payroll Service Level Agreement (SLA) with Grampain and discussed a number of controls that would be introduced to ensure more oversight and proactive involvement.

Members were advised Azets had undertaken a portfolio refresh, Stephanie Hume would replace David Eardley and Rachel King would continue.

The Chair thanked David for all his work over the years.

Decision / Conclusion

The Committee approved the report for onward submission to the Board.

9.2 External Audit

9.2.1 External Audit Plan 2025/26 (External Auditor)

The External Auditor presented the External Audit Plan 2025/26 outlining significant risks including fraudulent expenditure recognition and management override of controls, and discussed the focus on financial management and sustainability, with no specific concerns identified for NHS Orkney beyond sector norms.

Decision / Conclusion

The Committee took assurance on the External Audit Plan 2025/26.

10. STRATEGIC OBJECTIVE – PLACE – No papers to be presented

11. ITEMS TO BE INCLUDED ON THE CHAIR'S ASSURANCE REPORT (Presenter: Chair)

No risk or matters of concern to be escalated to the Board.

A discussion was held at the end of the meeting to agree major actions commissioned or underway, decisions and positive assurance to be included in the Chair's Assurance Report.

12. ANY OTHER COMPETENT BUSINESS (Presenter: Chair)

13. ITEMS FOR INFORMATION AND NOTING ONLY (Presenter: Chair)

13.1 National Audit Reports - no reports presented

13.2 Record of Attendance 2026/27

Decision / Conclusion

The Committee noted the Record of Attendance 2026/27

13.3 Reporting timetable 2026/27

Decision / Conclusion

The Committee noted the Reporting timetable 2026/27

The Chair closed the meeting at 11:10am

Orkney NHS Board

Minute of meeting of **Area Clinical Forum** of **Orkney NHS Board** held on
Wednesday, 04 February 2026 at 12:15 via MS Teams

Present:

- Dr. Kirsty Cole – Chair
- Nick Crohn – Radiology Manager / Vice Chair ACF
- Lynn Adams – NAMAC Representative
- Ellen Kesterton – Quality Improvement Lead / NAMAC Representative
- Rona Harcus – Allied Health Professional Lead / TRADAC Chair
- Kirsty Jones – TRADAC Representative
- Lyndsay Steel – Practice Pharmacist / APC Chair
- Samantha Thomas – Executive Director of Nursing, Midwifery, Allied Health Professions, and Chief Officer of Acute Services

In Attendance:

1 Apologies

The Chair welcomed members to the meeting and confirmed that it would focus primarily on Chairs' Assurance Reports and the review of actions and escalations due to a relatively light agenda and reduced corporate governance capacity during the reporting period.

The Chair acknowledged attendee participation and informally confirmed attendance at the outset of the meeting. It was noted that no formal apologies had been received in advance of the meeting, and Committee Support confirmed that there were no additional apologies to record at the time of discussion.

No issues were raised regarding quorum, and the meeting proceeded on the basis that sufficient representation was present to enable discussion and assurance to be provided in line with the Forum's remit.

NOTED:

- The Chair welcomed attendees and confirmed the purpose and focus of the meeting.
- No formal apologies had been received or recorded at the start of the meeting.

2 Declarations of Interests - Agenda Items

No declarations of interest were raised regarding agenda items.

3 Minute of the Meeting held on 04 February 2026

Members confirmed that the minute was an accurate reflection of the discussions and decisions taken at the previous meeting. No substantive amendments were requested.

The minute was **APPROVED** as an accurate record.

4 Matters Arising

No matters arising were brought to attention at the meeting.

5 Action Log

The Action Log was reviewed and updated accordingly.

6 Log of Escalated Items

The Log of Escalated Items was reviewed and updated accordingly.

7 Professional Advisory Committees

7.1 Area Dental Committee (ADC)

An update was provided on ongoing efforts to re-establish the Area Dental Committee. It was reported that progress continued to be challenging, with active engagement taking place with independent contractor dental practices to identify a sustainable structure and approach.

It was confirmed that relevant clinical leads were working collaboratively to progress this work, and further updates would be brought to the Forum as developments emerge.

Members acknowledged the importance of re-establishing the Committee to strengthen governance and clinical input within dental services.

7.2 Area Pharmacy Committee (APC)

The Committee received a positive assurance report regarding the Area Pharmacy Committee. Significant improvements in attendance were highlighted, attributed to the introduction of hybrid meetings and structured educational sessions.

It was noted that recent sessions had included external contributions focusing on topics such as artificial intelligence in medication safety and digital prescribing pathways. Future sessions were planned, including areas such as sleep hygiene and clinical care pathways.

Members welcomed the enhanced engagement and recognised the Committee's role in driving quality improvement and shared learning.

7.3 GP Sub Committee

Discussion relating to general practice was incorporated across several agenda areas. It was noted that general practice continued to experience system pressures, including workload challenges and the impact of broader organisational issues such as accommodation shortages.

Members discussed the importance of improving understanding of the current GP working environment, with proposals brought forward for a future development session to include a "day in the life" perspective to increase awareness across sectors.

This was considered an important step in strengthening cross-sector understanding and collaboration.

7.4 Hospital Sub Committee

No standalone Hospital Sub Committee report was formally presented; however, hospital-related pressures were reflected in wider discussions, particularly in relation to clinical services and workforce challenges.

It was noted that ongoing work within clinical services remained sensitive, with communications being managed incrementally to ensure appropriate engagement prior to wider dissemination.

Members acknowledged the need for careful handling of communication and ongoing assurance through governance routes.

7.5 NAMAC

An update was provided on the Non-Medical Acute Care Committee (NAMAC), with assurance given on progress relating to welfare proxies under Section 47. It was reported that compliance had improved, although concerns remained regarding staffing approaches and their sustainability.

It was further noted that accommodation challenges were impacting workforce stability, and the Committee proposed closer alignment with TRADAC to strengthen advocacy on these issues.

The Forum recognised the progress made while noting the continued risks associated with workforce pressures.

7.6 TRADAC

The Therapies and Rehabilitation Advisory Committee (TRADAC) reported ongoing workforce challenges across multiple disciplines, including radiology, occupational therapy, dietetics, and speech and language therapy. Recruitment delays and staffing shortages continued to present risks to service delivery.

Positive assurance was provided regarding interim leadership arrangements within allied health professional services, with continued monitoring of key roles and funding streams.

Members acknowledged both the ongoing risks and the mitigations in place, noting the importance of sustained oversight.

7.7 Area Drugs & Therapeutics Committee

Discussion highlighted ongoing work within the Area Drugs & Therapeutics Committee, particularly in relation to private prescribing and improving public communication.

It was reported that further work was required to ensure safe and appropriate messaging regarding access to private healthcare and prescriptions, including legal and indemnity considerations. The topic would be escalated to a future ADTC meeting for further discussion.

Additional opportunities for collaboration were identified, including proposals for pharmacy-led presentations to other committees to improve awareness of medication assessment and referral pathways.

8 Chairs Reports

8.1 Board

It was confirmed that key issues discussed at the Forum, particularly accommodation challenges and workforce pressures, were recognised at Board level.

Members noted that housing constraints continued to have a direct impact on recruitment and retention, including delays to appointments and challenges in sustaining staffing across services.

The Forum acknowledged the importance of continued escalation and alignment with Board priorities.

8.2 ACF Chairs Group

The Committee was advised of ongoing discussions within the ACF Chairs Group, including alignment of priorities across committees and sharing of emerging risks and pressures.

Members noted the value of this forum in strengthening coordination and ensuring consistent escalation of key issues across governance structures.

8.3 ACF to Board - Chairs Assurance Report

It was confirmed that the Chairs' Assurance Report from the Area Clinical Forum to the Board would reflect the key risks, assurances, and areas of progress discussed during the meeting.

Particular emphasis would be placed on:

- Workforce and accommodation challenges
- Ongoing service pressures across clinical and therapy services
- Positive developments within committee functioning and engagement

The importance of clearly articulating both risks and assurances to support Board oversight and decision-making was highlighted.

Items for Discussion

9 Governance

9.1 Area Clinical Forum Annual Report

The Chair introduced the Area Clinical Forum Annual Report for consideration, outlining its role in providing a comprehensive overview of the Forum's activity, assurances, and key issues over the reporting period.

It was confirmed that the Annual Report aimed to reflect the breadth of work undertaken across the Forum and its sub-committees, including areas of progress, continuing risks, and key themes requiring Board oversight. Members noted that the report would form an important component of the organisation's wider governance and assurance framework.

Discussion highlighted that the content of the report should align with themes raised throughout the year, including workforce pressures, accommodation challenges, service delivery risks, and improvements in committee engagement and functioning.

Members emphasised the importance of ensuring that both quantitative and qualitative assurance was clearly articulated, alongside any areas of concern.

It was further noted that the report should accurately capture the balance between positive developments—such as improved attendance and engagement within committees—and ongoing systemic challenges impacting service sustainability. The need for clarity, consistency, and alignment with Board expectations was reinforced. In accordance with governance guidance, members recognised the importance of ensuring that the report clearly distinguishes between assurances provided, risks identified, and decisions taken, to support effective scrutiny at Board level.

The Forum supported the development and progression of the Annual Report, subject to finalisation and submission through appropriate governance routes.

10 Policies & Procedures

10.1 No items were raised or submitted

11 Development Sessions

11.1 Members agreed that the session would focus on medicines management, with input from pharmacy colleagues to provide insight into prescribing practices, medication processes, and system pressures. It was recognised that this would support broader clinical understanding and improve cross-sector collaboration.

In addition, a proposal was supported to include a “day in the life” presentation from general practice, aimed at increasing awareness of the current working environment within GP services, particularly in light of changes since the COVID-19 pandemic.

The Forum noted that both elements would provide valuable learning opportunities for clinical staff across disciplines and would contribute to improved system-wide understanding.

It was confirmed that the session would be advertised through internal communications channels, and members would be encouraged to cascade details within their respective teams to maximise attendance and engagement.

AGREED

12 Any Other Competent Business

Concerns were raised regarding the lack of representation from the Area Clinical Forum and Allied Health Professionals at a recent Chief Executive stakeholder event. Members noted inconsistency in the invitation process, with some attendees invited in individual capacities rather than as representatives of their respective committees.

It was agreed that clarification would be sought regarding the process for issuing invitations to such events, to ensure appropriate and consistent representation from relevant clinical groups in future. The importance of inclusive engagement and visibility of clinical voices within strategic discussions was emphasised.

13 Items to be brought to the attention of the:

13.1 Board

The Forum considered the key issues requiring escalation to the Board to support strategic oversight and decision-making.

It was agreed that particular attention should be drawn to the ongoing impact of accommodation shortages on recruitment and retention across clinical services, noting the associated risks to service sustainability and workforce stability.

Further escalation was deemed necessary in relation to:

- Persistent workforce pressures across multiple clinical areas, including therapy services and general practice
- Ongoing challenges in service delivery linked to staffing constraints and system pressures
- Communication and safety concerns relating to Emergency Department discharge processes, particularly the completeness and timeliness of discharge information

Members also agreed that positive assurance should be provided to the Board regarding improvements in committee engagement and attendance, particularly within the Area Pharmacy Committee, as well as ongoing collaborative efforts to address cross-system challenges.

AGREED

13.2 Governance Committees

The Forum identified several areas requiring further consideration or oversight by relevant governance committees.

It was agreed that issues relating to prescribing, including private healthcare access and communication, should be progressed through the Area Drugs & Therapeutics Committee for further review and guidance.

Concerns regarding medication-related communication, particularly in relation to Emergency Department discharge processes, were to be shared with appropriate governance groups, including emerging interface arrangements, to support system-wide improvement.

Additionally, workforce and accommodation challenges were recognised as cross-cutting issues requiring coordinated oversight across governance structures, with opportunities for joint working between committees highlighted.

AGREED

14 Items to be Communicated with the Wider Clinical Community

The Forum considered key messages to be communicated to the wider clinical workforce to support awareness, engagement, and shared understanding.

It was agreed that communication should include:

- Details of the upcoming development session, including its focus on medicines management and general practice, to encourage broad clinical participation

- Ongoing work to improve prescribing practices and access to appropriate guidance, including safe use of private healthcare pathways
- Awareness of system pressures, including workforce and accommodation challenges, to promote shared understanding across services
- Opportunities for increased collaboration and learning across committees, including pharmacy-led education and cross-sector engagement

Members noted the importance of using established communication channels, including staff bulletins and committee networks, to ensure consistent and effective dissemination.

AGREED

15 Items to be Escalated

- Matters of Concern or Key Risks to Escalate
 - o Ongoing accommodation shortages across Orkney were identified as a significant strategic risk impacting recruitment and retention across multiple clinical groups, including general practice, AHPs and other services. The issue was noted to be causing delays in staff start dates and service capacity pressures.
 - o Persistent issues with ED discharge communication, particularly incomplete documentation of medication changes and delays in availability of discharge letters, were highlighted as a patient safety concern. These issues continue despite local education efforts and are compounded by system limitations within Track.
 - o Continued difficulty in re-establishing the Area Dental Committee was noted, with reliance on engagement from independent contractor practices presenting an ongoing dependency and risk to governance oversight.
 - o Digital system pressures and engagement challenges with eHealth were raised, with previous attempts at engagement unsuccessful and a need to agree clearer processes and support mechanisms.
- Positive Assurances to Provide
 - o Significant improvement in Area Prescribing Committee (APC) attendance and engagement was reported, attributed to the introduction of hybrid meetings and structured educational sessions.
 - o Positive feedback was provided on educational input and external speakers, including sessions on AI in medicines safety and digital prescribing pathways, supporting wider clinical learning.
 - o Progress was noted in welfare proxy compliance (Section 47), with improving adherence and ongoing work to strengthen processes and training, including enabling appropriately trained nurses to undertake assessments.
 - o Assurance was provided in relation to interim leadership arrangements within AHP services, including oversight of the interim Lead HP role and planned monitoring of the Associate Director and Children's HP posts.
- Major Actions Commissioned / Work Underway

- o The Chair confirmed an intention to write to the Community Planning Partnership to raise accommodation challenges at system level and support a coordinated, cross-sector response.
 - o Work is progressing to establish the AMC interface group, with a focus on improving cross-system communication and addressing issues such as ED discharge processes.
 - o A July development session was commissioned, focusing on:
 - o Medicines management and pharmacy input
 - o A “day in the life” overview of general practice to improve system-wide understanding of primary care pressures
 - o Pharmacy colleagues will provide further guidance and shared advice on private healthcare and prescribing, to improve consistency and communication across services.
 - o Continued work is underway to improve community communication regarding access to private healthcare, with liaison ongoing with Wendy Lycett.
- Decisions Made
 - o It was AGREED that examples of incomplete ED discharge documentation will be collated and used to support escalation through appropriate governance routes, including the interface group.
 - o It was AGREED that accommodation challenges should be escalated beyond NHS structures, including engagement with local authority and national forums.
 - o It was AGREED to progress planning and promotion of the July development session, with broad clinical engagement encouraged.
 - o It was AGREED that concerns regarding stakeholder event representation will be followed up to ensure appropriate ACF and HP inclusion in future events.
 - Comment on Effectiveness of Meeting
 - o The meeting was effective in identifying cross-cutting system risks, particularly accommodation and communication challenges, and in agreeing coordinated actions to address these.
 - o Strong engagement from committee representatives supported clear assurance reporting and identification of improvement actions, particularly in relation to governance interfaces and clinical communication.

16 For Information and Noting

16.1 Correspondence

The Chair confirmed that no issues had been raised through correspondence prior to the meeting. Members noted this position.

16.2 Schedule of Meetings 2026/27

Members reviewed and **NOTED** the attached schedule of meetings for 2026/27. No amendments were proposed.

Item 18.3

Area Partnership Forum Action Note

Title of meeting: Area Partnership Forum (APF)		Date:	19 May 2026
		Time:	14:00
Chair:	James Goodyear		
Executive Support:	Jade Rosie		
Members	Present	Apologies	
James Goodyear (JG), Chief Executive (Joint Chair)	X		
Ryan McLaughlin (RM), Employee Director (Joint Chair)	X		
Stephen Brown (SB), Chief Officer IJB			
John Daniels (JD) Head of Primary Care Services		X	
Lauren Flett (LF), RCM	X		
Tariro Gandiya (TG) – British Medical Association (BMA) representative			
Tony Miller (TM) – UNISON representative		X	
Wilma Brown (WB) – Unison Regional Officer			
Willem Venter, Health & Safety Advisor	X		
Damian Reid – Interim Director of Finance	X		
Anna Lamont (AL), Medical Director	X		
Kath McKinnon, (KM), British Dental Association (BDA)	X		
Caitriana McCallum (CM), British Dietetic Association (BDA)		X	
Margaret MacRae (MM) RCN	X		
Steven Phillips (SP), Head of People and Culture	X		
Yvonne Stewart, (YS), Society of Radiographers (SOR)			
Sharon Keyes (SK), Head of Facilities & NPD Contract	X		
Samantha Thomas, (ST), Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services	X		
Kate Smith, Society of Radiography Representative			
Amanda Manson, Royal College of Nursing (RCN) Representative	X		
Karen Merriman, UNISON Representative		X	
Dave Harris - Director of People & Culture	X		
Lynn Adam, (LA), Clinical Lead for Workforce		X	
Lorna Major, Royal College of Midwives (RCM) Representative			
Lisa Huggard, Royal College of Midwives (RCM) Representative			

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In Attendance		
Alan Scott, Head of Estates & Property		
Gilbert Gunn, Violence and Aggression Trainer		
Stuart Falconer, RCN		
Debs Crohn, Head of Corporate Governance		X
Mandy Ward, Facilities Manager	X	
Barbara Leslie, Physiotherapist	X	
Michelle Mackie, Deputy Director of Nursing & Midwifery / Lead Midwife	X	

MEL

No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
1.	Cover Page	Chair	AWARENESS	Members noted the purpose and principles of the Area Partnership Forum (APF).
2.	Welcome	Chair	WELCOME	All members were welcomed to the meeting and NOTED as above.
3.	Apologies	Chair	AWARENESS	Apologies were received and NOTED as above. James Goodyear agreed to Chair the meeting in Ryan McLaughlins absence.
4.	Minutes and CAR of meeting held on 21 April 2026.	Chair	DECISION	Members to feedback to Corporate Governance Team any amendments to minutes. Minutes and CAR APPROVED for onward submission to Staff Governance and Board.
5.	Matters arising	Chair	DISCUSSION	No matters arising
6.	Area Partnership Forum Action log	Chair	ASSURANCE	The Action log was updated as per comments.

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No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
CORE BUSINESS				
7.	Chief Executive and Executive Team Updates	Chief Executive	AWARENESS	Members noted updates from the Chief Executive and Executive Team. It was reported that the national policy direction is expected to remain broadly consistent following the Scottish election, with continued focus on reducing waiting times, improving patient flow, and strengthening sub-national planning arrangements. Locally, it was noted that NHS Orkney had made significant progress in reducing long waits for patients, with only a small number remaining above 52 weeks. Updates were also provided on the ongoing implementation of the Health and Care Staffing Act, with emphasis on embedding safe staffing practices and use of workforce systems such as Optima and SafeCare. Progress on equality outcomes and development of a staff equality network was also highlighted.
8.	Staff Side Updates	Staff Side Leads	DISCUSSION	Staff Side representatives raised concerns regarding the impact of public holiday arrangements and the reduced working week on annual leave for certain staff groups. It was agreed that this would be progressed locally with operational managers, with further escalation if required.
ITEMS FOR DISCUSSION OR APPROVAL				
9.	Staff Side Response to 26/27 Financial Plan	Employee Director	DISCUSSION	A discussion was held regarding the Staff Side response to the Financial Plan. Members discussed the need for greater transparency and clarity around workforce data, particularly in relation to establishment levels, staffing costs, and the use of variable staffing. The Executive Team outlined the financial context, including efficiency requirements and the focus on reducing reliance on agency and overtime while maintaining safe staffing levels.

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No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
				It was acknowledged that further work is required to align establishment, workforce data, and financial planning, and to improve the quality and accessibility of data to support partnership working. It was agreed that outputs from this work would be brought back to APF, and a written response to Staff Side would be provided. Action : JG to provide a written response to Staff Side
10.	Workforce Report Review of 2025/26	Head of People & Culture	DISCUSSION	The Workforce Report was presented and noted. Members acknowledged improvements in areas such as training compliance but expressed concern regarding trends in sickness absence, particularly stress, anxiety and depression-related absence. The importance of analysing trends at an organisational level, as well as improving manager capability to support staff wellbeing, was emphasised. It was noted that work is underway to bring together workforce, occupational health, and wellbeing data to better understand these patterns and inform future action.
11.	Draft People Delivery Plan	Director of People & Culture	DISCUSSION	Members were provided with an overview of the development of a People Delivery Plan, intended to bring together key workforce priorities under a single framework. Key areas identified included workforce planning, leadership and management development, staff wellbeing, equality outcomes, and recruitment and retention. Discussion highlighted the importance of strengthening local workforce development, including apprenticeships, placements, and partnerships with local education providers. It was recognised that delivery would require both organisational focus and system-wide collaboration with partners

Item 18.3

No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
12.	Orkney Pride 2026	Employee Director	DISCUSSION	The paper was introduced for discussion, Members raised considerations regarding risk assessment, organisational capacity, and the need to ensure an inclusive approach across all protected characteristics. It was agreed that further work is required before approval, and that comments would be collated and brought back for consideration.
13.	Draft Accommodation Policy	Medical Director	APPROVAL	The draft Accommodation Policy was presented. Members noted that significant feedback had been received and that further revisions were required. It was agreed that comments would be provided directly to the policy author, with a revised draft to be brought back to APF following further development and engagement.
ITEMS FOR NOTING				
14.	AOCB	Chair	DISCUSSION	No additional items of business were raised.
15.	Items to be included in the Chairs Assurance Report to Staff Governance Committee	Chair	DECISION	The Chair noted that the Chair's Assurance Report would be circulated along with the Meeting Pack ahead of the next meeting.
16.	Attendance record 2025/26	Chair	AWARENESS	Attendance record updated as of the 19 May 2026.
17.	Area Partnership Forum Reporting Timetable 2026-27	Chair	AWARENESS	Members noted the Area Partnership Forum Reporting Timetable 2026/27.

Meeting closed at 16:39pm

Item 18.3

** Items marked with an asterisk are for noting only and any queries should be raised out with the meeting with the Committee Support, Chair or Lead Director*

Area Partnership Forum Members:

In Attendance / By Invitation:

Paula Buchan, Regional Officer - UNITE
 John Daniels - Head of Primary Care
 Samantha Thomas - Director of Nursing, Midwifery, AHPs and Acute
 Lauren Flett – Royal College Midwives (RCM)
 Lorna Major – Royal College Midwives (RCM)
 Lisa Huggard - Royal College Midwives (RCM)
 Tariro Gandiya – British Medical Association (BMA)
 Damian Reid, Director of Finance
 Willem Venter, Health and Safety Advisor
 Margret MaCrae – Royal College of Nursing (RCN)
 Amanda Manson - Royal College of Nursing (RCN)
 Catriona McCallum, British Dietetics Association (BDA)
 Kath McKinnon, British Dental Association (BDA)
 Ryan McLaughlin, Employee Director – Joint Chair
 Tony Miller - Unison
 Dave Harris - Director of People and Culture
 Steven Phillips - Head of People and Culture
 James Robertson - Unison
 James Goodyear -Interim Chief Executive – Joint Chair
 Sharon Keyes - Head of Facilities & NPD Contract
 Kate Smith - Society of Radiographers (SoR)
 Karen Merriman – Unison
 Lynn Adam, (LA), Clinical Lead for Workforce
 Wilma Brown – Unison (papers only)
 Karen Davidson - Unison (papers only)
 Yvonne Stewart – Society of Radiographers (SoR) (papers only)

Minute Finance and Performance Committee

Monday 25 May 2026

Attendance

Fiona MacKay (Chair – Non-executive Board Member), Debs Crohn (Head of Corporate Governance), Tammy Sharp (Director of Performance and Transformation), Sam Thomas (Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services), Dave Harris (Director of People and Culture), James Goodyear (Interim Chief Executive), Jason Taylor (Non-Executive Board Member), Mohammed Sohail (Chief Finance Officer – IJB), Damian Reid (Interim Director of Finance), Dr Louise Wilson (Director of Public Health), Dr Anna Lamont (Medical Director), Jean Stevenson (Non-Executive Board Member), Alan Scott (Head of Estates) and Hazel Aim (Senior Corporate Governance Officer – minute).

Guests

Kirsty Francis (Procurement Manager), Chloe Crawford (NPD/Facilities Business Support Officer), David Miller (Resilience Manager) attended for agenda item 10.1.

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Finance and Performance Committee Purpose

To review the financial and non-financial targets of the Board, to ensure appropriate arrangements are in place to deliver against organisational performance measures, to secure economy, efficiency, and effectiveness in the use of all resources, and provide assurance the arrangements are working effectively.

Quorum

Three members present including at least two non-executive Board Members, one of whom must be Chair or Vice-Chair, and one Executive Member.

2. Welcome and Apologies (Presenter: Chair)

The Chair (Fiona MacKay) opened the meeting at 09.30 am and welcomed members.

Apologies received from Dave Harris (Director of People and Culture) and Richard Rae (Head of IT) Sharon Keyes (Head of Facilities and NPD Contract), Ryan McLaughlin (Employee Director) and Stephen Brown (Chief Officer IJB).

Members agreed the meeting was quorate in accordance with the Boards Code of Corporate Governance.

3. Declarations of Interest (Presenter: Chair)

There were no declarations of interest raised.

4. Minute of the Finance and Performance Committee held 29 April 2026 (Presenter: Chair)

The Chair asked for comments on the minutes of the meeting held on 29 April 2026.

Decision/conclusion

Minute of the meetings held on 29 April 2026 were accepted as an accurate record of the meeting and approved subject to amendments discussed.

5. Matters Arising

The Medical Director updated the Committee that the medical staffing papers remain confidential at this stage and that further consideration is being given to how and when staff engagement will take place. An update on the Medical Staffing Workstream will be brought back to Committee 24 June 2026.

Decision/Conclusion

The Committee took assurance from the verbal update.

6. CHAIR'S ASSURANCE REPORT - Finance and Performance Committee Chair's Assurance Report 29 April 2026 (Presenter: Chair)

The Chair presented the Chair's Assurance report of the Finance and Performance Committee meeting held on 29 April 2026 for assurance.

Decision/Conclusion

Committee took assurance on the Chair's Assurance Report from the meeting held 29 April 2026 for onward submission to the Board 25 June 2026.

7. Action Log (Presenter: Head of Corporate Governance)

The Head of Corporate Governance presented the Finance and Performance Committee Action Log 2026/27.

Decision/conclusion

The action log was reviewed, no outstanding issues (see action log for details).

8. Corporate Risks aligned to the Finance and Performance Committee (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Corporate Risks aligned to the Finance and Performance Committee. The Committee noted the continuing risk relating to financial performance and year-end delivery, with the current position being worse than predicted but in line with the deficit support funding awarded from Scottish Government.

Members noted that once the month 2 position is confirmed this will provide a clearer basis for further discussions.

The risk relating to the Robertsons Facilities Management contract was discussed, including ongoing defects and the need for continued monitoring. The Committee received assurance that a team from mainland Scotland have inspected approximately one third of the fire dampers to date and that regular updates on progress and risk management would be brought back to Committee.

Members discussed capacity pressures in social care and noted that, although there has been some recent improvements, the risk remained relevant. A verbal update was provided by the EDoNMAHP in relation to Delayed Transfers of Care (DTOCs); since the report was produced there has been a reduction from 16 to 8 DTOCS, noting that this remains above the target level of 4 patients.

The financial sustainability risk was discussed, it was agreed that the Interim Director of Finance to bring an update to Committee June 2026 in relation to reviewing the wording and score of the Financial Sustainability risk in 2026/27.

Decision/conclusion

The Committee took assurance on the progress and mitigations presented in relation to the latest Corporate Risk Register.

9. Month 12 Financial Results on Improving Together Programme Update (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Month 12 financial results and Improving Together Programme update.

Committee noted that the year-end position was largely finalised, with a deficit of £3.92 million, which was slightly better than the deficit support funding position but adverse to the original budget. Members heard that savings of £2.088 million had been delivered, although this remained below the original plan.

Committee noted some improvements in Service Level Agreement (SLA) expenditure in month 12, including lower than expected costs in relation to the mental health SLA with NHS Grampian.

Ongoing financial pressures were highlighted in relation to agency costs, medical staffing and prescribing, with some of these areas now reflected within the efficiency plan.

An underspend against the capital plan was also noted following the agreed transfer of £0.5 million to revenue.

In discussion, Members considered workforce growth and the challenge of reconciling approved establishment levels with what is affordable within the funding available.

It was noted that NHS Scotland would set out the criteria for financial de-escalation in quarter 4, and that work was underway to align budgets, staffing establishments and benchmarking information to support a more sustainable staffing model and reduce reliance on agency expenditure. Concern was raised regarding the lack of business cases for some additional posts and the Committee agreed this remained an area requiring close scrutiny.

The Committee also discussed specific overspends, including theatres and patient travel. It was noted that theatre overspends were linked in part to agency staffing, long-term sickness absence and maternity cover, with an expectation that this would improve as substantive recruitment took effect.

In relation to patient travel, Members heard that although use of Near Me had reduced the number of journeys, the cost of travel had increased significantly, including higher air fares, with these increases falling directly to the Board. It was noted that work is underway to improve the capture and forecasting of patient travel costs, while recognising that average journey costs may continue to rise due to greater escort needs and higher patient acuity an update will be brought back to Committee in July 2026.

Decision/Conclusion

The Committee took assurance on the Month 12 financial results and the Improving Together Programme update.

10. STRATEGIC OBJECTIVE – PLACE**10.1. Integrated Emergency Planning Update (Presenter: Director of Public Health)**

The Director of Public Health presented the Integrated Emergency Planning update and the Resilience Manager attended for this item.

The Committee noted a correction to paragraph 3.1 of the report, which should refer to “the live play exercise held on 23 June 2025.”

The Director of Public Health advised that progress in taking forward lessons learned had been slower than intended due to staff absence.

Members heard that the phone escalation process was being reviewed, that work was ongoing to strengthen leadership support for emergency planning, and that further work had also been undertaken in relation to fuel preparedness in response to Scottish Government requirements. It was noted that reactive work arising from winter issues, including those associated with the subsea cable, had affected progress on some planned actions.

In discussion, the Interim Chief Executive welcomed the paper and highlighted the need to put in place executive director on-call training as a priority. The Director of Public Health advised that e-learning had been identified and that this would be reviewed to determine whether it was sufficiently comprehensive, with the matter to be discussed further at the Executive Team meeting.

The Chair noted the challenge of maintaining focus on emergency planning alongside day-to-day operational pressures and emphasised the importance of ensuring that senior managers remain clear about their responsibilities, particularly where there have been staffing changes.

Decision/conclusion

The Committee took assurance on the Integrated Emergency Planning update.

11. PATIENT SAFETY, QUALITY AND EXPERIENCE

11.1. Transformational Priorities Highlight Reports (Presenter: Director of Performance and Transformation)

The Director of Performance and Transformation presented the Transformational Priorities Highlight Reports covering four workstreams: GP Out of Hours, Redesign of Isles Care, Older Persons and Frailty, and Medical Staffing.

Medical Staffing

The Committee noted that the overall position was reported as on track, although it was recognised that progress to date had been stronger in relation to planning and process development than full implementation.

Members heard that there are two key aspects to the work: reviewing locum pay arrangements, where NHS Orkney is an outlier, and progressing discussion on the future medical staffing model. It was noted that further work was planned to consider how a more sustainable model could be operationalised.

Older Persons and Frailty

The Committee heard that the programme was gathering pace, with good system-wide engagement and a different approach being taken to engagement with the public and clinical teams. Members noted positive feedback on the frailty workstream and the benefit of stronger clinician engagement.

The Committee also heard that data challenges remain, including the need to improve triangulation of information, and that national work on digital maturity may provide helpful support.

Redesign of Isles Care

The Committee noted that there had not yet been significant progress and that lobbying for additional funding had been paused due to the election period.

Members expressed concern given the importance of this workstream to delivery of planned savings. It was noted that the next milestone involved Healthcare Improvement Scotland and that the appropriate lead had committed to training by the end of June. The Committee asked that the feedback also be relayed to the Integration Joint Board.

GP Out of Hours

The Committee heard that although the report recorded the workstream as off track, progress was being made and much of the current work related to understanding unintended consequences and refining the model. Further discussions were planned on the output and proposed model changes, including implications for staffing. Members noted that, despite the overall status, many of the individual actions appeared to be on track.

Decision/Conclusion

The Committee took assurance from the updates.

12. STRATEGIC OBJECTIVE - PERFORMANCE

12.1. Capital Plan 2026/27 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Capital Plan 2026/27 for approval. The Committee noted that this represented an early view of the capital plan pending confirmation of the formal capital allocation, but that it provided a clear indication of current commitments and priorities. Members heard that a direct allocation had been received to support replacement of the CT scanner and that the tender process was being progressed.

The Committee also discussed the value of longer-term planning and heard that development of a 10-year capital plan would support earlier planning, including building warrants and procurement, and reduce the need to undertake works during the winter period when transport to the isles can be more difficult. Members asked that quarterly updates on the capital plan be brought to Committee to support oversight of progress and future priorities, including visibility of planning for 2027/28.

In discussion, the Committee welcomed the clearer presentation of the capital position and noted the importance of avoiding underspend, while recognising that routine capital replacement schemes can take longer than anticipated to deliver.

Members heard that the projected underspend had reduced from £263,000 to around £150,000 following slippage, changes in delivery and the capital to revenue transfer, and that a 10% contingency had been retained for emergency capital projects.

Decision/Conclusion

The Committee approved the Capital Plan 2026/27.

12.2. Contract Register/Service Level Agreement Update (Presenter: Procurement Manager)

The Procurement Manager presented an update on the Contract Register and Service Level Agreements (SLA).

Committee noted that three contracts were due to expire, with two extension requests already approved and the remaining MRI contract dependent on confirmation of Scottish Government funding. Members heard that work on the SLA programme is currently focused on visiting specialties and remains at an early stage, with the current priority being to establish a clear baseline

rather than fully redesign arrangements. It was noted that many agreements are longstanding and that there are gaps in the understanding of associated financial arrangements, with further work underway alongside service managers and finance colleagues to strengthen oversight.

In discussion, the Committee heard that a number of the key themes relate to consultant-led services and that partner Boards have shown an appetite to explore different ways of working, including review of pathways and more effective management of travel and accommodation costs. Members noted that there is significant variation in travel arrangements and that greater control is needed to improve consistency and value for money.

Committee also discussed the importance of strengthening governance around contracts and service level agreements, including more formal review arrangements and clearer performance monitoring.

Members welcomed the progress being made and acknowledged the scale of the work involved in bringing historic arrangements into a more robust and consistent framework. Specific points were also raised regarding dermatology service costs and phototherapy arrangements, which were noted as a current cost pressure.

Decision/Conclusion

The Committee took assurance from the update.

Jean Stevenson left the meeting at 10:50am the Head of Corporate Governance advised that this meant the remainder of the meeting would not be quorate but as there were no further decisions to be made, the meeting could still continue.

12.3. Robertsons Facilities Management Contract Update (Presenters: Interim Director of Finance, NPD/Facilities Business Support Officer)

The NPD/Facilities Business Support Officer presented an update on the Robertsons Facilities Management contract.

The Committee heard that work was continuing with Robertsons and that there was now greater clarity regarding the operational risks associated with the contract. Members noted progress in relation to fire damper inspections, with 294 inspected to date and 35 requiring referral to the constructor for further action. It was noted that only one damper had so far been found to be faulty.

The Committee heard that further work was required in relation to the water tank, with this currently being reviewed through the Water Committee before works could proceed. Members were advised that a number of defects and outstanding issues remain and that regular updates would therefore continue to be brought back to Committee.

In discussion, the Committee heard that subcontractor support had been brought in from the mainland Scotland to assist with the backlog and that progress was being made. The Head of Estates reported that inspections were currently progressing at approximately 20 fire dampers per week, meaning completion of the current programme was likely to take a further six to eight weeks. Members also heard concerns that, as these are annual tests and the Board is already a quarter into the testing cycle, some dampers may need to be revisited before the full programme is complete.

Other ongoing concerns were highlighted in relation to the water tank breach, which has remained unresolved for a significant period, and the air source heat pump, which has been out of use for around a year.

The Committee discussed the wider implications of these issues, including the impact on sustainability and the need for a clearer overall picture of whether the contract is delivering effectively. Members noted the need for a sharper dashboard and key performance indicators to support clearer oversight of performance, corrective actions and risk. It was confirmed that a technical adviser and financial adviser had now been appointed to support contract management, and that the monthly meetings with Robertsons would inform a developing action plan. This would include clearer ownership of issues and better visibility of how long individual defects have remained unresolved, with the intention that future reporting will provide greater assurance to the Committee.

Decision/Conclusion

The Committee took assurance from the update. The Interim Director of Finance to liaise with Head of Facilities and NPD Contract on improvements to the reporting and key performance indicators.

13. STRATEGIC OBJECTIVE – PEOPLE – No papers to be presented to Committee.

14. STRATEGIC OBJECTIVE – POTENTIAL - No papers to be presented to Committee.

15. CHAIRS ASSURANCE REPORTS

15.1. Chair's Assurance Report – Sustainability Group (Presenter: Head of Facilities and NPD) - No meetings have taken place since the last meeting

15.2. Chair's Assurance Report – Improving Together Programme Board 24 April 2026.(Presenter: Interim CEO)

The Interim Chief Executive presented the Chair's Assurance Report from the Improving Together Programme Board meeting held on 24 April 2026. The Committee noted the update from the Programme Board and the progress being made across the Improving Together workstreams.

Decision/Conclusion

The Committee took assurance from the update.

15.3. Chair's Assurance Report – Digital Information Operations Group 27 April 2026 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Chair's Assurance Report from the Digital Information Operations Group meeting held on 27 April 2026. The Committee noted that the highest digital risk related to the Picture, Archiving and Communication System (PACS) rollout, which remained off track and was now expected to go live in August, with delivery being driven by the national team.

Members also heard that the Radiology Information System (RIS) was expected to be reviewed further in September as part of the national programme. Progress was noted in relation to migration to OneDrive, and the Committee welcomed the work of digital champions in supporting implementation and adoption across the organisation.

Decision/Conclusion

The Committee took assurance from the update.

15.4. **Chair's Assurance Report – Capital and Property Strategic Group 5 May 2026 (Presenter: Interim Director of Finance)**

The Interim Director of Finance presented the Chair's Assurance Report from the Capital and Property Strategic Group meeting held on 5 May 2026. The Committee heard an update from the Head of Estates on the King Street property and the former Balfour Hospital site.

Members noted that King Street had now been sold with effect from 1 April 2026. It was also reported that funding had been secured from the Scottish Government for the pre-demolition survey of the former Balfour Hospital site, with this work due to take place that week and intended to support progression to tender for demolition. The Committee heard that the asbestos report was expected by the end of June 2026 and that costs for the pre-demolition and demolition works would be met by the Scottish Government, although the final cost position could not be confirmed until the asbestos report had been received.

Decision/Conclusion

The Committee took assurance on the report.

16. **Agree Items for Chairs Assurance Report to Board**

Members agreed the content for inclusion in the Chair's Assurance Report, structured as follows:

Areas of Concern

- Financial sustainability, and ongoing requirement to deliver recurrent savings.
- Isles Network of Care workstream – pace of progress and associated savings risk.
- Robertsons Facilities Management contract – continued concerns regarding planned maintenance at The Balfour.
- PACS rollout – delayed implementation, with revised go-live anticipated August 2026.
- RIS upgrade – requirement for detailed risk assessment covering service delivery and patient impact.
- OneDrive/SharePoint migration – cyber security risk associated with insufficient resourcing.

Major Work Commissioned / Underway

- Further update on financial sustainability risk scoring.
- Review of outpatient activity and travel costs.
- Ongoing development of the medical staffing model.
- Actions to ensure full utilisation of 2026/27 capital allocation.
- Strengthening KPI reporting in relation to the Robertsons contract.
- Review of Corporate Risk Register reporting frequency.

Positive Assurance

- Assurance on corporate risk mitigation and oversight.
- Assurance on Integrated Emergency Planning arrangements.
- Positive progress on Older Persons and Frailty and GP Out of Hours workstreams.
- Assurance on improvements in delayed discharge performance.
- Strengthened oversight of Contract Register and SLAs.
- Assurance via Chair's reports from Improving Together Programme Board, Digital Information Operations Group, and Capital and Property Strategic Group (including King Street sale and Balfour site funding).

Decisions Made

- Minutes and Chair's Assurance Report (29 April 2026) approved.
- Capital Plan 2026/27

17. AOCB (Presenter: Chair)

Members agreed that the current meeting frequency remains appropriate; however, consideration should be given to streamlining routine reporting, with some papers moving to a quarterly cycle where appropriate.

18. Key Items for Noting (Presenter: Chair)

No documents were presented for noted.

18.1 Meeting Schedule 2026/27 (Presenter: Chair)

Committee noted the meeting schedule 2026/27.

18.2 Evaluation of meeting (Presenter: Chair)

Useful discussions, challenging but supportive.

The Chair bid farewell to the Director of Performance and Transformation and thanked her for her significant contribution to the improvement programme of work.

The Chair closed the meeting at 11:22.

Minute Finance and Performance Committee

Wednesday 24 June 2026

Attendance

Fiona MacKay (Chair – Non-Executive Board Member), Debs Crohn (Head of Corporate Governance), Sam Thomas (Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services), Dave Harris (Director of People and Culture), Jason Taylor (Non-Executive Board Member), Damian Reid (Interim Director of Finance), Dr Louise Wilson (Director of Public Health), Dr Anna Lamont (Medical Director), Alan Scott (Head of Estates), Hazel Aim (Senior Corporate Governance Officer – minute), Ryan McLaughlin (Employee Director), Joanna Kenny (Non-Executive Board Member) and Mohammed Sohail (Interim Chief Finance Officer, IJB) attended from item 8.

Guests

John Daniels (Head of Primary Care), Chloe Crawford (NPD/Facilities Business Support Officer), Richard Rae (Head of IT).

1. Cover Page

Finance and Performance Committee Purpose

To review the financial and non-financial targets of the Board, to ensure appropriate arrangements are in place to deliver against organisational performance measures, to secure economy, efficiency, and effectiveness in the use of all resources, and provide assurance the arrangements are working effectively.

Quorum

Three members present including at least two non-executive Board Members, one of whom must be Chair or Vice-Chair, and one Executive Member.

2. Welcome and Apologies (Presenter: Chair)

The Chair (Fiona MacKay) opened the meeting at 09.30 am and welcomed members.

Apologies received from T Sharp (Director Performance and Transformation), D Campbell (Board Chair), S Brown (Chief Officer IJB), Carrie Somerville (Head of Performance, Planning and Information), James Goodyear (Interim CEO) and Jean Stevenson (Non-Executive Board Member).

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

3. Declarations of Interest (Presenter: Chair)

There were no declarations of interest raised.

4. Minute of the Finance and Performance Committee held 25 May 2026 (Presenter: Chair)

The Chair asked for comments on the minute of the meeting held on 25 May 2026.

Decision/conclusion

The minute of the meeting held on 25 May 2026 was accepted as an accurate record of the meeting.

5. Matters Arising

No matters arising.

6. CHAIR'S ASSURANCE REPORT - Finance and Performance Committee Chair's Assurance Report 25 May 2026 (Presenter: Chair)

The Chair presented the Chair's Assurance Report of the Finance and Performance Committee meeting held on 25 May 2026.

Decision/Conclusion

Committee took assurance on the Chair's Assurance Report from the meeting held 25 May 2026 for onward submission to the Board 25 June 2026.

7. Action Log (Presenter: Head of Corporate Governance)

The Head of Corporate Governance presented the Finance and Performance Committee Action Log 2026/27.

Decision/conclusion

The action log was reviewed, no outstanding issues (see action log for details).

8. Integrated Performance Report (IPR) (Presenter: Executive Directors)

The Executive Directors presented the Integrated Performance Report (IPR) and highlighted areas of positive performance and areas requiring continued focus.

It was noted that several indicators remained green, with Emergency Department (ED) performance continuing to be reported as amber, largely reflecting increased presentations associated with seasonal activity, including cruise ship activity.

The Committee noted the significant reduction in delayed transfers of care, while recognising that bed days continued to accrue. Positive performance against maternity standards was also highlighted.

The community performance position was discussed, including strong performance in psychological therapies compliance. Members recognised that, although standards were being met, an 18-week wait remained a long period for children and young people and that further improvement should continue to be explored.

Allied Health Professional (AHP) performance was noted to include a number of red and amber indicators. Work was underway to review performance management arrangements, strengthen reporting, and identify areas where improvements could be made.

The Medical Director highlighted improvements across areas of outpatient activity and waiting times, while noting continuing challenges in relation to radiology reporting. Members also discussed cancer waiting times, noting that performance could fluctuate due to small numbers, out of area pathways, patient choice to delay treatment, and multidisciplinary team pathways, particularly in relation to prostate cancer. It was reported that patients were not being carried forward month on month and that overall compliance remained high.

The Interim Chief Finance Officer IJB joined the meeting at 09:50.

Members sought further assurance regarding off-track performance, particularly in relation to AHP indicators and Musculoskeletal (MSK) services. It was agreed that a focused update on MSK performance would be provided as part of the next Integrated Performance Report submission. Committee also discussed whether broader AHP data, including areas such as speech and language

therapy, could be reflected in future reporting. It was noted that work was planned to strengthen AHP leadership and provide a broader, more integrated approach.

The Committee discussed the impact of guardianship and power of attorney delays on patient flow and length of stay. It was noted that the number of patients affected could fluctuate, but that delays could result in people remaining in hospital when this was not the right setting for them. The issue was being considered through the frailty and older persons workstream and by the IJB. Members also discussed the national position and the potential to raise concerns through appropriate local and national routes.

In relation to the Primary Care Improvement Plan (PICIP), members noted that funding changes had affected recruitment to posts intended to relieve pressure on GP workload, including first contact physiotherapy. It was reported that, although recruitment had not progressed as intended, there was no direct correlation identified with current waiting times. Further work would be undertaken to understand capacity and whether any additional funding requirements should be explored.

Emergency Department performance was discussed. The Committee was advised that NHS Orkney continued to perform strongly compared with other Boards, with daily escalation arrangements in place to monitor flow. It was noted that increased summer presentations could affect performance, but that the service continued to focus on appropriate treatment and discharge, with length of stay remaining low. Members welcomed the assurance that the service was focused not only on meeting the target but on taking the right clinical decisions for patients.

The Head of Primary Care left the meeting at 10:13.

The financial component of the report was also considered, including performance on payment of invoices within 10 days of receipt. It was reported that there was no significant delay in processing payments once authorised, but that authorisation delays, particularly in relation to travel invoices, remained challenging.

Committee noted that work continued to maintain oversight and improve performance. It was also noted that radiology reporting data was being reviewed to ensure the reported position accurately reflected performance.

Decision/conclusion

The Committee took assurance from the Integrated Performance Report.

9. Month 2 Financial Results Update (Presenter: Interim Director of Finance)

The Interim Director of Finance presented Month 2 financial results update, advising that the reported deficit was favourable to budget. However, it was noted that the budget had been planned on the basis of a higher deficit and that a significant proportion of the required savings were profiled for later in the financial year.

The Committee recognised that, while Month 2 position appeared more favourable than anticipated, there remained a material risk around the organisation's ability to deliver the required efficiencies in full.

The Committee discussed the budget-setting position and noted that further work was required to tighten budgets and ensure they reflected realistic staffing and expenditure assumptions. It was reported that the draft budget would have left a deficit of approximately £7.3 million, and that adjustments were being made to take account of issues such as locum costs and other staffing-related pressures. Members expressed concern that budget holders had not yet received finalised budgets and noted the importance of ensuring managers had the information required to manage and be held accountable for their budgets.

Members discussed the need to maintain appropriate controls on recruitment and discretionary spending, while recognising the distinction between holding vacancies and disestablishing posts. It was noted that a more constrained approach, aligned to last year's expenditure and additional savings requirements, would

be required to avoid over-recruitment and ensure the organisation remained within financial limits. The Committee also noted the importance of staff-side involvement and consideration of any implications arising from the Health and Care Staffing Act.

The Committee sought assurance on governance and financial control arrangements. It was noted that several controls were already in place, including scrutiny of larger expenditure and recruitment decisions through multiple approval routes. The Head of Corporate Governance emphasised the importance of staff adhering to Standing Financial Instructions. Members were advised that the Finance Team reviewed the financial position in detail and that the position would be discussed further by Executive Directors over the following days.

Members raised concerns regarding the accuracy and consistency of figures within the cover paper and the main report, particularly in relation to savings targets. It was clarified that there were two savings figures: the target reported to Scottish Government and the organisation's internal improvement target. It was reported that performance against the savings target was slightly ahead of plan, but that the cover paper would be reviewed and corrected prior to submission to Board.

The Committee also noted that a late fuel bill from Robertson Facilities Management had been received, which had adversely affected Month 2 position. Members agreed that the position should continue to be progressed at pace, with further clarity required on budgets, savings delivery and financial controls.

Decision/Conclusion

Committee noted the Month 2 financial position and the continuing risks associated with savings delivery, budget finalisation and financial control.

Committee took assurance from the update, noting that further work was underway to tighten budgets, clarify the savings position and maintain appropriate financial oversight.

10. STRATEGIC OBJECTIVE – PLACE – no papers were presented to the meeting.

11. PATIENT SAFETY, QUALITY AND EXPERIENCE

11.1. Transformational Priorities 2026/27 Highlight Reports (Presenter: Director of Finance)

The Interim Director of Finance presented the transformational priorities 2026/27 highlight reports and advised that progress was being made across the four priority areas, with continued focus required on delivery, consistency of reporting and local efficiencies.

Older Persons and Frailty

Committee noted that most areas were on track, although case studies remained off track. Work was ongoing to progress dementia mapping, with positive clinician engagement reported. Members noted that the work was broader than ward-based activity and had been widened to reflect frailty across the population, rather than being limited to those aged over 75. The Committee welcomed the progress made and discussed the importance of understanding whether the work was having a measurable impact, including on length of stay. Concern was raised that the review of social care services could divert resources and affect momentum. It was noted that the work remained a priority, with learning being taken from other Boards and a focus on progressing work ahead of winter pressures.

Redesign of Isles Care

Members noted that a further update would be provided at the next meeting due to the absence of key presenters. The Committee noted that service sustainability in the Isles remained at risk and was reflected on the IJB risk register.

Out of Hours

It was reported that the programme was mostly on track, with continued focus on the service model and service sustainability. The Committee noted that financial constraints remained a key challenge. Discussions had taken place and further information was being collated to support progress.

Medical Staffing

The Medical Director provided an update on Mental Health Staffing and advised that all areas were reporting green. Members noted that this remained a challenging area to deliver and that, while progress was positive, there continued to be a need to focus on performance and developing a more sustainable clinical position.

The Interim Director of Finance advised that progress was being made across all four areas and that there would be a continued focus on local efficiencies. Members noted the importance of ensuring consistency between the cover paper, the main report and the information being reported to Scottish Government. It was agreed that the transformation team would be asked to check the position to ensure consistency of reporting.

Decision/Conclusion

The Committee took assurance from the update.

11.2 Local Efficiency Scheme Highlight Report (Presenters: Executive Directors)

Committee noted that the local efficiency schemes sat alongside the four transformational priorities and formed an important part of the wider financial recovery and sustainability programme.

It was reported that delivery was ahead of target at this stage; however, members recognised that there remained a risk to the overall delivery of efficiency plans. Committee discussed the importance of maintaining sufficient detail within the Finance and Performance Committee reporting to enable appropriate scrutiny, while also ensuring that the key high-level points were reflected through the regular financial update.

Members noted that the position should continue to be monitored closely as part of the wider financial recovery work.

Decision/Conclusion

Committee took assurance from the update, noting that delivery was ahead of target at Month 2 but that risks remained in relation to the delivery of the overall efficiency programme.

It was agreed that future reporting should continue to provide sufficient detail for Committee scrutiny, with key high-level points reflected in the financial update.

12. STRATEGIC OBJECTIVE - PERFORMANCE

12.1. Medical Staffing Plan 2026/27 (Presenter: Medical Director)

The Medical Director presented the Medical Staffing Plan 2026/27 and advised that it built on previous discussions and papers considered by the Committee. The Committee noted that NHS Orkney continued to rely heavily on locum medical staffing, with very limited substantive staffing in some areas. Although the organisation had access to high quality locum clinicians, the current model was financially challenging and did not provide the level of sustainability required for the longer term.

The Committee discussed the clarification provided in relation to whole-time equivalent figures previously reported. It was noted that some figures had represented a cost-equivalent measure, rather than the actual WTE employed. This did not alter the reported spending but reinforced the need for change, as the Board was incurring the cost-equivalent of a larger establishment while securing a much smaller clinical presence through the current locum model.

Members noted that work was underway to develop a more sustainable medical workforce model for Orkney, including efforts to recruit substantively to anaesthetics. It was recognised that recruitment remained difficult, with consultants seeking flexibility and some potential applicants unlikely to accept new terms or rates. The Medical Director advised that engagement had taken place with individual clinicians and that, while there was recognition of the need for change, implementation would be challenging. The Committee noted that a new model had worked effectively in Shetland and the Western Isles and that learning was being taken from other island Boards, while recognising that local circumstances differed.

The Committee discussed the financial implications of the revised approach and noted that changes to rates were expected to contribute to the savings plan. It was recognised that the work formed part of a wider cultural and sustainability programme and would require continued executive, Board and staff-side support. Members also discussed the importance of communication, noting the sensitivity of the issue and the need for appropriate reactive communications while continuing proactive engagement with Scottish Government.

Members welcomed the progress being made and recognised the significant challenge involved in securing a sustainable medical staffing model for Orkney. The Committee noted that further updates would be required as the work progressed.

Decision/Conclusion

The Committee took assurance from the report.

12.2. Planned Care – Elective Trajectories 2026/27 (Presenter: EDoNMAHP)

The Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services (EDoNMAHP) presented the Planned Care Elective Trajectories 2026/27 update.

The Committee discussed the relationship between planned care and medical staffing. It was noted that elective services were less directly dependent on the local medical staffing model than some other services, as a number of services were delivered by visiting clinicians or through Near Me appointments.

Members noted that data-driven planning was strengthening decision-making; however, demand continued to exceed available capacity. The Committee was advised that work was ongoing with colleagues to model demand and capacity and to manage waits through targeted activity.

Additional specialisms had been brought in to support reductions in long waits, including 52-week waits, with further focus on 104-week waits, particularly in orthopaedics.

The Committee noted that non-recurrent targeted national investment of approximately £288,000 was anticipated and would support planned care delivery. It was recognised that this funding would need to be used carefully to maximise impact, with an ambition to reduce waiting times to 12 weeks where possible. Members noted that a Planned Care Group was in place, chaired by the relevant senior manager, and would support decision-making on the use of any additional funding.

Members questioned whether the level of detail in the report was appropriate for the Committee and suggested that key points may be more appropriately reflected through the Chair's Assurance Report. The Committee also welcomed the focus on paediatric waiting times, recognising that waits could represent a significant period in a child's life.

Decision/Conclusion

The Committee took assurance from the update.

12.3. Robertsons Facilities Management Contract Update (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Robertson Facilities Management Contract Update and advised that progress had been made since the previous report to Committee. However, it was noted that progress had plateaued in some areas and that a number of issues remained outstanding, including long-standing action plan items. The Committee noted that continued focus was required to tighten performance management and maintain pressure on Robertson Facilities Management to deliver required improvements.

Members sought further assurance on the current position, including the status of fire damper works, water tank issues and other red-rated actions. It was agreed that a clear list of reported issues, progress to date, outstanding actions and timescales would be prepared. The Committee noted that the Interim Director of Finance would meet with estates colleagues before further engagement with Robertson Facilities Management.

The Head of Estates advised that work was underway to review the outstanding action plan items across the contract and to introduce monthly operational meetings to provide clearer oversight, timescales and accountability. It was noted that some actions had been outstanding for a significant period and required continued focus. The Committee also noted that Robertson Facilities Management was experiencing challenges in maintaining core staffing levels, which was affecting delivery.

Members discussed the application of contractual performance measures and deductions where standards were not being met. It was noted that deductions were applied where possible; however, the way the contract was written limited the extent to which charges could be applied in some circumstances. Members expressed concern that they were unable to take full assurance until clearer information was available on the scale of outstanding issues, the actions being taken and the timescales for resolution.

The Committee also discussed the scope of the contract management arrangements and agreed that relevant representation should be widened, including infection prevention and control input where appropriate. It was reported that an action log was being developed to support clearer tracking of actions, timescales and accountability. The Committee requested that, where appropriate, a further update be brought to the next meeting.

Decision/Conclusion

Committee noted the update and recognised that some progress had been made. However, members were unable to take full assurance until further detail was provided on outstanding issues, timescales, performance indicators and the application of contract management arrangements.

13. STRATEGIC OBJECTIVE – PEOPLE – No papers presented to Committee.

14. STRATEGIC OBJECTIVE – POTENTIAL - No papers presented to Committee.

15. CHAIR’S ASSURANCE REPORTS

15.1. Chair’s Assurance Report – Digital and Information Operational Group (DIOG) 27 May 2026 (Interim Director of Finance)

The Interim Director of Finance presented the Chair’s Assurance Report from the Digital and Information Operational Group (DIOG) meeting held on 27 May 2026. The Committee noted the key issues escalated, including capacity pressures within leadership and administrative support, and the need to maintain oversight of implementation and delivery across a number of digital programmes.

Members discussed the implementation of the national Picture Archiving and Communication System (PACS) programme and noted that NHS Orkney was part of a wider national rollout involving a significant number of Boards. It was reported that implementation was anticipated towards the end of December. Project management arrangements for national GP IT re-provisioning were also noted.

Members asked for clarity on the timescale for MORSE (Electronic Patient Record) and were advised that the programme was back on track. It was noted that the previous challenges had not been digital in nature but related to leadership within the mental health team, with additional support now in place. The Committee also noted that the child health system had benefited from early identification of issues by NHS Orkney as a small Board, allowing concerns to be escalated at an early stage.

The Committee noted positive progress in relation to the development of a more structured approach to a single Electronic Patient Record and the ongoing work to progress single finance and HR systems.

Members recognised that changes to any system could create anxiety and disruption for staff, particularly where new systems required significant adjustment. It was noted that, although implementation would require staff to become familiar with different ways of working, the systems provided the functionality required.

Decision/Conclusion

The Committee took assurance from the update.

15.2. Chair’s Assurance Report – Capital & Property Strategic Group – No meetings have taken place since last committee.

16. Agree Items for Chair's Assurance Report to Board

Members agreed the following content for inclusion in the Chair's Assurance Report to Board:

Areas of Concern

- Month 2 financial performance
- The sustainability of the Isles model of care
- The Committee was unable to take full assurance on the Robertson Facilities Management contract

Major Work Commissioned / Underway

- Work continued to strengthen sustainability through the transformational priorities and local efficiency schemes.
- Further work was underway to improve community performance reporting, including AHP indicators and a focused update on MSK performance through the next Integrated Performance Report.
- The impact of guardianship and power of attorney delays on patient flow and length of stay continued to be explored through the frailty and older persons workstream and by the IJB.
- Workforce implications, including medical staffing sustainability, staff-side engagement and the implications of the Health and Care Staffing Act, continued to be progressed.
- The transformation team would review the Transformational Priorities reporting to ensure consistency between the cover paper, main report and Scottish Government reporting.
- Further work would be undertaken to clarify Robertson Facilities Management outstanding actions, performance measures, timescales and escalation arrangements.
- Medical staffing updates would continue to be provided to Committee as the revised sustainable staffing model progressed.

Positive Assurance

- Integrated Performance Report
- Positive progress was noted in relation to outpatient activity and waiting times, including the ultrasound service waiting list.
- Committee noted strong performance against the Emergency Department 4-hour target, with the Board consistently among the top three performing Boards in Scotland. Mental Health Staffing within the transformational priorities was reporting green, while recognising the need to maintain focus on sustainable clinical performance.
- Older Persons/Frailty and Out of Hours Transformational Priorities Workstreams.

Decisions Made

- Minutes and Chair's Assurance Report approved from the meeting held on 25 May 2026.
- Committee agreed to recommend to the Risk Management Group an increase to the financial sustainability risk score to 16.
- Agreed that high-level efficiency schemes will be included in the monthly financial update brought to Committee.

17. AOCB (Presenter: Chair)

No other competent business raised.

18. Key Items for Noting (Presenter: Chair)

No documents were presented for noting.

18.1 Attendance Record

Committee noted the attendance record 2026/27.

18.2 Meeting Schedule 2026/27 (Presenter: Chair)

Committee noted the meeting schedule 2026/27.

The Chair thanked those who attended for their input and contributions and closed the meeting at 12:01.

Minute of the Joint Clinical and Care Governance Committee

Wednesday 8 April 2026

Attendance

Fiona Mackay (Non-Executive Board Member - Chair), Dr Kirsty Cole (Area Clinical Forum Chair), Debs Crohn (Head of Corporate Governance), Dr Anna Lamont (Medical Director), James Goodyear (Interim Chief Executive), Councillor Lindsay Hall (Orkney Island Council Elected Representative), Councillor Ivan Taylor (Orkney Island Council Elected Representative), Wendy Lycett (Interim Director of Pharmacy), Dr Louise Wilson (Director of Public Health), Darren Morrow (Head of Children's Services, Criminal Justice and Chief Social Worker) and Kat Jenkin (Head of Patient Safety, Quality and Risk) and Ryan McLaughlin (Employee Director, Non-Executive Board Member).

Guests

Dr Elvira Garcia (Consultant in Public Health), Sarah Walker (Infection, Prevention Manager), Michelle Mackie (Interim Deputy Director Nursing and Lead Midwife), John Daniels (Head of Primary Care Services for item 13.5), Diane Young (All Age Disability and Mental Health Service Manager for Item 15.2), Lynda Bradford (Head of Health and Community Care), Louise Willis (Service Manager – Children's Services for Item 15.3) and Nick Crohn (Radiology Manager for item 15.4).

1. Cover Page

Joint Clinical and Care Governance Committee's Purpose

The Chair reminded members that the purpose of the Joint Clinical and Care Governance Committee (JCCGC) (the Committee') provides assurance through oversight of NHS Orkney and the Integrated Joint Board. The scope of the Committee's oversight fulfils the purposes of:

- The function of the non-executive members of NHS Orkney and advisors providing the Board of NHS Orkney with the assurance that robust clinical governance controls and management systems are in place and effective in NHS Orkney, in relation to delegated and non-delegated services it delivers.
- The function of providing the Integration Joint Board with assurance that robust clinical and care governance controls and management systems are in place and effective for the functions that NHS Orkney and Orkney Islands Council have delegated to it.
- The requirements set out in MEL (1998)75, MEL (2000)29 and HDL (2001)74 around the guidance on the implementation of Clinical Governance in the NHS in Scotland.

Quoracy

Meetings of the Committee will be quorate when at least four members are present and at least two of whom should be Non-Executive Members of NHS Orkney, one of whom must be the Chair or Vice Chair, and two Orkney Island Council voting members of the Integration Joint Board. Meetings will not take place unless at least one Clinical Executive Director of NHS Orkney and the Chief Officer IJB, or nominated depute, is present.

2. Apologies (Presenter: Chair)

Fiona Mackay (Vice-Chair) opened the meeting at 2.00 pm, welcoming members.

Apologies received from Rona Gold (Chair, Non-Executive Board Member), Jean Stevenson (OIC representative), Stephen Brown (Chief Officer, Integration Joint Board), Sam Thomas, (Executive Director Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services), Morven Brooks (CEO, Voluntary Action Orkney).

Members agreed the meeting was quorate in line with the Boards Code of Corporate Governance.

3. Declarations of Interests Agenda Items (Presenter: Chair)

No declarations of interest were recorded.

4. Minute of Joint Clinical and Care Governance Committee 4 February 2026 (Presenter: Chair)

Minute of the Joint Clinical and Care Governance Committee meeting held on 4 February 2026 were discussed and reviewed for matters of accuracy.

Decision/conclusion

Members approved the minute of the Joint Clinical Care Governance Committee 4 February 2026.

5. Chair's Assurance Report (CAR) from meeting 4 February 2026 (Presenter: Chair)

The Chair presented the Chair's Assurance Reports from the meeting held on the 4 February 2026 noting this was presented to Board in February 2026.

Members' noted that issues raised at Board have been actioned in relation to PPE

Dr Kirsty Cole asked if the weight management service update would be coming to Committee. Dr Elvira Garcia advised that this is covered in the Public Health Quarterly Report. It was agreed that a further update will be brought to the July 2026 meeting. Dr Anna Lamont advised that in Scotland injectable weight loss medication follows the same process as weight loss surgery. NHS Orkney are awaiting confirmation from NHS Grampian's position; this remains under active discussion through the Area Drugs and Therapeutic Committee noting a national position has not yet been agreed.

Decision/conclusion

Members took assurance on the Chair's Assurance reports from the meetings held on the 4 February 2026.

6. Action Log (Presenter: Head of Corporate Governance)

The action log was discussed with corrective action taken and providing updates where required. Members were content to close the items listed on the action log, noting that two actions are not yet due (Public Protection Accountability Assurance Framework and His Majesty's Inspectorate of Constabulary in Scotland (HMICS) - Draft Custody Inspection Report).

One action remains open in relation to weight management and one action remains off-track (Patient falls data in the IPR).

Decision/conclusion

Members noted the action log updates.

7. Corporate Risks aligned to the Joint Clinical and Care Governance Committee (Presenter: Medical Director)

The Chair invited questions in relation to the Corporate Risks aligned to the Joint Clinical and Care Governance Committee.

Risk 122.5 (lack of capacity within social care) has been updated to reflect the impact on the GP systems.

Dr K Cole asked if the Committee was content that the risk in relation to the lack of capacity within social care sits within the IJB. The Head of Patient Safety, Quality and Risk advised that the discussion in relation to the risk is in relation to the acute impact, the risk in relation to social care sits with the IJB as the provider of community services. Dr Anna Lamont acknowledged that Committee does not currently have sight of the social care risk register.

Head of Patient Safety, Quality and Risk provided assurance that the risk in relation to social care is being managed by Orkney Islands' Council with an update being provided ahead of the next meeting.

The Interim CEO asked that a conversation take place with the Head of Children's Services, Criminal Justice and Chief Social Worker and the Chief Officer IJB to discuss visibility of the social care risk register at JCCGC.

The risk in relation to the Public Protection Framework has been revised and downgraded due to the work undertaken between Orkney Islands Council, the Board and the IJB.

Decision/conclusion

Members took assurance on the Corporate Risk Register aligned to the JCCGC.

8. Integrated Performance Report (IPR) (Presenter: EDoNMAHP)

The Medical Director noted improved compliance with stage 2 complaints in the Integrated Performance Report and thanked the Patient Safety and Clinical Teams.

The Head of Patient Safety, Quality and Risk advised that there have been no Scottish Public Services Ombudsmen upheld complaints

Reporting fall rates is difficult. The Board is participating in the Scottish Patient Safety Programme falls programme, which aims to develop a national definition of falls with harm. This is expected to significantly reduce fall numbers once established.

Reduced compliance in relation to Serious Adverse Event Reviews (SAER's) with 2 of the outstanding reports showing an improved position.

Paediatric Early Warnings Scores (PEWs) compliance has shown a month-on-month improvement.

The Interim CEO noted that there was a misalignment of data in the IPR and the Quarter 3 Report

noting this may be in relation to timings of reports.

The Interim CEO asked for an update on the outcomes from the Maternity Early Warning Scores (MEWs) deep dive noting compliance is now at 100%. The Interim Director of Nursing and Lead Midwife advised that work has been undertaken with the team to support the collection of data and to track any trends.

The Interim CEO asked for clarity on the decrease in the number of bloodspot screening undertaken due to capacity. The Interim Director of Nursing and Lead Midwife advised that the target was not met due to timings but there was no significant risk to the patient in this instance. The Consultant in Public Health advised that the IPR was submitted without being updated, data presented to Committee was from December and January 2026. The Chair reminded the Executive Team that they have ownership of the IPR and the updates – not the performance team. Members were asked to note that 1 missed screening impacts significantly on the Key Performance Indicators.

The Chair asked that mitigating actions are updated and made clearer to improve assurance being provided to Committee with KPIs being owned by the Executive team.

The Chair noted that the number of SAERs remains stagnant, whilst 5 SAERs have been commissioned in the past 12 months, there are still 5 SAERs outstanding. The Head of Patient Safety, Quality and Risk advised that one has been closed since this data was pulled. One of the outstanding SAERs is extremely complex, the time taken to complete the reviews reflects their complexity. Two are awaiting external expert opinions and this is being followed up and escalated due to the delays. It is noted there is a need to increase the number of SAER trainers over the next 12 months and a plan for this is in progress. Chair thanked the Head of Patient Safety, Quality and Risk for assurance in relation to SAERs.

Decision/conclusion

Members discussed the IPR and took assurance where Key Performance Indicators (KPIs) are off track and the improvement actions in place to bring deliverables back on track.

9. Feedback from National Meetings

9.1 Scottish Executive Nurse Directors (SEND)

The Chair invited questions on the SEND feedback report.

Decision/conclusion

Members noted contents of the report.

9.2 Scottish Association Medical Directors (SAMD) – no report received. The Medical Director advised that a SAMD meeting has not been attended since the last meeting.

9.3 Chief Officers network - no report received.

9.4 Directors of Public Health – no report received.

Decision/Conclusion

Feedback from national meetings to be moved to for noting section of future agendas.

10. CHAIR'S ASSURANCE REPORTS

10.1. Area Drugs and Therapeutics Committee Chair's Assurance Report 4 March 2026 (Presenter: Medical Director)

The Chair asked members if they had any questions in relation to the report of the meeting held 4 March 2026.

The Medical Director provided assurance on digital dermatology, quoracy at meetings and prescribing.

Dr Kirsty Cole extended an invite to the ADTC to attend the Area Clinical Forum.

Decision/Conclusion

Members took assurance from the update.

10.2. Infection, Prevention Control Committee Chair's Assurance Report 4 February 2026 (Presenter: Infection Prevention Manager)

The Chair asked members if they had any questions arising from the Chair's Assurance Report from the meeting held on 4 February 2026.

The Infection Prevention Manager advised that work in relation to the planned care maintenance at The Balfour has been escalated to the Director of Finance.

A preparedness plan for High Consequence Infectious Diseases (HCID) is underway, there is a challenge in relation to Personal Protection Equipment this has been raised nationally.

There has been a drop in the number of face-fit testing, this has been raised with our Health and Safety Team.

Funding has been identified to remove splash risks in clinical areas.

Dr K Cole asked that the assistance dog policy be shared with the 2 Balfour based GP Practices.

Decision/Conclusion

Members received escalated items and took assurance on performance.

10.3. Social Work and Social Care Governance Board (SWSCGB) Chair's Assurance Report - (Presenter: Head of Children's Services, Criminal Justice and Chief Social Worker)

No report presented as the Board has not met since the last Committee meeting on to the Chair's Assurance Report from the Social Work and Social Care Governance Board 9 January 2026.

10.4. Clinical Governance Group Chair's Assurance Report 10 March 2026 (Presenter: Medical Director)

The Medical Director invited questions from committee members in relation to the Clinical Governance Group Chairs Assurance Report from the meeting held 10 December 2026.

Self assessment against the HIS Clinical Governance Standards will commence shortly.

Decision/Conclusion

Members received escalated items and took assurance on performance.

10.5. Improving Together Programme Board Chair's Assurance Report 27 February 2026 (Presenter: Medical Director)

The Chair invited questions from committee members in relation to the Improving Together Programme Board Meeting held 27 February 2026.

Dr Kirsty Cole inquired whether measures should be implemented to address the increased number of MRI scans and the accompanying rise in associated costs. The Medical Director explained that although the volume of completed scans has grown, the expenses pertain primarily to reporting and noted this has resulted in fewer patients needing to travel to Aberdeen. Funding has been secured for the next three months, and an additional update will be provided at the upcoming meeting.

Cllr L Hall reflected on the success of having an MRI scanner in Orkney.

The Interim CEO advised that a Business Case has been submitted to Scottish Government and funding has been secured for Quarter 1 2026/27.

It was noted that a further discussion on the MRI would be useful particularly in relation to savings made against travel costs.

Decision/Conclusion

Members received escalated items and took assurance on performance.

11. JCCGC Annual Report 2025/26 (Presenter: Chair)

The Chair presented the JCCGC Annual Report 2025/26 for approval.

Decision/Conclusion

Members approved the JCCGC Annual Report 2025/26 for onward submission to Audit and Risk Committee May 2026.

12. STRATEGIC OBJECTIVE - PLACE

12.1. Quarterly Public Health Report (Presenter: Director of Public Health)

The Director of Public Health presented the Quarterly Public Health Report. The Committee was asked to note the positive work in the East Region on remote, rural and island impact assessments being led by Orkney. A presentation has been delivered to Public Health Scotland in relation to vaccinations. Funding has been awarded to implement the NASH sexual health system. There has been an increase in the number of workplace sexual health newsletters.

Councillor Taylor asked the Committee to consider if they were content with the data being presented in relation to screening. The Consultant in Public Health advised that data is only

available on an annual basis. There have been challenges in relation to screening data quality, noting that more work is required to improve uptake.

The Interim CEO expressed appreciation to the Public Health team for their report and asked if the decrease in referrals and quit rates for smoking cessation suggested a reduction in overall smoking prevalence. The Director of Public Health responded that Orkney has the lowest rate of smoking in Scotland. The team continues its outreach efforts through social and local media and encourages referrals from within the organisation.

The Interim Deputy Director of Nursing and lead midwife advised that more work will be required in relation to cervical screening. From a maternity perspective the number of pregnant women has decreased, women are automatically referred from our maternity service.

Councilor L Hall inquired whether data is collected regarding the initiation of smoking among young people. The Director of Public Health advised that the data is not routinely available, there is a reliance on national data capture.

Dr K Cole asked if the pilot for vaping would continue. The Director of Public Health advised that the focus from Scottish Government is for smoking cessation, update to be provided at the next meeting. The Head of Children's Services, Criminal Justice and Chief Social Worker advised that data could be obtained from the school nursing team on the number of young people vaping.

Decision/conclusion

Members took assurance on the update.

13. STRATEGIC OBJECTIVE - PATIENT SAFETY, QUALITY AND EXPERIENCE

13.1. Realistic Medicine Year-end Report 2025/26 and Action Plan 2026/27 (Presenter: Medical Director)

The Chair invited questions on Realistic Medicine Year-end Report 2025/26 and Action Plan 2026/27.

The Medical Director thanked Gina McMahon for the report and raising the profile of Realistic Medicine, particularly the work undertaken in schools which has been included in the national Realist Medicine Report.

Recruitment is underway to replace the Realistic Medicine Lead, who leaves to take up an opportunity with NHS Grampian shortly.

The Director of Public Health asked if the Board is fully leveraging values-based medicine in relation to our clinical services review and our financial position. The Medical Director advised that funding for realistic medicine is about ways of working/thinking within the clinical governance space. A good example of realistic medicine is the use of Near Me and moving to digital by default.

The Interim CEO advised that the principles of realistic medicine should be better aligned to our improvement team. There is an opportunity to focus more on this through the population health matrix.

Decision/conclusion

Members received assurance on the Realistic Medicine Year-end Report 2025/26 and Action Plan 2026/27.

13.2. Safety, Quality and Experience Quarter 3 Report 2025/26 - (Presenter: Head of Patient Safety, Quality and Risk).

The Chair invited questions on the Safety, Quality and Experience Quarter 3 Report 2025/26. Key highlights include the increase in incident reporting. Falls remain the most frequently reported incident due to patient complexity

No inpatient pressure sores reported.

Excellence in Care compliance has increased quarter by quarter, conversations are taking place in relation to metrics.

There has been an increase in relation to quality improvement across the organisation and the impact this has.

Decision/conclusion

Members welcomed the Safety, Quality and Experience Quarter 3 Report 2025/26.

13.3. External Maternity Peer Review (Presenter: Interim Deputy Director of Nursing/Lead Midwife)

The Interim Deputy Director of Nursing and Lead Midwife presented the external maternity peer review and advised that whilst an action plan was requested by Committee that was not provided due to information not being available.

Reassurance was provided from the external reviewers, in particular the culture and feedback from patients. Improvements were required in relation to clinical governance.

A maternity clinical governance group has been re-started this will look at Standard Operating Procedures, risks, pathways, the entrance to maternity and a dedicated bereavement room.

The Interim CEO welcomed the report and asked if resources were available for a dedicated bereavement room and asked that women and families are involved in the design of the room. The Interim Deputy Director of Nursing and Lead Midwife advised that whilst space has been identified this does require additional space.

Dr K Cole asked for clarity on developing digital guidelines and Standard Operating Procedures (SOP's) and asked if this was a bigger issue across the organisation in relation to the need for a central repository for clinical guidelines. This is particularly important in NHS Orkney because of the high number of locum and itinerant staff. The Head of Patient Safety, Quality and Risk advised that work is underway to review the clinical policy framework and where guidelines etc should be stored.

Director of Public Health celebrated the great work our staff does, which is reflected in the number of Daisy Awards.

The Head of Children's Services, Criminal Justice and Chief Social Worker advised that Orkney Islands Council (OIC) are looking at policy storage, the vulnerable children policy has also been approved and will be presented to the Public Protection Committee shortly

Decision/conclusion

Members received and noted the update.

Diane Young, Lynda Bradford and John Daniels joined the meeting at 4.00pm

13.4. Quality Impact Assessment Quarterly Report March 2026 (Presenter: Interim Deputy Director of Nursing/Lead Midwife)

The Medical Director presented the QIA report noting that Scottish Government have complimented the Board on the use of the template.

Dr K Cole asked for confirmation on whether the reduction in postage costs in the paper include text messaging. The Medical Director advised that costs do not include text messaging, noting it is our ambition to move to digital letters as part of the roll out of the national Digital Front Door programme.

Decision/conclusion

Members received and noted the update.

13.5. Primary Care – Dental Services Update (Presenter: Director of Dentistry)

The Head of Primary Care Services provided an update on the public dental services. Whilst staffing challenges remain within the team, a new full-time dentist joined the team on the 30 March 2026,

A dental nurse has been appointed to the Garson Clinic and approval has been given to recruit additional dental staff removing the need for reliance on locums.

A new chair has been installed at the Garson Clinic improving access to patients.

The Chief Dental Officer visited Orkney 3 weeks ago, productive conversations took place within the private sector with further recruitment underway with Clyde Munro committing to have 100% of people in Orkney having access to a dentist in the near future.

The Employee Director asked for confirmation on the special care service and the number of cancellations patients have received. The Head of Primary Care Services advised that they continue to work with the dental teams to avoid short notice cancellations and how we can build resilience moving forward.

Decision/conclusion

Members took assurance from the verbal update.

14. STRATEGIC OBJECTIVE – PEOPLE – no papers to be presented to Committee

15. STRATEGIC OBJECTIVE – PERFORMANCE

15.1. Healthcare Improvement Scotland un announced Inspection - Verbal Update (Presenter: Interim Deputy Director of Nursing/Lead Midwife)

Interim Deputy Director of Nursing/Lead Midwife provided a verbal update on the Healthcare Improvement Scotland unannounced inspection.

Feedback on the day was positive, particularly in relation to leadership. Evidence was submitted on 8 April 2026 as requested. The final report is expected within 12 weeks of the inspection.

The Interim CEO confirmed that the inspection team found no areas of concern; the inspection will be used as part of our commitment to continuous improvement.

Decision/conclusion

Members noted the update.

Lou Willis Service Manager – Children's Services joined the meeting at 16.31

15.2 Mental Health Assurance Update (Presenter: Head of Health and Community Care – Lynda Bradford)

The Head of Health and Community Care and All Age Disability and Mental Health Service Manager presented the Mental Health Assurance Report.

Key reportable targets for treatment continue to be met in respect of waiting times for CAMHS, Psychological Therapies; access to treatment for substance misuse and post diagnostic dementia support.

Recruitment issues prevent the full introduction of the All-Age Nurse Led Psychiatric Liaison Team. Dr K Cole asked if the difficulty recruiting to the Psychiatric Liaison service provides an opportunity to revisit recruitment in Primary Care. The Head of Health and Community Care advised that this has not yet been considered.

The imminent retirement of the GP with Special Interest (Dementia) will bring challenges albeit covered in the short term. Dr K Cole asked if this would impact post diagnostic support. The Head of Health and Community Care acknowledged this will be impacted.

Ongoing pressure with regard to the numbers of people seeking assessment, diagnosis and treatment for neuro- developmental conditions.

The Mental Welfare Commission report and action plan was received by Committee.

Dr K Cole asked if consistency could be applied to all sections of the report going forward and asked for clarity on the timeframe for adults waiting for a review for ADHD. The Head of Health and Community Care advised that the move to MORSE will support the better presentation of data going forward.

The Interim CEO asked that Key Performance Indicators (KPIs) are included in the IPR going forward and asked that priority be given to reviewing people with a Learning Disability. The Head of Health and Community Care confirmed that this will be a priority.

The Employee Director asked if the whistleblowing actions plans have been closed and what is being done to look at alternatives to the psychiatric liaison model noting the inability to recruit to date. The Head of Health and Community Care advised that some of the actions remain open, it was agreed that the next report would be taken earlier in the agenda at the next meeting.

All Age Disability and Mental Health Service Manager advised that all activity is monitored, the team have worked hard to reduce the number of presentations at The Balfour. Recruitment remains a challenge across Scotland for Band 6s, development posts are being considered.

The Medical Director asked Committee to celebrate the work undertaken to date in relation to recruitment within the Mental Health Service.

Decision/conclusion

Members welcomed the Mental Health Assurance update.

15.2. Children's Health Assurance Update (Presenter: Service Manager – Children's Services- Lou Willis)

The Service Manager – Children's Services asked for questions on the Child Health Assurance Report.

The Interim CEO asked for clarity on the training data being in progress. The Service Manager – Children's Services confirmed that the training in progress is in relation to external supervision. The Interim CEO advised that they are content to ask other CEOs to support if this is required.

The Head of Children's Services, Criminal Justice and Chief Social Worker asked Committee to note the progress being made in relation to the children's neuro developmental single assessment pathway.

Decision/conclusion

Members welcomed the Children's Health Assurance update.

Nick Crohn joined the meeting at 16.45

15.3. Radiology Service Verbal Update (Presenter: Radiology Manager – Nick Crohn)

The Radiology Manager, Nick Crohn provided a verbal update on the Radiology Service.

The Board is currently unable to provide a safe ultrasound service due to ongoing staffing challenges. A risk assessment has been completed, and weekly updates are being shared with the Executive Management Team.

Although temporary support has been secured from NHS Shetland and a bank sonographer, there remains a national shortage of sonographers.

The Board is also receiving assistance from NHS Grampian and is considering bringing in a radiologist to cover additional activities.

The Medical Director thanked the Radiology Manager for their support, particularly the Obstetrics/Gynecology team who are supporting the service.

Decision/conclusion

Members noted the update.

16. STRATEGIC OBJECTIVE – POTENTIAL – no papers presented to Committee.

17. Emerging issues and key National updates (Presenters: Medical Director, Chief Officer Integration Joint Board, Executive Director of Nursing Midwifery, AHP and Chief Officer Acute, Consultant in Public Health)

Committee noted there may be additional work required following the HIS unannounced inspection.

18. Agree items to be included in Chair's Assurance Report to Board (Presenter: Chair)

Members discussed areas to be included within the Chair's Assurance Report, these include.

Positive assurance

- Corporate risks associated with JCCGC
- Paediatric Early Warnings Scores (PEWs) compliance has shown a month-on-month improvement.
- Compliance with stage 2 complaints was celebrated as an area of improvement with thanks being offered to the Patient Safety and clinical Teams.
- Following a deep dive, Maternity Early Warning Scores (MEWs) compliance is now at 100%
- Assurance taken from the Chairs Assurance Reports (CARs) for Area Drugs and Therapeutics Committee (4 March), Infection Control Committee (4 February) Clinical Governance Group (10 March) and the Improving Together Programme Board (27 February).
- Quarterly Public Health Report
- Safety, Quality and Experience Quarter 3 Report 2025/26
- Quality Impact Assessment Quarterly Report March 2026

Risks to be escalated to the Board

- Capacity in the Ultrasound service

Work underway

- Weight management to be added to the July 2026 meeting
- Insufficient social care capacity risk to be discussed with Orkney Islands Council
- Chief Officer IJB to discuss the social care risk register's visibility at Committee with the Head of Children's Services, Criminal Justice and Chief Social Worker.

- The Interim Deputy Director of Nursing and Lead Midwife will present the Maternity External Review Action Plan to the Committee in July 2026.

Decisions made

- Minute and Chairs Assurance Report of Meeting 4 February 2025 approved.
- JCCGC Annual Report 2025/26 approved for onward submission to Audit and Risk Committee May 2026
- Realistic Medicine Year-end Report 2025/26 and Action Plan 2026/27 approved.

19. AOCB (Presenter: Chair)

No other competent business raised.

20. EVALUATION OF THE MEETING (Presenter: Chair)

21. ITEMS FOR INFORMATION AND NOTING ONLY

21.1. Collaborative Community Care Group (CCC) Chair's Assurance Reports

Members noted the following papers

- 21.1a - Collaborative Community Care Group (CCCG) Chair's Assurance Report 5 February 2026
- 21.1b - Collaborative Community Care Group (CCCG) Chair's Assurance Report 5 March 2026

21.2. Schedule of Meetings 2026/27

- Members noted the schedule of meetings 2026/27.

The meeting closed at 17:15

Timetable for Submitting Agenda Items and Papers 2026/27

Initial Agenda Planning Meeting ¹	Final Agenda Setting Meeting	Papers in final form ²	Agenda & Papers	Meeting held virtually via MS Teams
with Chair, Lead Executive and Corporate Governance ³ < day of or 1 day after previous meeting>	with Chair, Lead Executive and Corporate Governance 21 days before date of meeting	to be with Corporate Governance < 9 days before Date of Meeting >	to be issued no later than < 7 days before Date of Meeting >	(unless otherwise notified) < Day of Meeting >
26 February 2026	26 March 2026	21 April 2026	23 April 2026	30 April 2026
30 April 2026	4 June 2026	16 June 2026	18 June 2026	25 June 2026
25 June 2026	6 August 2026	18 August 2026	20 August 2026	27 August 2026
27 August 2026	8 October 2026	20 October 2026	22 October 2026	29 October 2026
29 October 2026	19 November 2026	1 December 2026	3 December 2026	10 December 2026
10 December 2026	4 February 2027	16 February 2027	18 February 2027	25 February 2027

¹ Draft minute of previous meeting, action log and business programme to be available

² Any late papers will be placed on the agenda of the following meeting unless the Chair determines that they are urgent

³ Draft agenda, minute and action log issued to Directors following meeting