NHS HIGHLAND BOARD	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk/	
MINUTE of BOARD MEETING Virtual Meeting Format (Microsoft Teams)	**27th January 2026 – 9.30am**	

Present

Alexander Anderson, Non-Executive
Emily Austin, Non-Executive
Graham Bell, Non-Executive
Louise Bussell, Nurse Director
Muriel Cockburn, Highland Council stakeholder Non-Executive
Sarah Compton-Bishop, Board Chair
Heledd Cooper, Director of Finance
Garret Corner, Argyll & Bute Council stakeholder Non-Executive
Jennifer Davies, Director of Public Health
Fiona Davies, Chief Executive
Albert Donald, Non-Executive
Graham Illsley, Non-Executive
Karen Leach, Non-Executive
Philip MacRae, Non-Executive
Joanne McCoy, Non-Executive
Gerard O'Brien, Non-Executive
Dr Boyd Peters, Medical Director
Janice Preston, Non-Executive
Gavin Smith, Employee Director
Brian Steven, Non-Executive
Allyson Turnbull-Jukes, Chair of Area Clinical Forum
Steve Walsh, Non-Executive
Dr Neil Wright, Non-Executive

In Attendance

Gareth Adkins, Director of People and Culture
Evan Beswick, Chief Officer, Argyll & Bute Health and Social Care Partnership (A&B HSCP)
Bryan McKellar, Whole System Transformation Manager
Arlene Johnstone, Chief Officer, Highland Health and Social Care Partnership (HHSCP)
Richard MacDonald, Director of Estates, Facilities and Capital Planning
Stephanie McAllister, Corporate Administrator
Laura Neil, Associate Director of Quality and Clinical Governance
David Park, Deputy Chief Executive
Nicki Sturzaker, Head of Communications and Engagement
Katherine Sutton, Chief Officer, Acute
Nathan Ware, Deputy Head of Corporate Governance
Dominic Watson, Head of Corporate Governance

1.1 Welcome and Apologies

The Chair welcomed attendees to the meeting and recognised several individuals who had been acknowledged in the King's New Year Honours list:

- Dr Tim Allison, former NHS Highland Director of Public Health and Policy, who received an MBE for services to the NHS in Scotland.
- Ann Clark, former Vice Chair of the NHS Highland Board, who was awarded an OBE for her services to the NHS in Scotland which included extensive contribution to governance and community partnership work.
- Professor Angus Watson, Clinical Lead for the Scottish Capsule Programme, who received an OBE for services to research and surgical care.

Draft

The Chair congratulated those involved and noted their achievements reflected the talent and dedication seen across the wider organisation.

She also congratulated Nathan Ware on his appointment as Deputy Head of Corporate Governance, welcoming his continued support to the Board over the last several years.

Apologies were received from Heather Bain

1.2 Declarations of Interest

There were no declarations of interest.

1.3 Minutes of Previous Meetings and Action Plan

The Board **Approved** the minutes as an accurate record of the meeting.

The Chair noted that many actions had a March deadline and requested that the timelines be checked to ensure they remained achievable.

Board Members discussed the corporate parenting action. It was noted that clarification was still required regarding which committee should have oversight of the multi-agency plan. Board Members suggested the need for a development session to cover corporate parenting duties and potentially broader board responsibilities.

The Board **Noted** the updates to the Action Plan.

1.4 Matters Arising

None

2 Chief Executive's Report

The Chief Executive updated the Board on significant winter pressures and noted that early flu activity in December required additional surge capacity and thanked staff for their continued hard work which also involved the temporary reintroduction of face mask usage.

During her visit to Raigmore Hospital she noted the introduction of patient flow initiatives such as Same Day Emergency Care were helping but acknowledged staff continued to experience pressure during peak demand and highlighted her commitment to ongoing engagement with staff as improvement work progressed across NHS Highland.

She also updated the Board on the response to severe weather in early January, particularly in Caithness and Sutherland and thanked resilience partners and highlighting the exceptional efforts made to maintain care for vulnerable people.

The Chief Executive provided an update on NHS Scotland Sub-National planning arrangements, confirming her role as co-chair of the Scotland West Finance, Planning and Workforce workstream. She noted that governance proposals would be brought to the Board in due course.

During discussion:

- Board Members sought assurance that involvement in sub-national NHS work would not overstretch the executive team. The Chief Executive explained that, while formal assurance could not yet be given, she was confident that responsibilities could be shared within the experienced executive team. She emphasised the mutual benefit expected from regional collaboration.
- The Chair highlighted the importance of ensuring the needs of Highland, Argyll and Bute, and other rural areas were well represented in national and sub-national forums. The Chief Executive confirmed input would be shared regularly to ensure remote and rural areas were well considered.
- Board Members noted the organisation's recently updated business continuity and incident response framework had been tested during the January severe weather incident and had proved effective which evidenced strong partnership working.

The Board **Noted** the update.

3 Spotlight Session – Drug & Alcohol Recovery Service

The Board received a spotlight session on the Drug and Alcohol Recovery Service, delivered by Lesley Campbell with contributions from Mary Miller and Bob Kirk. This session marked the return of spotlight sessions, which had previously given the Board valuable insight into frontline work, service challenges, innovations and the connection between operational delivery and strategic direction.

Lesley presented an overview of the service's work, highlighting the increased focus on early intervention, strengthening relationships with individuals accessing support and maximising the impact of existing resources through partnership working, particularly with third sector and community organisations. Board Members noted the service demonstrated strong innovative practice and clear alignment with strategic priorities.

During discussion, the following points were raised:

- Board Members praised the service's effective community engagement, strong relational approach and innovative use of partnerships to enhance support for individuals with drug and alcohol issues.
- The Nurse Director emphasised the longstanding contribution of the Highland Alcohol and Drug Partnership, highlighting the breadth of partnership work across the region and the importance of recognising existing, well-established collaborations.
- Lesley's receipt of the Queen's Nurse Award was formally acknowledged. The Nurse Director noted that Lesley had used the award to strengthen data-driven service improvement and to progress significant areas of development within the service.
- Lesley reported that a colleague had recently completed her Advanced Nurse Practitioner training and would take a leadership role in public health-focused work, particularly relating to OST patients and individuals with chronic alcohol dependence.
- Board Members commended the strong partnership working approach and the teams contributions that underpinned the service
- Board Members expressed their appreciation for the team's contribution, acknowledging the significant pressures on the service and the level of work undertaken behind the scenes to deliver improvements.

4 Governance and other Committee Assurance Reports

a) Finance, Resources and Performance (FRP) Committee agreed minutes of 5th December 2025 and summary of meeting of 9th January 2026

The Chair of FRP reported the Month 7 and Month 8 financial positions remained stable but continued to carry significant risks, including Adult Social Care funding pressures, delivery of savings targets and a substantial increase in the Glasgow SLA charge, which was being challenged. A slight reduction in carbon emissions was noted alongside utility cost reductions which were supporting savings delivery.

b) Staff Governance Committee agreed minutes of 3rd November 2025 and summary of meeting of 13th January 2026

The Vice Chair of the Staff Governance Committee reported Committee received a spotlight session from the Director of Psychology, noting significant improvement in waiting times with the service moving from the lowest to among the top three nationally. The Committee commended the contingency planning undertaken for potential strike action and assurances were sought in areas of concern including appraisal completion, leadership and culture training, and safe staffing data. Discussion also took place regarding the impact of caring responsibilities on staff and the need to review supporting policies. The Committee highlighted the need for continued focus on appraisal processes and violence and aggression training.

c) Highland Health and Social Care Committee (HHSCC) agreed minutes of 5th November 2025 and summary of meeting of 14th January 2026

The Chair of HHSCC reported the Committee remained concerned about the pace of progress in delivering required savings. The annual Children and Young People's Report was reviewed. The Committee reviewed Level 2 risks, with workforce shortages highlighted as a significant and persistent challenge. Moderate assurance was taken from the annual Engagement Framework report, with the volume of activity identified as the primary limitation; increased engagement was expected as integration and strategy work progressed. An early draft of the commissioning strategy was considered noting the need for clarity on whether it functioned as a strategy or an operational plan. The Committee also formally recognised the contribution of staff during recent severe weather.

d) Clinical Governance Committee agreed minutes of 6th November 2025 and summary of meeting of 15th January 2026

The Chair of Clinical Governance Committee highlighted sustained operational pressures across staffing, resources and facilities. Committee noted that further improvement was required in the management of complaints and duty of candour responses, including strengthening staff capability and response times. The annual care inspection report was reviewed, with the Committee emphasising the importance of drawing together learning from inspections to support wider organisational improvement.

The Committee welcomed the new Associate Director for Quality and Clinical Governance, who had begun supporting the development of strengthened governance arrangements. Assurance around maintaining safe services under continued pressure remained a core focus of the Committee's oversight.

The Medical Director highlighted the continued challenges faced in the Vascular service and noted that this had been raised to Committee and also Board on several occasions. He added that this was an area under constant focus. He assured the Board that although the vascular service continued to experience significant workforce challenges that reflected a UK wide shortage the service is safely maintained through a networked delivery model, which allowed NHS Highland to draw on specialist clinical capacity from partner Boards. He confirmed the model provided the necessary resilience for urgent and emergency vascular care, and that Clinical Governance Committee continued to monitor the service closely.

He noted all available mitigations were in place which included shared on-call arrangements, access to specialist interventions through the network, and ongoing oversight of patient pathways to maintain safety despite recruitment constraints.

e) Area Clinical Forum Agreed minutes of 6th November 2025 and summary of meeting of 15th January 2026

The Chair of Area Clinical Forum discussed the continued development of Realistic Medicine and highlighted significant operational pressures in the North Highland acute sector, including discharge and flow challenges which resulted in reduced ACF attendance due to clinical demands. Representation gaps were noted but was being worked on.

Forum Members identified a disconnect between population health strategy and professional advisory committees. It was confirmed this would be addressed as a priority through further development and engagement discussions.

f) Population Health & Planning Committee Agreed minutes of 2nd October 2025 and summary of meeting of 14th January 2026

The Chair of the Population Health & Planning Committee reported that the Committee continued to establish its role and had held a constructive discussion focused on the emerging approach to strategy development and wider engagement on population health and inequalities. The Committee reviewed the framework timeline and agreed to revise the target date for the initial strategy framework from March to May/June 2026, recognising operational pressures and the impact of the forthcoming election period. Members noted confidence that a draft strategy would still be available for discussion by late autumn 2026.

g) Audit Committee Agreed minutes of 9th September 2025 and summary of meeting of 12th January 2026

The Chair of Audit Committee noted the appointment of a new Vice Chair and member, reviewed five internal audit reports, and noted progress on associated actions. Members discussed the impact of revised global audit standards, the need to monitor implications for the annual audit opinion, progress with the risk management framework, and development of the forthcoming internal audit plan. Concerns were raised regarding delayed audit reports, with a request for timely submission of evidence ahead of the March meeting.

h) Argyll & Bute IJB Noted the minutes of 19th November 2025

The Chair of Argyll & Bute Integration Joint Board reported that the meeting was held in Helensburgh and included a local focus on issues affecting the Helensburgh and Lomond area. The IJB began an in-depth review of its challenging budget position, with further discussion planned for the next meeting. The IJB also received its annual public health review and considered the annual update from the Alcohol and Drugs Partnership, noting the complexity of contributing factors such as social isolation and the importance of strong relationships in delivering effective services.

The Board took a break at 11:25am and the meeting resumed at 11:40am

5 Integrated Performance and Quality Report

The Deputy Chief Executive provided an overview of the IPQR and confirmed that the report had undergone detailed scrutiny through Finance & Resources, Clinical Governance, and Staff Governance Committees prior to

presentation. He highlighted that 11 of 19 indicators were meeting target or within tolerance and noted improvements in two of the three red-rated measures. The Board were asked to take moderate assurance.

The Deputy Chief Executive highlighted:

- CAMHS performance remained just below target but had shown sustained improvement across the year, with continued focused work in Argyll and Bute to support wider de-escalation aims.
- Vaccination performance showed improved COVID uptake and flu performance was expected to increase based on data still to be received beyond November.
- Emergency Department (ED) performance showed improvement in the reported period, although pressures had increased heading into the Christmas period with significant system strain felt by staff and patients.
- Delayed discharge numbers had improved but had since increased to around 225 and continued to present a major challenge.
- Outpatients and Treatment Time Guarantee (TTG) performance remained under close national scrutiny, with daily work underway to reduce waits over 52 weeks and active engagement with Scottish Government to secure additional support.
- 31-day Cancer pathway performance had continued to improve.
- Clinical indicators (including complaints, SAERs, falls and tissue viability) and workforce metrics were reviewed, with gradual progress in training compliance but appraisal rates remained static.

During discussion, the following points were raised:

- Board Members raised concerns that Stage 2 complaints performance was not sustainable. The Deputy Chief Executive explained this reflected concern about maintaining improvement rather than lack of action and noted new oversight arrangements were in place and that Board reports lag behind operational progress.
- Board Members sought assurance NDAS waiting list targets for March 2026 would be achieved. The Deputy Chief Executive confirmed the current waiting list reflected a historic pathway and didn't fully capture the support being provided, he emphasised that children were not left without help and alternative metrics may be required.
- Board Members highlighted staff appraisal completion rates remained stagnant. The Deputy Chief Executive acknowledged system pressures caused part of the challenge in addition to other complex driveres, and confirmed it remained an executive focus. It was agreed that a review of how appraisal data and assurance was presented to the Board would be undertaken.
- Board Members raised concerns with the twelve-hour ED waits. The Deputy Chief Executive confirmed they were predominantly caused by bed capacity rather than staffing levels and that some improvements in care delivery were not fully reflected in the metric.

The Board:

- Took **Moderate Assurance**.
- **Noted** the continued and sustained pressures across the system.
- **Considered** the level of performance across the system.

6 Operational Improvement Plan (OIP) Deliverables Report

The Whole System Transformation Manager spoke to the circulated report on the OIP and confirmed it was the first report to the Board following establishment of bi-monthly monitoring through FRP Committee. He noted that the 20 deliverables reflected Scottish Government priorities for all NHS Boards for 2025–26, with delivery expected by March 2026. The appendix provided a detailed status overview, and the Board were invited to take substantial assurance.

He highlighted that two deliverables had been noted as delayed:

- Pressures within CT and ultrasound continued to impact achievement of the six-week imaging performance diagnostic target. Active discussions with Scottish Government and other Boards were ongoing, although no agreed mitigation had been confirmed at the time of reporting.
- AHP provision at Raigmore linked to the Urgent and Unscheduled Care portfolio had experienced challenges with the service model and recruitment which had delayed progress. He confirmed a recruitment plan had since been approved and was being implemented.

During discussion, the following points were raised:

- Board Members queried why the report was recommended for substantial assurance given the challenges described. The Deputy Chief Executive advised the wider Annual Delivery Plan (ADP) would continue to support alignment and oversight with a large proportion of the OIP deliverables were on track or improving.

- The Chair acknowledged the challenges highlighted but noted the balanced nature of the report and was content with the proposed assurance rating.

The Board took **Substantial Assurance** on NHS Highland's delivery against the Scottish Government OIP and **Noted** the content of the report.

7 Finance Assurance Report – Month Eight Position

The Board received a report from the Director of Finance outlining the financial position as at Month 8, 2025/26. The Board were invited to take limited assurance, noting that while the position remained aligned with Scottish Government expectations, it continued to be significantly adrift from financial balance.
The Director of Finance reported a year-to-date deficit of just over £41m and confirmed that the forecast deficit remained £40m at Month 8. She highlighted the adult social care funding gap and the unresolved SLA charges with NHS Greater Glasgow & Clyde as the most substantial risks to the financial position. A risk to delivery of the full savings target had been identified in Month 6, with non-recurrent mitigation measures implemented in-year to offset this.

She highlighted the expected Month 9 position had been formally recognised by Scottish Government with particular focus on the adult social care gap as a probable pressure, and following detailed review an increased forecast deficit of £50m had been submitted. Work with Highland Council and Scottish Government continued in an effort to reduce the forecast deficit figure.

The Director of Finance highlighted:

- A deterioration of £850k within the partnership had occurred since the last report, driven by a £1.1m worsening in adult social care, partially offset by improvements in primary care.
- A minor deterioration within acute services, with further pressure anticipated over winter due to delayed discharge and flow issues.
- Mitigations and discussions with Scottish Government on the use of existing funding streams were ongoing.

During discussion the following points were raised:

- Board Members challenged the proposition the adult social care gap would be met, highlighting that this has not been the case for several years. The Director of Finance acknowledged this was the largest risk but had been recognised as a likely cost rather than a theoretical risk which had been raised with Scottish Government.
- Board Members raised concerns at the NHS Greater Glasgow and Clyde SLA cost and its impact on NHS Highland's budget. The Director of Finance confirmed an invoice had been received based on a new costing model but value for money and cost transparency were not yet assured.
- Board Members considered the wider implications around workforce sustainability, productivity and service redesign. The Director of Finance and other Executives acknowledged the importance of reviewing high-cost staffing models and exploring opportunities for regional collaboration.
- The Chair acknowledged the challenges highlighted but noted the balanced nature of the report and the significant work undertaken across the system.

Having **examined** the Month 8 financial position, the Board **considered** the implications and **agreed** to take **limited assurance** from the report.

8 Public Bodies (Joint Working) (S) Act 2014 – Annual Performance Reports: Argyll & Bute Health and Social Care Partnership

The Chief Officer for the Argyll & Bute HSCP delivered the Argyll & Bute Annual Performance Report, which outlined performance across health and social care services during the previous year.

The report highlighted the pressures faced across the partnership, the work undertaken by staff in challenging circumstances, and the continued commitment to delivering compassionate and evidence-informed care.

The Chief Officer for the Argyll & Bute HSCP reflected on the scale of financial challenge, confirming that £6m of reserves had been used over the past two years on the social care side and that a further £4m of reserves were being drawn down in-year to support financial balance. It was noted that these reserves would not be available in future years. The Chief Officer acknowledged the report contained a time-lag and that system pressures had improved slightly since the reporting period.

During discussion the following points were raised:

- Board Members sought clarity on reserve depletion and asked about the scale and timing of their use. The Chief Officer confirmed the total drawdown and noted the unsustainable reliance on non-recurrent funding.
- Board Members highlighted concerns regarding the impact of the NHS Greater Glasgow and Clyde SLA cost which was now larger than the total value of available reserves. The Chief Officer agreed and acknowledged further work was required.
- Board Members acknowledged the significant pressures on staff and emphasised the importance of recognising the achievements delivered despite the challenging operating environment.

The Board **Noted** the content of the report and took **Moderate Assurance**.

The Board took a lunch break at 1:30pm and the meeting resumed at 2pm

9 Review of Argyll & Bute Integration Scheme – Approval of Final Revised Document

The Director of People and Culture delivered a report on the review of the Argyll and Bute Integration Scheme.The report confirmed the scheme had undergone the full statutory review process between Argyll & Bute Council and NHS Highland, noting that the scheme sat outwith the remit of the IJB and is an agreement between the two partner bodies. The Board were invited to take Substantial Assurance on the robustness of the process followed.
The Director of People and Culture spoke to the circulated report and confirmed that the final step of the review, public consultation, had been completed jointly by both organisations. He advised that the updated scheme incorporated feedback received and would be submitted to Scottish Government following approval by both NHS Highland and Argyll & Bute Council. He noted that the review process is undertaken every five years and that a clear and compliant procedure had been followed.

During discussion the following points were raised:

- Board Members queried the nature and content of public consultation responses, noting that many comments related to broader service issues rather than the integration scheme itself. It was highlighted that contributors may have misunderstood the purpose of the consultation and that clearer signposting toward strategic planning and locality planning structures may be required in future.
- Board Members suggested that further communication could help acknowledge feedback and direct the public to appropriate routes for ongoing engagement, while recognising that anonymous submissions limited opportunities for direct follow-up.
- Board Members also referenced existing community engagement mechanisms through Argyll & Bute Council that could support future consultation activity and strengthen links with locality planning groups.

The Board:

- Took **Substantial Assurance**
- **Noted** the detail of the 36 responses received during the 8-week consultation period
- **Agreed** the revised integration scheme which has been further updated to take account of feedback received as part of the consultation process
- **Agreed** the Chief Executives of the two partner bodies jointly submit the revised scheme to Scottish Government for their consideration and approval at the appropriate time.

10 Quarter 2 Health & Care Staffing Act Report

The Board had received a report from the Director of People and Culture on the Quarter Two Health and Care Staffing Act report, which provided assurance on compliance with statutory duties and outlined progress against Safe Staffing requirements. The Board were invited to take Moderate Assurance, recognising both the continued progress made and the organisational challenges that remained.

The Director of People and Culture spoke to the report and confirmed it formed part of the Board's regular statutory reporting. He highlighted ongoing work to roll out SafeCare and the development of standard operating procedures for real-time staffing, and continued activity to implement the common staffing method. He noted that assurance remained moderate due to the need for greater consistency across the organisation and the requirement to further develop system capability to support compliance and local processes.

He advised that the annual Health and Care Staffing report would accompany the Quarter Three update at the March Board meeting, noting that annual reporting timelines did not align with financial-year reporting. He also

emphasised that quarterly reporting would not show significant movement and that year-end comparison would offer a clearer picture of progress.
During discussion the following points were raised:

- Board Members highlighted limited staff capacity to complete required training, noting that this contributed to inconsistent use of staffing data. The Director of People and Culture confirmed that training formed part of the overarching implementation plan, including both TURAS modules and SafeCare-specific training, but acknowledged the challenge posed by competing training demands across the workforce.
- The Employee Director raised concerns around inconsistent use of Datix for recording severe or recurrent staffing risks and the need for robust training for any replacement system. Staff-side feedback emphasised the risk of inconsistent reporting if training was not prioritised.
- The Director of People and Culture outlined the complexities created by overlapping healthcare and social care legislation, noting differences in statutory obligations between councils and health boards under the Act.

The Board **Noted** the content of the report and took **Moderate Assurance**, recognising both the progress to date and the continuing challenges in achieving full implementation across the organisation.

11 Corporate Risk Register

The Board received a report from the Deputy Chief Executive on the Corporate Risk Register, he confirmed the risks had been scrutinised through the relevant governance committees prior to Board. The report provided an overview of the current corporate risks and highlighted that no new risks had been added. The Board were invited to take Substantial Assurance on the progress of ongoing risk management improvements.

The Deputy Chief Executive explained that some review dates within the report had been overdue due to timing of submissions and confirmed that these had now been updated to provide greater assurance. He advised that several process improvements to risk management had already been initiated following recent audit committee scrutiny, and that work was underway to strengthen the robustness and consistency of the organisation's risk processes.

During discussion the following points were raised:

- Board Members highlighted the need for an updated governance map, noting this presented a risk to organisational clarity and decision-making. The Deputy Chief Executive agreed to consider how this type of risk should be formally raised and recorded within the organisation's established processes.
- The Director of People and Culture noted that, whilst further improvement was needed, the Board already had a governance framework in place. He emphasised the current work was focused on refining and strengthening this framework to provide greater clarity and assurance.
- Board Members asked how risks would be reviewed in future, particularly in relation to financial risks and those linked to the developing organisational strategy. The Deputy Chief Executive confirmed that risk owners would continue to review scoring and narrative as circumstances evolved and all updates reported through the appropriate committees as part of routine governance.

The Board **Noted** the content of the report and took **Substantial Assurance**.

12 Board & Committee Membership Review

The Board had received a report from the Deputy Head of Corporate Governance detailing the Board and Committee Membership Review, which outlined updated committee allocations following recent changes to Board membership and the appointment of the new Employee Director.

Board Members highlighted the report contained some references to former members. The Deputy Head of Corporate Governance confirmed these would be corrected out with the meeting.

The Board **Approved** the changes to Governance Committee membership.

13 Blueprint for Good Governance Improvement Plan 6-Monthly Update

The Deputy Head of Corporate Governance provided an update on the Board Blueprint for Good Governance Improvement Plan, noting recent progress in the areas of quality and risk. He noted the Board held a development session in November which initiated a refresh of the improvement plan, with further work underway.

The Board **Noted** the update and took **Substantial Assurance**

14 NHS Highland Code of Conduct Update

The Board **Noted** the update.

15 Any Other Competent Business

None

The meeting closed at 2.45pm

NHS Highland Board Spotlight Session

Presenting Team Briefing Note

Service / Team Name	Procurement
Presenter(s) and Role(s)	Becky Myles, Head of Procurement Ewan MacGregor, Deputy Head of Procurement (Business Services, Tendering and Contracting) Andy MacPherson, Deputy Head of Procurement (P2P Processing, e-Procurement and Safe Haven)
Title of Presentation	Delivering Value Through Outstanding Collaborative Procurement

Overview of presentation topic and why the Board should be aware of this.

NHS Highland's Procurement Department provides strategic oversight and a comprehensive operational procurement service for functions across the health board. Our activities include strategic sourcing and contract implementation and management, supplier relationship management, non-pay spend control and management of eProcurement systems and processes.

We are a professional procurement service, providing expert advice and guidance to improve effectiveness and value for money on all expenditure for goods, services and works. We launched a new 5 year Procurement Strategy (2025–30) aligned closely to the first Scottish Government Public Procurement Strategy for Scotland (2023-28) and the NHS Scotland Public Procurement Strategy (2024-28).

This presentation gives the Board an opportunity to hear directly about the team's strategic objectives, service improvement programme, as well as recognising examples of innovation and value in procurement practice.

What is the key challenge or opportunity your team has addressed?

Since its inception in November 2022, the Service Improvement Programme has delivered projects across Procurement and Supply Chain, with some significant Board-wide changes across multiple Value and Efficiency Workstreams, creating capacity for growth.

In financial year 2023–24, the prescribing budget carried an overspend forecast of £2.1 million. The team identified an opportunity to shift wound management product spend from a traditional pharmacy prescribing route, to a PECOS purchase ordering model, reducing costs and improving supply chain control.

What outcomes or progress will you be sharing?

The Prescribing to PECOS project has delivered a net cost reduction of £171k on wound management products to date (mid 2025–26), with 44% of wound management products now ordered through PECOS rather than the prescribing route. The target is to reach approximately 90% by end of 2026–27.

Is there anything specific you would like the Board to consider?

The Board may wish to note that the Prescribing to PECOS model has subsequently been recommended by the national Commercial Improvement Taskforce as a best practice opportunity for other Scottish territorial health boards to consider.

HIGHLAND NHS BOARD	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk NHS Highland na Gàidhealtachd
MINUTE of the FINANCE, RESOURCES AND PEFORMANCE COMMITTEE TEAMs	**6 February 2026 at 9.30am**

Present Alexander Anderson, Chair
Graham Bell, Non-Executive Director
Heledd Cooper, Director of Finance (Lead Officer)
Garret Corner, Non-Executive Director
Fiona Davies, Chief Executive (until 10.26 am)
Jennifer Davies, Director of Public Health and Policy
Richard MacDonald, Director of Estates, Facilities and Capital Planning
Gerald O'Brien, Non-Executive Director
David Park, Deputy Chief Executive
Boyd Peters, Medical Director
Steve Walsh, Non-Executive Director

In Attendance Natalie Booth, Senior Corporate Administrator
Rhiannon Boydell, Head of Service Integration, Planning and Performance – Deputising for Arlene Johnstone
Stephen Morrow, Deputy Head of eHealth
Elaine Ward, Deputy Director of Finance
Nathan Ware, Deputy Head of Corporate Governance
Neil Wright, Non-Executive Director
Dominic Watson, Head of Corporate Governance

1 STANDING ITEMS

1.1 Welcome and Apologies

No formal apologies for absence were received from Committee Members. Apologies were received from non-Committee Member I Ross.

1.2 Declarations of Interest

There were no formal Declarations of Interest.

1.3 Minutes of Previous Meetings held on 9 January 2026, Associated Rolling Action Plan and Committee Work Plan 2025/26

The draft Minutes of the Meeting held on 9 January 2026 were **Approved.**

The Committee further **Noted** the Rolling Action Plan. Regarding the associated Committee Work Plan for 2025/26.

2 MATTERS ARISING

There were no matters arising raised.

3 FINANCE

3.1 NHS Highland Financial Position (Month 9) Update

The Deputy Director of Finance spoke to the circulated report detailing the NHS Highland financial position as at end Month 9, advising the Year-to-Date (YTD) Revenue over spend amounted to £45.246m, with the overspend forecast increasing to £50.043 as of 31 March 2026. It had not been possible to deliver a solution which would enable a breakeven position to be delivered within Adult Social Care (ASC). The movement from Month 8 reflected an overspend position of £25.792m within ASC. The overall Board position had been mitigated in part by £10.000m of additional funding received from Scottish Government and the remainder managed through improvements to the Health position.

The circulated report further outlined planned versus actual financial performance to date as well as the underlying data relating to Summary Funding and Expenditure, noting the relevant Key Risks and Mitigations. It was noted £ 1,345.736m of funding had been confirmed at end of Month 9. There had been a second tranche of Resident doctor pay award received plus additional improving flow funding.

Specific detailed updates were also provided for the Adult Social Care; Acute Services; Argyll & Bute; the Cost Reduction/Improvement activity position, including relevant financial targets; the wider position relating to Value and Efficiency activity; Supplementary Staffing; and Capital Spend. The report proposed the Committee take **Limited** Assurance.

During discussion, the following points were raised:

- Engagement with Highland Council. Members noted that discussions with the Council remained ongoing for both the current and forthcoming financial years. It was highlighted that rising adult social care costs, limited growth funding and increased in-house activity continued to drive a widening structural gap.
- Funding Position and Transparency. Members stressed the importance of presenting the full gross pressure within adult social care to ensure clarity in negotiations. It was confirmed that part of the gap was being offset by health resources due to undelivered savings and unavoidable cost pressures.
- Comparison with Argyll and Bute. It was noted that Argyll and Bute had received regular uplifts for pay and service changes, unlike Highland, contributing to diverging financial positions despite shared accounting methodologies.
- Governance and Local Accountability. Members discussed the historic impact of the lead agency model on accountability and visibility of financial risk. It was recognised that this position was beginning to move.
- SLA Position and Uplift Assumptions. It was noted that a 3% uplift had been applied nationally for planning purposes, with the final figure still to be confirmed nationally. Further changes were still to be made following agreement of pay settlements and allocations would be available to cover this cost, so the net risk is minimal.
- Glasgow SLA. It was noted that the additional charge remains as a risk and is currently not agreed.
- System Pressures Not Reflected in Adult Social Care Spend. The Committee highlighted that delayed discharges represented significant additional cost pressures that did not appear within the adult social care budget but formed part of the wider deficit.

- Scottish Government Engagement. Members acknowledged the value of Scottish Government involvement at the appropriate stage and noted that the timing of their participation should be considered carefully considering the wider policy context.
- Capital Programme Delivery. It was highlighted that capital expenditure remained on track, with major schemes profiled across this and next year. Contingency funds were being released in line with priorities, and the programme was expected to land close to forecast.

The Committee **noted** the content of the report and **agreed** to take **limited** assurance.

3.2 Draft Financial Budget

The Deputy Director of Finance spoke to the presentation on the NHS Highland financial plan for 2026/27. She highlighted that the budget gave a 2 percent baseline uplift for 2026/27 and built in the recurring impact of the 2025/26 pay awards while meeting expected pay costs. She noted the additional national allocations which supported NRAC parity, Agenda for Change commitments, sustainability funding and investment linked to national policy priorities. She confirmed that Boards in escalation would receive further support and that overspends beyond available funding would be reflected in the Annual Accounts.

Specific detailed updates were also provided for the 2026/2027 Financial Plan Initial Headlines; Additional Funding; Additional Costs & Brought Forward Pressures; Inflation/ Uplift Assumptions; Cost Reduction/ Improvement Challenge; Value & Efficiency Schemes; 15 Box Grid; Adult Social Care; Risks & Opportunities.

Next steps included a refresh of the 15-box grid, update the financial plan as further information emerged; continue developing value and efficiency schemes; and work with budget holders to finalise pressures and set budgets ahead of submitting the detailed plan by 16 March.

During discussion, the following points were raised:

- Adult Social Care Reporting Approach. Members discussed the importance of presenting the full adult social care gap on a gross basis and agreed that the position should not assume break-even, ensuring transparency when the final plan is submitted.
- Council Engagement and Settlement Risks. It was noted that current discussions on the 26/27 budget settlement were ongoing and would be subject to the final Highland Council budget. The current position included within the plan represents the worst case funding scenario.
- National System Pressures and Funding Initiatives. Members sought assurance on whether further national measures were planned to support system pressures such as delayed discharge and waiting times, and it was confirmed that while policy frameworks existed, no significant new funding streams were anticipated beyond current programmes.
- Funding for National Initiatives. Assurance was provided that approved initiatives continued to align with requested funding levels and that any additional investment would need to be a strategic Board decision.
- Prevention and Long-Term Impact Evidence. Members discussed the evidence supporting prevention approaches and were advised that strong data existed around avoidable admissions and rising-risk cohorts, although demonstrating immediate financial impact remained challenging.
- Unfunded Policy Pressures. It was noted that some policy changes, such as elements of the reduced working week, were not fully funded and therefore required efficiencies that could not be recognised as savings.
- Alignment of Financial Plan and Departmental Budgets. Members stressed the need to align departmental budgets with the high-level financial plan, with ongoing work to understand longer-term service trajectories and ensure budget assumptions reflect current operational models.

- Budget Setting and Future Modelling. It was confirmed that budget-setting work for the coming year was underway with budget holders, alongside early discussions on longer-term modelling and the impact of new service developments.
- Cost of Policy Decisions Over Time. Members asked whether cumulative policy-related costs were tracked, and it was confirmed that while individual risks were flagged, maintaining a detailed running total would be disproportionate for the benefit gained.

After further discussion, the Committee **noted** the draft financial budget.

4 Capital Asset Management Group Update

The Director of Estates, Facilities, and Capital planning advised spending levels remained higher than previously reported and were around £3 m further through the ledger than shown in the paper. Grip and control measures were in place, and the position was expected to deliver a small overspend that could be managed through contingency. Recent management group discussions provided assurance that all areas were on track to achieve their planned spend.

During discussion the potential Impact of MyCare was queried whether the upcoming MyCare programme would affect funding assumptions. It was confirmed that there was no immediate cost pressure arising from MyCare, it remained a nationally driven and nationally funded programme. Members were advised that while most investment would be made centrally, some local costs were likely to arise in due course as the programme progressed.

The Committee **noted** the allocation and delivery of the Capital Formula Spend delivered through NHS Highland's Capital Asset Management Group and take **moderate** assurance.

5. New Craigs PFI Handback Closure Report

The Director of Estates, Facilities, and Capital planning spoke to the circulated report and outlined the work undertaken over the past three years to prepare for the PFI hand back, supported by national partners and specialist technical, legal and financial advisors. The project established clear commercial, contractual, asset and service-delivery objectives, most of which were fully achieved. The site was handed back in good condition, with repair and maintenance functions brought in-house, future service plans established, and key contractual payments completed. Lifecycle and fabric works were largely resolved, and an advance payment made at project inception was identified and returned. TUPE transfers, property lease updates and asset data transfer were completed with significant effort from operational, legal and HR teams.

A substantial element of the programme involved resolving issues linked to RAAC identified in three buildings. Negotiations resulted in a settlement totalling £1.726m to cover availability deductions, demolition, lifecycle works, FM costs and relocation expenses, leading to full resolution of liability and demolition of the affected buildings. Minor outstanding works related only to areas requiring clinical access. There was a future service delivery plan in place, with early savings identified and further efficiencies under review. Lessons learned from the programme had been documented and were being used nationally as an exemplar for future hand backs due to the effective partnership approach and successful resolution of complex contractual issues.

During discussion the following points were raised:

- RAAC Position. Members noted that the organisation had resolved the RAAC issues successfully, with the affected buildings demolished and the cleared site now being reviewed with support from the Scottish Futures Trust for potential future use.
- Recognition of the Team. Members agreed that the project's success reflected strong planning, disciplined scope management and effective negotiation, and requested that

thanks be formally recorded to the team for their work on one of the first major healthcare PFI hand back.

- Infrastructure Model. It was confirmed that traditional PFI was no longer in use, with current public-sector projects adopting alternative models such as DBFM, and national work underway to develop a new revenue-funded approach for future NHS infrastructure.

The Committee **considered** the report and agreed to take **substantial** assurance.

6. Digital Front Door Update

The Deputy Head of eHealth spoke to the circulated report advising the national MyCare digital app, noting that it had been developed over several years to provide patients with simple and intuitive access to key health information. It was confirmed that NHS Highland would take part in a soft national launch from April, with early functionality limited to core information drawn from primary care records and no immediate impact expected on current service delivery. Members were advised that the programme aimed to improve access, reduce pressure on busy services and support more efficient ways of working across the system.

The system had been piloted elsewhere and would expand in stages to include a broader range of information from both primary and secondary care. It was noted that NHS Highland would evaluate its use once live, with further development work and support needs to be identified in due course. Members were assured that the app represented an important first step in improving digital access for patients, with national partners and local teams continuing to shape its future direction.

During discussion, the following points were raised:

- Accessibility for Older Patients. It was asked whether older or less digitally confident patients would still be able to use non-digital routes, and it was confirmed that all existing contact methods would remain in place and the app would act only as an additional option.
- Parallel Systems and Delegated Access. It was noted that parallel systems would need to run for some time, and it was explained that the system served as a new access point rather than a replacement, with delegated access being explored for those needing support.
- Timeline and Development Pace. Questions were raised about how long full functionality might take, and it was confirmed that development would progress in phases over several years, supported by significant national investment.
- Political Context and Rollout Approach. Members observed the political interest in the programme, and it was confirmed that while politics may have influenced the timing, a phased rollout was the correct approach for a national digital system of this scale.
- Return on Investment. The potential for future cashable savings was queried, and it was noted that a business case had not yet been seen and that some national initiatives were driven by necessity rather than direct financial savings.
- Data Ownership and Information Accuracy. Questions were raised about future online booking functionality and responsibilities for correcting data, and it was confirmed that statutory data ownership remained with Boards and GP practices, with national work underway to design processes for handling inaccuracies.
- Legal Constraints on Records. It was highlighted that many clinical records were legal documents that could not be altered directly, only amended, which would influence how data corrections were managed.
- Prevention and Public Health Engagement. The system's long-term potential to support self-management and prevention was noted, alongside the need to proactively support engagement among those less likely to access preventative care.
- National System and Governance. Clarification was sought on whether the system operated nationally, and it was confirmed that it was a single national platform providing

access to selected information rather than a full health record, with updates to follow through established digital governance routes.

The Committee **considered** the report and agreed to take **substantial** assurance.

7. 2025/2026 and 2026/2027 Meeting Schedules

The committee **Noted** the dates provided as follows:

2026:

13 March 2026
10 April 2026
8 May 2026
5 June 2026
10 July 2026
7 August 2026
11 September 2026
2 October 2026
13 November 2026
4 December 2026

2027:

8 January 2027
5 February 2027
12 March 2027

The Chair confirmed that the next meeting is scheduled for **Friday 13 March 2026 at 9:30am.**

The Committee Noted the meeting schedules for 2026/27.

10. DATE OF NEXT MEETING

The next meeting of this Committee was to be held on Friday 13 March at 9.30am

The meeting closed at 11.47 am.

HIGHLAND NHS BOARD	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk NHS Highland na Gàidhealtachd
MINUTE of the FINANCE, RESOURCES AND PEFORMANCE COMMITTEE TEAMs	**9 January 2026 at 9.30am**

Present Alexander Anderson, Chair
Graham Bell, Non-Executive Director
Heledd Cooper, Director of Finance (Lead Officer)
Garret Corner, Non-Executive Director
Richard MacDonald, Director of Estates, Facilities and Capital Planning
Gerald O'Brien, Non-Executive Director
Steve Walsh, Non-Executive Director
Fiona Davies, Chief Executive

In Attendance Natalie Booth, Senior Corporate Administrator
Addy Massey, Corporate Administrator
Elaine Ward, Deputy Director of Finance
Nathan Ware, Deputy Head of Corporate Governance
Neil Wright, Non-Executive Director
Bryan McKellar, Whole System Transformation Manager
Rhiannon Boydell, Head of Service Integration, Planning and Performance – Deputising for Arlene Johnstone

1 STANDING ITEMS

1.1 Welcome and Apologies

Apologies for absence were received from Committee Members D Park, J Davies, and non-Committee Member A Johnstone.

1.2 Declarations of Interest

There were no formal Declarations of Interest.

1.3 Minutes of Previous Meetings held on 5 December 2025, Associated Rolling Action Plan and Committee Work Plan 2025/26

The draft Minutes of the Meeting held on 5 December 2025 were **Approved.**

The Committee further **Noted** the Rolling Action Plan. Regarding the associated Committee Work Plan for 2025/26.

2 MATTERS ARISING

The Chair asked if there were any matters arising not already covered by the agenda. No specific matters were raised by members. The Committee agreed to proceed to the substantive agenda items.

3 FINANCE

3.1 NHS Highland Financial Position (Month 8) Update

The Director of Finance spoke to the circulated report detailing the NHS Highland financial position as at end Month 8, advising the Year-to-Date (YTD) Revenue over spend amounted to £41.159m, with the overspend forecasted to be £40.005m as of 31 March 2026. The forecast assumed further action would be taken to deliver a breakeven Adult Social Care (ASC) position and the Value and Efficiency programme will deliverto the planned forecast, with mitigation in place for the slippage. The circulated report further outlined planned versus actual financial performance to date as well as the underlying data relating to Summary Funding and Expenditure, noting the relevant Key Risks and Mitigations. It was noted £ 1,344.608m of funding had been confirmed at end of Month 8.

Specific detailed updates were also provided for the Highland Health and Social Care Partnership area; Adult Social Care; Acute Services; Argyll & Bute; the Cost Reduction/Improvement activity position, including relevant financial targets; the wider position relating to Value and Efficiency activity; Supplementary Staffing; Subjective Analysis; and Capital Spend. The report proposed the Committee take **Limited** Assurance.

The Director of Finance highlighted ongoing engagement in relation to the Glasgow SLA, noting that NHS Highland continues to seek clarity and assurance over the revised charging methodology, with an £8 million invoice expected to be held pending further discussion with Glasgow, Scottish Government, and other Boards. The Director of Finance also advised that Scottish Government had been informed of the intention to reflect the £20m adult social care gap within the forecast at Month 9, increasing the projected position to around £60m, with further discussions continuing with Government and the Council.

During discussion, the following points were raised:

- Scottish Government Financial Support. Members noted that the financial support available was non-recurrent and non-repayable, with no brokerage or loan arrangements, and consistent with other support provided during the year.
- National Tariff and Costing Methodology. It was confirmed that there was no national tariff in Scotland, resulting in the use of activity averages to manage risk. Concerns were raised that Glasgow's patient-level costing approach relied on mixed systems and historic data that could not be fully reconciled, leading NHS Highland to challenge the methodology and request clearer breakdowns.
- Cross-Board Charging and SLA Risk. Members discussed that cross-Board charging is based on historic costs plus the agreed national uplift and noted that reopening SLAs or moving to patient-level costing without national agreement could expose NHS Highland to wider financial risk.
- National Consistency Requirement. It was agreed that any move towards tariff-based charging must be taken forward on a nationally agreed basis.
- Month 9 Forecast Position. Discussion focused on how the Month 9 forecast should be presented to Scottish Government, with emphasis on transparency despite the underlying position being relatively stable.

- Adult Social Care Engagement. The importance of a tripartite approach involving NHS Highland, Highland Council, and Scottish Government was emphasised to support sustainable funding and governance.
- Care Home Cost Pressures. Members noted rising costs in care homes brought back in-house, particularly due to agency staffing, and the wider implications for local service provision.

After discussion, the Committee:

- **Examined** and **Considered** the content of the circulated report.
- **Agreed** to take **Limited** assurance.

3.2 Redefining Financial Assurance and Stewardship and Budget Setting Approach

The Director of Finance presented the report on financial assurance and stewardship, outlining the proposed structure for strengthening financial governance, assurance, and stewardship across the organisation, including a clearer focus on value, efficiency, and effective use of resources. The rationale for implementing elements of the approach over time was explained, recognising organisational priorities, capacity constraints, and the need to align with the budget-setting timetable. The importance of embedding stewardship principles across all levels of the organisation and ensuring that budget-setting processes were aligned with these principles was emphasised.

During discussion, the following points were raised:

- Budget-Setting Timeline. Members noted that the initial draft budget would be submitted to Scottish Government on 2 February, with the first draft shared with the Finance and Resources Committee thereafter, and that budgets would not be presented to the Board until Scottish Government sign-off.
- Budget-Setting Approach. The practical budget-setting approach was welcomed, with discussion noting the distinction between the immediate process and the longer-term cultural shift towards stronger stewardship and value-based care.
- Financial Assurance and Stewardship. It was emphasised that the proposed structures would strengthen assurance, consistency, and accountability, operating as oversight and support rather than decision-making bodies.
- Budget Holder Accountability. Members highlighted the need to clarify delegated authority and strengthen documentation and training to support effective financial management.
- Outturn Alignment Risk. Discussion highlighted the risk of matching budgets to outturn and embedding inefficiencies, with support for a hybrid approach that distinguishes between controllable and unavoidable pressures.
- Service Redesign Oversight. The proposed service change process was noted to improve visibility and assurance over redesign activity.
- Capacity and Implementation. Members recognised capacity constraints and noted that existing groups would be adapted to minimise duplication.
- Value and Efficiency Capacity. It was confirmed that funding had been approved for two years to support a focused value and efficiency function, distinct from strategic transformation work.

After further discussion, the Committee otherwise:

- **Examined** and **Considered** the content of the circulated report.
- **Agreed** to take **Moderate** assurance.

3.3 Support and Intervention Framework – Scottish Government Quarterly reporting Q2

The Director of Finance provided an update on Stage 3 work, sharing correspondence as previously agreed, outlining the risks highlighted to Scottish Government, the current position, and the letter issued to Glasgow, with the item noted for information and to invite any feedback

After discussion, the Committee:

- **Considered** the content of the circulated report.
- **Agreed** to take **Moderate** assurance.

4 Capital Asset Management Group Update

The Director of Estates provided an update noting that expenditure was expected to be incurred once orders arrived on site, with eHealth projects progressing as planned despite slower invoicing. Capital projects were generally on track, with only a potential weather-related risk identified for the Mid Deal roof works, for which contingencies were in place, and significant expenditure anticipated in Month 9 as fire prevention and fire protection works continued to schedule.

Members discussed the risk of invoice timing, with assurance provided that equipment procurement was on schedule, funding was available, and no delivery or timing issues were anticipated.

After discussion, the Committee:

- **Considered** the content of the circulated report.
- **Agreed** to take **Moderate** assurance.

5. Integrated Performance and Quality Report

The Whole System Transformation Manager spoke to the circulated report on performance against national targets using the most recent data available. A dashboard and narrative commentary were included to highlight areas of improvement, emerging pressures, and mitigating actions, alongside benchmarking where appropriate. Updates were provided across a range of services, including Communications, Neurodevelopmental Assessment Services, Vaccination Uptake, Smoking Cessation, Alcohol Brief Interventions, Drug and Alcohol Recovery Services, Psychological Therapies Waiting Times, Emergency Department Access, Delayed Discharges, Planned Care, Diagnostics, Cancer Waiting Times, and Systemic Anti-Cancer Therapy access.

During discussion the following points were raised:

- Performance Improvement Recognition. Members welcomed the improving performance across several key areas and acknowledged the significant contribution of staff in delivering these improvements.
- Use of Targets and Metrics. Discussion considered the usefulness of performance targets, noting that some areas of concern, including vaccinations, delayed discharges, and longer waits, were not always reflected through national targets.

- 12-Hour Waits. Members raised concerns about ongoing pressures relating to 12-hour waits, with discussion noting that these were closely linked to patient flow and admission pressures rather than emergency department processes alone.
- Return Outpatients. Members discussed the increase in return outpatient activity and queried whether this was an expected consequence of the focus on reducing long waits for new outpatients, with further analysis requested.
- Sustainability of Planned Care Improvements. Discussion highlighted the risk that progress in reducing long waits could be difficult to sustain without additional resource, with recognition from Scottish Government that further reform would be required to maintain momentum beyond March 2026.
- Sub-National Approach. Members noted that sub-national planning was emerging as an important mechanism to support accelerated improvement in high-volume specialties such as orthopaedics and ophthalmology.
- Vaccination Uptake Reporting. Members suggested that staff vaccination uptake would be clearer if presented as a percentage rather than absolute numbers and queried whether local targets could be introduced.
- Frailty Pathways. Discussion welcomed the development of frailty assessment pathways at the emergency department front door and noted that similar approaches were being considered across other acute sites.

After discussion, the Committee:

- **Considered** the content of the circulated report.
- **Agreed** to take **Moderate** assurance.

6. Operational Improvement Plan Deliverables Report

The Whole System Transformation Manager provided a brief update on the Operational Improvement Plan, noting a positive overall shift in the assessment of the 20 deliverables. Two key risks were highlighted, relating to imaging performance against the six-week access target for ultrasound and CT, and the urgent and unscheduled care intervention at Raigmore, with the latter now progressing positively following recruitment. Progress was also noted in digital innovation and prevention activity, with a further iteration of the Operational Improvement Plan anticipated once additional detail is available.

Members sought assurance on whether all Operational Improvement Plan deliverables were being measured and whether any milestones were overdue. It was confirmed that all deliverables were in progress with target completion by the end of March 2026, with some dependencies on national teams, and that no deliverables were due for completion at this stage.

After discussion, the Committee:

- **Considered** the content of the circulated report.
- **Agreed** to take **Substantial** assurance.

7. Risk Register Level 1 Risks

The Deputy Head of Corporate Governance presented on behalf of the Deputy Chief Executive. The Committee reviewed the Level 1 risks as recorded in the risk register.

The Director of Finance advised that the risk profile and financial risks would be reviewed and refreshed considering the Q3 financial submission, ensuring that risks are current and appropriately mitigated.

After discussion, the Committee:

- **Considered** the content of the circulated report.
- **Agreed** to take **Substantial** assurance.

8. Annual Review of the Terms of Reference

The Deputy Head of Corporate Governance presented the annual review of the Committee's Terms of Reference (ToR). Several minor tweaks were outlined to be incorporated ahead of submission to the Audit Committee and Board in March 2026, including:

- Reflecting sub-national working and its potential impact on organisational governance structures and the Committee's role.
- Ensuring correct naming conventions for capital governance ("Capital Asset Management Group") and alignment to efficiency objectives described as valuing efficiency.
- Maintaining clarity on how the FRP Committee ties into the Population Health Committee, with linkages to be worked through as governance evolves.

After discussion, the Committee:

- **Considered** the content of the circulated report.
- **Agreed** to take **Substantial** assurance.

9. 2025/2026 and 2026/2027 Meeting Schedules

The committee **Noted** the dates provided as follows:

2026:

6 February 2026
13 March 2026
10 April 2026
8 May 2026
5 June 2026
10 July 2026
7 August 2026
11 September 2026
2 October 2026
13 November 2026
4 December 2026

2027:

8 January 2027
5 February 2027
12 March 2027

The Chair confirmed that the next meeting is scheduled for **Friday 6 February 2026 at 9:30am**, where the Committee will receive the first look at the draft budget submitted on 2 February 2026 to the Scottish Government.

The Committee Noted the meeting schedules for 2026/27.

10. DATE OF NEXT MEETING

The next meeting of this Committee was to be held on Friday 6 February at 9.30am

The meeting closed at 11.09 am.

NHS Highland	

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name of Committee	Finance, Resources and Performance Committee
Date of Meeting	13th March 2026
Committee Chair	Alex Anderson

KEY POINTS FROM DISCUSSION AND ESCALATION
ALERT
• Forecast overspend of £44.6m for year-end which was £4.6m worse than Scottish Government expectations, this included £10m Scottish Government support. • Adult Social Care (ASC) is no longer assumed to break even; full projected overspend of £27.2m was now reflected in the reporting.
ASSURE
• NHS Highland Financial Position (Month 10) Update (Limited) • Draft Financial Plan 2026/27 agreed to be submitted to Scottish Government • Risk Register Update (Substantial) • Operational Improvement Plan Deliverables (Substantial) • IPQR (Moderate) • Capital Asset Management Update (Moderate) • Lochaber Redesign Project Update presented
ADVISE
• Quarterly Committee updates on Lochaber Redesign Project progress until construction begins was agreed. • Committee acknowledged the financial plan gap could not be reduced by £40m support level but agreed to submit to Scottish Government with narrative clarifying.
RISKS
• The adult social care gap remained a significant structural concern that was not improving • Applying a 3% savings target to ASC may be unrealistic due to historic non-delivery. • There remains a lack of clarity from GG&C around the SLA invoice • Concerns around the continued dependency on supplementary staffing • Emergency Department performance and persistent high delayed discharges across the Board area • Emerging concern around rising oil prices due to recent middle east tensions in relation to utility costs, construction inflation and supply chain stability
ACTIONS
• Energy inflation would be added to the risk register
LEARNING

STAFF GOVERNANCE COMMITTEE	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk NHS Highland na Gàidhealtachd
MINUTE of MEETING of the STAFF GOVERNANCE COMMITTEE	**13 January 2026 at 10.00 am**

Present

Steve Walsh, Non-Executive (Chair)
Bert Donald, Whistleblowing Champion
Kate Dumigan, Staffside Representative
Janice Preston, Non -Executive
Gerry O'Brien, Board Vice Chair
Gavin Smith, Employee Director

In Attendance:

Gareth Adkins, Director of People and Culture
Gaye Boyd, Deputy Director of People
Heledd Cooper, Director of Finance
Fiona Davies, Chief Executive
David Park, Deputy Chief Executive
Richard Macdonald, Director of Estates, Facilities and Capital Planning
Sarah Compton-Bishop, Board Chair
N Sturzaker, Head of Communications and Engagement
Boyd Peters, Medical Director (until 11.25am)
Arlene Johnstone, Interim Chief Officer, Highland Health and Social Care Partnership
Heather Richardson, Head of Operations
Karen Doonan, Corporate Administrator
Brian Mitchell, Corporate Administrator (observing)
Gavin Anderson, Senior Corporate Administrator (observing)
Nathan Ware, Governance and Corporate Records Manager
Jo McBain, AHP Director (Item 4)
Allyson Turnbull-Jukes, Director of Psychology (Item 4)
Isla Barton, Director of Midwifery (Item 4)
Louise Bussell, Nursing Director (Item 4)

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. Apologies were received from P Macrae and J Davies.

1.2 Declarations of Interest

There were no declarations of interest.

2 ASSURANCE REPORTS & COMMITTEE ADMINISTRATION

2.1 MINUTES OF MEETING HELD ON 3rd November 2025

The minutes were **approved** and **agreed** as an accurate record.

2.2 ACTION PLAN

Action no 138 – 5.1 People and Culture Portfolio Update – D Macdonald to meet with the Director of People and Culture regarding concerns raised in specific areas. The Whistleblowing Champion had begun meeting staff without managers present so they could raise concerns freely. The Director of People and Culture had contacted D Macdonald about reports that some staff felt unable to speak up and was awaiting a reply, which he would follow up. This action was now closed.

Action no 139 – 4. Spotlight session – People and Culture – The Director of People and Culture to share slides with Corporate Administrator for circulation to committee. This action was now closed.

2.3 COMMITTEE WORKPLAN 2025-2026

It was noted that the Diversity Inclusion and Mainstreaming Report would be removed from the March 2026 agenda as this report was a two-yearly requirement and it would therefore be put on the agenda for March 2027.

Action: Corporate Administrator to remove from the March 2026 to March 2027 on the workplan.

The Committee is asked to:

- **Approve** the minute.
- **Consider** actions arising therefrom.
- **Note** the latest version of the committee Action Plan and **agree** to the proposed closure of any noted actions**.**
- **Note** the Committee Workplan 2025 - 26

3. MATTERS ARISING NOT ON THE AGENDA

None

4. Spotlight Session

4.1 Nursing, Midwifery and Allied Health Professionals (NMAHP)
Louise Bussell, Nurse Director

A comprehensive overview of the Nursing, Midwifery, Allied Health Professions (AHP) and Psychology workforces was presented. Key themes included ongoing demographic challenges, high sickness-absence levels in some sectors, strong statutory and mandatory training performance in others, and varying levels of appraisal completion across professions. Recruitment remained challenging in remote and rural areas, particularly for midwifery and psychology, with longstanding under-resourcing highlighted in psychology.
Significant progress had been achieved across several professions, including improved waiting-list performance in psychology, increased training compliance in nursing and AHPs, strengthened workload-planning tools, and enhanced data processes. Succession planning, training capacity, staff development and improved workforce diversity were identified as shared priorities across all groups.

The AHP Director reported that NHS Highland had continued work to become an Armed Forces-friendly employer and service provider. This included collaboration with recruitment teams, Developing the Young Workforce, and other partners. She noted that NHS Highland had supported members of the Armed Forces community entering the workforce, with two apprentices placed through the NES Armed Forces Talent Programme. The organisation also maintained links with the Careers Transition Partnership to support individuals leaving military service.

Over recent years, staff groups had received training to improve awareness of the needs of veterans, serving personnel, and their families. The AHP Director highlighted ongoing secondary care provision for serving personnel in the region and emphasised the need to maintain continuity of care for children in Armed Forces families who moved frequently due to deployment.

It was noted that almost half of the Board's workforce sat within NMAP, so cultural work could not sit solely with NMAP leadership, although they played a significant role. The need to work closely with HR and operational colleagues to deliver consistent cultural messages was also emphasised. The Nurse Director highlighted the importance of visible leadership and clear communication and noted that work to bring together a wider leadership group would be key in strengthening shared understanding and consistency across the organisation. As NHS Highland was a highly dispersed board, ensuring alignment on messages such as "civility saves lives" and collaborative working remained a challenge. It was noted that the corporate workforce was varied and geographically spread, and work was underway to better understand how to achieve both consistency and recognition of differences across teams.

J Preston sought clarification on the grading profile specifically the number of Band 4 posts and whether this reflected the national picture across Scotland. She also sought clarification on how unpaid carers were recorded querying whether the caring responsibilities were included within the sickness data or treated separately.

The Nurse Director reported 71% TURAS compliance in her team, with remaining gaps due to new staff. She noted the need for closer data analysis to identify further improvement. She explained that work was ongoing nationally around the Band 4/Nursing Associate role, which continued to cause variation in Band 4 use locally. She also advised that unpaid-carer-related absence was usually recorded as personal stress. The Director of Psychology highlighted that, in her operational role, she had increasingly needed to consider flexi-time, special leave and carers' leave which did not always reflect the situations she was dealing with.

The Board chair agreed and noted that understanding these issues would be valuable given current demographic pressures, challenges in social care capacity, and the direction of future demand. She highlighted the organisation's responsibilities as an anchor institution and within community planning. She supported further work to understand the issues raised, recognising that this would be complex and not easily measured, but would offer wider benefits for workforce planning and employability strategies.

The Director of People and Culture advised that caring responsibilities needed to be considered in a wider organisational and national policy context. He noted differences in Scottish parental leave and highlighted a potential gap around planned caring leave. He observed that staff often struggled to obtain planned time off and sometimes resorted to sickness absence, suggesting the policy might need review. He also raised concern about possible misuse of short-term special leave and the lack of options for longer-term caring needs.

Action: The Director of People and Culture to have a broader discussion with senior managers around unpaid carers with a view to potentially having this topic as a Board Development Session going forward.

The Chair stated that as a veteran himself he felt that NHS Highland provided first-class support to veterans, serving personnel and their families and the organisation should be proud of how it upheld the military covenant. Also noted was the relatively short time scale that the Director of Psychology had been in post and the move for NHS Highland from being in the bottom three performing boards to the top three in respect of the psychological services that were offered.

5. Items for Review and Assurance

5.1 People and Culture Portfolio Board Update

Report by Gaye Boyd, Deputy Director of People

The Deputy Director of People introduced the standard assurance report covering the programme boards overseen by the People and Culture Committee, including key workstreams such as the Healthcare Staffing Act, cultural leadership, and equality and diversity in employment. She noted that the appendix provided an at-a-glance summary of the assurance report presented to the Board in November, which had offered a moderate level of assurance. She confirmed that all workstreams were progressing well and in line with the agreed action plan, while recognising that significant work still remained.

J Preston welcomed the reduced use of agency staff across all disciplines and asked for further detail on the health and wellbeing workstream, noting that the update was brief and appeared not to have progressed. She queried what the underlying risk was and whether limited staff buy-in was a factor.

The Deputy Director of People acknowledge point made and confirmed that the health and wellbeing workstream required review. She noted the strategy had been in place since 2023 and was due for renewal the following year, providing an opportunity to reassess priorities. She explained that staffing changes had affected capacity, though the team continued progressing work such as the employee assistance programme, roadshows, and awareness sessions, with ongoing analysis of usage data to determine next steps.

The Board Chair welcomed the progress reported but queried why the leadership and culture workstream was rated green. She noted the numbers provided for the leadership network lacked context, making it difficult to judge engagement or provide true assurance. She highlighted low attendance as a known challenge and asked how the organisation identified and targeted leaders who were not engaging, rather than only those already motivated to participate. She also requested more detail on the planned review of people and culture governance arrangements.

The Director of People and Culture clarified that the green rating related to delivery of the leadership development programme, not engagement levels. He acknowledged low attendance and said more work was needed to understand capability, training needs and appropriate measures of assurance. He also outlined ongoing work to streamline people and culture governance structures and improve alignment with Board governance.

The Employee Director asked how consistent unsafe staffing was escalated through the risk process, referring to an example in the labour suite where long-term unsafe staffing had not appeared on the risk register. He sought assurance that persistent issues were being

accurately recorded so the organisation had a clear, up-to-date picture of operational risk.

The Director of People and Culture noted that the new SOP for real-time staffing and risk escalation had been approved but was still being fully embedded. Tools such as SafeCare and OPAL supported daily risk management, and recurrent and severe staffing risks continued to be monitored. Maternity was highlighted as an example where historic staffing risks had now been addressed, with further work planned to ensure long-term sustainability. Any additional risk areas should continue to be identified and managed through established governance routes.

The Whistleblowing Champion requested fuller updates on the leadership and culture workstream at future meetings. It was noted that current reporting focused mainly on attendance numbers and planned activities, but more detail was needed on what was actually happening, the application and selection process, and how outcomes and success were being measured. The importance of maintaining strong focus on leadership and culture was emphasised.

It was proposed that leadership and culture should be explored in greater depth through a future spotlight session, as originally intended. A more detailed update would also be provided in the relevant section of the portfolio report going forward.

Action: Deputy Director of People to provide a more detailed update in the relevant section of the Portfolio Board report going forward.

The Chair noted that Leadership and Employability both showed resourcing risks, despite being rated green. He stressed that employability was vital to addressing workforce availability and that both areas appeared under-resourced. He reminded the committee of its role in providing support and suggested that any additional resource requirements should be raised so they could be prioritised.

The Director of People and Culture advised that the team was developing Level 2 risks to improve clarity on risks and mitigations. He stressed the need to prioritise within existing resources due to financial constraints and noted that additional funding would require reprioritisation. He agreed to look further into the relevant workstream, including use of the apprenticeship levy, and to follow this up with the team.

The Committee took **moderate** assurance in the progress being made in the People and Culture portfolios relating to the Together we Care Strategy

5.2 Integrated Performance and Quality Report
Report by Gareth Adkins, Director of People and Culture

The Director of People and Culture reported that sickness absence remained stable at around 6.5–6.6%. Time-to-fill vacancies had begun to rise again, and he highlighted risks linked to the reduced-working-week recruitment activity, noting that performance might dip further in the coming months. He confirmed that processes within the redesigned recruitment team were being reviewed and monitored. He noted steady progress in e-learning completion, with substantive staff now at 80%, though bank staff remained lower due to activity levels. He suggested further review of inactive bank workers.

The Director of People and Culture also highlighted continued concerns about low appraisal completion rates. He advised that a new, systematic approach was being developed, involving change partners working directly with teams to identify barriers and provide support and training. A formal paper would be taken through the Executive Directors Group (EDG).

The Deputy Board Chair noted the importance of ensuring bank staff were only recorded as active if they had completed the required training and welcomed the Director of People and Culture's clarification on this. He then sought clarification on the "violence and aggression practical training" metric, observing that other committees had reported much higher overall violence and aggression figures. He asked whether the term "practical" in the IPQR referred to a specific element of the training.

The Director of People and Culture advised that the "practical" violence and aggression training figure covered several different training levels, making the overall average difficult to interpret. He explained that training ranged from e-learning to high-level interventions, with requirements varying by setting and risk level. Compliance was highest in mental health inpatient areas, where risk was greatest, and stronger in acute patient-facing areas than the overall figure suggested. He noted challenges in identifying the correct staff denominator and had asked the team to explore reporting the training levels separately, as the combined percentage might be unduly harsh.

J Preston noted the need for clearer data on appraisals, particularly within the TURAS system. She asked whether TURAS issued prompts to staff, whether the process could be simplified, and what local support could be offered to managers who had not completed the process. She emphasised the importance of understanding how many staff were not receiving appraisals so that support could be better targeted. She also suggested that reporting by team size or directorate would help identify high- and low-performing areas, noting examples where staff had previously not been offered appraisals at all. She stressed that without improved TURAS data, it would remain difficult to analyse gaps or focus improvement efforts effectively.

The Director of People and Culture explained that TURAS was a national system currently being refreshed as part of wider business system changes. He noted that although more detailed data could be helpful, the organisation already had enough information to recognise that appraisal completion was a significant issue. He emphasised the need to focus on understanding what was happening within teams, using change partners to gather insight and address barriers. He highlighted that context varied across services: in high-pressure clinical areas, staffing pressures could make appraisals harder to complete, while in corporate services the same barriers did not apply. He stressed the importance of identifying where appraisals were achievable but still not happening and supporting teams accordingly.

The Committee took **moderate** assurance of the workforce position as of December 2025

Comfort Break 11.40am to 11.50am

5.3 Staff Governance Monitoring Update
Report by Gaye Boyd, Deputy Director of People

The Deputy Director of People reported that the annual return to the Scottish Government was required to provide assurance on compliance with the Staff Governance Standards and to highlight areas for improvement. Following last year's National Review, the revised template led to significant discussion and queries, and the Board was unable to reach agreement in time. This year's updated template allowed clearer discussion on the content. A partnership group had been set up to support future monitoring and develop an action plan, but this work was not yet complete, so discussions continued through the Committee, the Area Partnership Forum (APF) and staffside.

The return had been reviewed by the APF and was presented for substantial assurance and

approval prior to submission. Although the return was submitted after the 18 December deadline, the Scottish Government had been informed, and the delay was due to the governance cycle.

The Employee Director advised that a dedicated session had been held to review the Staff Governance return in detail, working through it line by line. This informed the text and supporting submission documents. The update was provided for information, and it was noted that this approach appeared to be new compared with previous years.

The Director of People and Culture noted that a positive outcome of the work to date was the establishment of a mechanism and structure for taking the programme forward in partnership. He emphasised, however, that it remained a continuous-improvement process and that significant work was still required in several areas. The Employee Director requested that papers from the Staff Governance Monitoring Group be included within the papers submitted to the Staff Governance Committee. He advised that this would allow issues to be identified in real time and provide a clearer overall picture of progress throughout the year.

Action: Papers for the Staff Governance Monitoring group to be submitted to the Staff Governance Committee.

The Deputy Board Chair queried the rationale for including retirement statistics within the Staff Governance Monitoring Return. He noted that areas such as bullying, harassment, whistleblowing and equality were clearly aligned to staff governance, but retirement data appeared less directly relevant in that context. He added that this was an observation rather than a question directed to commit as it related to Scottish Government requirements.

The Committee took substantial assurance that it received the necessary updates and reports to give assurance on Staff Governance Standards.

5.4 Strategic Risk Review
Report by Gareth Adkins, Director of People and Culture

The Director of People and Culture highlighted that the key points were set out in the paper, which was taken as read. He noted that work on Level 2 operational risks had been ongoing for some time but was now nearing completion. Three leadership sessions had been held in recent months to strengthen senior leadership understanding and oversight of Level 2 risks. He hoped that the outcomes of this work would be available for the next committee meeting.

He confirmed that Level 1 strategic risk scores had not changed significantly, and that ongoing work was reflected within the update. He also drew attention to two continuing areas of focus: appraisal processes and work relating to the common staffing methodology under the Health and Care (Staffing) (Scotland) Act.

The Chair made two observations relating to Risk 706 (Workforce). He queried where long-term absence and general absence should sit within workforce availability, noting that although it did not relate to recruitment or turnover, it had a significant impact on overall capacity. He highlighted that absence levels were continuing to trend upwards and were notable within other reported data.

He asked for clarification on where this issue was currently captured within the risk framework and how the Board could best scrutinise the management actions in place to address and mitigate absence, without creating an additional separate risk.

The Director of People and Culture reflected on whether absence, including long-term

absence, should be captured as a separate Board-level risk, noting that it was not currently included within the strategic risk framework. He acknowledged the need for wider consideration of how best to oversee this issue. He highlighted that Staff Governance provided one lens of scrutiny, while organisational performance reviews also monitored workforce metrics across operational areas. He noted the multifaceted nature of the issue and that a definitive position had not yet been reached.

K Dumigan highlighted the importance of safe staffing requirements under the legislation. She noted that teams experiencing sustained gaps in service — whether due to vacancies or long-term sickness absence — should be clearly flagged within that reporting framework. She supported the Director of People and Culture's view that further consideration was needed, as her expectation was that such issues should already be captured through the safe staffing process.

The Director of People and Culture reported that work was underway to embed SafeCare and rostering data into staffing oversight arrangements. He noted that discussions were ongoing about how this information should escalate from ward to Board. The data would show roster fulfilment and daily mitigation but needed local interpretation before being aligned with wider workforce indicators such as sickness absence. The Head of Operations agreed that safe-staffing reporting should clearly show red-flagged areas and staff availability, including sickness absence. She noted that the system already allowed visibility from team level through to directorate and acute levels, and that the key requirement was ensuring staff were trained and able to interrogate the data locally to make meaningful correlations.

The Committee took **moderate** assurance from: • The review and refresh of the people and culture strategic risks • Ongoing work to finalise level 2 risks.

5.5 Health and Care Staff Act Q2 Report

Report by Brydie Thatcher, Workforce Planning/Analytics Manager & HCSA Workforce Lead

The Director of People and Culture stated that work was ongoing in respect of the role out of SafeCare and rostering which had been discussed earlier in the meeting.

The Deputy Board Chair noted that, given the moderate assurance rating, some data within the report needed further detail. He highlighted the SafeCare figures showing use in 69 locations and asked for clarity on what proportion of total areas this represented. He also requested more information on the rollout of e-rostering and on issues being escalated. He further observed that the report referenced a "complete cessation" of non-medical agency use, which did not align with current finance data showing reduced—but not zero—agency spend. He suggested that additional data was required to strengthen the assurance level.

The Director of People and Culture advised that a paper was being developed on rostering options, noting that SafeCare and e-rostering were linked through the same system. He agreed that additional context on coverage levels would be helpful. He explained that the organisation had paused the e-rostering rollout due to the financial impact of double data entry, and that a technical solution—originally expected this quarter—had been delayed until the summer. This delay affected progress toward full rollout by March 2028. He also clarified that the report's reference to a "complete cessation" of non-medical agency use was inaccurate, as usage had reduced significantly but not stopped entirely.

The Employee Director queried the rollout of SafeCare, noting variations in data quality and maturity across locations. He sought clarification on what support was being provided to staff to reduce this variability and what the plan was to ensure consistent, reliable data going

forward. The Director of People and Culture confirmed that support for SafeCare data quality would be delivered through the associated training programme, noting that significant work had already been undertaken in this area.

J Preston sought clarification on the delays in governance decision-making, noting that such delays were a concern. She also queried the reference in the report to “disquiet” about the tool, asking what this related to and how it was being addressed. The Director of People and Culture explained that the Health and Care (Staffing) (Scotland) Act and the common staffing methodology created challenges in areas where current operational pressures—such as delayed discharges and additional open beds—did not reflect the intended staffing model. He highlighted the risk of interpreting the tool outputs too literally, as this could suggest a need for additional staffing that did not align with the long-term operating model or financial constraints. It was noted that these complexities had contributed to delays in some governance decisions, particularly in areas where short-term staffing needs differed from the organisation’s strategic direction. He emphasised the importance of using the tool outputs alongside system-level planning, cultural implementation work, and day-to-day operational support.

The Employee Director noted the tension between current staffing pressures and future service redesign. He highlighted that staff were continuing to work in environments that were not safely staffed, even though longer-term plans aimed to resolve these issues. He emphasised the need for clarity on how concerns were escalated and managed during this interim period, as staff were effectively “stuck in the middle.”

The Chief Executive cautioned that staffing tool outputs sometimes indicated requirements that did not align with available funding or the organisation’s longer-term aim of shifting toward prevention-focused services. She stressed that, although redesign might be the long-term solution where demand and resource were misaligned, it would be unacceptable to allow services to operate with unsafe staffing in the meantime. She noted that temporary or alternative staffing solutions might therefore be required without committing to a long-term model that was unaffordable. She added that the organisation was developing more sophisticated approaches as further examples emerged, while recognising that financial constraints were likely to continue.

The Director of People and Culture noted that staffing tool runs had also identified areas where fewer beds and staff were needed, allowing resources to be released. He stressed the need for a mindset that considers both efficiencies and pressures, ensuring the narrative reflects opportunities to reallocate resource as well as areas needing investment.

This Quarter 2 update was noted by Committee. NHS Highland proposed an overall moderate level of assurance in relation to delivery of the statutory duties set out in the Health and Care (Staffing) (Scotland) Act 2019 for the period 1 July – 30 September 2025.

6 Items for Information and Noting

6.1 Area Partnership Forum update of meeting held on 10th October 2025

The Committee noted the minutes.

7. Any other Competent Business

7.1 Junior Doctors Strike Action – Update

The Director of People and Culture reported that planned strike action had been postponed within the past week. He confirmed that the organisation had fully prepared for the initial strike date, with contingency plans developed through business-continuity processes and HR guidance on pay arrangements. He added that the BMA was now advising acceptance of the offer, though final confirmation was still pending.

The Chief Executive asked that formal thanks be recorded for staff—particularly in acute services—who prepared extensively for the planned strike action and remained steady during the final stages of negotiations. She noted that the decision to postpone came only minutes before patient notifications would have needed to be issued and expressed appreciation for the calm and professional approach shown throughout.

7.2 Review / summary of meeting for Chair to highlight to Board.

The Chair would highlight to the Board:

- Spotlight session—particularly the significant three-year reduction in waiting times within the psychology services
- The discussion on caring and potential future development sessions.
- The contingency planning undertaken for the potential strike action.
- The key points from the IPQR discussion - including the need to improve understanding of violence and aggression data and the planned systematic approach to appraisals.

8. **Date & Time of Next Meeting**

The next meeting is scheduled for Tuesday 3rd March 2026 at 10 am via Microsoft Teams**.**

9. **Future Meetings Schedule**

The Committee is asked to note the remaining meeting schedule for 2025/26:

3 March 2026

The meeting closed at 12.30pm

NHS Highland	

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name of Committee	**Staff Governance Committee**
Date of Meeting	3 March 2026
Committee Chair	Philip MacRae

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

- People and Culture Portfolio Update – Advised assessment required of leadership session uptake capacity and associated demand.
- Staff Governance Committee Terms of Reference – Advised there were no changes proposed at this time.
- Staff Governance Committee Annual Report 2025/26 – Advised circulated report to be submitted as part of Annual Accounts process.
- Models of Integration and Single Authority Model – relevant papers highlighted.

ASSURE

- People and Culture Portfolio Update – Moderate.
- People Metrics and Integrated Performance and Quality Report – Moderate.
- iMatter National Report. Discussed thematic findings and action plan development – Moderate.
- People and Culture Strategic Risk Review – Moderate.
- Health and Care Staffing Act Implementation Q3 & Annual Reports – Moderate.
- Workforce Policies Report. Updated on HR Sub Group responsibilities, local guidance consideration requirements and future Counter Fraud reporting - Substantial.
- Whistleblowing and Confidential Contact Q3 Report - Moderate.
- Communication and Engagement 6 Monthly Update- Moderate.

ADVISE

- People and Culture Portfolio Update – Updates provided on Employability, funding streams, development of the Leadership and Culture Annual Report, and Health Passport. SOP agreed for escalation of matters relating to HCSA, tool runs for which over next 6 months. Maternity Staffing Tool referenced.
- People Metrics and Integrated Performance and Quality Report – Updates provided on Long Term Absences, reduced working week arrangements, Time to Fill, wider recruitment and retention activity. There was in depth discussion around a number of aspects relating to appraisal activity.
- iMatter National Report. Advised setting priority areas to address, noting visibility an issue Highlighted across NHS Boards.
- People and Culture Strategic Risk Review. Advised relevant risk ratings will be reviewed.
- Area Partnership Forum Update on Meeting on 12 December. Relevant meeting detail noted.

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ACTIONS
• People and Culture Portfolio Update – Agreed update on Bernardo's Pilot Programme to next meeting. • People and Culture Strategic Risk Review – Agreed update on mitigations and any required escalations be brought to next meeting.

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NHS Highland
na Gàidhealtachd

MINUTE of HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE
Virtual Meeting Format (Microsoft Teams)

14 January 2026 13.00 pm

Present

Cllr. Christopher Birt, Highland Council
Thomas Brown, Lead Doctor (GP)
Louise Bussell, Nurse Director
Claire Copeland, Medical Lead
Jennifer Davies, Director of Public Health
Fiona Duncan, Highland Council Chief Social Work Officer
Cllr. David Fraser, Highland Council
Helen Eunson, Area Clinical Forum
Arlene Johnstone, Chief Officer, Highland Health and Social Care Partnership (HHSCP)
Julie Gilmore, Nurse Lead
Ian Kyle, Highland Council
Joanne McCoy, Non-Executive
Moira Miller, Staffside representative
Gerard O'Brien, Vice Bord Chair (Committee Chair)
Kaye Oliver, Staffside representative
Dr Neil Wright, Non-Executive
Mhairi Wylie, Third Sector Representative

In Attendance

Gareth Adkins, Director of People and Culture
Natalie Booth, Senior Corporate Administrator
Rhiannon Boydell, Head of Integration, Strategy and Transformation, HHSCP
Paul Chapman, Associate Director AHPS (North Highland)
Gavin Davidson, Senior Administrator
Gillian Grant, Interim Head of Commissioning Adult Social Work and Social Care
Frances Gordon, Head of Finance for Highland HSCP
Michelle Johnstone, Area Manager
Laura Neil, Associate Director of Quality and Clinical Governance
Addy Massey, Corporate Administrator
Ruth MacDonald, Head of Service - Social Work Services
Marie McIlwraith, Community Engagement Manager
Nathan Ware, Deputy Head of Corporate Governance

Apologies: Ron Gunn, Philip MacRae, Fiona Malcolm, Nicki Sturzaker, Elaine Ward

1.1 Welcome and Apologies for absence

The meeting opened at 13.00 pm, and the Chair welcomed the attendees. The meeting was quorate.

Moira Miller was welcomed to her first meeting as she joined the committee to take up one of the vacant staff-side posts, strengthening staff-side representation.

The committee also formally thanked Mhairi Wiley for her significant contribution as the third sector interface representative, noting that this was her final meeting before moving to a new role.

1.2 Declarations of Interest

There were no declarations of interest.

1.3 Minutes of Previous Meetings and Action Plan

The Committee approved the minutes of meeting of 05 November 2025 and noted the action plan and work plan.

The Chief Officer for the Highland HSCP noted closure of three actions and the briefing on the current use and accessibility of anticipatory care plans and emergency care records across North Highland would be included in the March 2026 meeting Chief Officer Report.

1.4 Matters Arising

There were no matters arising from last meeting discussed.

2. Finance

2.1 Finance Report – Month 7 2025/2026

The Head of Finance for the HSCP advised that NHS Highland had submitted a financial plan to the Scottish Government for the 2025/2026 in March 2025. The financial plan submitted to Scottish Government (SG) in March 2025 was not accepted and they indicated that a resubmission was necessary. A revised plan was submitted in June 2025 and accepted by SG detailing a net financial deficit of £40.005 million. The Board had continued working with SG to improve the financial position.

At the end of October 2025 (Month 7), an overspend of £35.241 million had been reported, with projections indicating this could increase to £40.005m by the end of the financial year. The forecast position had assumed further work would enable a breakeven outcome within Adult Social Care (ASC) by 31 March 2026. Within the Highland Health & Social Care Partnership, a year-to-date overspend of £20.474 million had been reported, with forecasts suggesting this could rise to £24.129 million by year-end. This projected overspend included £20.758 million relating to ASC, which the Board had assumed would be brought into financial balance by the end of the financial year.

Further detail was provided in relation to North Highland Communities; Adult Social Care; Value & Efficiency; and Supplementary Staffing.

During discussion, the following points were raised:

- Progress on the Adult Social Care (ASC) Finance Plan. The Chief Officer Highland HSCP noted that all ASC finance plan workstreams had been initiated to strengthen grip, control and cost-containment measures, although the expected impact had not yet been realised.
- Need for Additional Measures. It was highlighted that some planned changes required policy, procedural and structural adjustments, and that “emergency measure” discussions had begun to identify further actions to reduce the overspend.
- Operational Savings Requirement. The committee reiterated that the key priority was delivery of operational savings linked to ASC, including the Board’s share of the value and efficiency programme and the 3% savings target.
- Frontline Operational Context. Members discussed the pressures created by winter demand, staff shortages and hospital flow, and queried how budget control could be achieved. It was noted that while frontline care should remain unchanged for service users, the organisation was not operating on a “business as usual” basis and several grip and control measures were already in place.
- Timescales for Action. It was confirmed that immediate measures were underway, while the timelines for more significant actions would depend on policy requirements and governance processes. ASC financial recovery was identified as a high priority over the coming months and years.

- Financial Reporting and Data Consistency. Concerns were raised regarding the absence of month eight data in the slide pack, with members asking that the most up-to-date financial information, including value and efficiency delivery by area, be provided at future meetings to ensure consistent reporting across committees.
- Overall Financial Position. The committee noted the position remained broadly in line with expectations, with the recurring savings challenge continuing to represent a significant risk as the Board prepared for future 3 per cent savings requirements.

The Committee is **discussed** and **noted** the Highland HSCP financial position at month 7 and associated mitigating actions and accept **limited** assurance.

Performance and Service Delivery

3.1 Integrated Performance and Quality Report

The Head of Integration, Strategy and Transformation, HHSCP highlighted work underway to develop a consistent set of KPIs at strategic and tactical levels with operational indicators to follow, aiming to create a uniform information pack for use across services and committees. Work at service level was due to finish at the end of the month and would include trajectories once available. The executive summary showed mixed performance with red, amber and green ratings linked to national targets, and local targets were planned for future reports. It was highlighted that improvement work continued to address the concerns of the vaccination uptakes for children through the working group. A further update was provided for ASC; Unmet Needs; and Delayed Discharge.

During discussion, the following points were raised:

- Development of KPI Targets. Members noted that services were finalising their key performance indicators and trajectories, with work due to complete at the end of January to support clearer measurement of improvement.
- Setting Realistic and Evidence-Based Targets. It was confirmed that benchmarking data, national datasets and research evidence were being used to shape targets that were stretching yet achievable, with regular review planned by the senior leadership team.
- Phased Approach to Avoid Over-Complexity. The Chief Officer highlighted the risk of paralysis when tackling system-wide measurement issues and emphasised the need to focus first on agreed KPIs for the IPQR before expanding to wider population-level and preventative indicators.
- Preventative Activity and System Outcomes. Members discussed the importance of understanding the impact of preventative services, including those commissioned from the third sector, and noted the risk of misdirecting future investment without better visibility of system-wide outcomes.
- Data Quality and Consistent Definitions. Concerns were raised about the reliability of data and variation in reporting practices, and assurance was given that clear definitions, standard operating procedures and improved use of systems were being implemented.
- Vaccination Delivery Model. An update was provided on negotiations to implement the new hybrid vaccination model, with a proposed three-month lead-in period for GP practices and confirmation that work was underway on wider delivery elements.
- Care Home Data and Waiting Lists. Members requested improved reporting on care-home waiting lists, with a future update proposed due to the complexity of tracking placements across in-house and independent sector providers.
- Population Health and Commissioning. The Committee discussed the need for better data on need and outcomes to guide future commissioning decisions, highlighting prevention, long-term conditions and system-wide impact as priority areas for development.

Following the discussion, the Committee:

- **Considered** the progress made with the development of KPIs across the HSCP to be managed within a performance framework.
- Accepted **limited** assurance and **noted** the continued and sustained stressors facing both NHS and commissioned care services.
- **Considered** further indicators that are required to support the assurance for the Highland Health and Social Care Partnership

3.2 Highland HSCP Rick Register

The Head of integration, Strategy and Transformation, HHSCP introduced the paper and highlighted movements in the Level 2 risk register, noting one new risk, several changes in risk ratings, and highlighting key themes including workforce availability, financial sustainability, care-home capacity and information technology.

During discussion, the following points were raised:

- Workforce Availability Risk. Members noted that workforce availability remained a long-standing high risk and sought clearer information on mitigation plans, expected timelines, progress milestones and when these actions were likely to reduce the overall risk level.
- Adult Social Care Financial Risk. Similar requests were made for transparency on Adult Social Care financial containment and transformational plans, with members asking when these actions would realistically influence the financial risk rating.
- CareFirst System Replacement. Concerns were raised about the Highland Council–led CareFirst replacement, with members seeking assurance that the new system would interface effectively with NHS systems and support reporting, commissioning and data needs across services.
- Use and Purpose of the Risk Register. The Chief Officer noted that the register aimed to provide assurance on identified risks and mitigations rather than detailed operational updates and advised that broader operational information might be more appropriate for future Chief Officer reports or development sessions.
- Clarity of Mitigations and Tracking Progress. Members reported difficulty linking risks to their associated mitigations and asked for clearer presentation and regular updates to support monitoring of progress and impact.
- System-Wide Workforce Impact. It was recognised that workforce shortages underpinned and influenced multiple risks across the HSCP, and members stressed the need for redesign and efficiency rather than assumptions about new staffing availability, given the demographic challenges facing the Highlands.
- Enhanced Service Risks. Concerns were raised regarding risks linked to the diabetes enhanced service, and assurance was provided that the issue was captured on the appropriate risk register and scheduled for discussion at a forthcoming committee.
- Future Development Session. The committee agreed that a development session on the practical use of the risk register, mitigations and assurance processes would be beneficial, and confirmed that no risks required further escalation at this stage.

The Committee **considered** the report, accepted **moderate** assurance, and identified any matters that require further assurance or escalation to NHS Highland Board.

3.3 Children and Young Peoples Services Report 25/26

I Kyle presented an update on delivery of the 2023–2026 Integrated Children's Services Plan, confirming statutory requirements were being met and highlighting strong progress, including a new multi-agency strategic group, a revised child's plan being piloted, and workforce training to support consistent GIRFEC practice. He noted improvements in mental health and well-being through aligned funding, a needs-led locality model, and strengthened support for children affected by substance use. Work on The Promise had progressed through clarified responsibilities and the development of a specialist health team, while children's rights and participation continued to gain influence and had received national recognition. The whole-family well-being programme was advancing, with the Family Links project offering valuable insight.

He also referred to the performance framework containing detailed measures used to monitor progress and noted that detailed data queries would be picked up offline. Planning had begun for the 2026–2029 plan and was supported by a joint strategic needs assessment to provide refreshed evidence on need, inequalities and required system change. This ensured the next plan would be informed by robust analysis and meaningful engagement with children and young people.

During discussion, the following points were raised:

- Delivery of The Promise. Members received assurance that a local Partnership Promise Board and delivery plan were in place, aligned to national expectations, and a recent Council report was offered for further reference.

- Vaccination Indicators and Interpretation. The committee noted that different reports presented varying views of vaccination performance due to the use of different indicators, and members stressed the need to consider the full vaccination picture and avoid reliance on single metrics.
- Use of Data and Performance Measures. It was highlighted that previous frameworks contained an unmanageable volume of indicators, and members discussed the need to balance meaningful oversight with manageable reporting that focused on the most relevant measures.
- Public Health Trends. Members welcomed the increase in breastfeeding rates and noted the positive implications for child and maternal health.
- Data Gaps and System Issues. Concerns were raised about missing or delayed datasets, and assurance was given that updated information could be provided quarterly and that system-related delays were being addressed.
- Future Reporting and Comparability. Members requested comparator data in future reports to support trend analysis and noted the value of more regular performance updates to the committee.
- Support for Plan Development. Assurance was given that NHS colleagues were actively contributing to the development of the next Integrated Children's Services Plan, with strong engagement across delivery groups.
- Data Sharing Across Agencies. The committee noted ongoing challenges in information sharing between health and council services, and assurance was if partnership data-sharing agreements existed, with further discussion offered offline.

Following discussion, the Committee:

- **Noted** the progress made in delivering the Integrated Children's Services Plan 2023–2026.
- **Endorsed** the continued implementation of delivery group action plans and improvement programmes.
- **Supported** alignment of funding streams and strategic priorities to sustain improvements.

3.4 Engagement Framework Assurance Report 24/25

The Community Engagement Officer presented slides to the Committee highlighting NHS Highland's new engagement online platform 'The Engagement Hub' and the range of benefits associated with the platform.

The presentation highlighted the following:

- The Engagement Hub continued to develop as NHS Highland's main platform for community-wide engagement, offering a range of tools to support participation, improve accessibility, and strengthen relationships with communities and partners.
- Fifteen projects were launched during the year, attracting over 6,300 visits and 435 direct engagements, with higher engagement levels seen in projects where views directly informed decisions, and lower levels for strategic consultations.
- The Hub supported staff by providing planning templates, training materials and oversight processes, although challenges remained around staff awareness, confidence, and the perceived time required to manage projects.
- Priorities for the coming year included increasing organisational awareness, expanding collaborative projects, improving governance and data-handling processes, establishing an advisory panel, and mapping engagement channels through a new short-life working group.

During discussion, the following points were raised:

- Commitment to Increasing the use of the Engagement Hub. The partnership confirmed its intention to embed the Engagement Hub more fully into everyday practice, ensuring it became a routine and integrated part of engagement activity rather than a standalone process.
- Growth in Engagement and Remaining Limitations. Members recognised progress made through the Hub but noted that overall engagement numbers remained low when compared with the population size, particularly in relation to protected and vulnerable groups.
- Future Representation and Recruitment. Concerns were raised about how representation from vulnerable groups would be secured, with members asking whether future recruitment could be subdivided by topic or need to ensure relevant voices were captured.

- Budget and Resource Constraints. It was highlighted that engagement ambitions were constrained by the limited £20,000 budget, with £17,500 already committed, raising concerns about the Hub's capacity to support meaningful growth and transformation.
- Quality and Nature of Engagement. Members observed that much of the current activity remained consultative rather than collaborative and discussed the need to align future work more clearly with recognised engagement frameworks such as Arnstein's Ladder and the NHS engagement matrix.
- Short-Life Working Group and Wider Collaboration. Assurance was given that a short-life working group was being established to strengthen engagement culture, improve structures, and make better use of existing mechanisms such as Community Planning Partnerships and patient-experience workstreams.
- Staff Skills, Confidence and Cultural Change. It was noted that staff confidence in undertaking engagement varied, and members recognised the importance of shifting organisational culture so that engagement became embedded, supported and valued across services.
- Reporting Frequency. The committee reflected on the early-stage development, data limitations and resource pressures, and requested a further update later in the year once progress from the short-life working group was available.

After **examining** and **considering** the content of the report and the Committee accepted **moderate** assurance.

The Committee took a break from 14.57 pm until 15.10 pm.

3.5 Draft Adult Social Care Commissioning Strategy and Intentions

The Chief Officer for Highland HSCP explained that the first draft of the partnership's commissioning strategy had been developed by the senior leadership team and was presented in draft for final comment and discussion before being presented to the Joint Monitoring Committee for approval.

The Interim Head of Commissioning explained that the draft Adult Social Care Commissioning Strategy for 2026–2029 had been produced to meet the clear need for an updated strategic framework. She noted that the document set out commissioning intentions based on the Joint Strategic Needs Assessment and wider statutory requirements, and that it described the challenges facing services, the priorities for change, and the initial market messages for providers. She confirmed that further detail would be developed through supporting plans and that additional work was required to strengthen the content.

The Chief Officer clarified that the committee was being asked to provide feedback on whether the draft commissioning strategy clearly set out NHS Highland's commissioning approach and whether it would enable independent providers and the public to understand the organisation's future intentions.

During discussion, the following points were raised:

- Purpose and Early Stage of the Strategy. Members recognised the draft commissioning strategy as an important first step in defining the partnership's commissioning intentions and agreed it should focus primarily on outcomes rather than service volumes.
- Separation of Strategy, Planning and Procurement. It was highlighted that commissioning, procurement and market facilitation needed to be distinguished more clearly, with future supporting documents expected to provide greater detail on how commissioning intentions would be delivered.
- Clarity and Accessibility of the Document. Members noted the document was difficult to digest and requested a clearer structure, stronger narrative flow and versions tailored for different audiences, including independent providers, staff and the public.
- Level of Detail and Use of Data. Concerns were raised about the lack of context around key figures, such as assessment waiting lists, and members asked for clearer explanations of the scale of need and intended investment shifts.
- Role of the Third Sector and Preventative Services. The committee emphasised that third sector contributions and preventative activity were not sufficiently reflected, and that these should be incorporated more explicitly to support a whole-system commissioning approach.
- Registration, Quality and Provider Responsibilities. Members highlighted the need to reference responsibilities held by NHS Highland as both a provider and commissioner of registered services, including expectations around quality assurance, governance and regulatory compliance.

- Workforce and Integration Considerations. It was noted that commissioning decisions would have significant workforce implications, and members requested clearer alignment with integration work, workforce planning and financial recovery to help understand cumulative impact.
- Future Development and Supporting Plans. Members accepted the document as a starting point but noted that further enabling plans—such as the market facilitation plan, procurement plan and workforce plan—would be essential to complete the commissioning framework.

Following discussion, the Committee **noted** the draft strategy and accepted **moderate** assurance.

3.6 Chief Officer's Report

The Committee Chair introduced the report, and it was agreed that the paper would be **noted** by the Committee. No further comments were raised regarding the report.

4. Committee Function and Administration

4.1 Annual review of Terms of Reference

The Deputy Head of Corporate advised that the report formed part of the annual review of the committee's terms of reference following updates to the Code of Corporate Governance. He invited members to highlight any further adjustments and noted that changes could be made at any point during the year if required.

The Committee Chair advised that he had contacted the Deputy Head of Corporate Governance about several amendments to the terms of reference, including removing the agenda format, clarifying the committee's role in community planning oversight, and deleting the reference to establishing a strategic commissioning group. He confirmed these points would be discussed and agreed offline before being added to the final document. He also invited members to submit any further changes before the paper progressed to the Audit Committee in March.

The Committee:

- **Reviewed** the Terms of Reference and highlighted required change.
- **Noted** that the Terms of Reference will be submitted to the Audit Committee and the Board for approval in March 2026 and included in the updated Code of Corporate Governance thereafter.

5. Any Other Competent Business

6. Date of next meeting – Wednesday 4 March 2026 at 1pm

The meeting closed at 15.59 pm.

NHS Highland	

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name of Committee	Highland Health and Social Care
Date of Meeting	04 March 2026
Committee Chair	Gerry O'Brien

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

- Significant and worsening financial overspend, including ASC overspend of £25.792m and HSCP projected overspend of £29.649m.
- Delayed discharge pressures remained a major system outlier, impacting community hospitals and flow.
- Workforce shortages across ASC and community services continued to drive multiple risks.
- Rising guardianship and adults with incapacity cases created statutory pressure.

ASSURE

- Finance Report – Month 9 2025/2026 (Limited)
- Integrated Performance and Quality Report (Limited)
- SDS Assurance Report 25/26 (Moderate)
- Highland Care Model Update (Moderate)
- Carers Strategy Update (Moderate)
- Community Services Report (Moderate)

ADVISE

- Need for clearer financial reporting, including actual savings achieved and consistent district out-turns.
- Need for clearer risk-mitigation tracking, linking risks to actions and progress.
- Recommendation to strengthen engagement culture, including better representation of vulnerable groups.
- Advice that community hospital strategy and pathway variation require further strategic work.

RISKS

- Financial risk: large savings gaps, delayed implementation, and reliance on supplementary staffing.
- Workforce risk: shortages affecting SDS delivery, ASC, community services, and engagement capacity.
- System flow risk: high delayed discharge numbers and potential backlog or unmet need.
- Digital risk: uncertainty around CareFirst replacement and NHS system interface.
- Service sustainability risk: fuel costs, care-at-home capacity, and third-sector fragility.

ACTIONS

- Chief Officer and Committee Chair to discuss topics for next Development session.
- Committee to follow up with Director of People and Culture, to clarify the Act's implications for social care, ensure accurate monitoring, and confirm whether current budget and staffing levels meet statutory requirements.

LEARNING

- A number of development session topics were highlighted by the Committee including risk-register mitigations and assurance processes; Understanding Rising Delayed Discharge Trends and Hidden Demand; Deep Dive into Unpaid Carers.

CLINICAL GOVERNANCE COMMITTEE	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Textphone users can contact us via Typetalk: Tel 0800 959598 www.nhshighland.scot.nhs.uk/ NHS Highland na Gàidhealtachd
MINUTE	**15 January 2026 – 9.00am (via MS Teams)**

Present

Karen Leach, Chair
Louise Bussell, Board Nurse Director
Sarah Compton-Bishop, Non-Executive
Joanne McCoy, Vice Chair and Non-Executive Director
Gerry O'Brien, Non-Executive
Dr Boyd Peters, Board Medical Director
Dr Neil Wright, Non-Executive

In attendance

Isla Barton, Director of Midwifery
Stephanie Govenden, Consultant Community Paediatrician
Rebecca Helliwell, Deputy Medical Director (Argyll and Bute)
Elaine Henry, Deputy Medical Director (Acute)
Arlene Johnstone, Chief Officer (Community)
Jo McBain, Director (Allied Health Professions)
Brian Mitchell, Board Committee Administrator
Mirian Morrison, Clinical Governance Development Manager
Heather Richardson, Head of Operations
Leah Smith, Complaints Manager
Katherine Sutton, Chief Officer (Acute)
Nathan Ware, Deputy Head of Corporate Governance
Derick MacRae, Cancer Services Manager
Dawn MacDonald, Staffside Representative
Paul Chapman, Team Leader, Physiotherapy
Andrew Nealis, Information Governance & IT Security Manager
Sarah Buchan, Director of Pharmacy
Stacey Charles-Evans, Lead Nurse Tissue Viability
Jennifer Davies, Director of Public Health
Gavin Smith, Employee Director
Alison Felce, Senior Business Manager
Dr Claire Copeland, Deputy Medical Director
Julie Gilmore, Associate Nurse Director
Laura Neil, Associate Director of Quality and Clinical Governance
Anna Chisholm, Senior Corporate Administrator
Bryan McKellar, Whole System Transformation Manager
Linda Currie, Associate AHP Director
Elspeth Caithness, RCN Representative
Jenny Wares, Consultant in Public Health

1.1 WELCOME AND APOLOGIES

Formal Apologies were received from Muriel Cockburn, Liz Henderson and Seamus McMillan.

1.2 DECLARATIONS OF INTEREST

The Chair noted the recent departure of Alistair, who had previously been the individual most likely to declare interests. No members declared any interests.

1.3 MINUTE OF MEETING THURSDAY 6 NOVEMBER 2025, ROLLING ACTION PLAN AND COMMITTEE WORKPLAN 2025/2026

The Minute of Meeting held on 6 November 2025 was **Approved.** The Committee Work Plan and Action Plan – this has been substantially updated, with members thanking colleagues for the significant work involved. Early preparatory work has been carried out to ensure the Work Plan is aligned for the rest of the year and into next year. The Chair plans to meet individually with committee members before the March meeting to refine the workplan further. Members were encouraged to submit topics that should be added, particularly national developments or areas needing additional scrutiny. It was recognised that the workplan will continue to evolve as priorities shift.

The Nurse Director confirmed progress on the first outstanding action regarding structural governance changes, work is advancing however it is not complete.

Argyll & Bute related actions were referenced. Clear progress was noted, with some items still in development.

The Committee:

- **Approved** the draft Minute.

1.4 MATTERS ARISING

Women's Services Update

I Barton and H Richardson spoke to their six-monthly report covering maternity, neonatal, and gynaecology services.

Maternity and neonatal services face high national scrutiny. The service is preparing for unannounced HIS maternity inspections, benchmarking Highland against findings from other boards and developing an associated action plan.

The new Scottish Government maternity services policy was largely positive, noting good practice. Areas needing improvement include training, education data, and compliance with required modules for midwives and obstetricians. A second submission is due in March.

Workforce remains under pressure, especially in midwifery, but a recent staffing uplift has been approved. A short-life working group is addressing workforce culture, communication, roles, and escalation processes. Recruitment of an obstetric sonographer trainee was highlighted as a key step toward sustainability.

Improvements have been made to the birthing pool and labour suite rooms, though compliance with infection control remains challenging due to estate limitations.

Data show a decline in spontaneous vaginal births and an increase in caesarean sections, reflecting rising complexity among service users (e.g., comorbidities, age, mental health). Members requested deeper analysis in the next report.

Updated clinical and professional governance structures including new subgroups and cross-system alignment are now in place, with Highland showing areas of good practice in risk review compliance.

The Committee took **moderate** assurance, noting significant progress but ongoing workforce and operational challenges.

2 SERVICE UPDATES

2.1 Audiology National Review Update

A Graham advised Audiology has strengthened its patient-feedback mechanisms, including rolling out questionnaires and working directly with community partners such as Hearing Insight Care and Deaf Services to inform service improvements. The service is participating in the national ABR paediatric peer-review pilot and has focused on building in-house testing capability. As a result, reliance on external paediatric providers has been eliminated. Staff training and competency development continue as priorities. Paediatric clinic capacity has doubled, dual-trained staff have been recruited, and the service is now consistently meeting the 4- and 6-week assessment targets. Reporting is up to date and aligned with national standards. Work is underway to implement new frameworks such as AI CLIP, ISO standards, and upcoming national paediatric quality standards. Efforts continue to align service delivery across Highland and with neighbouring boards. There is active joint working with ENT consultants, including joint clinics, improved shared pathways, and reduced unnecessary MRI referrals.

The Committee gave **moderate** assurance, recognising strong progress but with further national and local work still in motion.

2.2 Cancer Services Update

D MacRae spoke to the circulated paper and reported that cancer services remain a significant area of concern, with sustained pressures across diagnostics, treatment pathways, and workforce capacity. The service is receiving weekly oversight from the Chief Executive due to operational fragility.

NHS Highland is actively engaged in the national review of oncology. The future Target Operating Model aims to reduce competition between boards for specialist staff and strengthen mutual aid. Local leaders emphasised that although full implementation may take time nationally, Highland needs TOM principles in place now due to recruitment challenges and increasing service vulnerability.

Existing mutual aid remains essential:

- Lothian and Grampian support consultant-level oncology.
- Grampian supports head and neck pathways.
- Oncology mutual-aid discussions occur weekly across Scotland.

Highland has already shifted some pathways to TOM-style shared models out of necessity.

Recruitment challenges are acute across oncology roles (consultants, radiographers, specialist nurses). Workforce gaps are increasingly affecting high-volume tumour pathways (e.g., breast, lung, prostate), not just low-volume specialist cancers.

Rising demand is adding pressure at the front end of pathways:

- Urgent suspected cancer referrals have doubled over five years.
- Radiology and labs are under strain.
- Dedicated support staff are helping guide patients through diagnosis to improve experience and communication.

Members highlighted cases where patients were unclear about their pathway. Improved communication—particularly when care involves other boards was identified as a key improvement area.

The Committee emphasised the need for:

- Clear assurance on quality and safety, not just workforce risk.
- Visibility of patient outcomes and pathway performance.
- More structured reporting, including assurance by cancer type/pathway, acknowledging some pathways are functioning well while others are under strain.

A concern was raised about possible AI generated patient letters being issued within the system. E Henry confirmed there is no policy or instruction authorising the use of AI for patient letters and committed to investigate the specific case raised.

The Committee were asked to take **limited** assurance from the report content.

After discussion, the Committee: **Noted** the report content and agreed to take **Limited** assurance, reflecting ongoing vulnerabilities, operational pressures, and the need for strengthened pathway oversight. **Agreed** E Henry will review the issuing of governance concerns regarding AI patient letters

3 EMERGING ISSUES/EXECUTIVE AND PROFESSIONAL LEADS REPORTS BY EXCEPTION

L Bussell noted the system wide pressures with acute, community, and social care services experiencing sustained and significant pressure, driven by winter demand, viral illness, weather-related disruption, and reduced flow across the system.
Pressures are resulting in:

- Increased escalation levels in acute care.
- Use of additional beds in six-bedded bays (placing 7 patients in 6-bed spaces).
- Compromised flow from Emergency Departments, impacting ambulance offloading times.

Senior nursing teams are carrying out daily risk assessments on overcrowded areas, focusing on falls, harm, and safety compromises. Delays in discharging patients contribute to front-door pressures, prompting calls for more distributed risk-holding across the whole system (not concentrated in ED/acute assessment areas).

Community services report a lag effect, continuing to manage the aftermath of severe weather and unmet visits, requiring “catch-up” activity while also supporting hospital flow. A multi-agency incident management approach is in place within the Partnership to maintain safe flow, manage delays, and balance workforce, acuity, and available space.

Acute and community teams face ongoing staffing constraints, resulting in difficult decisions around stepping down elective activity in some areas while protecting urgent and cancer-related work.
Improved collaboration between acute and community leadership is helping distribute workload and manage risk more consistently. Leadership teams are working collaboratively, using real-time monitoring, escalation mechanisms, and cross-sector coordination to maintain safety and flow.

The Committee acknowledged the significant operational strain and expressed appreciation for staff working in challenging and continually shifting circumstances.

The Committee Noted the reported position.

4 PATIENT EXPERIENCE AND FEEDBACK

M Morrison spoke to the circulated report providing the committee with an update on the high volume of complaints. All complaints are shared with the relevant teams, and the full dataset feeds into the annual reporting process. One negative case with clear learning was highlighted to demonstrate how feedback is driving service improvement.

Members noted the value of positive stories and discussed whether wider sharing across the organisation would help reinforce staff morale and learning which would be explored further. The Committee agreed to take **moderate** assurance.

After discussion, the Committee:

- **Noted** the detail of the report and **Agreed** to take **Moderate** assurance, recognising ongoing improvements in how feedback is captured and used.
- **Agreed** that the wider sharing across the organisation will be explored further

5 CLINICAL GOVERNANCE AND PERFORMANCE DATA

M Morrison spoke to the circulated report, advising performance remained below target, with more complaints coming in than being responded to. However, early data for the next reporting month showed an improving trend, with more responses issued than complaints received.

Activity levels were steady. The SPSO is returning decisions more quickly, and in most cases is not upholding complaints, indicating satisfaction with NHS Highland's handling processes. Two complex cases remain under active dialogue.

The number of new SAERS remained consistent, but completion within the 26-week timeframe continues to be challenging. Outstanding SAER actions remain high, though next-month data indicates a significant reduction, showing progress. National work is ongoing to improve reporting and thematic analysis.

There is a notable increase in Grade 2 pressure ulcers. A deeper analysis is underway to clarify data discrepancies—specifically, whether ulcers relate to patients known versus not known to district nursing services. National standardisation work and updated grading tools are being implemented.

Falls data was not updated in this report due to system pressures, but leadership committed to update the dataset retrospectively for committee visibility.

Members described the complaints performance as disappointing and asked for clearer thematic analysis to understand what is driving volume increases. A future thematic report will be provided.

The report proposed the Committee take **Moderate** assurance.

After discussion, the Committee:

- **Noted** the detail of the report and **Agreed** to take **Moderate** assurance, recognising improvement work underway but with clear areas requiring sustained focus.
- **Agreed** that the falls data would be deferred to the next meeting.
- **Agreed** a complaints thematic report will be required for the next meeting.

6 OPERATIONAL UNIT REPORTS BY EXCEPTION AND EMERGING ISSUES WITH MINUTES FROM PATIENT QUALITY AND SAFETY GROUPS

6.1 Argyll and Bute

R Helliwell spoke to the circulated report, summarising the period is stable with no new major service pressures. Long-standing challenges continue in care at home, ADHD, dementia/LD pathways, and links with NHS Greater Glasgow & Clyde for cancer and other services. Positive recruitment reported in Oban Hospital (consultant physicians and rural emergency practitioners), improving local quality and resilience. Regulatory reviews noted no new escalations; a recent fatal accident inquiry resulted in no criticism of NHS Highland.

After discussion, the Committee Noted the content of the circulated report and **Agreed** to take **Moderate** assurance.

6.2 Highland Health and Social Care Partnership

C Copeland spoke to the circulated report, summarising the persistent workforce pressures across community nursing, AHPs, mental health, and primary care. A live issue in pharmacy regarding unsafe prescribing patterns at a GP practice is under active investigation, with improvement actions already underway. Deep dives into falls and tissue viability show isolated spikes rather than systemic deterioration. Work continues to strengthen interface governance between acute and community pathways.

After discussion, the Committee Noted the content of the circulated report and **Agreed** to take **Moderate** assurance.

6.3 Acute Services

K Sutton spoke to the circulated report, summarising vascular services is showing early stabilisation: four supporting boards now in place; a new fixed-term consultant appointed; external review of DATIX entries underway and showing no significant concerns. Oncology pressures echoed earlier discussion, with strong reliance on national mutual aid and updated governance structures. The diabetes pathway improvements are progressing, with backlog vetting and additional clinics planned. Improved tissue viability and infection prevention performance highlighted (e.g., reduction in C. diff cases after unified antimicrobial stewardship).

After discussion, the Committee Noted the content of the circulated report and **Agreed** to take **Moderate** assurance.

6.4 Infants, Children and Young People's Clinical Governance Group (ICYPCGG)

S Govenden spoke to the circulated report, expressing concerns with NDAS, though not discussed in depth due to separate programme reporting. The child death review annual report which contains over 60 reviews has been completed, with themes too small for trend analysis at this stage. Ongoing issues include lack of a bereavement nurse and pressures on school nursing, especially related to safeguarding and vaccination work.

L Bussell advised that NHS Highland is actively reviewing how Child Death Reviews intersect with other statutory review processes, such as SAERs and health and safety in. She emphasised that in some cases, multiple review processes may be triggered for the same child. This can place unnecessary burden and distress on families, who may be asked to participate repeatedly. Work is underway with colleagues to determine when combined or better-aligned review approaches could be used to avoid duplication while still fulfilling all statutory requirements.

After discussion, the Committee Noted the content of the circulated report and **Agreed** to take **Moderate** assurance.

7 INFECTION PREVENTION AND CONTROL REPORT AND COMMITTEE ANNUAL REPORT 2024/25

L Bussell spoke to the circulated report and advised IPC performance continues to be heavily constrained by wider system pressures, particularly lack of physical space in key hospital areas (e.g., Raigmore). These constraints limit the team's ability to maintain optimal infection-control standards. Despite interim arrangements and operational pressures, the IPC team remains stable, highly engaged, and able to provide cross-cover across both acute and community services. This continuity is helping maintain patient and staff safety.

The Committee acknowledged the varying levels of assurance across different aspects of the IPC report but recognised that the team is performing well under challenging circumstances.

The Committee:

- **Agreed** to accept the varying levels of assurance across different aspects of the circulated report.

8 ANNUAL DELIVERY PLAN 2025/26

B McKellar presented an update on the ADP and Operational Improvement Plan, confirming progress across: Access to treatment, Shifting the balance of care, Digital innovation, and Prevention. Work continues to reduce waiting times for planned care, cancer, and diagnostics, with a specific aim to ensure no patient waits more than 52 weeks by end of March, and progress is on track. Improvements highlighted in urgent and unscheduled care, including hospital-at-home, discharge-to-assess, and enhanced frailty pathways. Collaboration between acute and community services remains central. The key developments in digital and technological innovation include: a new theatre scheduling tool, work towards the national digital front door, digital solutions for dermatology and diabetes to increase access and efficiency. Ongoing pressures were noted in ultrasonography due to anticipated retirements. Mitigation includes rota redesign, short-term staffing options, and single waiting lists. Preventative work (aligned to national frameworks and the Board's renewed strategic direction) forms part of the ADP's longer-term commitments.

The committee noted substantial assurance in relation to the ADP update.

9 PUBLIC HEALTH

9.1 Joint Health Protection Plan 2025-27

J Davies and J Wares spoke to the circulated report, outlining its statutory basis and the broad scope of public-health protection activities delivered jointly with Argyll & Bute Council and Highland Council. They highlighted challenges in performance measurement, particularly around incident response, due to the complexity and breadth of public-health activity. Work is underway to develop more robust and measurable indicators for future iterations. Incident response standards were queried. It was clarified that established outbreak-management processes are in place, incident-management teams are rarely required, and a Scotland-wide approach to performance evaluation is likely needed.

The report proposed the Committee take **Moderate** assurance, with the assurance that strengthened governance mapping be undertaken.

After discussion, the Committee approved the plan and **Agreed** on **Moderate** assurance, reflecting increasing demand and the need for strengthened governance mapping.

10 SIX MONTHLY UPDATES BY EXCEPTION

10.1 Duty of Candour Annual Report

A Felce spoke to the circulated report outlining the number of cases, the review process, and legislative requirements. The number of recorded cases was similar to other boards.

Several improvement needs were identified:

- Earlier involvement of families in the process.
- Improved adherence to the 12-week completion timeframe.
- Enhanced data extraction and reporting, as the current system required manual review.
- Transition to the new Enphase system to support better reporting.

Training is on TURAS, although it is not currently mandatory. Alison confirmed that staff involved in duty of candour cases understand the requirements, and the Committee emphasised the importance of embedding this within governance and leadership development.

Members raised concerns about delays in reporting due to system limitations, the need for improved tracking of compliance. Alison addressed these, highlighting planned system improvements and interim measures.

The Committee agreed to receive a six-month interim update. Duty of Candour training will be built into the wider clinical governance workplan, supported by leadership oversight.

After discussion, the Committee:

- **Agreed** to receive a six-month interim update.
- **Agreed** Duty of Candour training will be built into the wider clinical governance workplan, supported by leadership oversight.
- **Agreed** on **Moderate** assurance.

10.2 Transfusion Committee – 6 Monthly Update

F Gunn spoke to the circulated report advising the transfusion committee continues to meet quarterly, reviewing clinical and laboratory issues, updating policies, and overseeing transfusion governance. A recent major haemorrhage protocol simulation was completed successfully. All NHS Highland sites are now using the national transfusion record (v2), which includes strengthened safety checks for pre-transfusion assessment. A key issue raised was the lack of an executive lead, as required by the Scottish Government following the infected blood inquiry. Despite previous requests, no appointment had yet been made. The Committee agreed this must be escalated urgently.

The Committee agreed moderate assurance, acknowledging robust activity within the Transfusion Committee but noting unresolved governance gaps pending appointment of the Executive Lead.

After discussion, the Committee:

- **Agreed** to escalate the lack of executive lead to the next EDG meeting, and update at the March meeting.
- **Agreed** on **Moderate** assurance, acknowledging robust activity within the Transfusion Committee but noting unresolved governance gaps pending appointment of the Executive Lead.

10.3 Information Assurance Group – 6 Monthly Update

A Nealis spoke to the circulated report advising the organisation achieved 89% compliance score in the NES Cybersecurity Audit, a 6% improvement, placing NHS Highland in the upper quartile of NHS Scotland Boards. Andy emphasised that operational practice matters more than the headline score. A short-life working group has been established to overhaul disaster-recovery plans. Documentation is actively being rewritten and strengthened, with initial work expected to conclude soon. Regulators are moving away from single-point-in-time audits toward continuous assurance, including scenario testing and stakeholder interviews. This will give a more realistic understanding of cyber-resilience. New tools for device management, monitoring and ransomware protection have been rolled out. However, the associated high alert volume is creating operational pressure for teams managing incidents. A national cyber-incident retainer is now in place, offering specialist expertise to NHS boards should a major incident occur.

The Committee recognised the significant work undertaken and noted the update as part of ongoing digital-governance assurance. The Committee agreed on **Substantial** assurance.

The committee noted substantial assurance in relation to the Information Assurance Group – 6 monthly update.

10.4 Tissue & Organ Donation Committee 6-Month Update

Consideration of this item has been deferred.

Agreed the Workplan cycle will be adjusted

11 CLINICAL RISK

Consideration of this item has been deferred to the next development session.

12 ANNUAL REVIEW OF COMMITTEE TERMS OF REFERENCE

The Chair noted no changes have been made to the Committee Terms of Reference however changes may be required when the mapping work has been completed. L Bussell suggested the inclusion of the Clinical and Care Governance and Quality Assurance Group.

N Ware will coordinate the required updates and ensure associated governance documents reflect the changes.

13 CALENDAR OF MEETING DATES

The Committee **Noted** the following schedule of meetings:

5 March 2026
7 May 2026
2 July 2026
3 September 2026
5 November 2026
7 January 2027
4 March 2027

14 REPORTING TO THE NHS BOARD

Discussion of relevant matters would be referenced in the Committee Summary to be provided to the NHS Board.

15 ANY OTHER COMPETENT BUSINESS

A review of the membership will be undertaken.

16 DATE OF NEXT MEETING

The Chair advised the Members the next meeting would take place on **Friday, 5 March 2026** at 9.00am.

The meeting closed at 12.30pm

NHS Highland	

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name of Committee	**Clinical Governance Committee**
Date of Meeting	**6 March 2027**
Committee Chair	**Karen Leach**

KEY POINTS FROM DISCUSSION AND ESCALATION
ALERT
• No matters were highlighted in discussion.
ASSURE
• **SCI Gateway Referral Update** – substantial • **Patient experience and feedback** - moderate • **Clinical Governance and Performance Data** – moderate • **Infant Children Young Person Clinical Governance Group** – moderate • **Infection Prevention and Control** – varying levels of assurance • **Highland Health and Social Care Partnership Update** – moderate • **Acute Services Update** – moderate
ADVISE
• **NDAS Service Update** – limited, taking the active mitigation and system-wide transformation work into consideration. 6-monthly updates to the CGC. • **Argyll & Bute Update** - Moderate, reflecting ongoing pressures alongside active management and improvement activity. • **Annual Delivery Plan 2025/26 and Operational Improvement Plan** – moderate, due to the ongoing fragilities, particularly in workforce dependent areas. • **Area Drugs and Therapeutics Committee** - noting the need to refresh leadership, membership and the Terms of Reference.
RISKS
• **SACT / Cancer Services** – The Committee were informed that Regional Cancer had advised that NHSH was now in escalation for SACT waiting times. Several areas within cancer services are under increasing pressure due to workforce changes. While recruitment is ongoing, national shortages of specialist personnel make this challenging. A report will be brought to May CGC focusing on SACT services followed by the planned annual report on cancer services in July. No matters were highlighted in discussion • **System Pressures** – Current system pressures across the whole health and care system in Highland. These are most evident in ED and in acute in-patient areas but impacting all teams. Dedicated work underway to improve flow through closer collaboration and new approaches to unscheduled care. Interface lead now in place to support this work alongside operational and clinical leadership colleagues.

ACTIONS
• No matters were highlighted in discussion
LEARNING
• No matters were highlighted in discussion

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MINUTE of MEETING of the AREA CLINICAL FORUM	**15th January 2026 – 1.30pm Microsoft TEAMS**	

Present

Allyson Turnbull-Jukes, Psychological Committee (Chair)
Andrew Strain, Area Medical Committee
Catriona Brodie, Area Pharmaceutical Committee
Gerry O' Brien, Board Vice Chair
Graham Bell, Non-Executive Director
Grant Franklin, Area Medical Committee
Helen Eunson, NMAHP Advisory Committee
Ian Flemming, Area Optometric Committee
Joanne McCoy, Non Executive-Director
Linda Currie, NMAHP Advisory Committee

In Attendance

Lorien Cameron-Ross, Clinical Lead, Realistic Medicine (Item 4.1)
Arlene Johnstone, Chief Officer, HHSCP
Boyd Peters, Medical Director (Item 4.3)
Karen Doonan, Corporate Administrator (minutes)
Tania Godwin, Corporate Administrator (Observing)
Nathan Ware, Deputy Head of Corporate Governance

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting, apologies were received from L Neil, R Helliwell and A Javed. It was noted that there were quoracy issues due to availability, the meeting was rescheduled to begin at 2.15pm. Agenda items were therefore not taken in the order presented on the agenda and a short break was taken from 3.50pm until 4pm to accommodate Item 4.3.

The Chair welcomed Dr Andrew Strain as the second vice chair of committee.

1.1 DECLARATIONS OF INTEREST

There were no declarations of interest.

2. DRAFT MINUTE OF MEETING HELD ON 6th November 2025

The minutes were **approved** as accurate and correct.

3. MATTERS ARISING

None

4. ITEMS FOR DISCUSSION

4.1 Realistic Medicine – Lorien Cameron-Ross, Clinical Lead, Realistic Medicine

Dr Lorien Cameron-Ross introduced herself as the Realistic Medicine Clinical Lead for NHS Highland. She explained that communication and engagement continued to be challenging due to limited resources, with only a small team available to cascade information across patients, community teams and hospital staff. Although quarterly newsletters were issued, it was unclear how widely they were read or whether staff recognised the relevance to their roles.

She highlighted the need for a "ripple effect" to spread messages more effectively. Dr Cameron-Ross noted the significant potential benefits of Realistic Medicine, including improving health span, reducing health inequalities, decreasing clinician burnout, strengthening community resilience and supporting action on the climate emergency. She emphasised that failing to improve current approaches would worsen these issues.

She described the previous action plan, which had used the theme "little stones, big cairn" to demonstrate that small individual contributions could collectively create meaningful change. Work over the past year had involved a wide range of projects at national, local and departmental levels, and NHS Highland had shared successes nationally through conference posters and inclusion in the Scotland Realistic Medicine casebook.

Dr Cameron-Ross explained that she was beginning to develop the next action plan and invited input from members. She proposed a theme centred on nutrition across the organisation, reflecting priorities discussed at the recent global forum in Glasgow. The aim would be to promote balanced, sustainable and seasonal nutrition for staff, patients and communities. A community of practice might be established to support this work.

She also highlighted upcoming national work, including another "It's OK to Ask" campaign from NHS 24, which NHS Highland would support. The team planned to continue encouraging engagement with learning modules, explore opportunities for a local conference and progress work on laboratory optimisation.

Forum members were encouraged to act as exemplars of Realistic Medicine within their own teams, enabling staff, supporting cultural change and sharing examples of innovation and improvement. Dr Cameron-Ross acknowledged that individuals' capacity fluctuated but noted that even small contributions were valuable.

The Chair highlighted that the Forum could help promote the modules but expressed concern that many staff may not be aware of them. She asked about the overall uptake of the Turas modules across Highland. Dr Cameron-Ross stated that 186 people had completed the shared decision-making module and 29 had completed the introduction. The team had promoted the Turas modules through the weekly Sway and during teaching sessions. She noted that when delivering Flying Start Nursing and Midwifery teaching, she directed staff seeking CPD or further learning to the relevant modules.

She added that for those undertaking quality improvement activities, modules such as Shared Decision Making or Managing Risk were particularly useful. When registration opened for the conference, she also encouraged attendees—via the confirmation email—to complete a baseline module in advance.

G Franklin noted that some staff felt the term *Realistic Medicine* implied they were otherwise practising "unrealistic" medicine, creating a barrier to engagement. He added that many clinicians had applied the principles for years before the term existed, citing examples such as choosing not to carry out investigations that would not alter management. He asked how best to communicate the importance of increasing the use of Realistic Medicine, given its significance for the future sustainability of the NHS.

Dr Cameron-Ross agreed that Realistic Medicine was not a binary concept and aligned with core clinical values. She noted that system pressures, workload and limited access to information sometimes made it harder to practise consistently. She emphasised the importance of supporting reflection, reducing unnecessary tests, and creating a culture where staff felt able to question whether actions added value.

The Medical Director thanked Dr Cameron-Ross for bringing the item forward and stressed that Realistic Medicine was relevant to all staff, not only doctors. He described it as a set of principles many already applied in practice and gave an example from his own experience. He highlighted ongoing work on

diagnostics and reducing unnecessary investigations and encouraged colleagues to support the work and share their own examples to help raise awareness.

The Vice Chair thanked Dr Cameron-Ross for the presentation and noted her previous involvement in Realistic Medicine from a mental health perspective. She agreed that the title could discourage wider engagement and supported exploring a rebrand to reflect its broader relevance. She also invited Dr Cameron-Ross to speak at the NHS Highland and Highland Council learning disability nurse leadership group to help further awareness.

The Chair thanked Dr Cameron-Ross for her presentation and agreed to invite her back to a future meeting for further updates.

4.2 Staff Engagement – Developing the Strategic Framework for the 10-year Strategy - Paul Nairn, Regional Planning Manager

The Chair explained to the Forum that P Nairn had not been able to make this meeting due to other commitments. He would be invited to a future Forum meeting.

4.3 Clinical/Care System Risk – Boyd Peters, Medical Director, Louise Bussell, Nurse Director

It was noted that L Bussell was not available to present due to other commitments. B Peters clarified that the agenda item was in relation to the system risk in North Highland that was focused within Acute which was reflecting the whole system pressures. It was noted that there was no one within the Forum who were present from Acute in North Highland to speak to their experiences. It was agreed to postpone this presentation to a future date to discuss in depth.

A Strain noted that the Area Medical Committee had invited Kay Cordiner to attend its next meeting to discuss system-pressure measurement, analytics, and potential national developments across acute and primary care. He advised that the committee was seeking to become more informed and involved in these discussions and welcomed a future presentation and discussion at the Forum.

4.4 Constitution / Terms of Reference – Discussion

The Chair explained that the previous Nurses Midwives and Allied Health Professionals Advisory (NMAHP) Group had now split into an AHP Advisory group and an Area Nursing and Midwifery Advisory Group (ANMAC). Within the Allied Health Professionals there were approximately 14 different professions. L Currie requested that there were more representatives added in order that these professions could be appropriately represented at the Forum.

N Ware stated that from a Governance perspective the forum required to have appropriate representation from all areas including North Highland. G Frankiyn highlighted the need to have a representative from Raigmore Hospital, it was noted that the previous representative had stepped down leaving a gap in representation for more than a year.

H Eunson explained that the ANMAC group would have two chairs and three vice chairs for the first year of meeting to fully embed and requested that those five people be able to attend the Forum as representatives from the group.

The Chair noted that the discussion linked back to the forum's Constitution and the need to ensure the right representation and skill mix to support its advisory role and connection with the Board. She invited further questions on the Constitution and Terms of Reference, confirming these would be reviewed and brought back to the March meeting.

C Brodie queried whether the Terms of Reference and representation would be reviewed for all groups reporting to the Forum. The Chair confirmed that part of the Forum's remit was to review the Terms of Reference for the professional advisory groups, as significant changes had occurred since they were last

updated. She invited N Ware to comment from a governance perspective. N Ware advised that NHS Highland was undertaking a wider governance review, led by the Head and Deputy Head of Corporate Governance, to ensure structures were robust and appropriately aligned. He outlined how ACF governance linked with the Board and acknowledged that the Forum had not always felt fully connected in terms of communication. He noted ongoing work to strengthen two-way governance and communication between the Board, ACF, other committees and professional advisory groups, supported by recent development sessions.

L Currie queried whether standardisation of the templates for the Terms of References would be appropriate. N Ware agreed with this approach.

Action: N Ware to meet with the Chair and with the Board Chair to discuss standardisation of the Terms of Reference of the professional advisory committees.

G Franklin noted that the issues discussed were highly relevant to both the Hospital Subcommittee and the Area Medical Committee. He explained that the Hospital Subcommittee had long struggled to remain quorate and that both groups were considering how to make their roles more relevant to encourage better engagement from secondary-care colleagues. He added that the Area Medical Committee, established under the 1978 Act, was now operating in a very different NHS landscape, and that standardised Terms of Reference would be helpful. A review of the Constitution and membership was underway to improve secondary-care representation. He confirmed he would take the discussion back to both committees.

4.5 Nursing & Midwifery Terms of Reference – Discussion and Approval

H Eunson reported that the Forum had approved the split of the NMAHP Advisory Committee, with L Currie leading the AHP's and H Eunson leading Nursing and Midwifery. A Short Life Working Group (SLWG) had met three times and developed a proposed constitution following consultation with Executive Directors, Deputies and the Corporate Records Manager. Relevant national guidance had also been considered.

Two key proposals were presented:

1. Expanded Chair and Vice Chair roles to ensure full representation across all 55 clinical areas.
2. Creation of a Health Care support Worker and Associate Practitioner Sub Group whose Chair and Vice Chair would become full ANMAC members.

Membership had been kept concise to support attendance, whilst allowing future expansion, particularly for rural general hospitals. Around 40% of areas had already submitted nominations. Subject to approval, the first joint ANMAC meeting would take place on Monday with a SLWG acting as interim Chairs and Vice Chairs for the first year before a formal nomination process began.

There were no concerns nor questions raised. The Forum approved the Terms of Reference.

H Eunson thanked Forum members for their support.

The Area Partnership Forum **approved** the Terms of Reference.

5. MINUTES FROM PROFESSIONAL ADVISORY COMMITTEES AND EXCEPTION REPORTS

5.1 Area Dental Committee meeting – 10th December 2025

There was no one in attendance from the Area Dental Committee.

5.2 Adult Social Work and Social Care Advisory Committee meeting – meetings on hold until new chair appointed

5.3 Area Pharmaceutical Committee – 20th October 2025

C Brodie reported that the APC had met in December and the meeting had been productive. The committee had been working with the Director of Pharmacy on the five-year pharmacy strategy, which included nine workstreams. C Brodie led the communications workstream, which included updating the intranet. She sought the Forum's permission to increase APC visibility across the organisation by sharing a graphic through the NHS Highland Weekly Mailing, accompanied by a short explanation highlighting that all professions have advisory groups and encouraging staff to speak to their line managers if interested in contributing. This aimed to support engagement, particularly as several professional advisory groups were not currently meeting.

C Brodie presented the draft graphic, which outlined the role of the advisory committee, listed its members, and encouraged staff to bring forward topics for discussion. H Eunson queried whether the Forum required to look at its branding and asked permission from C Brodie to use the graphic that she had shared as a template for the new ANMAC group. C Brodie agreed to put H Eunson in contact with the person who had created the template.

Action: C Brodie to give contact details to H Eunson regarding the creator of the graphic

C Brodie advised that recent work had been undertaken with N Ware and Community Pharmacy Services on governance arrangements relating to new pharmacy applications. Due to the mix of contracted providers and directly employed staff, managing conflicts of interest had been challenging. C Brodie and colleagues had worked with Eleanor Rose to develop improved governance procedures. She highlighted the need for all professional advisory groups involving contractors to remain mindful of potential business interests while balancing their responsibility to represent both patient and Health Board interests.

5.4 Area Medical Committee meeting – 14th October 2025

A Strain noted that he had no further items for the open committee. He advised that he had sent a letter to the Chair for her consideration regarding whether it should be brought to the full Forum. He reported that the most recent Area Medical Committee minute available was from October, with a further meeting having taken place in December. At that meeting, members received a presentation from George Reed, Deputy Director of Estates, on the organisation's environmental sustainability work. A Strain confirmed that there were no other substantive items from December to bring to the Forum.

The Chair noted that she had received a letter from A Strain on behalf of the Area Medical Committee and this would be on the agenda for the March meeting of the Forum. She had further escalated the letter received to the Medical Director, B Peters.

5.5 Area Optometric Committee meeting – no meeting since 6th October 2025

I Fleming reported that there were no significant items to raise. He clarified that the previous optometry representative on the Forum had stepped down, and the Area Optical Committee had agreed that representation would now rotate among its members. This was his turn to attend. He noted that, as each representative would be new to the Forum processes, optometric input might be limited in the short term while members familiarised themselves with procedures. He confirmed he would report this back at their next meeting in April.

The Chair queried whether there was anything that the Forum could do to help encourage membership of the Optometric group going forward. Ian Fleming explained that the optometry group continued to encourage wider engagement from colleagues. He noted ongoing difficulties securing input from multiples, as these employers often did not release staff to attend meetings. This challenge would be highlighted again at their next optometry meeting. C Brodie explained that this was also a challenge for pharmaceutical colleagues also. I Flemming sought permission from C Brodie to use the graphic that was shared in order further advertise the Optometric Committee and their remit and C Brodie

offered to have the graphic edited with the relevant information.

Action: C Brodie to send I Flemming the altered graphic

5.6 Area Nursing, Midwifery and AHP (NMAHP) Advisory Committee meeting – 4th December 2025

L Currie reported that the last meeting had covered the transition to the two new advisory committees and a presentation from P Nairn on the draft NHS Highland 10-year strategy. While there was enthusiasm, members had concerns about how the strategy could be delivered given current financial pressures and reductions in prevention and early-intervention services. She stressed the need for realistic planning and for the Forum to give clear advice on the strategy's achievability.

The Chair acknowledged L Currie's concerns about the gap between the ambition of the draft NHS Highland10-year strategy and the current financial and operational realities. She noted that this was why P Nairn had been invited to return regularly, as ongoing dialogue would be essential to build engagement and ensure the strategy felt achievable. The Chair emphasised the need for the Forum to work closely alongside the strategic vision and invited further comments from members.

G O'Brien emphasised that a shift to prevention and early intervention was essential, as current service pressures were unsustainable. He supported the need for a realistic NHS Highland10-year strategy but cautioned against lowering ambition due to present difficulties. He highlighted the importance of strong engagement from the Forum and all professional advisories. He confirmed that the Population Health Committee would lead the strategy's governance and that work was underway to ensure all key voices were involved. The aim was to produce a substantial draft by the end of the year, with supporting infrastructure and commissioning intentions aligned to prevention. He acknowledged the challenges, particularly around supporting third-sector partners, but encouraged full participation.

It was noted that G O'Brien was more than happy to be invited back to the Forum to discuss alongside P Nairn the strategy and more than happy to be invited to any of the professional advisory committees also.

5.7 Psychological Services Meeting – no meeting held

5.8 Area Health Care Sciences meeting – no meeting held

The Forum **noted** the circulated committee minutes, and feedback.

6 Asset Management Group – 10th December 2025

There was no representative in attendance from the Asset Management Group.

7 HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE – 5th November 2025

There were no additional comments.

The Forum **noted** the minutes

8 Argyll and Bute IJB minutes

There were no questions or comments.

9 Dates of Future Meetings 2026

5th March
7th May
2nd July
3rd September
5th November

10 FUTURE AGENDA ITEMS

It was noted that the letter received by the Forum Chair from the Chair of the Area Medical Committee would be put on the agenda for the next Forum meeting.

- The Health and Care Staffing Act returns from the Board
- Recruitment and the Job Train platform, specifically in relation to the “killer question”

11 ANY OTHER COMPETENT BUSINESS

12 DATE OF NEXT MEETING

The next meeting will be held on Thursday 5th March 2026 at **1.30pm on Teams.**

The meeting closed at 3.55pm

NHS Highland	

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name of Committee	**Area Clinical Forum**
Date of Meeting	**6th March 2026**
Committee Chair	**Allyson Turnbull-Jukes**

KEY POINTS FROM DISCUSSION AND ESCALATION
ALERT
• Forecast overspend of £44.6m for year-end which was £4.6m worse than Scottish Government expectations, this included £10m Scottish Government support. • Adult Social Care (ASC) is no longer assumed to break even; full projected overspend of £27.2m was now reflected in the reporting.
ASSURE
• ACF will introduce a 45 minute huddle for any issues that require an urgent response and cant wait until the next scheduled meeting • Diabetes referrals have been triaged and interim risk mitigation is active
ADVISE
• Nursing and Acute leadership are progressing clinical review work • Population health strategy development has clear timelines, governance and a structured engagement plan. • Engagement hub has been launched to obtain staff, patient, public and partner feedback on the new 10-year strategy
RISKS
• High patient harm potential in ED and ambulatory care due to overcrowding • Blockages in acute care currently being caused by delayed discharges and community capacity issues • Misaligned understanding of risk could lead to delays and inconsistent decision making • Digitally excluded groups may not be able to participate fully in the population health strategy development
ACTIONS
LEARNING

HIGHLAND NHS BOARD	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk NHS Highland
MINUTE of MEETING of the POPULATION HEALTH AND PLANNING COMMITTEE	**14 January 2026 – 9.30am**

Present:

Gerard O'Brien, Non-Executive Director (Chair)
Gareth Adkins, Director of People and Culture
Alex Anderson, Non-Executive Director
Emily Austin, Non-Executive Director
Heledd Cooper, Director of Finance
Louise Bussell, Nurse Director
Sarah Compton-Bishop, Board Chair
Fiona Davies, Chief Executive
Jennifer Davies, Director of Public Health and Policy
Arlene Johnstone, Chief Officer for Highland Health and Social Care Partnership
Karen Leach, Non-Executive Director
Dr Boyd Peters, Medical Director
David Park, Deputy Chief Executive
Gareth Adkins, Director of People and Culture
Evan Beswick, Chief Officer, Argyll & Bute Health and Social Care Partnership
Iain Ross, Head of eHealth
Graham Illsley, Non-Executive Director
Laura Neil, Associate Director of Quality and Clinical Governance
Paul Nairn, Regional Planning Manager

In Attendance:

Natalie Booth, Senior Corporate Administrator
Kristin Gillies, Interim Head of Strategy and Transformation
Addy Massey, Corporate Administrator
Gavin Davidson, Senior Administrator
Nathan Ware, Deputy Head of Corporate Governance

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. An apology for absence was received from P Macrae.

1.2 Declarations of Interest

No Declarations of Interest were received.

1.3 Minutes of Previous Meeting and Action Plan

The minutes from the meeting held on 2 October 2025 was approved as an accurate record. No amendments were requested.

1.4 Matters Arising

There were no matters arising not otherwise covered on the agendum.

2. Performance and Service Delivery

2.1 Development of the Strategic Workplan 2025/2026

The Deputy Chief Executive introduced the paper and advised it outlined the context for developing the new strategic framework, highlighting the central role of the four-quadrant model and the sequence of work required. It was reported that the Strategy Development Group, which comprised of approximately 20–30 representatives across professional and operational areas. The group have met four times since early November and had demonstrated high levels of constructive and positive engagement. An update on the phased engagement plan was provided to Committee members, highlighting early engagement with leaders, staff and key partners to build a common understanding. This would be followed by wider public engagement once the framework had matured, with Public Health providing a critical checkpoint. The process will run in overlapping phases, allowing continual feedback.

Turning to timeline, the Deputy Chief Executive advised that the previously signalled aim to populate the framework by end-March was not achievable given operational pressures and the impact of the forthcoming election period on external consultation. It was therefore recommended a revised target was set for the end-June 2026 for the framework to be populated. It was noted that a publishable strategy could then reasonably follow in the subsequent quarter after consolidation and refinement. The establishment of a digital engagement hub to collate staff, partner and public feedback and to support ongoing dialogue was also referenced.

In discussion, the following points were raised:

- Confidence in Revised Timelines. The Committee Chair queried whether the shift from March to June remained achievable. The Deputy Chief Executive confirmed that June continued to be a reasonable target for producing a populated framework, although further refinement would be required beyond that point.
- Publication Expectations. It was noted that while substantive content was expected by June, a publishable strategy was more likely in the September period. Any slippage would be reported to the Committee.
- Strategic Positioning within the Sub-National Landscape. Members discussed the influence of emerging sub-national proposals. It was highlighted that these developments would inevitably shape NHS Highland's work, that a clear organisational strategy would support strong negotiation and representation within the collaborative model.
- Risks and Opportunities of Sub-National Working. Executives noted that the sub-national environment carried both risks and opportunities. Clarity on NHS Highland's strategic aims was emphasised by the Chief Executive as essential to help balance operational demands, to safeguard local priorities and to negotiate effectively where regional compromise is necessary.

- Timing and Approach to Engagement. Members explored the timing of public engagement, balancing benefits of early dialogue against the need to avoid confusion before the framework was sufficiently formed. The Committee acknowledged that more than one round of engagement with partners was likely to be required due to the different nature of questions being asked in this cycle to ensure internal readiness without losing sight of the imperative to involve citizens and communities meaningfully.

The Committee:
- **Accepted** Moderate Assurance
- **Approved** the outline and approach to the framework's development
- **Approved** the revised timeline, targeting end-June 2026 for a populated framework and recognising publication is most likely in the following quarter

2.2 Digital Front Door Update

The Head of eHealth provided an update on the national Digital Front Door, now branded MyCare.scot. It was noted the initial release to the first health board was on 3 December 2025, which focused on dermatology outpatients and testing appointments and communications functionality. For the rest of Scotland, the Whole-Population Availability (WPA) release is planned for April 2026, providing citizens with a secure access point to confirm identity/demographic details, view allergies, prescriptions (repeat and acute), vaccinations, and access a service finder. It was stressed that Boards are not required to complete any technical enablement for the April WPA release.

Subsequent national phases were highlighted, particularly those focused on making appointments and communications visible to patients at scale, and it was noted that these would require significant local standardisation and business change, most notably in outpatient clinic build and booking practices where variation already existed. Members were also updated on digital inclusion activity, including the February Inverness workshop, and noted that a national roadmap was expected to set out the phasing and local implementation requirements in more detail. Support for citizen access and account queries was confirmed as being provided by the National Contact Centre at go-live.

In discussion, the following points were raised:

- Strategic Impact of MyCare.scot. Members considered how the Digital Front Door would influence strategic aims, with the Deputy Chief Executive noting that increased transparency and direct access to information could shift citizens from a passive role to a more active one in managing their health.
- Equity and Digital Inclusion. Concerns were raised about the risk of widening inequalities, with emphasis on ensuring that people who are less digitally confident or lack access are not disadvantaged. The Committee noted the importance of influencing national design work to embed inclusion, prevention and person-centred approaches.
- Operational and Business-Change Requirements. Members discussed the significant local standardisation needed for outpatient clinic templates and booking processes to align with national expectations. It was recognised that this represented major business-change work rather than a purely technical issue.
- Resource Implications for Digital Teams. Questions were asked about whether NHS Highland had sufficient capacity to deliver the future demands of the programme. It was noted that boards would require resourcing for local implementation once national plans and timelines were confirmed.
- Impact on Demand and Expectations. Members reflected that wider visibility of appointments and health information could both increase demand and help reduce administrative workload, with implications for managing capacity and focusing resources on those with greatest need.
- Care System Integration. It was highlighted that long-term development would need to consider the wider health and care system, including how digital access might support people navigating social care services and the involvement of local authority partners.
- Digital Enablement and Strategic Risk. The Committee discussed the importance of sustained investment, user-centred design and alignment with national platforms, recognising that functionality and ease of use would determine whether the system supports or hinders strategic ambitions.
- Committee Reflection. Members agreed that digital enablement would form a core element of future strategic planning and noted the need for continued updates as national requirements and system functionality evolve.

The Committee:

- **Noted** the update on the national Digital Front Door also called MyCare.scot
- **Accepted** Substantial Assurance

2.3 Population Health Thematic Reviews

The Director of Public Health presented a developmental approach to thematic reviews designed to embed prevention and population-health thinking across NHS Highland, aligned to the Population Health Framework pillars and associated indicators. The discussion outlined how reviews would link outcomes, evidence and actions, with a focus on areas where the Board can directly lead, influence through partnerships, or advocate where levers sit elsewhere. It was highlighted that child poverty was a key focus with approximately 1,800 children required support to bring them out of poverty by 2030. Within the NHS Highland footprint to align

with national ambitions; partner dashboards and Community Planning Partnership datasets as sources to ground the work were signposted.

During discussion, the following points were highlighted:

- Novelty and Scale of the Approach. Members welcomed the developmental population-health methodology and noted that it represented a new and ambitious approach, with no existing blueprint to follow. The five core questions within the presentation were highlighted as particularly helpful in framing future work.
- Need for Baselines and Benchmarks. Members endorsed the need to agree clear baselines and to employ a balanced indicator suite containing lead indicators (to drive anticipatory action) as well as lag indicators (to evidence longer-term impact).
- Indicators, Targets and Measurement. The Director of Public Health confirmed that some benchmarks already existed, such as national child-poverty targets, but agreed that further work was required to define local aspirations, timelines and suitable indicators—recognising that some measures were long-term. Members also encouraged the inclusion of both lead and lag indicators to enable proactive monitoring.
- Use of Community Planning Partnerships. The committee emphasised that delivery of the Population Health Framework should not sit solely with NHS Highland. Stronger and more visible alignment with Community Planning Partnerships were encouraged so that Board efforts can complement wider system action.
- Avoiding Over-emphasis on Perfect Data. Members recognised that while data and indicators were essential for scrutiny and accountability, an excessive focus on measurement risked delaying action. It was acknowledged that population-health work is complex and that progress should not be stalled by waiting for perfect measures.
- Governance and System Influence. The need for clearer governance links between NHS Highland, CPPS and multi-agency duties—such as corporate parenting—was noted. Members also discussed whether future integration or governance-model changes might strengthen multi-agency impact.
- Logic Modelling and Influence. It was suggested that logic-model approaches could help articulate the relationship between actions, outputs and outcomes, particularly where NHS Highland's influence was indirect or shared with partners.

The Committee **noted** the update

2.4 Public Health Annual Report Update

The Director of Public Health advised the Public Health Annual Report was in the final drafting stage, themed "Best Start in Life." The report would incorporate lived experience gathered from children and parents and will adopt a more visual presentation. Subject to finalisation, the report would be brought back to the Population Health and Planning Committee in March prior going to Board. If there were agenda pressures, correspondence approval may be used.

The Committee **noted** the update.

Committee Function and Administration

3

3.1 Committee Workplan

The Deputy Head of Corporate Governance invited discussion on establishing a pragmatic, flexible workplan for the Committee. The Chair noted that the workplan should track and support the strategy-development timetable and provide scheduled touch-points for Thematic reviews, Digital Front Door readiness, and associated items, while retaining flexibility for emerging priorities. Members agreed that suggestions should be collated by Corporate Governance.

The Committee **noted** the Committees Workplan.

3.2 Committee Terms of Reference

The Deputy Head of Corporate Governance discussed the Committee Terms of Reference. The Committee noted that, while an annual review is required, the current ToR (agreed October 2025) remain appropriate. It was therefore agreed that no changes are required at this stage and that the ToR will proceed to the Audit Committee and Board in March 2026 for inclusion in the updated Code of Corporate Governance.

The Committee:

- **Reviewed** the ToR
- **Agreed** to make no further changes to the current ToR as shown in the appendix to this report
- **Noted** that the ToR will be submitted to the Audit Committee and the Board for approval in March 2026 and included in the updated Code of Corporate Governance thereafter.

4 Any Other Competent Business

No other competent business was raised

5 Date and Time of Next Meeting

The date and time of the next meeting would be **Wednesday 11 March 2026, 09:30–11:30**

NHS Highland	

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name of Committee	Population Health and Planning Committee
Date of Meeting	11 March 2026
Committee Chair	Gerry O'Brien

KEY POINTS FROM DISCUSSION AND ESCALATION
ALERT
No immediate matters requiring escalation were identified during the meeting.
ASSURE
The Committee received assurance on progress with the Population Health Strategy development, including the engagement approach, governance arrangements, and use of the Engagement Hub. Members were assured that early engagement activity was strong, that engagement would continue through a phased approach, and that mechanisms were in place to analyse feedback, identify gaps, and inform subsequent stages of strategy development. Assurance was also provided that clinical, professional advisory, and partnership structures were being actively engaged and would continue to inform both strategy development and implementation.
ADVISE
Members advised that clarity of language was critical, particularly around terms such as "high value sustainable care", and suggested development of a shared glossary to support consistent understanding. The Committee emphasised the importance of explicitly embedding equality, diversity, inclusion, and intersectionality within the strategy narrative. Members advised that engagement should be clearly inclusive of all geographies, including Argyll and Bute, and that partnership bodies such as Integration Joint Boards and Community Planning Partnerships should be visibly and meaningfully involved. The Committee further advised that the strategy should focus on a manageable set of strategic indicators, supported by clear links to tactical actions and operational delivery.
RISKS
Risks discussed included potential misunderstanding or disengagement arising from unclear terminology, the risk of perceived inequity in engagement across geographies, and the challenge of overwhelming stakeholders with excessive data without clear narrative or purpose. The Committee noted the risk of over-reliance on lagging indicators and highlighted the importance of balancing predictive (lead) and outcome (lag) measures. There was also recognition of the risk that partners may view population health as an NHS-led agenda rather than a shared system responsibility.

ACTIONS

- Noted progress on strategy development and early engagement activity.
- Agreed that the current engagement phase should continue, with feedback informing refinement during and after the PURDA period.
- Supported further work to clarify terminology, strengthen visibility of equality and inclusion, and ensure geographic balance in engagement.
- Agreed to progress development of a structured approach to indicators, including strategic, tactical, and operational linkages.
- Agreed to defer the Director of Public Health Annual Report to the next Committee meeting to allow for fuller partner engagement and impact.
- Agreed that a more substantive forward workplan would be brought to the next meeting.

LEARNING

The discussion reinforced the value of early and meaningful engagement in shaping strategy and building long-term ownership. It highlighted the importance of narrative alongside data, the need to align indicators with actions and outcomes, and the benefit of using population health as a shared system framework rather than a solely NHS-led agenda. The Committee recognised that strategy development is iterative and that success will depend on clarity, partnership working, and sustained engagement over time.

<table>
<tr><td>HIGHLAND NHS BOARD</td><td>Assynt House
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NHS Highland na Gàidhealtachd</td></tr>
<tr><td>MINUTE of MEETING of the
NHS Board Audit Committee
Microsoft Teams</td><td>12 January 2026 10.00 am</td></tr>
</table>

Present:

Emily Austin, Non-Executive (Chair)
Alex Anderson, NHSH Board Non-Executive
Heledd Cooper, Director of Finance
Bert Donald, NHSH Board Non-Executive
Brian Steven, NHSH Board Non-Executive

In Attendance:

Gareth Adkins, Director of People and Culture (from 10.50am)
Martin Baird, Azets, Internal Audit
Brian Battison, Audit Scotland
Louise Bussell, Board Nurse Director
Sarah Compton-Bishop, NHSH Board Chair
Garret Corner, NHSH Board Non-Executive
Charlotte Craig, Business Improvement Manager, Argyll and Bute
Gavin Davidson, Senior Administrator
Fiona Davies, Chief Executive
David Eardley, Azets, Internal Audit
Jamie Fraser, Azets, Internal Audit
Stephanie Hume, Azets, Internal Audit
Graham Ilsley, NHSH Board Non-Executive
Stephanie Innes, Assistant Financial Accountant
Arlene Johnstone, Interim Chief Officer, HSCP
Brian Mitchell, Board Committee Administrator
Gerry O'Brien, NHSH Board Non-Executive
David Park, Deputy Chief Executive
Liz Porter, Assistant Director of Financial Services
Iain Ross, Head of eHealth
Katherine Sutton, Chief Officer (Acute)
Nathan Ware, Corporate Governance and Records Manager
Dr Neil Wright, NHSH Board Non-Executive

1.1 WELCOME, APOLOGIES AND DECLARATION OF INTERESTS

Apologies were noted from Non-Committee members J Davies, J McCoy, J Mitchell and A Turnbull-Jukes.

The Chair took the opportunity to recognise A Christie, as outgoing Committee member, for his dedication and contribution to the work of the Committee including as previous Chair. She, in turn, welcomed B Steven to the membership of the Committee.

1.2 NOMINATION AND APPOINTMENT OF COMMITTEEE VICE CHAIR

The Chair advised B Donald had been nominated to and had provisionally accepted the role of Committee Vice Chair.

The Committee Agreed to Endorse the appointment of B Donald as Committee Vice Chair.

1.3 DECLARATION OF INTERESTS

There were no Declarations made.

1.4 MINUTE AND ACTION PLAN OF MEETING HELD ON 9 SEPTEMBER 2025

The Minute of the meeting held on 9 September 2025, and Committee Work Plan were **Approved.**

In relation to the circulated Committee Action Plan, the noted actions would be closed as a result of this meeting.

The Committee otherwise Approved the draft Minute.

1.5 MATTERS ARISING

1.5.1 Potential Deviation from SFIs – Payments

The Chair referenced previous Committee discussion and advised members the matter would more appropriately discussed within a separate forum, with the Population Health and Planning Committee being formally mentioned. The technical aspects of seeking change in this area were also outlined by the Director of Finance. It was noted aspects would also be considered as part of Third Sector audit activity.

After discussion, the Committee Noted the position and **Agreed** the subject be considered for inclusion as part of the work of the Population Health and Planning Committee.

1.5.2 NHSH Resident Doctor Compliance Update

There had been re-circulated the report considered by the Committee at the meeting held on 9 September 2025, at which it had been agreed a further update be requested for this meeting including on review of timescales for noted actions.

K Sutton outlined some of the background to the review and thanked Internal Audit colleagues for their detailed work in this area. She advised as to review findings and the work of her management team in preparing relevant responses and agreeing the stated recommendations and actions. It was confirmed a relevant action tracker had been developed, with one action remaining outstanding and due for completion by end January 2026 in association with Medical Staffing and Finance colleagues in relation to payments. An overview was provided in relation to ongoing associated rota activity and financial monitoring processes.

During discussion, members acknowledged the complex nature of the review and the progress made as a result. With regard to ongoing monitoring and governance in this area, members were advised a multidisciplinary team was in place and that governance aspects were to be discussed further with the Board Medical Director and Deputy Director of People and Culture. Aspects relating to previous changes in roles and responsibilities from the review in terms of rota management were noted and discussed in detail, with members also being advised achievement of zero non-compliance would require months to address. Activity relating to the monitoring and management/administration of relevant annual leave arrangements, including by relevant Service Leads, was also outlined.

After discussion, the Committee:

- **Noted** the circulated report and updates provided in discussion.
- **Agreed** a further progress update be provided to the September/December 2026 meeting.

1.5.3 Update on Timescale for Primary Care Management Actions

Members were advised relevant paperwork was being finalised and relevant contract documentation would be issued in early course.

The Committee Noted the position and **Agreed** an update be provided to the next meeting.

2 INTERNAL AUDIT PROGRESS REPORT AND INDIVIDUAL REPORTS

2.1 Remote Access Review and Update on Cyber Security Review Actions

M Baird spoke to the circulated report, the Executive Summary of which provided an audit rating of minor improvement being required. The report outlined the review background and scope, provided an overall control assessment and indicated 6 improvement actions had been identified, 3 of which related to compliance with existing procedures and 3 of which related to the design of controls themselves. Key findings were outlined, as was the impact on the NHSH Corporate Risk Register, and detail of the relevant Management Action Plan was included. I Ross advised on all management actions and confirmed these were due for completion by financial year end. He added, in terms of multi-factor authentication matters NHS Highland was reliant on National Services Scotland (NSS) for assurance reporting.

There was discussion, as follows:

- NSS Reliance for Assurance. Advised formal assurance reports to be requested moving forward. Noted NSS do provide a series of assurance reports for NHS Boards, including for IT and Payroll activity. It was stated reports can be tailored according to individual NHS Board need where required. Internal dissemination aspects were also highlighted.
- Ensuring Wider Assurance from External Sources. The NHS Board Chair highlighted the need to consider this matter more widely across NHS Highland services, where services were supplied by an external provider.
- Oversight of Management Actions. Advised Head of eHealth providing oversight and all actions confirmed as on track. Progress was reported to a number of formal groups, including the Finance, Resources and Performance Committee (FRP).
- Business Continuity Planning and Disaster Recovery Plan Testing. Advised relevant matters to be considered at April 2025 meeting of FRP Committee. Noted additional resource was being placed within the resilience team at that time, and this would enable enhanced testing to take place.

After discussion, the Committee Noted the circulated report and updates provided.

2.2 Third Sector Allocations

S Hume spoke to the circulated report, the Executive Summary of which provided an audit rating of substantial improvement being required. The report outlined the review background and scope, provided an overall control assessment and indicated 13 improvement actions had been identified, 12 of which related to the design of controls and 5 of which had been designated high risk as indicated and outlined in discussion. Key findings were outlined, as

was the impact on the NHSH Corporate Risk Register, and detail of the relevant Management Action Plan was included.

The following was discussed:

- Contract Management. Advised relevant documentation relating to contract performance management was in the process of being developed.
- System Variance. Questioned level of scope for harmonisation across operational areas. Advised the point being highlighted had related to budget setting activity within relevant Council bodies. Learning was being taken and applied across both areas in relation to Adult Social Care. Third Sector Interface involved.
- Commissioning Plan. The NHS Board Chair highlighted the need for further consideration in relation to the relevant Commissioning Plan elements.
- Timescale for Management Actions. Confirmed relevant actions were on track.
- Annual Procurement Reporting. View expressed that relevant annual reporting did not include this area of activity and consideration should be given to ensuring improved links.

After discussion, the Committee:

- **Noted** the circulated report and updates provided.
- **Agreed** a further progress update be provided to the next meeting, including from Argyll and Bute colleagues where appropriate.

2.3 Financial Management and Savings Plan

D Eardley spoke to the circulated report, the Executive Summary of which provided an audit rating of substantial improvement being required. The report outlined the review background and scope, provided an overall control assessment and indicated 16 improvement actions had been identified, 14 of which related to the design of controls in place and 5 of which had been designated high risk as indicated and outlined in discussion. Key findings, areas of good practice and areas for improvement were outlined, as was the impact on the NHSH Corporate Risk Register. Detail of the relevant Management Action Plan was included. The Director of Finance confirmed many of the areas highlighted for improvement, including in relation to governance had been identified in advance of the review and discussed at Executive level. The Value and Efficiency Team were actively involved in strengthening the improvement actions being taken forward.

There was discussion of the following:

- Management Action Plan. Advised small number of actions being reconsidered in terms of realising the anticipated improvement within current resource and processes. Relevant stated processes were in place and considered to be working well.
- Executive Ownership of Activity. Questioned level of ownership and oversight provided. Advised greater focus required and being placed on budget setting and budget holder level, to enable an increased culture appropriate stewardship etc.
- Admin and Clerical Review (Argyll and Bute). Advised activity had been placed on hold at that time, with activity being focussed across all organisational areas with a view to utilising appropriate digital solutions. The relevant workstream was in the process of being developed and progressed.

After discussion, the Committee Noted the circulated report and updates provided.

2.4 Operational Performance and Compliance Monitoring Report

J Fraser spoke to the circulated report, the Executive Summary of which provided an audit rating of minor improvement being required. The report outlined the review background and scope, provided an overall control assessment and indicated 3 improvement actions had been identified, all of which related to the design of controls in place. Key findings, areas of good practice and areas for improvement were outlined, as was the impact on the NHSH Corporate Risk Register. Detail of the relevant Management Action Plan was included.

After discussion, the Committee Noted the circulated report and updates provided.

2.5 Internal Audit Management Actions Update

The Chair advised the circulated report had been prepared for the December 2025 meeting that had not progressed and as such the report detail would require to be updated for the next meeting. S Hume then spoke to the circulated report, advising as to progress made by management in implementing agreed management actions previously identified. The summary of progress indicated that in relation to the 39 actions identified, updates had been received in relation to each. It was reported management had made progress with the completion of actions, with no outstanding actions where no progress had been made. 28 actions had been assessed as 'Action' on track or being progressed with revised completion date'.

After short discussion, the Committee:

- **Noted** the circulated report.
- **Requested** the report detail be updated for the next meeting.

2.6 Internal Audit Plan 2026/27

S Hume spoke to the circulated report outlining proposed audit areas for inclusion within the NHS Highland Internal Audit Plan for 2026/27. Members were invited to consider areas for inclusion and suggest areas of current and emerging risks where internal audit could add value in 2026/27. It was noted that following discussion, and receipt of comments the draft Plan would be further consulted upon directly with the Executive Directors Group with a view to the final draft Plan being presented for approval at the next Audit Committee meeting. Any agreed Plan would be subject to change through the review period as appropriate.

The Chair highlighted areas where the scope of intended review would require to be discussed in terms of narrowing relevant parameters. H Cooper advised as to the review process to date, confirmed further refining activity was continuing and that an updated draft Plan, based on best use of available audit resource had been developed.

There was discussion of the following:

- Mapping Wider Known External Best Practice. View expressed providing this wider detail would enable more informed consideration of proposed audit areas.
- Risk Management. Suggested as key area of activity for future review.
- Ensuring Appropriate Learning. Suggested greater focus on monitoring and ensuring learning activity was translated into action and appropriately captured.
- Statutory and Mandatory Training Activity. Members suggested an audit review would be beneficial and sought an update on work stated as being taken forward prior to any review being proposed. Advised current trajectory moving in positive direction, making this subject less of a priority area. National work on Protected Learning Time was being introduced alongside activity relating to national modules and TURAS data management capture, and actions arising from the previous review continued to be implemented.

After further discussion, the Committee:

- **Noted** the circulated report and draft Internal Audit Plan 2026/27.
- **Agreed** the potential scope of any review relating to Statutory and Mandatory Training be further considered to ensure appropriate added value to the current position.
- **Requested** the updated draft Plan be circulated for comment ahead of approval discussion at the next meeting.

2.7 Internal Audit Progress Report

D Eardley spoke to the circulated report providing a summary of internal audit activity since the last meeting and confirming the reviews planned for the upcoming quarter, including identifying any changes to the annual plan. It was reported progress had been made against the annual audit programme, with five reviews completed as indicated. Activity remained on track with a view to delivering the Internal Audit Opinion for 2025/26 by the June 2026 Audit Committee meeting. Progress to date was welcomed.

The Committee Noted the circulated report.

3 EXTERNAL AUDIT

There were no matters discussed in relation to this Item.

4 NHS HIGHLAND RISK MANAGEMENT REVIEW UPDATE AND DISCUSSION

D Park gave a presentation to members, advising an associated Appendix relating to processes and forms, would be circulated to members following the meeting. He provided updates in relation to the existing NHS Highland Risk structures, Risk Registers and review activity based on stated levels of risk and identified gaps and relevant opportunities for improvement. He stated relevant training provision and support activity was an active area within NHS Highland at that time. Suggested measures for further consideration and discussion were also outlined. Feedback from members was invited and welcomed.

There was discussion of the following:

- Adverse Events. The Chair highlighted the opportunity to use relevant Root Cuse Analysis information to sense check relevant Risk Register entries.
- Internal Audit Review Findings Impact on Risk Registers. Sought update on how this activity informed and updated associated Risk Register review and detail. Advised Register was used to inform relevant audit activity and confirmed further consideration would begiven to this point.
- Risk Information and Detail Required for Committee. The Chair invited members to consider what the Committee required to enable it to perform its stated role and remit on this activity area.
- Risk Escalation Process. Further detail was sought on the process for escalating relevant risks where appropriate. Suggested trending analysis would also be beneficial when considering this aspect. Advised ensuring appropriate oversight, in association with relevant metric consideration, was a key element.
- Reporting Arrangements and Detail Provided. Highlighted the need to avoid duplication of reporting at governance level. Suggested reporting should include greater detail on what risks were being reported to each of the governance Committees, and the level of Executive ownership of the same. This would be beneficial from an assurance perspective.

After discussion, the Committee:

- **Noted** the presentation content.
- **Noted** the presentation slide deck and associated Appendix would be circulated to members following the meeting.
- **Agreed** a further update and discussion be scheduled for the next meeting.

5 COUNTER FRAUD UPDATE

L Porter spoke to the circulated report, providing the Committee with an update as to the progress of Counter Fraud actions and services in order to highlight instances of fraud and provide assurance on the actions being taken to prevent fraud. Specific updates were provided in relation to Counter Fraud 12 components; 2025/26 Fraud Standard Statement return progress; Counter Fraud Services (CFS); current cases and recent events; Fraud Annual Action Plan completion for 2025/26; International Fraud Awareness Week activity; National Fraud Initiative (NFI) exercise activity; and relevant training actions. The report proposed the Committee take **Substantial** assurance.

There was discussion of the following:

- Operation Dunnet (eHealth). Advised formal report expected to be released and would be the subject of an update to the next meeting.
- Counter Fraud Standards. Further detail requested on activity relating to achieving relevant Standards.
- Cases and Allegations Reporting Detail. Advised limited as to the level of detail that can be provided to Committee, in terms of relevant actions undertaken where appropriate.

The Committee:

- **Noted** the circulated report and **Agreed** to take **Substantial** assurance.
- **Noted** an update on Operation Dunnet would be brought to the next meeting.
- **Agreed** further consideration would be given to the level of detail in future reports.

6 ARGYLL AND BUTE IJB AUDIT COMMITTEE SIX MONTH UPDATE

C Craig spoke to the circulated report on the activity of the Integration Joint Board Audit and Risk Committee over the previous six months, this having met twice during the reporting period. Matters relating to workforce risk were highlighted and the report proposed the Committee take **Moderate** assurance.

The Committee Noted the report content and Agreed to take **Moderate** assurance.

7 AUDIT SCOTLAND REPORTS

The Chair drew the committee's attention to the link for papers at the Audit Scotland website that had been selected for the interest of Committee members.

The Committee so Noted.

8 ITEMS ESCALATED FROM OTHER COMMITTEES

There were no matters raised in relation to this Item.

9 ANY OTHER COMPETENT BUSINESS

There were no matters raised in relation to this Item.

10 DATE OF NEXT MEETING

The next meeting was to be on **Tuesday 10 March 2026** at **9.00 am** on a virtual basis.

The meeting closed at 12.20pm.

NHS Highland	

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name of Committee	Audit Committee
Date of Meeting	10 March 2026
Committee Chair	Emily Austin

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

- Code of Corporate Governance Annual Review – Advised to be brought to May 2026 meeting.
- Legal Proceedings – Advised as to position in relation to specific ongoing activity and potential upcoming media interest.
- Health and Safety Review – Noted overall Red audit rating provided, mainly relating to water risk assessment and associated certification activity, including for Third Party premises. Highlighted Water Safety Group Terms of Reference did not include monitoring of remedial actions. Concern expressed by members in relation to ability to take assurance regarding water safety testing and wider management responses, including for RIDDOR activity. Governance aspects were highlighted.

ASSURE

- Health and Safety Review – Noted improved reporting at Committee level, and work/role of Technical Sub Groups in supporting this. Process improvements being identified and implemented. Confirmed regular discussion with HSE in relation to RIDDOR. Backlog maintenance prioritised through risk assessed process, with this specific review focussed on Health & Safety aspects. Strong cultural engagement was recognised.
- SSTS Processes – Noted improvements to date, with further improvement activity required. Aspects relating to Roster systems and Optima rollout discussed. Governance and process ownership requirements highlighted.
- IT Change Controls – Noted 6 improvement actions identified and action timelines agreed. Noted improved change oversight arrangements in place, and associated Policy to be developed for April 2026.
- Management Actions – Reported progress noted and overall improvement was acknowledged. Stated consideration required in relation to capturing activity with or requiring national input.
- Internal Audit Plan 2026/27 – Noted 9 separate audits proposed following EDG discussion. All audits linked to the Risk register, high level objectives outlined and further discussion required with Responsible Officers concerned. Plan approved.
- Internal Audit Progress Report – Noted position and thanked all involved to date.
- External Audit Annual Audit Plan 2025/26 – Noted as 4th year of appointment, relevant materiality aspects and reporting thresholds. Relevant timetable and audit fee were noted.

- Risk Timeline. Advised as to implementation of a structured management approach to review of all risk registers. Highlighted aspects relating to training, governance and reporting, support and standardisation, and identification of the registers to be reviewed. Programme objectives, roadmap, timelines and Risk Management Framework KPIs outlined – Substantial assurance taken.
- Counter Fraud Update – Substantial assurance taken.
- Operation Dunnet Update. Noted work underway in relation to responses to recommendations. Working Group referenced – Substantial assurance taken after in depth, detailed discussion of key aspects.
- Information Assurance Group Six Month Update. Substantial assurance taken.
- Review of Committee Terms of Reference. Noted no changes required.

ADVISE

- Update on Timescale for Primary Care Management Actions – Actions complete.
- Third Sector Allocations Update – Advised all relevant actions being progressed.
- SSTS Processes – Advised the review had highlighted need to reflect on scope of future Internal Audit Reviews.
- Audit Scotland National Reports – No reports noted.

RISKS

- Health and Safety Review – Noted risks associated with 3rd party premises and associated mechanism for confirming certification requirements for water safety. reporting processes to be updated. Risk register and overall Health and Safety Risk to be further considered.

ACTIONS

- Health and Safety Review – Agreed actions be reviewed in terms of timeline prioritisation and further update on progress be presented to May 2026 meeting. Issues of potential materiality were highlighted in relation to this area.
- Operation Dunnet Update – Agreed summary of respective learning points be provided a spart of closure report.
- Review of Committee Terms of Reference – Approved for onward transmission to NHS Board.
- Committee Work Plan 2026/27 – Approved.

LEARNING

MINUTES of MEETING of ARGYLL AND BUTE HSCP INTEGRATION JOINT BOARD (IJB) held ON A HYBRID BASIS IN KINTYRE COMMUNITY EDUCATION CENTRE, STEWART ROAD, CAMPBELTOWN AND BY MICROSOFT TEAMS on WEDNESDAY, 28 JANUARY 2026

Present:

Graham Bell, NHS Highland Non-Executive Board Member (Chair)
Councillor Dougie McFadzean, Argyll and Bute Council (Vice Chair)
Councillor Kieron Green, Argyll and Bute Council
Councillor Ross Moreland, Argyll and Bute Council
Councillor Gary Mulvaney, Argyll and Bute Council
Emily Austin, NHS Highland Non-Executive Board Member
Karen Leach, NHS Highland Non-Executive Board Member
Janice Preston, NHS Highland Non-Executive Board Member

Evan Beswick, Chief Officer, Argyll and Bute HSCP
Linda Currie, Associate Director AHP, NHS Highland
James Gow, Head of Finance, Argyll and Bute HSCP
Louise Bussell, Director of Nursing, NHS Highland
Julie Hodges, Independent Sector Representative
Kenny Mathieson, Public Representative
Kevin McIntosh, Staffside Lead, Argyll and Bute HSCP (Council)
Takki Sulaiman, Chief Executive, Argyll and Bute Third Sector Interface
Kirstie Reid, Carers Representative, NHS Highland
Fiona Thomson, Lead Pharmacist, NHS Highland

Attending:

Charlotte Craig, Business Improvement Manager, Argyll and Bute HSCP
Eilidh Gallacher, Head of Primary Care, NHS Highland
Nikki Gillespie, Head of Complex Care and Registered Services, Argyll and Bute HSCP
Jennifer Graham, Change Partner, NHS Highland
Kristin Gillies, Head of Strategic Planning, Performance and Technology, Argyll and Bute HSCP
Hazel MacInnes, Senior Committee Officer, Argyll and Bute Council
Gillian Neal, Area Manager – Kintyre and Islay Health and Community Services, Argyll and Bute HSCP
Caroline Robertson, Head of Adults – Hospitals and Community Care, Argyll and Bute HSCP
Saskia Schmitz, Public Health Intelligence Specialist, NHS Highland
Angela Tillery, Principal Accountant, Argyll and Bute Council

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Fiona Broderick, David Gibson, Rebecca Helliwell, Alison McGrory and Angus McTaggart.

2. DECLARATIONS OF INTEREST

There were no declarations of interest intimated.

3. MINUTES

The Minutes of the meeting of the Argyll and Bute HSCP Integration Joint Board held on 19 November 2025 were approved as a correct record.

4. MINUTES OF COMMITTEES

(a) **Argyll and Bute HSCP Finance and Policy Committee held on 18 November 2025**

The Minutes of the meeting of the Argyll and Bute HSCP Finance and Policy Committee held on 18 November 2025 were noted.

(b) **Argyll and Bute HSCP Strategic Planning Group held on 11 December 2025**

The Minutes of the meeting of the Argyll and Bute HSCP Strategic Planning group held on 11 December 2025 were noted.

(c) **Argyll and Bute HSCP Audit and Risk Committee held on 16 December 2025**

The Minutes of the meeting of the Argyll and Bute HSCP Audit and Risk Committee held on 16 December 2025 were noted.

(d) **Argyll and Bute HSCP Finance and Policy Committee held on 20 January 2026**

The Minutes of the meeting of the Argyll and Bute HSCP Finance and Policy Committee held on 20 January 2026 were noted.

5. CHIEF OFFICER REPORT

The Board gave consideration to a report from the Chief Officer providing an update on activity across the Health and Social Care Partnership since the last report to the Board in November 2025.

Decision

The Integration Joint Board noted the content of the report from the Chief Officer.

(Reference: Report by Chief Officer dated 29 January 2026, submitted)

6. SPOTLIGHT ON KINTYRE

The Board received a presentation on the following topics with a focus on the Kintyre Area –

Public health/demographic profile
Hospital and community health
Kintyre Care Centre

Decision

The Integration Joint Board noted the content of the presentation.

(Reference: Presentation – Spotlight on the Kintyre Locality)

7. FINANCE

(a) Budget Monitoring - 9 months to 31 December 2025

The Board gave consideration to a report providing a summary of financial performance for the first 9 months of the year. The report provided the financial position and forecast to the year end.

Decision

The Integration Joint Board –

1. noted the HSCP had overspent its budget by £1.1m or 0.4% as at M9;
2. noted an overspend of £756k was forecast and that management were seeking to bring spend back in line with budget;
3. noted recovery restrictions remained in place;
4. noted savings of £7.6m had been delivered, 85% of target;
5. noted that the HSCP was proposing to re-allocate a number of earmarked reserves to manage its financial situation; and
6. noted the strategic finance risk in respect of the SLA with Greater Glasgow and Clyde.

(Reference: Report by Head of Finance dated 28 January 2026, submitted)

(b) Budget Update

The Board gave consideration to a report providing an update on the process associated with the preparation of the 2026/27 budget. The report outlined the position in respect of the savings plans and gave an initial summary of the implications of the Scottish Government draft budget published on 13 January 2026.

Motion

Budget 2026/27 – Protecting Prevention and Community Capacity

The Integration Joint Board notes that:

A. The Budget Update (agenda item 7b) for 2026/27 identifies an opening budget gap of £16.4m, savings proposals of £6.0m, and a remaining gap of £10.4m, alongside an explicit acknowledgement that proposed service reductions will have "significant adverse impacts" on communities and partners and risk undermining national policy priorities.
B. The same report recognises a strategic risk that short-term financial measures may damage preventative capacity, reduce the effectiveness of the care system and increase future demand and cost pressures.
C. Current £6m savings proposals include reductions to third sector contracts and

grants, preventative services, carers centres and other community-based provision that are designed to reduce hospital admissions, delay escalation of need and support unpaid carers.

D. The Budget Update also highlights additional and emerging cost pressures of up to £8m in-year and potentially £14–16m in 2026/27 associated with acute Service Level Agreements with NHS Greater Glasgow and Clyde, which represent a material risk to the financial sustainability of services delivered locally in Argyll and Bute.

The Integration Joint Board believes that:

- A disproportionate focus on reducing preventative, early-intervention and community-based services risks storing up greater cost and harm elsewhere in the system, including increased delayed discharge, higher-cost care packages, greater reliance on unpaid carers and worsening health inequalities.
- This approach is inconsistent with the Partnership's stated strategic direction, the Population Health Framework, the National Health and Wellbeing Outcomes and the emerging Joint Strategic Plan, all of which emphasise prevention, community capacity and demand reduction.

The Integration Joint Board therefore agrees to:

1. Move away from the current emphasis of savings proposals that fall primarily on prevention, early intervention, carers centres and community provision, and request that these areas as a whole are explicitly protected within the 2026/27 budget.
2. Pause the consultation and the current savings proposals (pending work on item 4 below) that directly undermine preventative and community-based services, pending fuller consideration of system-wide impacts and cost avoidance.
3. Adopt an alternative approach to financial recovery, drawing on the six principles points set out in a letter to the Chief Executive, but specifically focusing on the following:
    - prioritising prevention and early intervention;
    - embedding Public Service Reform and Christie principles in practice;
    - progressing a whole-system transformation programme (as per February 2025 decision) focused on pathways from community to hospital/social care; and
    - engaging the third sector, carers and communities as equal partners throughout learning from models developed elsewhere.
4. Urgently require additional due diligence and scrutiny of the Greater Glasgow and Clyde acute SLAs, including the scale, assumptions and value for money of the proposed increases, before further reductions to community-based provision are progressed.
5. Request officers to report back to the IJB - in a February meeting if required - on revised budget options that better balance financial sustainability with the protection of preventative and community capacity.

Moved by Takki Sulaiman, seconded by Kirstie Reid.

Amendment

The Integration Joint Board agree the recommendations as contained within the submitted report –

The Integration Joint Board is asked to:

- Note the update in respect of the forecast budget gap in advance of final funding allocations being made by Government and Partners.
- Note the budget gap before savings is £16.4m.
- Note savings proposals totalling £6.0m are being developed with a remaining budget gap of £10.4m.
- Note that work on the savings plan is continuing in partnership with the Council and NHS Highland with each taking a different approach to addressing the shortfall.
- Consider the scale of service reduction that is likely to be required to achieve financial balance.
- Note expenditure control measures and financial recovery actions continue to be in place.
- Note that additional SLA costs for acute services delivered by Greater Glasgow and Clyde are an additional cost pressure of up to £16m in 2026/27.
- Endorse progressing to public consultation on the budget proposals.

Moved by Councillor Gary Mulvaney, seconded by Councillor Ross Moreland.

As the meeting was being held on a hybrid basis, the vote required to be taken by calling the roll and members voted as follows –

Motion	**Amendment**
	Graham Bell
	Councillor Kieron Green
	Councillor Dougie McFadzean
	Councillor Gary Mulvaney
	Councillor Ross Moreland
	Janice Preston
	Karen Leach
	Emily Austin

Decision

The Amendment was carried unanimously by 8 votes to 0, and the Integration Joint Board resolved accordingly.

(Reference: Report by Head of Finance dated 28 January 2026, submitted; Motion by Takki Sulaiman, seconded by Kirstie Reid, tabled; and Amendment by Councillor Gary Mulvaney, seconded by Councillor Ross Moreland, tabled)

(c) **Climate Change Reporting 2024/25**

The Board gave consideration to a report providing a copy of the Climate Change Report for 2024/25 which had been submitted to the Scottish Government in advance of the 30 November 2025 deadline.

Decision

The Integration Joint Board –

1. noted that the HSCP submitted its Climate Change Duties Report in advance of the 30 November 2025 deadline (appendix 1); and

2. endorsed the partnership approach taken by the HSCP in respect of its Climate Change Duties.

(Reference: Report by Head of Finance dated 28 January 2026, submitted)

The Integration Joint Board adjourned for a 10 minute comfort break at this point.

8. AUDITED ANNUAL ACCOUNTS 2024/25 AND EXTERNAL AUDIT REPORT

The audited Annual Accounts for 2024-25 had been endorsed by the Audit and Risk Committee at their meeting on 16 December 2025 and were before the Board for formal approval.

Decision

The Integration Joint Board –

1. noted that Forvis Mazars had completed their audit of the Annual Accounts for 2024/25 and issued an unqualified Independent Auditors Report;

2. considered the Annual Audit Report prepared by Forvis Mazars and management responses to their recommendations;

3. noted that the IJB was reporting an underspend of £0.9m carried forward in general reserves;

4. approved the letter of representation and the Audited Accounts for signature and publication; and

5. noted that the accounts were prepared on a going concern basis.

(Reference: Report by Head of Finance dated 28 January 2026, submitted)

9. 2026/27 SOCIAL WORK FEES AND CHARGES

The Board gave consideration to a report providing details of the proposed annual Social Work Fees and charges uplifts for 2026/27.

Decision

The Integration Joint Board –

1. reviewed and endorsed the 2026/27 Social Work Fees and Charges proposals so that the proposals could be submitted to Argyll and Bute Council for ratification at its 2026/27 budget meeting;

2. noted the ongoing review to the charging policy surrounding day services, transport and telecare charges with a view to amending charges at a later date following consultation.

(Reference: Report by Principal Accountant dated 28 January 2026, submitted)

10. Q3 WORKFORCE REPORT 2025/26

The Board gave consideration to a report detailing the workforce data of the Health and Social Care Partnership as at 30 November 2025.

Decision

The Integration Joint Board noted the content of the report.

(Reference: Report by Change Partner dated 28 January 2026, submitted)

11. WHOLE SYSTEM APPROACH

A report proposing the development and implementation of a whole system approach to health and social care within two high pressure areas was before the Board for consideration .

Decision

The Integration Joint Board agreed to defer consideration of this item to a development session.

(Reference: Report by Head of Service, Hospitals and Community Care dated 28 January 2026, submitted)

12. PROGRAMME OF MEETINGS 2026/27

A draft programme of meetings for the year 2026/27 was before the Board for approval.

Decision

The Integration Joint Board approved the draft programme of meetings for the year 2026/27.

(Reference: Draft programme of Meetings 2026/27, submitted)

13. SINGLE AUTHORITY MODEL - OPTIONS APPRAISAL

The Board gave consideration to a report proving an update in respect of the progress in the consideration of a Single Authority Model for Argyll and Bute.

Decision

The Integration Joint Board noted the update on the options for a Single Authority Model as presented to the NHS Highland Board.

(Reference: Report by Business Improvement Manager dated 28 January 2026, submitted)

14. REVIEW OF INTEGRATION SCHEME 2025 - CONSULTATION OUTCOME REPORT

The Board gave consideration to a report providing an update on the outcome of an 8 week consultation on the revised Integration Scheme and the proposed revisions to the scheme as a result of the feedback received during the consultation exercise.

Decision

The Integration Joint Board –

1. noted the detail of the 36 responses received during the 8 week consultation period, set out in appendix 1;

2. noted that reports would be tabled at the NHS Highland Board and Argyll and Bute Council on 27th and 29th January 2026, respectively, to seek approval on the revised Scheme of Integration, attached at appendix 2; and

3. noted that the Chief Executives of the two partner bodies would jointly submit the revised Scheme to the Scottish Government for their consideration and approval, ahead of the 23rd March 2026 timeframe.

(Reference: Report by Directorate Support Officer dated 28 January 2026, submitted)

15. DATE OF NEXT MEETING

The Integration Joint Board noted the date of the next meeting as Wednesday 25 March 2026 from 1.00pm, to be held in the Council Chamber, Kilmory, Lochgilphead and by Microsoft Teams.

NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**31st March 2026**
Title:	**Integrated Performance and Quality Report**
Responsible Executive/Non-Executive:	**David Park, Deputy Chief Executive (FPRC); Gareth Adkins (SGC); Louise Bussell, Director of Nursing & Dr Boyd Peters, Medical Director (CGC)**
Report Author:	**Sammy Clark, Performance Manager**

Report Recommendation: The Board is asked:

- To take moderate assurance on performance reporting and note the continued and sustained pressures facing both NHS and commissioned care services.
- To consider the level of performance across the system.

1 Purpose

Please select one item in each section ***and delete the others***.

This is presented to the Board for:

- Assurance

This report relates to a:

- 5 Year Strategy, Together We Care, with you, for you.

This report will align to the following NHSScotland quality ambition(s):

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well		Listen Well		Nurture Well		Plan Well	
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well		Progress well		**All** Well Themes	X		

2 Report summary

2.1 Situation

The Integrated Performance & Quality Report (IPQR) contains an agreed set of measurable indicators across the health and social care system aimed at providing the Finance, Resource and Performance Committee, Clinical Governance Committee, Staff Governance Committee and the Health and Social Care Partnership Committee a bi-monthly update on performance and quality based on the latest information available.

A narrative summary table has been provided against each area to summarise the known issues and causes of current performance, how these issues and causes will be mitigated through improvements in the service, and what the anticipated impact of these improvements will be.

2.2 Background

The IPQR is an agreed set of performance indicators across the health and social care system. The background to the IPQR has been previously discussed in this forum.

2.3 Assessment

A review of these indicators will continue to take place as business as usual and through the agreed Performance Framework.

2.4 Proposed level of Assurance

Please describe what your report is providing assurance against and what level(s) is/are being proposed:

Substantial		Moderate	X
Limited		None	

NHS Highland Board is asked to take moderate assurance on performance reporting and note the continued and sustained pressures facing both NHS and commissioned care services.

3 Impact Analysis

3.1 Quality/ Patient Care

IPQR provides a summary of quality and patient care across the system.

3.2 Workforce

This IPQR gives a summary of our related performance indicators relating to staff governance across our system.

3.3 Financial

Financial analysis is not included in this report.

3.4 Risk Assessment/Management

The information contained in this report is managed operationally and overseen through the appropriate Programme Boards and Governance Committees. It allows consideration of the intelligence presented as a whole system.

3.5 Data Protection

The report does not contain personally identifiable data.

3.6 Equality and Diversity, including health inequalities

No equality or diversity issues identified.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

This is a publicly available document.

3.9 Route to the Meeting

Sections through the relevant Governance Committees;

- Staff Governance Committee – 3rd March 2026
- Clinical Governance Committee – 6th March 2026
- Finance Resource Performance Committee – 13th March 2026

4.1 List of appendices

The following appendices are included with this report:

- Integrated Performance and Quality Report – March 2026 Board Meeting

Integrated Performance and Quality Report

Board Meeting

31st March 2026

Assuring NHS Highland Board on the delivery of the Board's 2 strategic objectives (Our Population and In Partnership) through our Well outcome themes.

Our Population

Deliver the best possible health and care outcomes

Our People

Be a great place to work

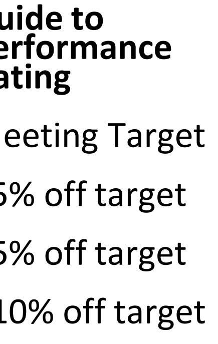
In Partnership

Create value by working collaboratively to transform the way we deliver health and care

Together We Care
With you, for you

Executive Summary of Performance Indicators: Slide 1 of 2

Wells	Area	Current Performance (Date)	Previous Performance (Date)	Performance Trajectory	Local Target	National Target	Performance Rating
Thrive Well	CAMHS <18-week referral-to-treatment	96.7% (Dec 25)	87.4% (Oct 25)	↑ (green)	90%	90%	Blue
Thrive Well	NDAS Waiting List Size	2138 (Dec 25)	2142 (Nov 25)	→ (grey)	Reduce	N/A	Red
Stay Well	Smoking Cessation Quits	53 (Q2 25/26)	83 (Q1 25/26)	↓ (red)	84 per quarter	336 per annum	Red
Stay Well	Breastfeeding	27.7% (25/26 so far)	28.3% (24/25)	↓ (green)	25.4% by 2030/31	25.4% by 2030/31	Green
Stay Well	Alcohol Brief Interventions (Number per Quarter)	967 (Q2 25/26)	944 (Q1, 25/26)	↑ (green)	1841 (End of Q2)	1841 (End of Q2)	Blue
Stay Well	Drug & Alcohol Waiting Times <3-weeks	87.4% (Q2 25/26)	83.7% (Q1 25/26)	↑ (green)	90%	90%	Green
Live Well	Psychological Therapies < 18-week referral to treatment	93.1% (Dec 25)	87.9% (Oct 25)	↑ (green)	90%	90%	Blue
Respond Well	Emergency Access (4 hour waits)	78.5% (Dec 25)	80.6% (Oct 25)	↓ (red)	83% by 31/03/26	95%	Red
Respond Well	Emergency Access (8 hour waits)	7.5% (Nov 25)	9.0% (Oct 25)	↓ (green)	Reduce	Reduce	Red
Respond Well	Emergency Access (12 hour waits)	4.2% (Nov 25)	5.1 % (Oct 25)	↓ (green)	Reduce	Reduce	Red
Respond Well	Delayed Discharges: All	241 (Dec 25)	214 (Oct 25)	↑ (red)	Reduce	Reduce	Red
Respond Well	Delayed Discharges: Standard Delays	198 (Dec 25)	175 (Oct 25)	↑ (red)	151 by 31/03/26	Reduce	Red



Executive Summary of Performance Indicators: Slide 2 of 2

Wells	Area	Current Performance (Date)	Previous Performance (Date)	Performance Trajectory	Local Target	National Target	Performance Rating
Treat Well	New Outpatients (NOP) Cumulative Performance against Activity Plan	-5.6% (3116 behind plan) (Dec 25)	-3.2% (1386 behind plan) (Oct 25)	↓	N/A	55563 (Dec 25)	
Treat Well	New Outpatients (NOP) number of patients waiting >52 weeks	2013 (Dec 25)	2990 (Oct 25)	↓	N/A	55 by 31/03/26	
Treat Well	TTG Cumulative Performance against Activity Plan	0.0% (4 behind plan) (Dec 25)	1.4% (164 ahead of plan) (Oct 25)	↓	N/A	15295 (Dec 25)	
Treat Well	TTG number of patients waiting >52 weeks	354 (Dec 25)	475 (Oct 25)	↓	N/A	124 by 31/03/26	
Treat Well	Radiology: Cumulative Performance Against Activity Plan	21.54% (6276 ahead of plan) (Dec 25)	12.14% (3479 ahead of plan) (Sept 25)	↑	N/A	27677 (Dec 25)	
Treat Well	Radiology <6-week waiting time	66.8% (Nov 25)	60.5% (Sept 25)	↑	80% short term 90% long term	100%	
Treat Well	Endoscopy: Cumulative Performance Against Activity Plan	22.24% (1154 ahead of plan) (Dec 25)	10.97% (568 ahead of plan) (Sept 25)	↑	N/A	5040 (Dec 25)	
Treat Well	Endoscopy <6-week waiting time	67.9% (Nov 25)	70.3% (Sept 25)	↑	80% short term 90% long term	100%	
Journey Well	31-Day Cancer Target	89.9% (Dec 25)	96.1% (Oct 25)	↓	95%	95%	
Journey Well	62-Day Cancer Target	68.1% (Dec 25)	71.1% (Oct 25)	↓	80% by 31/03/26	95%	
Journey Well	SACT Access and Benchmarking (SACT as 1st Treatment) – Average Waiting Time	16-20 Days (Dec 25)	25 days (Sept 25)	↓	< 28 days	N/A	

Guide to Performance Rating

- Meeting Target
- <5% off target
- >5% off target
- >10% off target

Integrated Performance & Quality Report Guidance

The Integrated Performance & Quality Report (IPQR) contains an agreed set of Key Performance Indicators across the health and social care system aimed at providing the Finance, Resource and Performance Committee with assurance around the performance monitoring of the board and linkages to key deliverables described in our Annual Delivery Plan.

Throughout the IPQR, the BRAG rating of KPIs is assessed in terms of an assessment of latest performance in relation to meeting local and national targets in each Strategic Well theme.

Individual KPIs will also be BRAG rated with services providing narrative summary of current performance and highlighting current key risks to performance improvement.

Performance is reported for the NHS Highland board area and narrative to include both HSCP areas has been added where appropriate.

Where applicable, upper and lower control limits have been added to the graphs as well as an average mean of performance.

Performance relating to areas in Scottish Government's Operational Improvement Plan (OIP) are annotated with "OIP" for reference.

Guide to Performance Rating

- Meeting Target (blue)
- <5% off target (green)
- >5% off target (amber)
- >10% off target (red)

Together We Care
With you, for you

Executive Lead
Louise Bussell,
Nurse Director

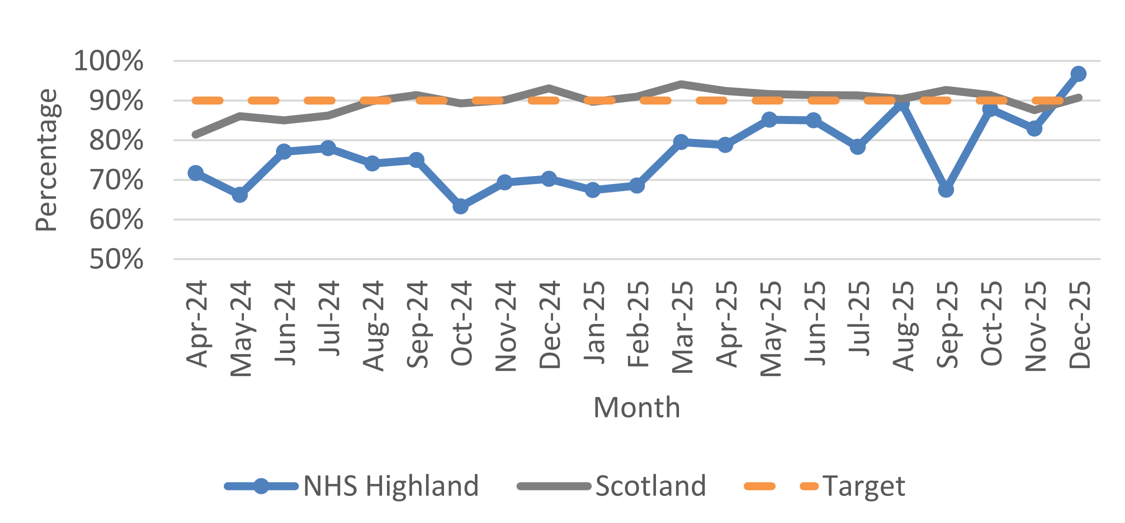
CAMHS (Child and Adolescent Mental Health Service)

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Achievement of CAMHS national standard of 90% of patients < 18 weeks from referral to treatment by December 2025 (Tier 3).		**Argyll & Bute** There has been considerable focus on compliance and interrogation of locality data ensuring action is taken as required, a focus on accuracy in data management and workforce activity. **Highland** The service continues to focus on the longest waits with no unbooked patients > 35 weeks.	Workforce across NHS Highland remains a vulnerability as the service look to build resilience for the future. **Argyll & Bute** Mitigations in place are the use of bank, temporary spend from reserves and pro-active recruitment. There has been a good response to recent advertisements. **Highland** 3 x newly qualified Clinical Psychologists case allocation in December. Additional capacity from Band 7 psychological therapist – temporarily reassigned to CAMHS. Exploring flexible cover ongoing (bank, secondments, additional hours).
Reduction of people who are currently on the Tier 3 CAMHS waiting list to <352 people by December 2025.			

PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	
Latest Performance	96.7%
National Average	90.7%
National Target	Full compliance to the National Service Specification by end of March 2026
National Target Achievement	n/a
Position	12th out of 14 Boards (note most boards achieved 100%)

CAMHS: Percentage of patients seen <18 weeks from referral



CAMHS Tier 3 Waiting List in Weeks

Executive Lead
Katherine Sutton
Chief Officer, Acute

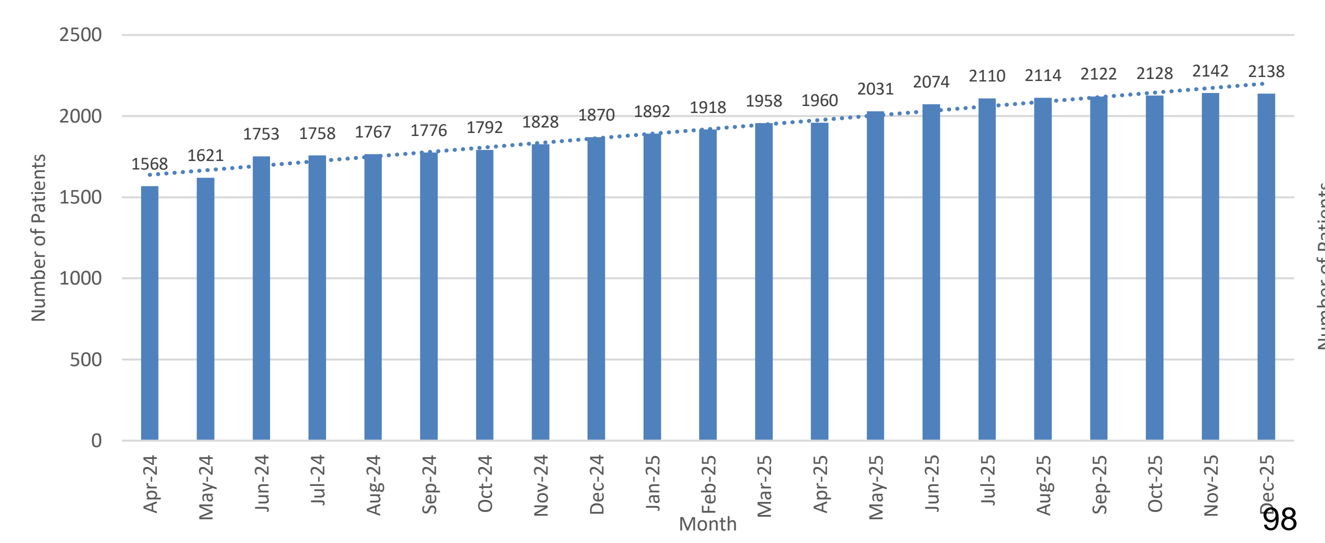
Neurodevelopmental Assessment Service (NDAS)

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Increasing percentage of NDAS patients seen within 18 weeks from referral, and towards meeting the national specification of greater than 95%.	(Red)	There is extremely limited clinical capacity within the service to complete any assessments.	• Independent sector assessments funded equating to 65 patients. • Recruitment of a fixed term Neurodevelopment Practitioner - requires training and support to provide capacity. • Fixed term (to end of fiscal year) Psychologist recruitment to conclude any ongoing cases. • Development of the ND Hub website in collaboration with the 3rd Sector organisation to improve access to approved information for families, carers, and children. • New model test of change reviewing children, on the waitlist, from a single primary school, by THC and NHS Health teams.
Reduction in the total number of patients on the NDAS waiting list compared to the current baseline by March 2026.	(Red)		

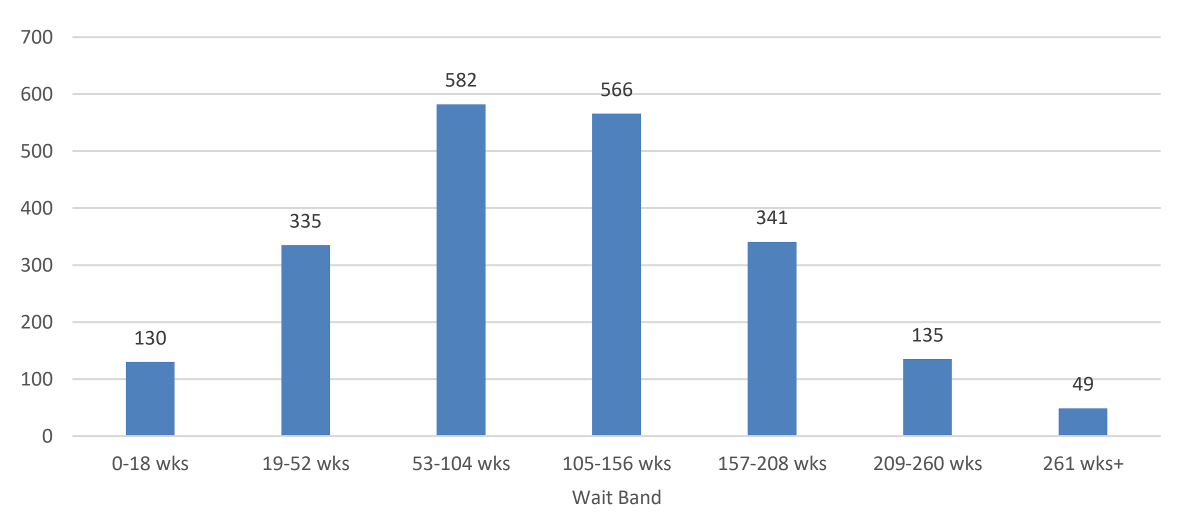
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	(Red)
Latest Performance	2138 on waiting list (Dec 2025)
National Average	n/a
National Target	Full compliance to the National NDAS Service Spec by end March 2026.
National Target Achievement	n/a
Position	n/a

NDAS Total Awaiting 1st Appointment (including unvetted)



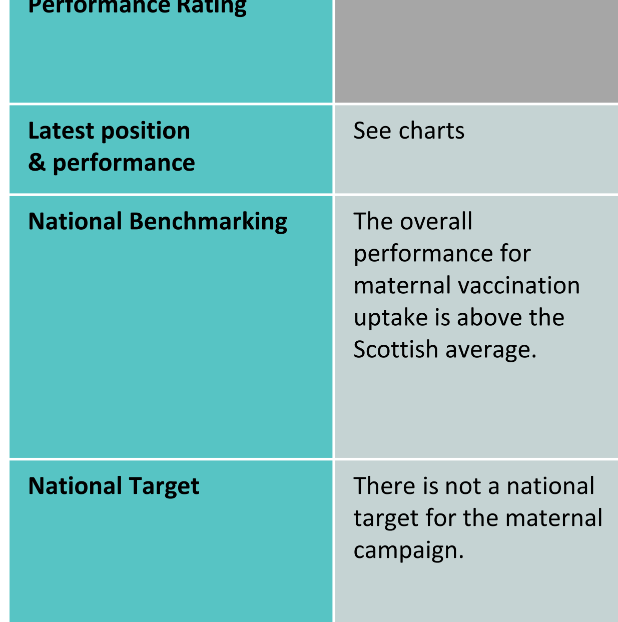
NDAS New + Unvetted Patients Awaiting 1st Appointment by wait band



Exec Lead
Jennifer Davies, Director of Public Health

Vaccinations

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Increased vaccination uptake – pertussis and RSV		**Winter vaccination programme:** Activity has now reduced significantly in relation to the delivery of the autumn/winter programme although flu vaccination continues to be promoted. The overall uptake for influenza vaccine for the 2025 season has exceeded the Scottish average (NHS Highland = 55.7%; Scotland = 55.5%). The staff vaccination programme has been particularly successful with NHS Highland achieving an uptake of 43.9% and ranked fifth across Scotland (Scotland = 41.9%). **Older adult RSV programme:** The uptake for the current RSV programme is equivalent to or has exceeded the Scottish average for each of the cohorts across Highland HSCP as detailed in the figure below. **Maternal programmes:** Uptake continues to be excellent across the board in relation to both pertussis and RSV maternal programmes. Both partnerships exceeded the national average in relation to vaccination uptake for both the RSV and pertussis vaccines. This is illustrated in the figure below.	Scottish Government is continuing to work with Highland HSCP in level 2 of its performance framework. A tripartite advisory group (SG, PHS, NHSH) is meeting to offer external support to NHS Highland as part of the implementation of the hybrid model of delivery in Highland HSCP. Work is ongoing in Argyll & Bute to maintain uptake rates and to support wider improvement work. Representation is provided at the national child health system meetings to support the effective rollout of the new child health system.



PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Stay Well	
Performance Rating	
Latest position & performance	See charts
National Benchmarking	The overall performance for maternal vaccination uptake is above the Scottish average.
National Target	There is not a national target for the maternal campaign.

Figure 1: Vaccination uptake for the pertussis and RSV maternal vaccination programmes for both partnerships

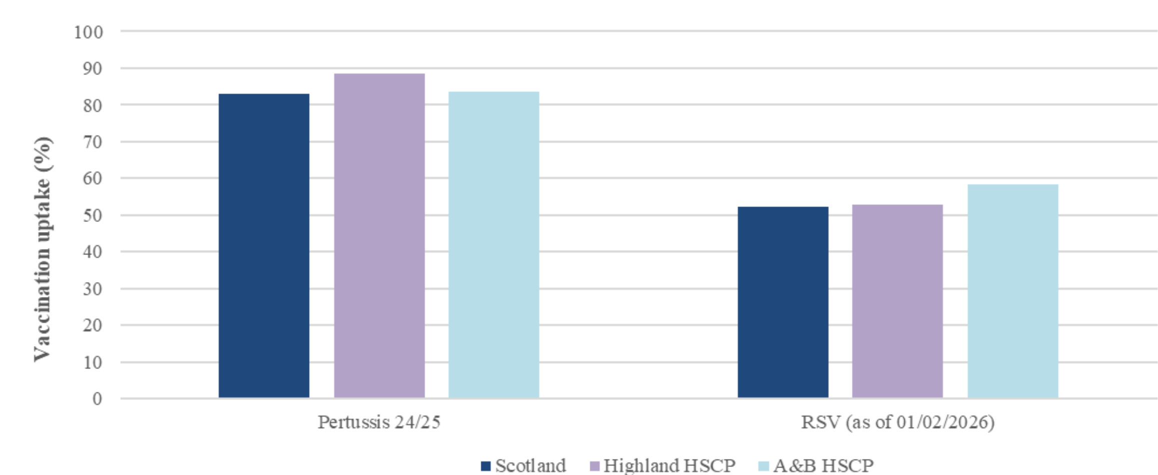
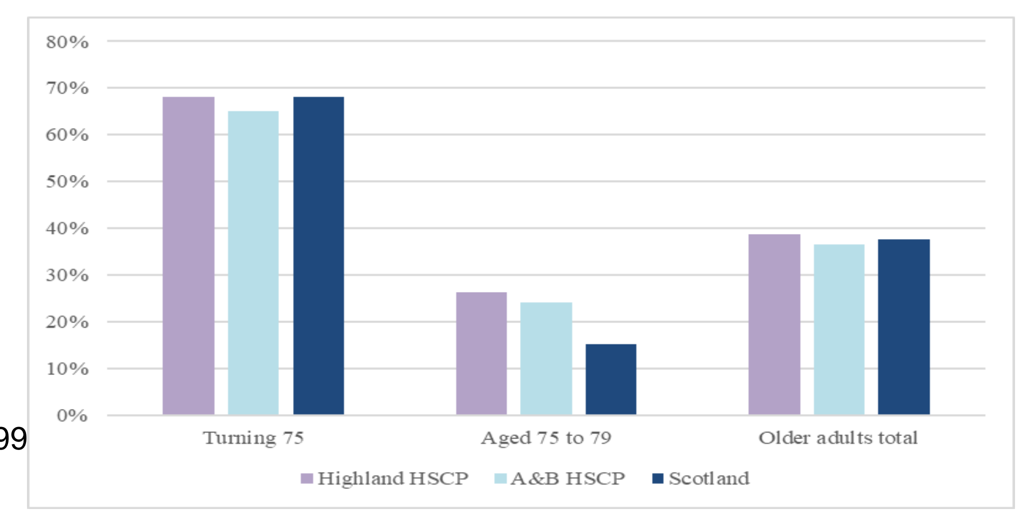


Figure 2: RSV vaccination uptake for older adults for the 2025/26 season (as of 1st February 2026)



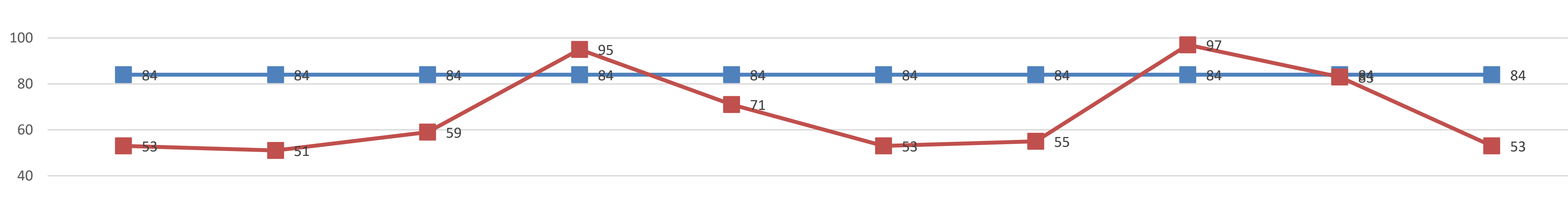
Exec Lead Jennifer Davies, Director of Public Health

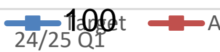
Smoking Cessation

Key Performance Indicators	Reasons for Current Performance (updated February 2026)	Plans, Mitigations and Actions
Delivery on national targets for Smoking Cessation interventions (12 week quits) >84 per quarter	• Poor follow up data within Community Pharmacy therefore many follow up outcomes have not been recorded. Capacity issues to complete these follow ups. • High incidence of smoking in young pregnant women. Services have struggled to engage this group in supporting them to quit • Limited support for patients within our acute setting. • Peak in Q4 is seen across Scotland and is likely due to individuals making plans about changes they want to make in their lives for a new year. • Q2 data is currently subject to validation.	•Missing data from quit dates set from 1st April 2025 – 1st September 2025 have been reviewed. 17.5% of individuals followed up had maintained a successful quit at 12 weeks and 11% of clients re-engaged with the service. Further missing data reviews have commenced. •Pilot to provide incentives for pregnant women commenced. So far, one woman is currently taking part, and another with her first appointment booked. Smoking Cessation Champions have been recruited in each community midwifery team and the Family Nurse Partnership team to aid communication and promote the pilot. •There has been 356 referrals for patients in Raigmore since the pilot began in May 2025, significantly higher than in the same period last year. A review of the pilot is currently being undertaken and due to be complete April 2026.

PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Stay Well

Performance Rating	
Latest Performance	53 quits in Q2 of 25/26 (unpublished data)
National Benchmarking	
National Target	336 successful quits in 12 weeks in 40 most deprived SIMD areas
National Target Achievement	136 quits delivered by end of Q2. This is 40% of the annual target
Position	Improved position compared to the same point in time in previous 2 years.

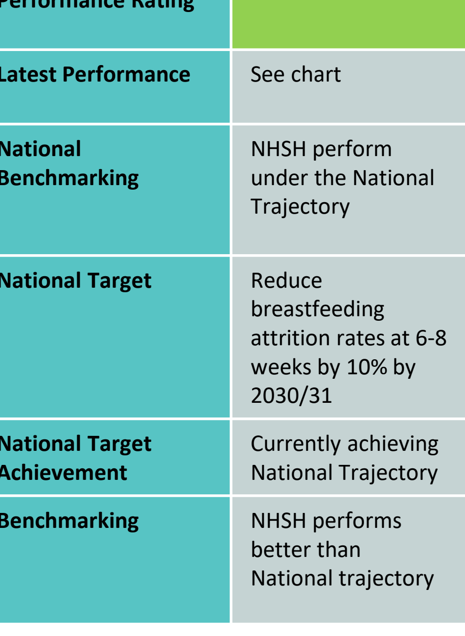




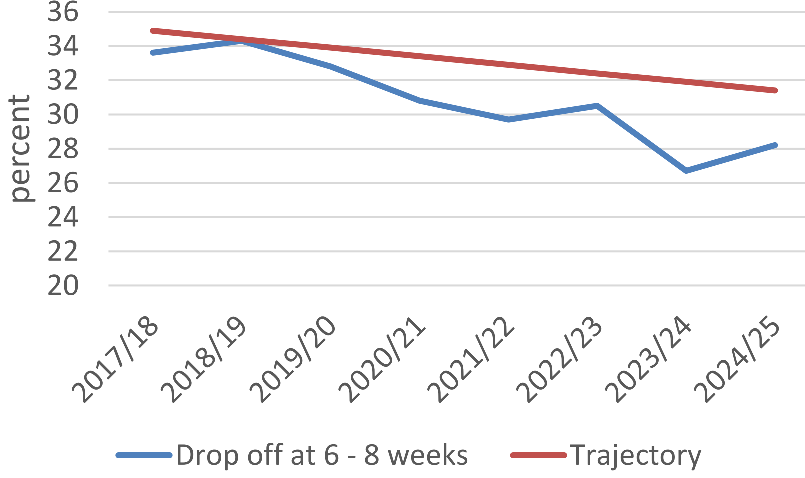
Exec Lead Jennifer Davies, Director of Public Health

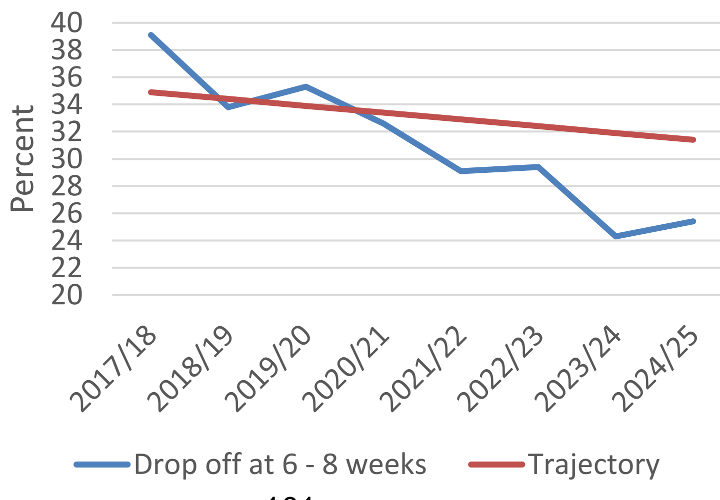
Breastfeeding

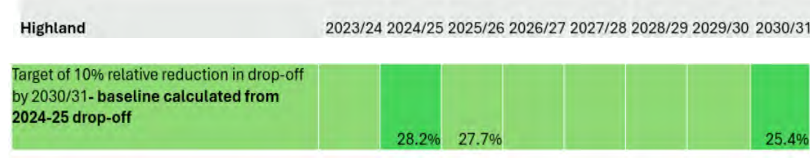
Key Performance Indicators		Reasons for Current Performance (Updated February 2026)	Plans, Mitigations & Actions
Reduce the attrition of any breastfeeding at 6 –8 weeks by 10% by 2030/1 (Provisional KPI: to be confirmed)		• National extension to breastfeeding stretch aim announced by Health Minister in November 2025. New trajectory to reduce attrition rates in any breastfeeding at 6 – 8 weeks by 10% by 2030/31. The baseline for NHS Highland for 23/24 is 26.1% meaning that the trajectory for 2030/2 is 23.5% and is an aspirational stretch aim for Highland. • Health in Early Years Scotland (HEYS) dashboard replaced the COVID child data in January 2024. This dashboard enables the timeliest breastfeeding data available. It is published quarterly, next quarterly report due in April 2026. • Infant feeding support worker recruitment funded by whole family wellbeing fund has been completed with new staff commencing posts in Fort William, Aviemore, Nairn and Raigmore. • A breastfeeding strategic group has been formed with the first meeting having taken place in December and includes representation from NHSH and Highland Council. Next meeting 10th of February • The breastfeeding key worker network has been reformed and pan Highland UNICEF BFI audits have been submitted to infant feeding lead for compilation • January and February breastfeeding training dates have been advertised to all staff; this includes an HIV masterclass run by HIV team and step by step guide to accessing ICON training • UNICEF portfolio due for North Highland community by end of February 2026	Work continues to drive improvements in all aspects of infant feeding workstreams. Publication of National Infant feeding strategy will support forward planning [Breastfeeding and Infant Feeding Strategic Framework and Delivery Plan]



PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Start well	
Performance Rating	
Latest Performance	See chart
National Benchmarking	NHSH perform under the National Trajectory
National Target	Reduce breastfeeding attrition rates at 6-8 weeks by 10% by 2030/31
National Target Achievement	Currently achieving National Trajectory
Benchmarking	NHSH performs better than National trajectory







Highland	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Target of 10% relative reduction in drop-off by 2030/31- **baseline calculated from 2024-25 drop-off**		28.2%	27.7%					25.4%

Public Health Scotland will publish trajectories in March 2026 – Trajectory for NHSH for **2030/1** likely to be: reduce attrition rates below **25.4%** at 6 – 8 weeks

Exec Lead Jennifer Davies, Director of Public Health

Alcohol Brief Interventions (ABIs)

Key Performance Indicators	Insights to Current Performance	Plans and Mitigations
Deliver at least 100% of the planned Alcohol Brief Intervention (ABI) activity target by March 2026	Fig 1.Total no of ABIs delivered in Q2 is 967. This number is 3.8% above target for NHS Highland as set out in the Scottish Gov Local Delivery Plan (LDP). Fig. 2: Delivery is being met largely by GP Practices in Highland H&SCP (90.4%) with the remainder mainly being delivered in wider settings across NHS Highland.	A&E: Work underway to contact local A&E departments to promote ABI and reinvigorate recording. Antenatal: ABI 4 ABI's delivered to women reporting in-pregnancy alcohol consumption. -Badgernet section on alcohol is being reviewed nationally to make it easier for midwives to complete. -Antenatal staff training and advice/ support sessions ongoing. ABI training for health visiting team held in January and early Feb. Total no of 27 Health visitors trained, Resources created to support conversations.

PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Stay Well

Performance Rating	1911 vs. target of 1841 by end of Q2
Latest Performance	967 Q2
National Benchmarking	n/a
National Target	NHS Boards to sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.
National Target Achievement	1841 (End of Q2)
Position	n/a

Fig.1

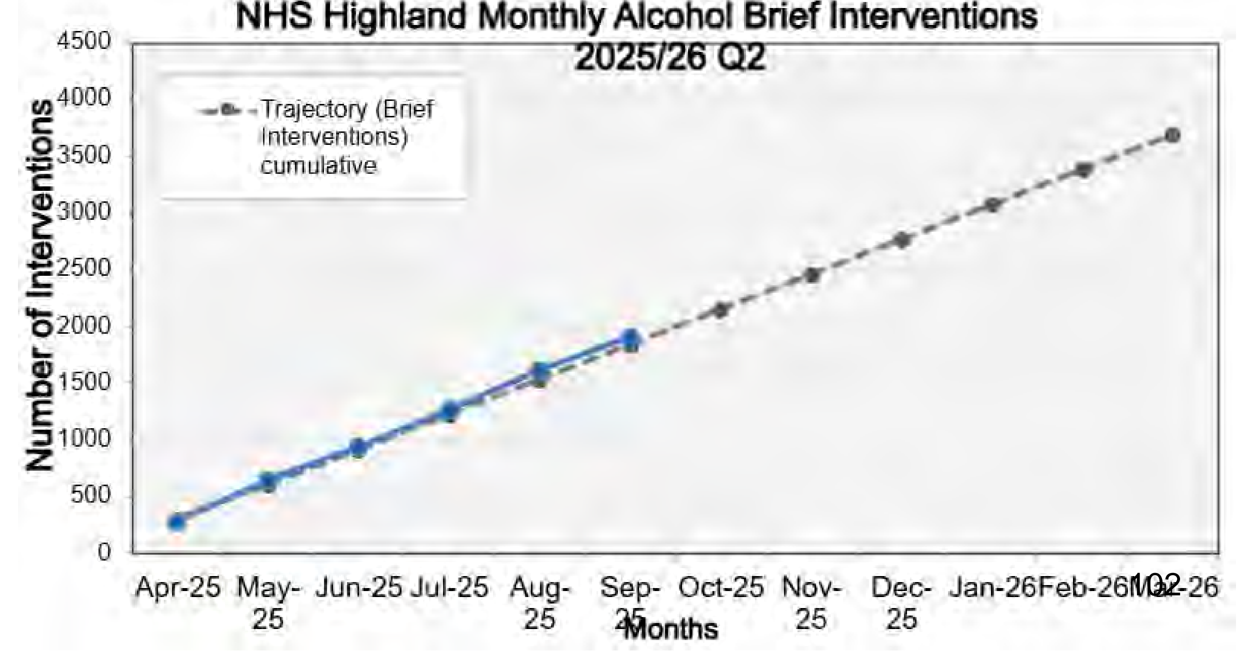
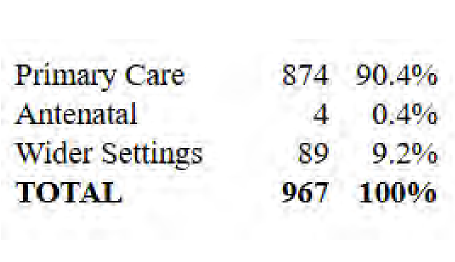
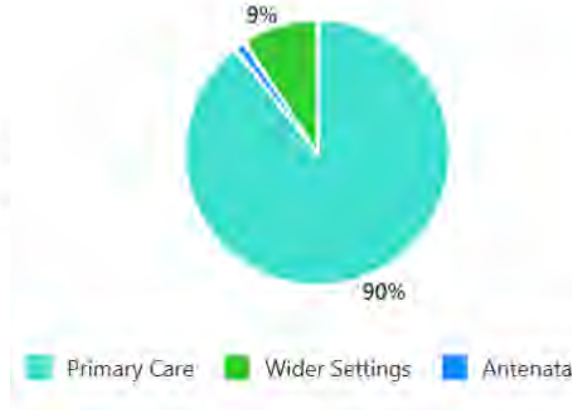


Fig.2 Setting Contribution 25/26 Q2



Primary Care	874	90.4%
Antenatal	4	0.4%
Wider Settings	89	9.2%
TOTAL	**967**	**100%**



Executive Lead
Arlene Johnstone
Chief Officer, HHSCP

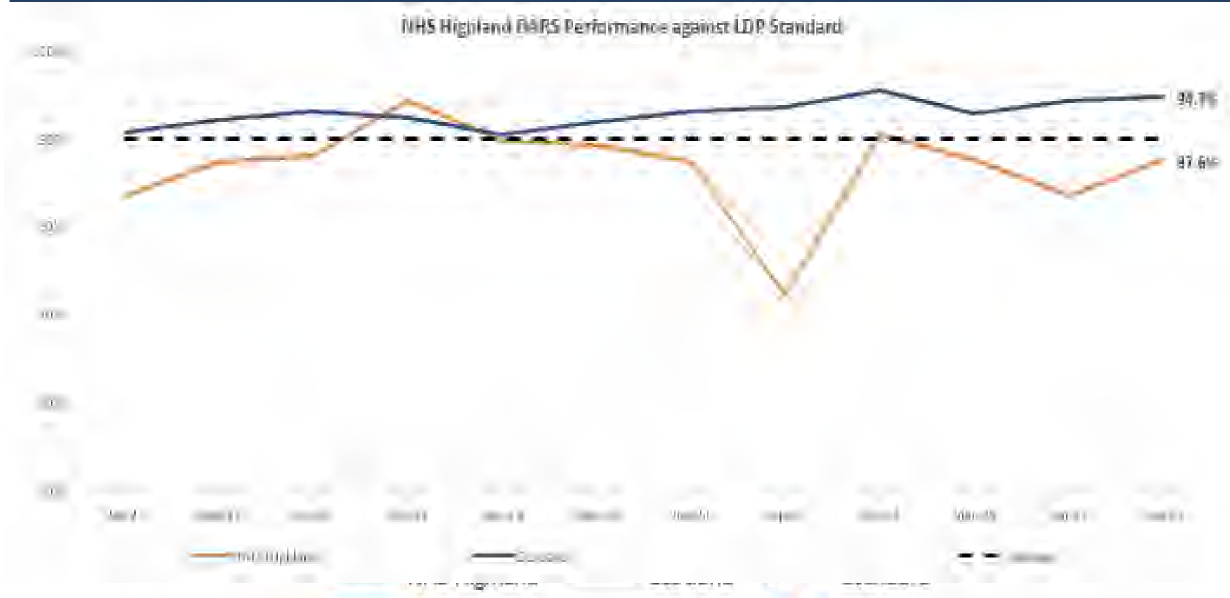
Drug & Alcohol Recovery (DARS)

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Achieve 90% of clients referred to DARS receiving a completed intervention or treatment plan within 3 weeks by March 2026.		Limited capacity versus demand has impacted waiting time targets. Recruitment difficulties are prevalent in some of the more rural areas across North Highland.	• Waiting list review processes are in place. • The recent commencement of a commissioned service for substance use will reduce referrals into the service. • Recruitment attempts are ongoing. • Some patients are being offered appointments in other areas outside of their immediate locality.

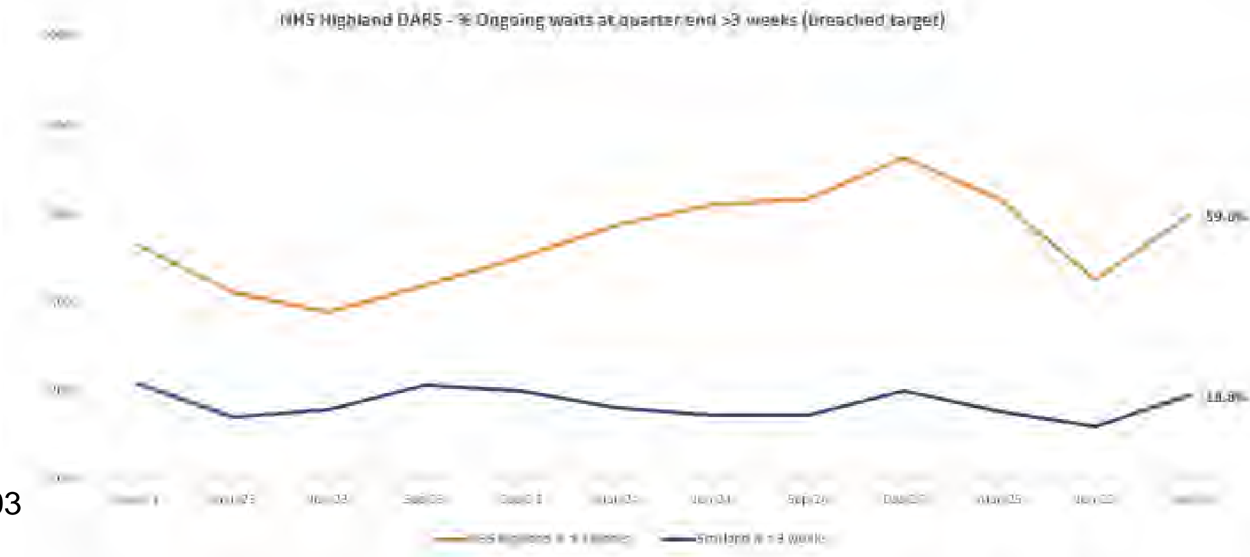
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Stay Well

Performance Rating	
Latest Performance	87.4% (Sep 25)
National Benchmarking	94.7% (Sep 25)
National Target	90% DARS referrals seen within 3 weeks
National Target Achievement	n/a
Position	n/a

NHS Highland DARS: Performance Against Standard for Completed Waits



NHS Highland DARS: % Ongoing Waits at Quarter End Waiting More than 3 Weeks (Breached Target)



Executive Lead
Louise Bussell,
Nurse Director

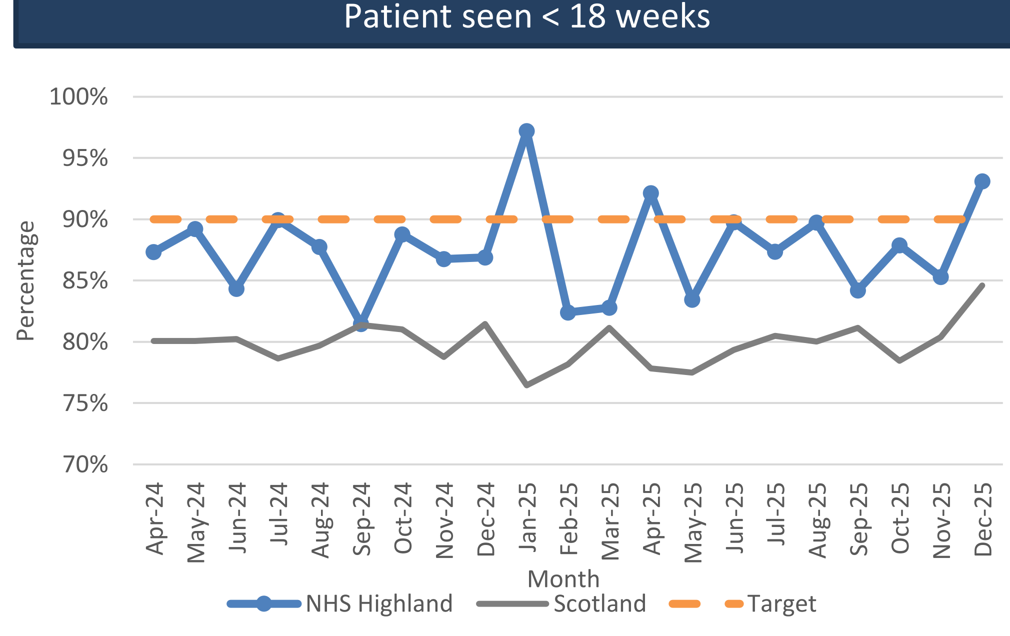
Psychological Therapies Waiting Times

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Ensure that at least 90% of patients referred to Psychological Therapy services are seen for their first appointment within 18 weeks of referral by March 2026. (pan-Highland) Increase number of completed PT waits (pan-Highland)	**Highland** - There is a slight downturn in trend for referral to treatment time (RTT) and this is thought to be as a result of ongoing vacancy challenges and within the recruitment process itself. For the 12-month period December 2025 – Nov 2026 87.9% of people referred to the service were seen within 18 weeks. **Argyll & Bute - A**rgyll and Bute Adult Mental Health Psychological Therapies (AMHPT) service continues to make improvements in referral to treatment time (RTT). At the end of December 2025, average waiting times for CBT treatment were 17 weeks and 19 weeks for Psychology treatment.	**Highland –** Psychology services continues to work with departmental colleagues to address ongoing recruitment and financial challenges. Progress is being made with eHealth colleagues to incorporate subspecialties into reporting systems. This will help improve data quality and forecasting. **Argyll & Bute -** Waiting times continue to be impacted by resource limitations, especially for Psychology, but active recruitment to vacant posts is in progress. Like for North Highland, there are issues with data quality, but work is in progress with the Scottish Government to address this.

PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	93.1%
National Average	84.6%
National Target	90%
National Target Achievement	Consistent improvements in targets
Position	3rd out of 14 Boards

Patient seen < 18 weeks



Waiting List Size

Executive Lead
Katherine Sutton
Chief Officer, Acute

Emergency Department Access

Key Performance Indicators

- Achieve a 5% improvement in the number of patients attending A&E being seen, treated, admitted, or discharged within 4 hours by March 2026.
- Reduce the number of A&E patients admitted, transferred, or discharged within 8 hours of arrival by March 2026, reducing extended waits and improving care quality.
- Reduce the number of patients waiting > 12 hours in A&E by March 2026, ensuring no patient experiences excessively prolonged waiting times.

Reasons for Current Performance

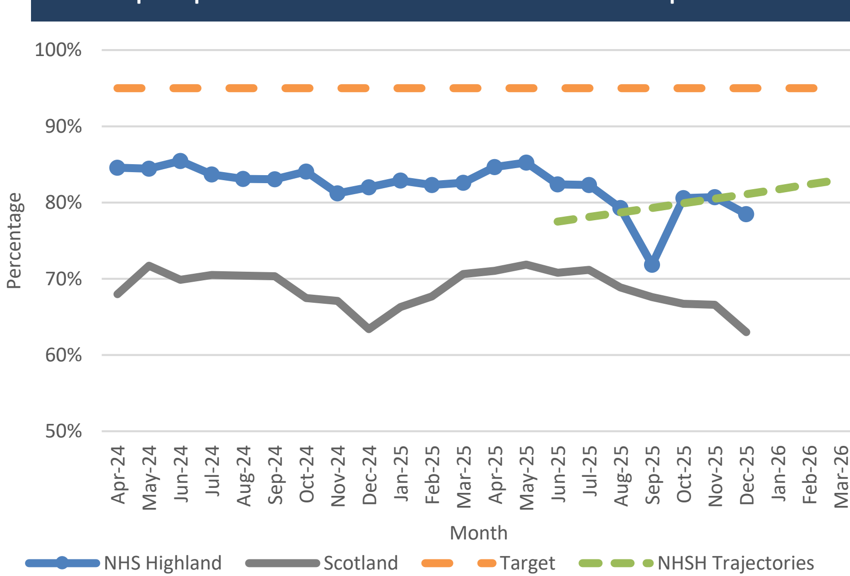
Raigmore Hospital: Pausing of the elective program to support capacity within Raigmore commenced 12 Jan 2026. Plans for full recommencement on 26 Jan 2026 are on track.
Increase in LOS for the second week across NHSH
H&SCP have supported the opening of extra capacity where possible to support movement out of the acute hospitals. This is being monitored and supported through the OPEL meeting framework.
The placement of patients in non-standard bed spaces continues
Caithness Hospital (CGH): Limited flow across the hospital and sustained delayed patients requiring patients to board in ED awaiting beds. 3 patients transferred out of area to Migdale hospital to support admissions
Belford Hospital (BH): The year has started under significant pressure due to fragile staffing and constrained patient flow. Discharge delays have driven A&E bottlenecks, reflected in January's static 4-hour performance of 81%.
Lorn & Islands (LIH): no exceptions to report – performance stable.

Plans, Mitigations and Actions

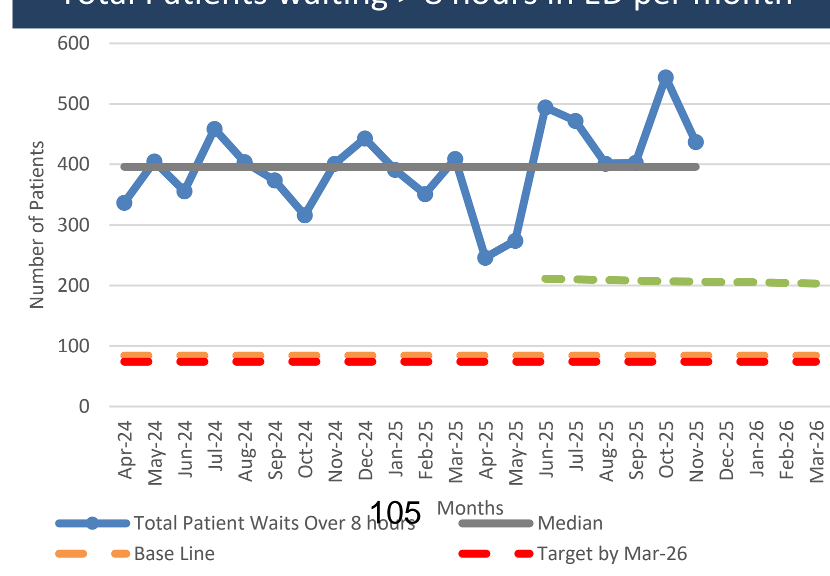
Raigmore:
Leadership support provided for the unscheduled program work, predominantly Hospital at Home, Frailty and AHP at the front door.
H&SCP have supported the opening of extra capacity where possible to support movement out of the acute hospitals. SAS HALO (Hospital Ambulance Liaison Officer) at Raigmore Hospital will be monitored for impact on hospital turn around times.
CGH: Weekly Leadership meetings in place to monitor and support. Ongoing UUSC work progressing with system partners
BH: Immediate focus remains on stabilising workforce resilience and improving patient flow. UUSC SLWG continues to progress alternative pathways to safely divert appropriate activity away from ED.

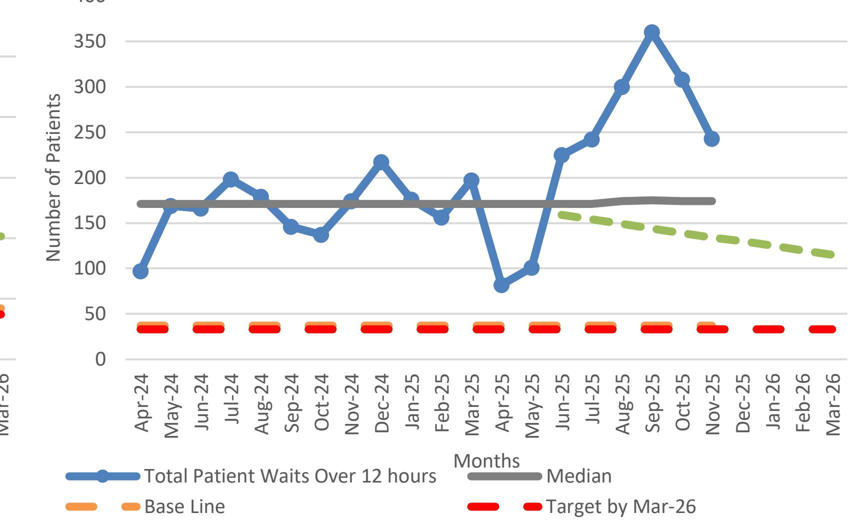
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Respond Well

Performance Rating	
Latest 4-hour Performance	78.5%
National 4-hour Average	63.0%
National Target	95%
National Target Achievement	NHS H as a whole remains above the Scotland average, but off target
Position	5th out of 14 Boards



Total Patients waiting > 8 hours in ED per month





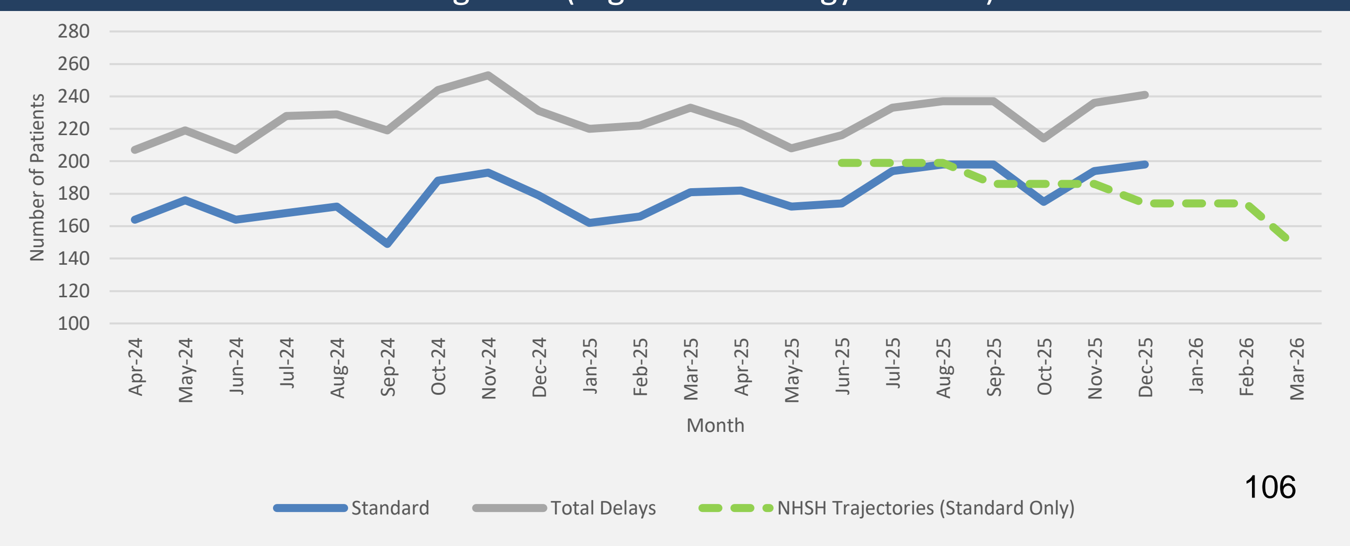
Executive Lead
Arlene Johnstone
Chief Officer, HHSCP

Delayed Discharges

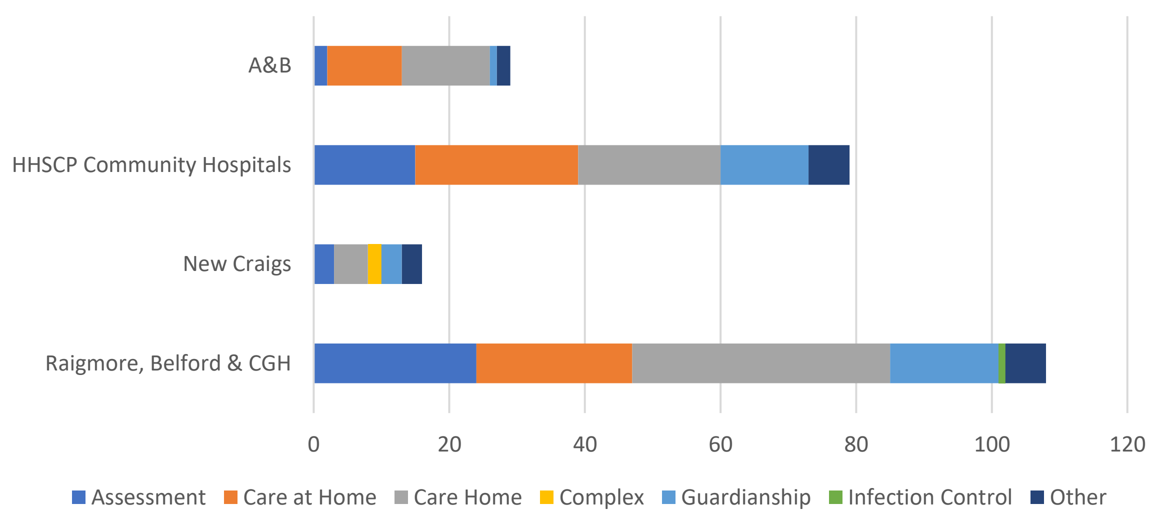
Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Reduce the total number of patients experiencing a standard delay in discharge from hospital across NHS Highland to agreed targets and trajectories. Target = 151 standard delays and 37 AWI by 31/03/26		There was an increase in standard delays in 2025 against our trajectory for reduction in standard delays. The reasons are multifactorial and are related to availability of care, complexity related to Adults with Incapacity legislation and process and coordination issues. Performance is subject to weekly oversight with EDG and further improvement plans are being instigated to respond to the recent deterioration in the overall position.	Pan-Highland workstreams are aligned to OIP in shifting the balance of care from acute to community services. **Highland HSCP** Links to the Adult Social Care Transformation Programme to provide alternative care for those with lower level of needs. Appointment of an Interface Manager to improve process and coordination issues in the discharge pathway. Pilot of Discharge to Assess programme is underway in East Ross which will impact 8 patients who are currently delayed, to be discharged home while awaiting assessment. It is hoped this model can be scaled across Highland. **Argyll & Bute** Actions to improve flow including interface with NHS GGC are underway, including additional governance around the allocation of care packages within the area. **Pan-Highland** Hospital at Home has now come on stream with capacity for 6 in Highland, while Argyll & Bute are moving forward with plans to expand from 12 to 16 available beds by 31/03.

PERFORMANCE OVERVIEW Strategic Objective: In Partnership Outcome Area: Respond Well	
Performance Rating	
Latest Performance	241 at Census Point
National Benchmarking	Engagement through national CRAG group and CfSD
National Target	Trajectories developed
National Target Achievement	Not Met
Position	14th of 14 Boards

Number of people delayed from hospital discharge at monthly census point NHS Highland (Highland and Argyll & Bute)



Number of people delayed from discharge – Location and Code



Executive Lead
Katherine Sutton
Chief Officer, Acute

Outpatients (New Outpatients – NOP – seen within 12 week target) – Slide 1 of 3

Key Performance Indicators	Status
Reduce the number of new patients waiting over 52 weeks for a new outpatient appointment to 55 by March 2026.	Blue
The number of completed new outpatients appointments is equal to or exceeds the monthly target	Amber
The number of completed new outpatients appointments is equal to or exceeds the cumulative target	Amber
Increase the percentage of new outpatient referrals seen within 12 weeks of referral equal to or above 95%.	Red
Total number of patients currently waiting for return outpatient appointments to be equal to or less than previous year's monthly average	Red

Reasons for Current Performance

Highland
The number of people waiting over one year for their appointment continues to reduce across NHS Highland. This is due to increase in activity from last year and the continued implementation of best practice including clinical validation and new pathways such as "straight to test" prior to appointments. We are behind plan in some areas such as Ophthalmology and Gastroenterology and plans are in place to increase activity and reduce the gap. Some independent sector activity planned for the end of the year has been delayed into January, impacting the volume of activity. With the increase in activity there is a corresponding increase in the number of people added to the return waiting list.

Argyll & Bute
Argyll & Bute HSCP is on track to record <10 patients waiting longer than 1 year for a new appointment at end March 2026. Performance continues to improve due to additionality from the independent sector/in-house and targeted appointing and data quality work.

Plans, Mitigations and Actions

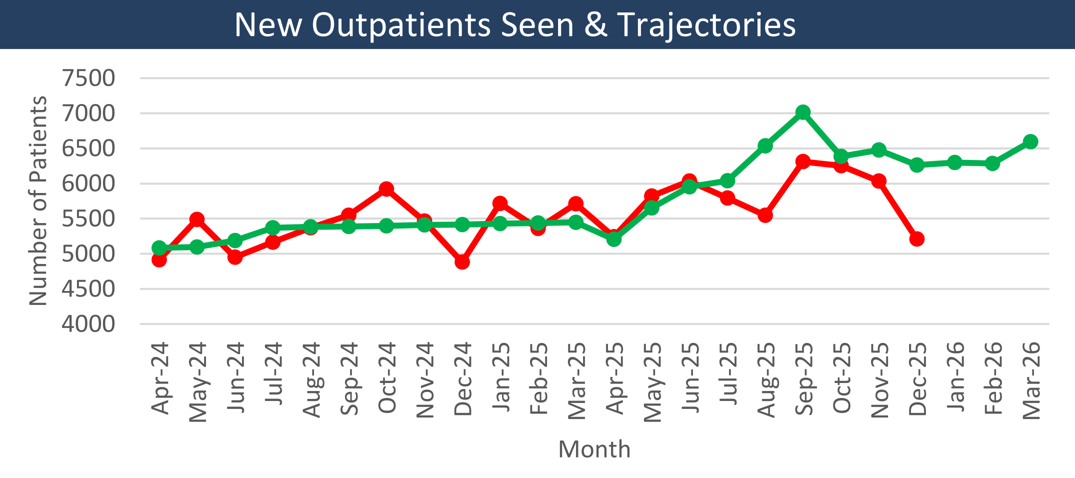
Highland
Additional funding to support Gastroenterology increase validation, straight to test and activity. Recovery plan in place for Ophthalmology.

Argyll & Bute
Patients who are at risk of breaching are being flagged at an early stage and conversations had with both NHSGGC and NHS Highland to identify how they can be seen and progress.

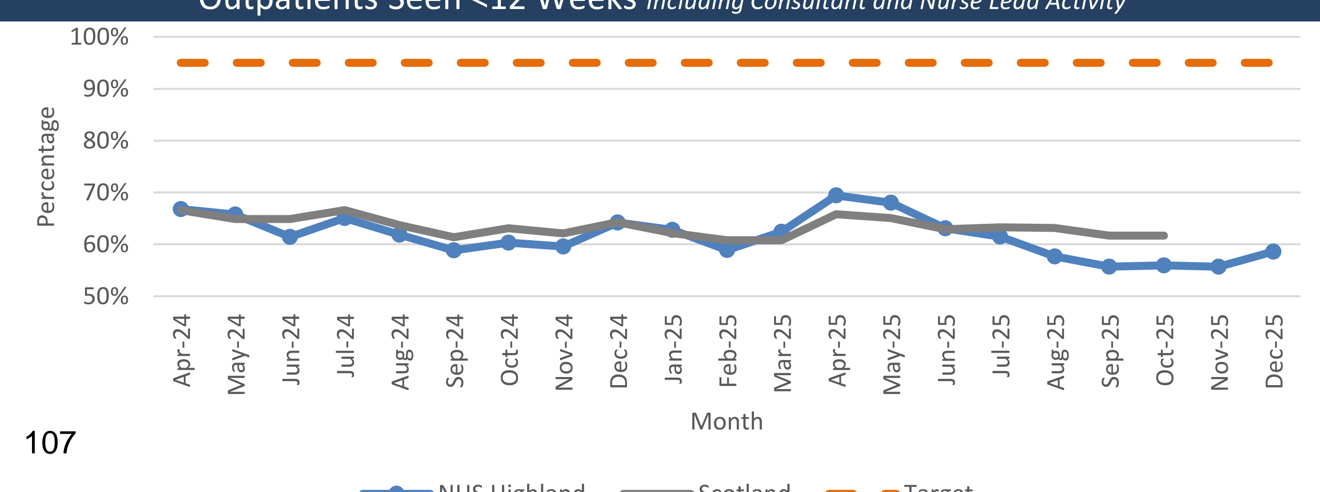
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating against Plan	Amber
Latest Performance against Plan	5.6% behind target
National Benchmarking against 12 week performance	48.5% (Scotland 43.3%)
National Target against 12 week performance	95%
National Target Achievement against 12 week performance	Target not met Below lower control limit
Position against 12 week performance	6th out of 15 Boards

New Outpatients Seen & Trajectories



Outpatients Seen <12 Weeks *Including Consultant and Nurse Lead Activity*



Executive Lead
Katherine Sutton
Chief Officer, Acute

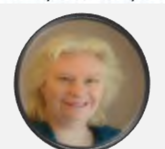
Outpatients (Long Waits) - Slide 2 of 3

NHS Highland remains positively ahead of trajectory in terms of reducing the number of patients waiting > 52 weeks to targets agreed with Scottish Government

ACTUALS
>52WKS TRAJECTORY

5K
4K
3K
2K
1K
0K

13 April 2025, 20 April 2025, 27 April 2025, 04 May 2025, 11 May 2025, 18 May 2025, 25 May 2025, 01 June 2025, 08 June 2025, 15 June 2025, 22 June 2025, 29 June 2025, 06 July 2025, 13 July 2025, 20 July 2025, 27 July 2025, 03 August 2025, 10 August 2025, 17 August 2025, 24 August 2025, 31 August 2025, 07 September 2025, 14 September 2025, 21 September 2025, 28 September 2025, 05 October 2025, 12 October 2025, 19 October 2025, 26 October 2025, 02 November 2025, 09 November 2025, 16 November 2025, 23 November 2025, 30 November 2025, 07 December 2025, 14 December 2025, 21 December 2025, 28 December 2025, 04 January 2026, 11 January 2026, 18 January 2026, 25 January 2026, 01 February 2026, 08 February 2026, 15 February 2026, 22 February 2026, 01 March 2026, 08 March 2026, 15 March 2026, 22 March 2026, 29 March 2026, 05 April 2026

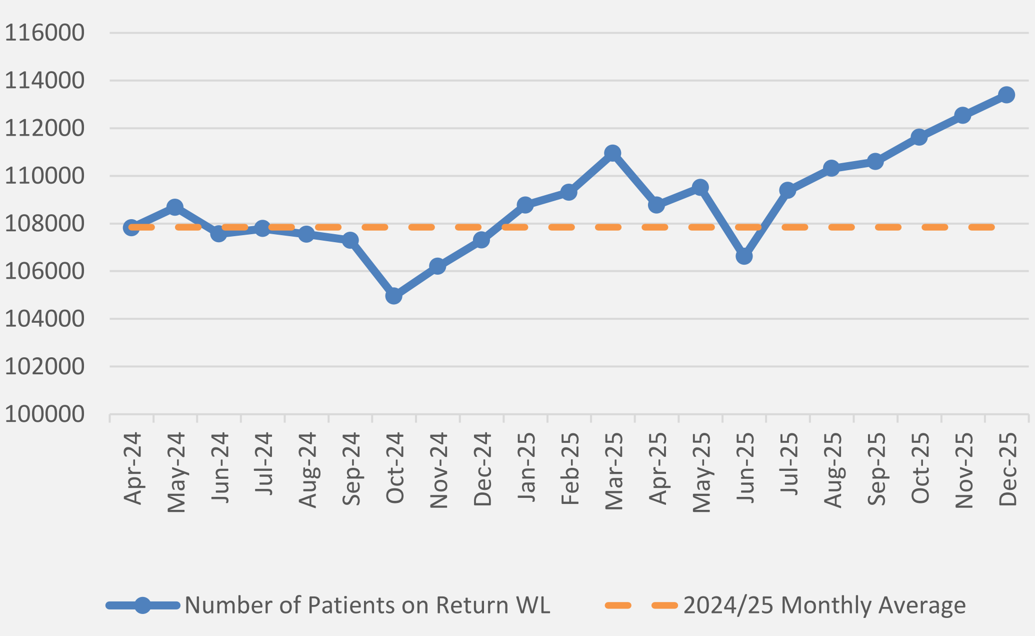


Executive Lead
Katherine Sutton
Chief Officer, Acute

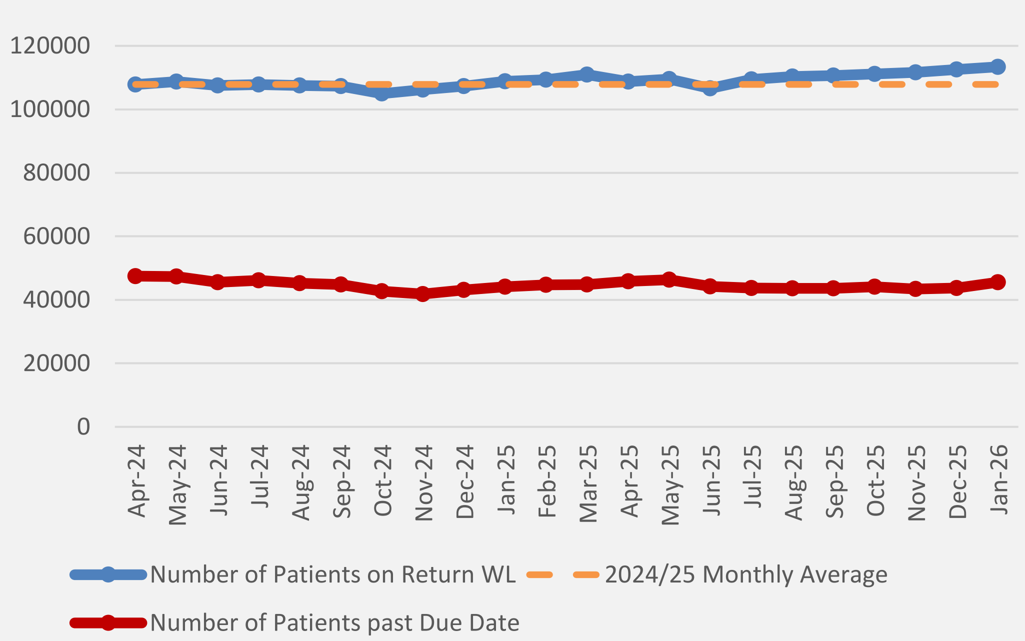
Outpatients (Return Outpatients) - Slide 3 of 3

NHS Highland continues to monitor the level of return outpatients on our waiting lists, and since summer 2025 we observe an increase on the average of this time last year. This may be a consequence of our focus on ensuring outpatient activity is focused on reducing the total number of new outpatients > 52 weeks.

Return Outpatients Wait List vs. 24/25 Average



Return Outpatients Wait List



Executive Lead
Katherine Sutton
Chief Officer, Acute

Treatment Time Guarantee (TTG) - Slide 1 of 2

Key Performance Indicators	Status
Reduce the number of TTG patients waiting over 52 weeks to 124 by March 2026	Blue
The number of inpatient/day case procedures undertaken is equal to or exceeds the monthly target	Blue
The number of inpatient/day case procedures undertaken is equal to or exceeds the cumulative target	Blue
Percentage of TTG patients seen within 12 weeks of referral equal to or above 95% every month. within 12 weeks of referral equal to or above 95% every month.	Red

Reasons for Current Performance

Highland -
Activity is ahead of plan and the number of people waiting over 52 weeks continues to reduce at a rate above our target. This is attributed to our continued focus on performance and the robust clinical validation and application of waiting times guidance we have in place.

Argyll & Bute -
Performance continues to be on or around 12 weeks but we are mindful of the emerging Oral Surgery backlog.

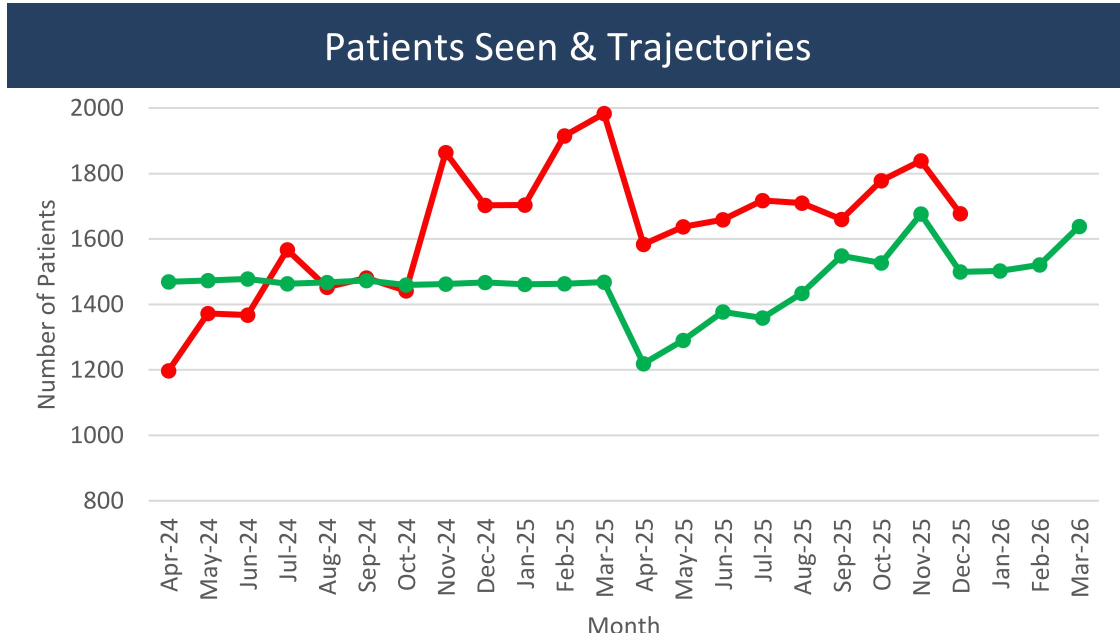
Plans, Mitigations and Actions

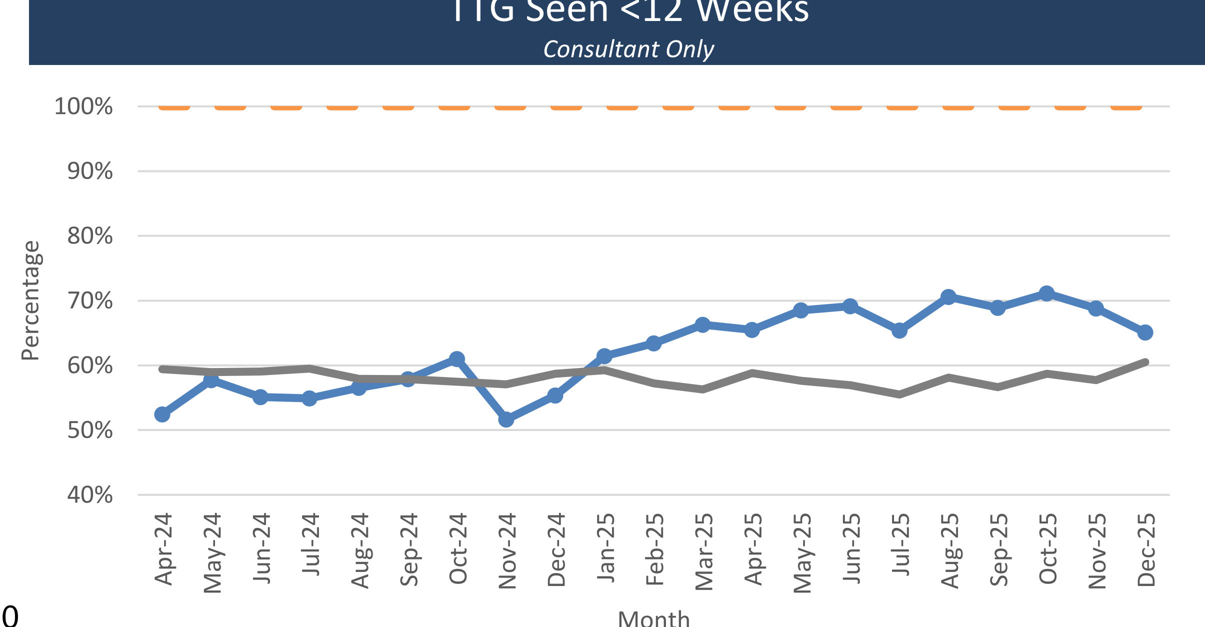
Highland –
Continue to monitor activity and progress across all acute sites to ensure delivery.

Argyll & Bute -
We expect a sharp increase in the number of patients waiting for Oral Surgery once the independent provider NOP activity is completed. Conversations around the future of the service are planned with NHS Highland.

PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating against Plan	Blue
Latest Performance against Plan	On target
National Benchmarking against 12-week performance	65.1% (Scotland 60.5%)
National Target against 12-week performance	100%
National Target Achievement against 12-week performance	Target Not Met; But consistently above Scotland average
Benchmarking against 12-week performance	6th of out 15 Boards





Exec Lead
Katherine Sutton
Chief Officer, Acute

TTG (Long Waits) - Slide 2 of 2

NHS Highland continues to be ahead of trajectory and while it is expected the gap will narrow to March 2026 – as additional activity was front-loaded in 2025 – there is good confidence that the target levels will be met by end of March 2026.

Long Waits >52 Weeks

ACTUALS ◆ >52WKS TRAJECTORY

1000
800
600
400
200
0

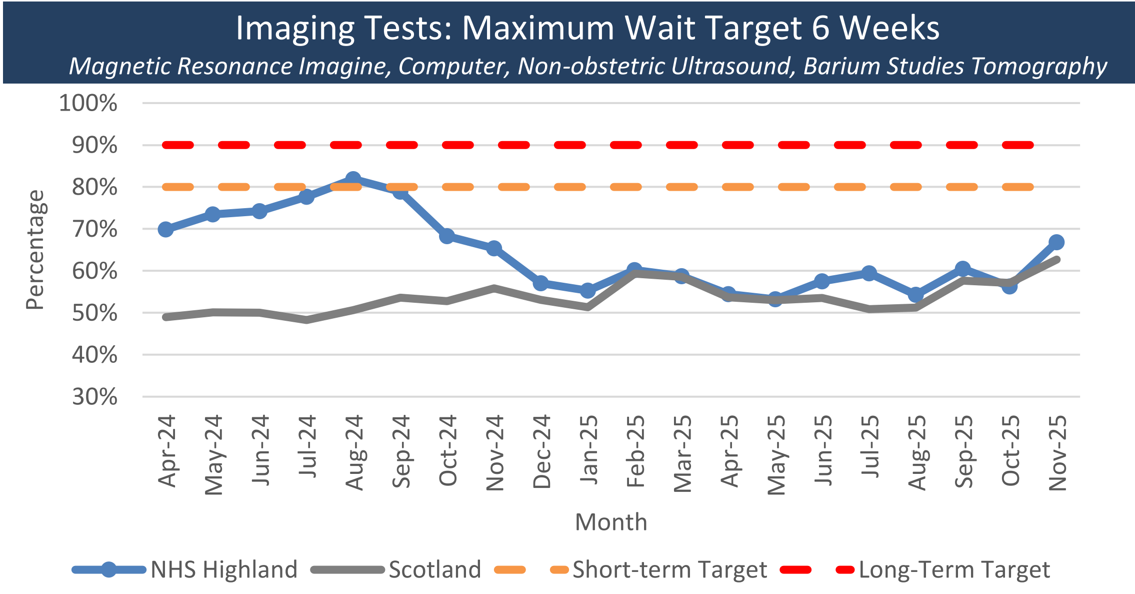
13 April 2025, 20 April 2025, 27 April 2025, 04 May 2025, 11 May 2025, 18 May 2025, 25 May 2025, 01 June 2025, 08 June 2025, 15 June 2025, 22 June 2025, 29 June 2025, 06 July 2025, 13 July 2025, 20 July 2025, 27 July 2025, 03 August 2025, 10 August 2025, 17 August 2025, 24 August 2025, 31 August 2025, 07 September 2025, 14 September 2025, 21 September 2025, 28 September 2025, 05 October 2025, 12 October 2025, 19 October 2025, 26 October 2025, 02 November 2025, 09 November 2025, 16 November 2025, 23 November 2025, 30 November 2025, 07 December 2025, 14 December 2025, 21 December 2025, 28 December 2025, 04 January 2026, 11 January 2026, 18 January 2026, 25 January 2026, 01 February 2026, 08 February 2026, 15 February 2026, 22 February 2026, 01 March 2026, 08 March 2026, 15 March 2026, 22 March 2026, 29 March 2026, 05 April 2026

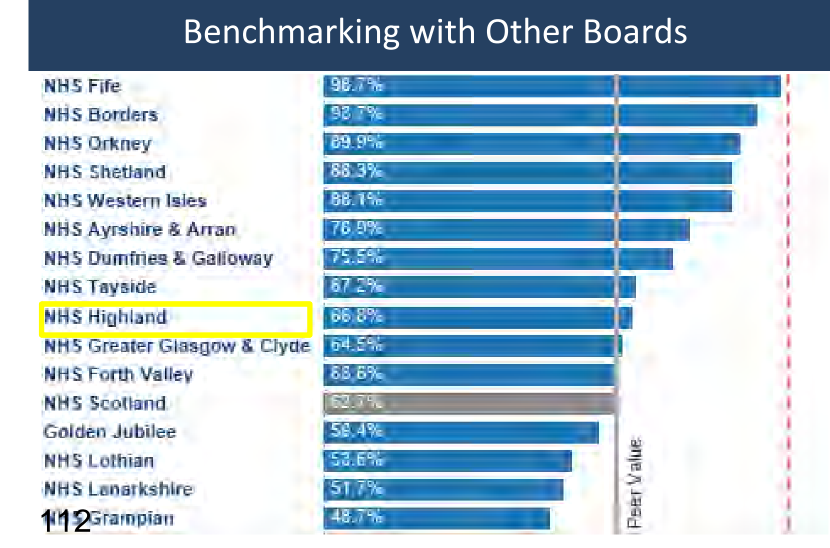
Exec Lead
Katherine Sutton
Chief Officer, Acute

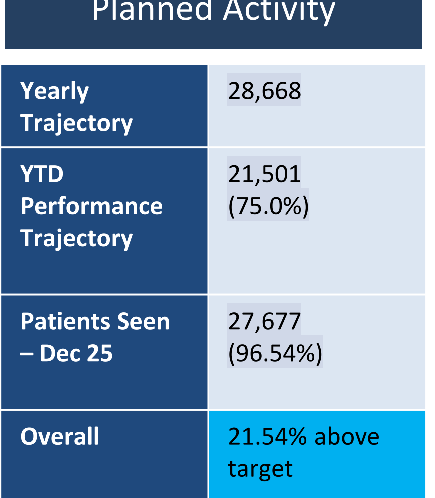
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
The number of patients who receive imaging (all) is equal to or exceeds the trajectory every month The number of patients who received a CT scan is equal to or exceeds the number of planned appointments every month Patients seen for non-obstetric ultrasound radiology testing is equal to or exceeds trajectory every month The number of patients who receive an MRI scan is equal to or exceeds the number of planned appointments every month Increase the number of patients receiving a key diagnostic test within 6 weeks from referral, in line with NHS Scotland guidance	**Highland** 10% increase in CT scanning December versus November, outpatient scans static though. MRI van and OP activity lower in December due to public holidays and equipment breakdowns. Increase in USC referrals in December. High number of inpatient referrals (all modalities) at times impinges on outpatient capacity. **Argyll and Bute** Radiographer staffing is limited, with specialist services such as CT Cardiac and CT Colon experiencing the longest waiting times. Reduced radiologist FTE also restricts service development and continues to drive outsourcing costs.	**Highland** Recovery plan in discussion with SG, SBARS signed off by ASLT and submitted. **Argyll and Bute** Ongoing workforce establishment review, including activity analysis and professional planning. SBAR developed outlining the trajectory for service improvement and sustainable radiology services for the A&B population.

PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating against Plan	
Latest Performance against 6-week target	66.8%
National Benchmark against 6-week target	62.7%
Local Target	80% (Short-term) 90% (Long-term)
National Target Achievement	National target not met, performance in NHSH is above Scotland average
Benchmarking	9th out of 15 Boards

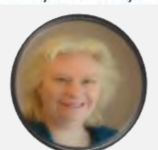




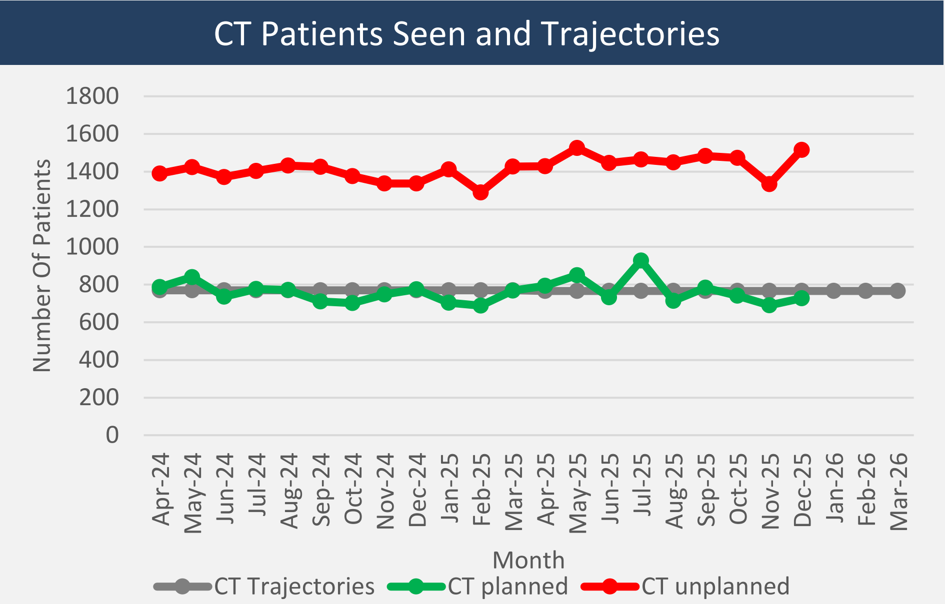


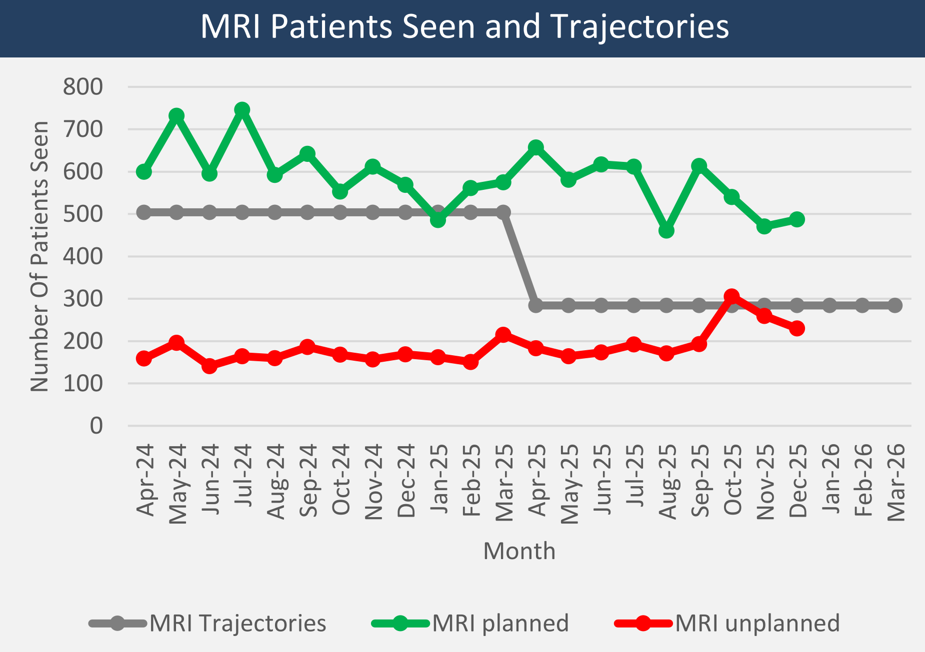
Planned Activity

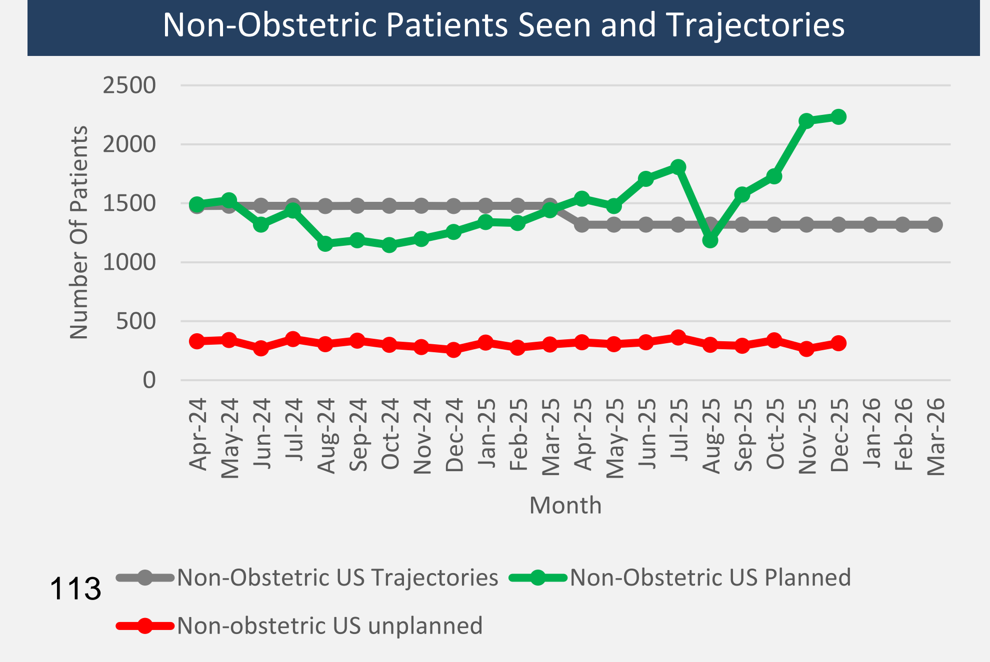
Yearly Trajectory	28,668
YTD Performance Trajectory	21,501 (75.0%)
Patients Seen – Dec 25	27,677 (96.54%)
Overall	21.54% above target

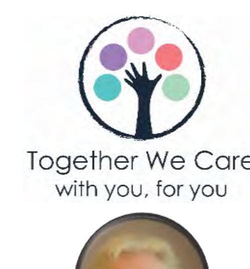


Exec Lead
Katherine Sutton
Chief Officer, Acute









Exec Lead
Katherine Sutton
Chief Officer, Acute

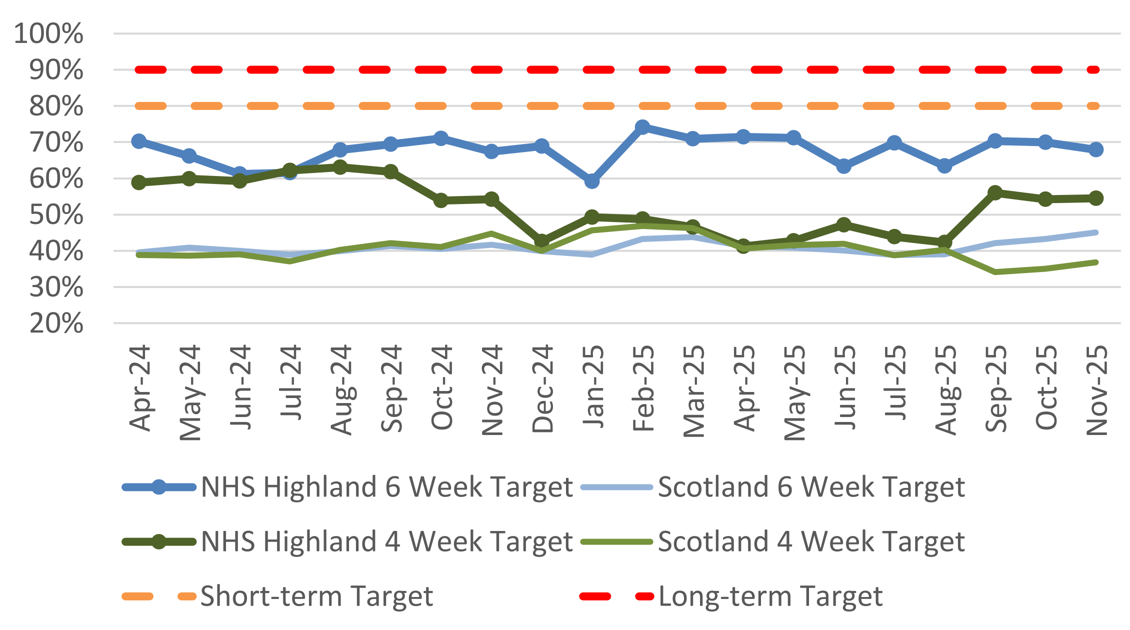
Diagnostics – Endoscopy – Slide 1 of 2

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
No patients waiting longer than 6 weeks for an endoscopy test (from referral to test) in line with Scottish Waiting Time Targets	**GI endoscopy:** Loss of colon capsule service is a challenge to performance, Maternity leave and other staffing challenges impact capacity, including challenges in RGH sites Belford, Wick and Oban sites. Significant waiting list initiative additionally in Gastroenterology and Gen Surgery causing demand pressures **Cystoscopy:** Reviewed staffing model to match demand and capacity underway.	**Overall:** raised PMS recording 28 days, rather than national 42 target. First raised 27/12/2023. Confirmation this is on digital delivery plan – can it be prioritised? **GI endoscopy:** Held meeting with Belford and Wick hospital managers to address loss of lower capacity at both sites. Awaiting mitigation plan Nurse endoscopists visiting Wick site in March to provide lower capacity **Cystoscopy:** Independent Sector and WLI running in Quarter 4 – data shows non-recurring demand/capacity gap
The number of patients seen for a new endoscopy appointment is equal to or exceeds the trajectory every month		
The number of patients seen for a new Colonoscopy, Cystoscopy, Flexi Sig and Upper GI is equal to or exceeds the number of planned appointments every month		

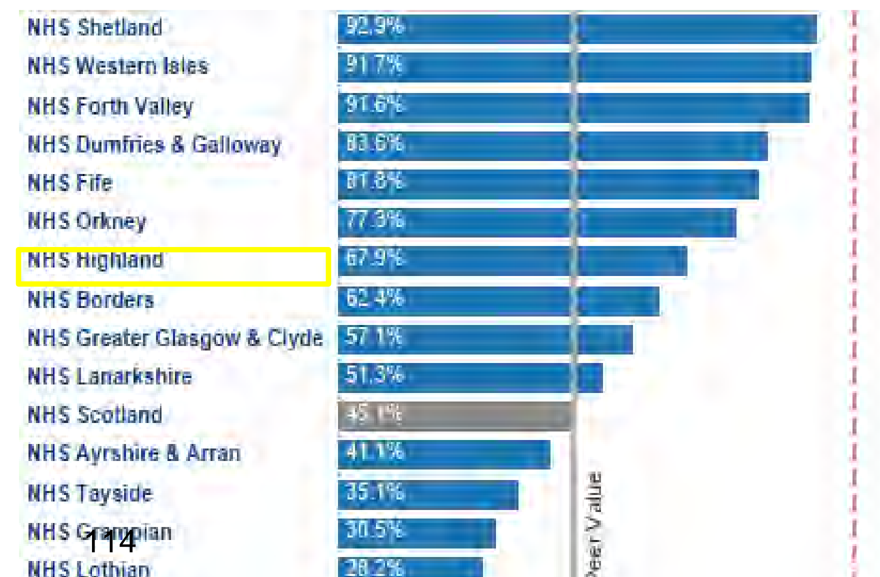
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	67.9%
National Benchmark	45.1%
National Target	80% (Short-term) 90% (Long-term)
National Target Achievement	While national target not met, performance in NHSH is ahead of Scotland average
Benchmarking	7th out of 15 Boards

Endoscopy Tests: Maximum Wait Target 4/6 Weeks
Colonoscopy, Cystoscopy, Flexi Sig, Upper GI



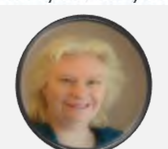
Benchmarking with Other Boards
6 Week National Target



Planned Activity

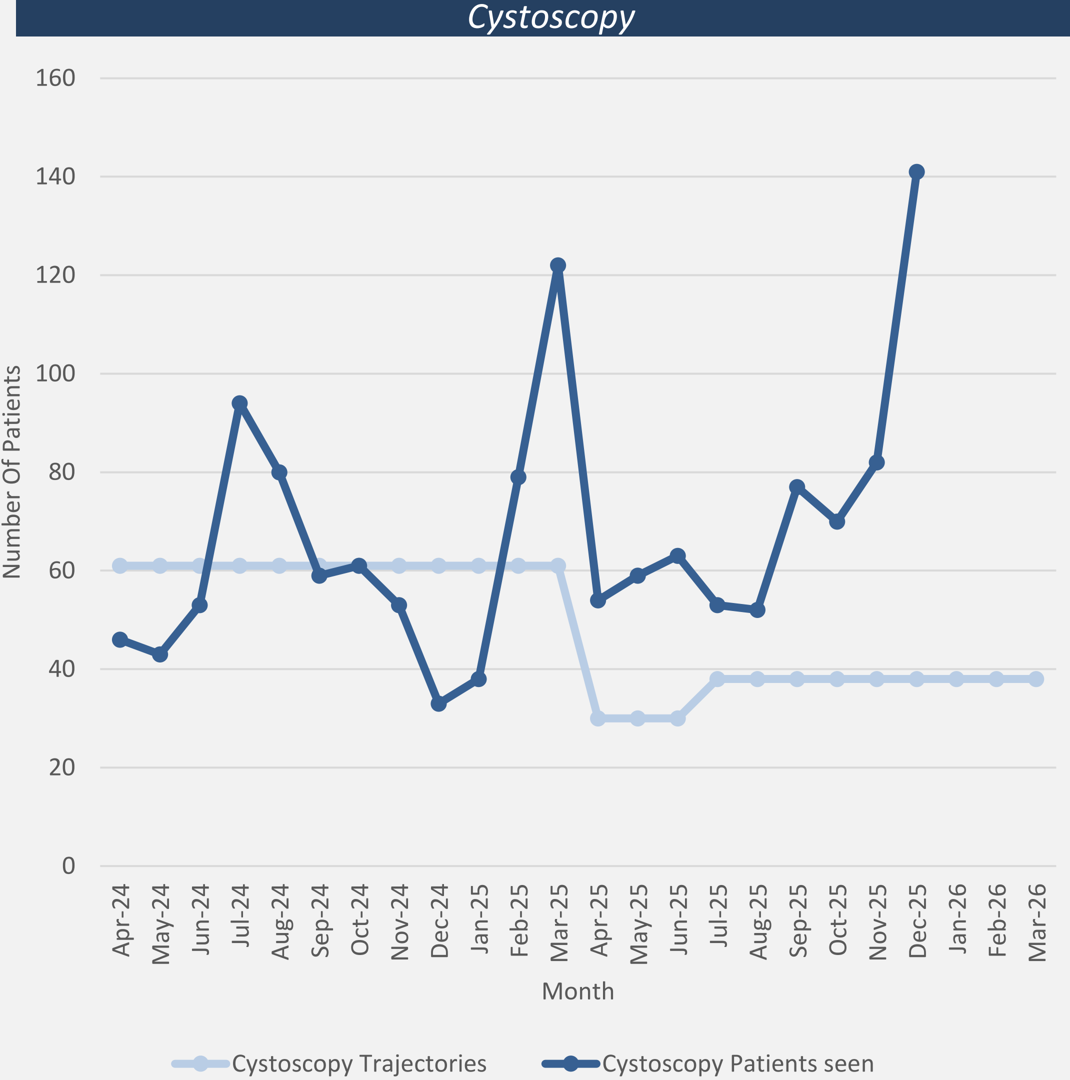
Yearly Trajectory	5,176
YTD Performance Trajectory	3,886 (75.08%)
Patients Seen – Dec 25	5,040 (97.31%)
Overall	22.24% above target

Diagnostics – Endoscopy – Slide 2 of 2

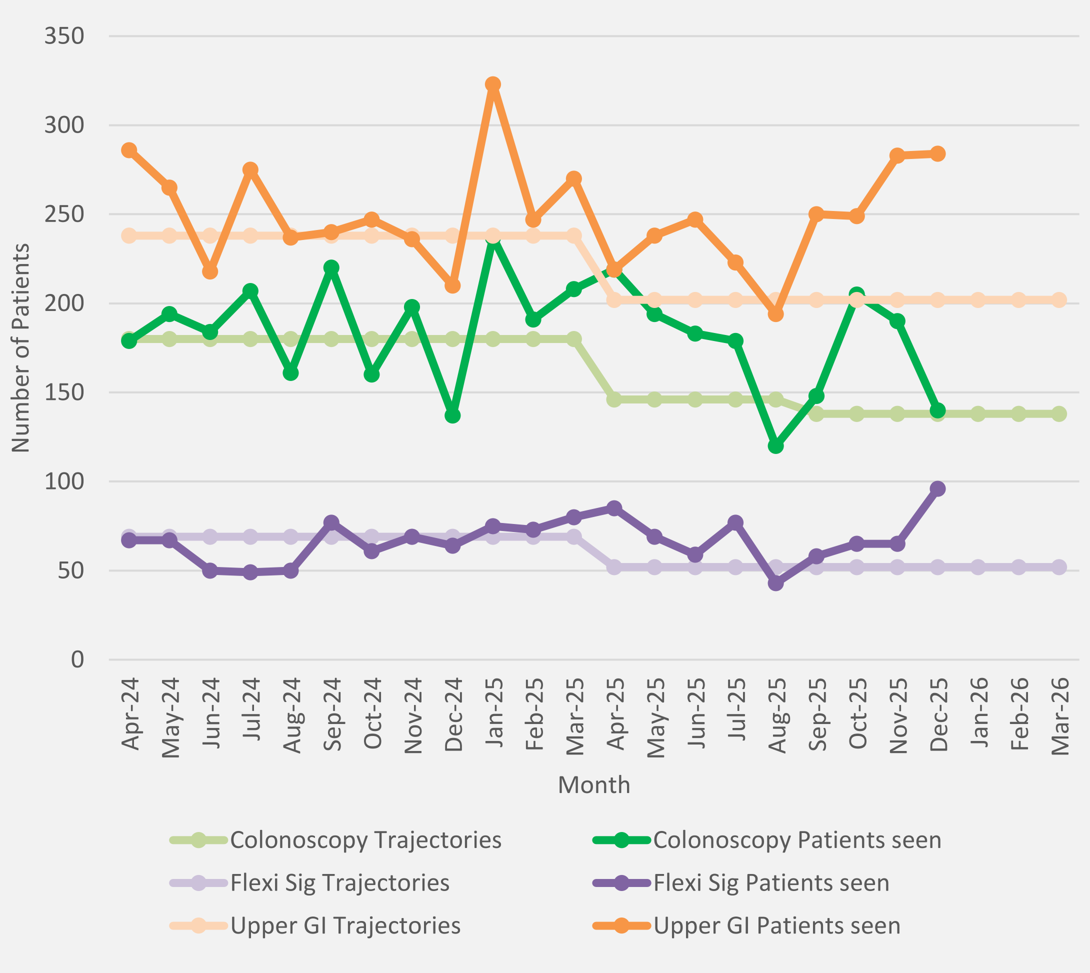


Exec Lead
Katherine Sutton
Chief Officer, Acute

Patients Seen and Trajectories: *Cystoscopy*



Cystoscopy Patients Seen and Trajectories: *Colonoscopy, Flexi Sig & Upper GI*



Exec Lead
Katherine Sutton
Chief Officer, Acute

Diagnostics - Wait List Other

Key Performance Indicators

Indicator	Status
Increase the number of patients waiting less than 6 weeks for an ECHO test (from referral to test) in line with Scottish Waiting Time Targets	Amber
Increase the number of patients waiting less than 6 weeks for an R Test / 24 ECG (from referral to test) in line with Scottish Waiting Time Targets	Red
Increase the number of patients waiting less than 6 weeks for an spirometry test (from referral to test) in line with Scottish Waiting Time Targets	Red

Reasons for Current Performance

Ambulatory ECG & Blood Pressure (R-Tests/Holter):
-Some Cardiography post(s) vacated and in recruitment a considerable period from latter 2025
-Some equipment stock (R-Teat) limiting as numbers deplete and to be replenished

Echo-cardiography:
-Locum post closed in Oct 2025
-Long vacant Principal Post (now re-advertised)

Spirometry (Raigmore & Caithness):
-Stable, following significant improvement from 2nd staff member starting in mid-2024

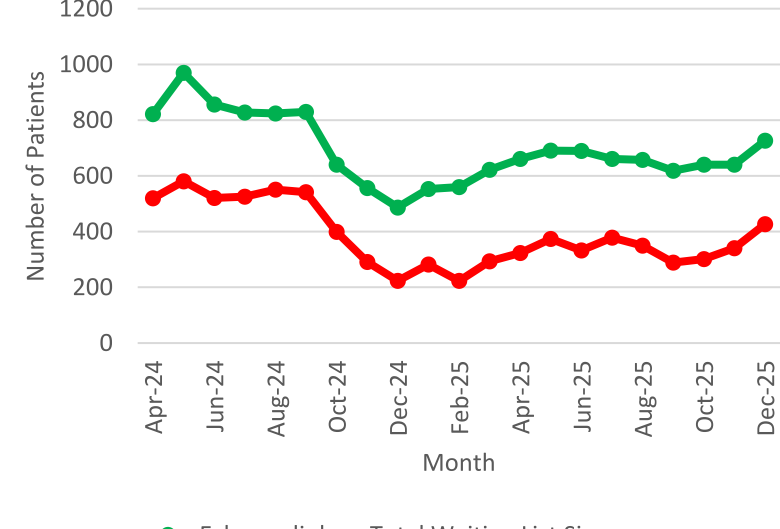
Plans, Mitigations and Actions

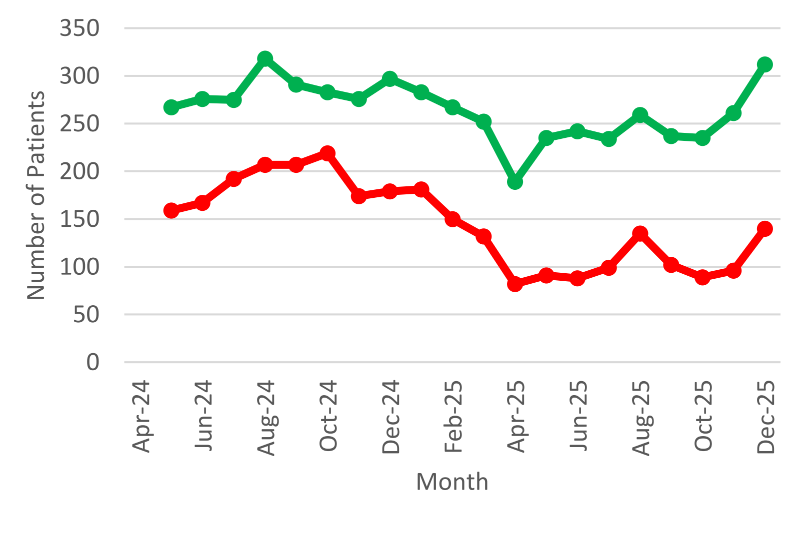
- Posts in Vacancy Management Process
- Paper to be at ASLT to renew R-Test stock
- 4th Echo machine nationally funded and ordered
- Key action to sustain improved situation

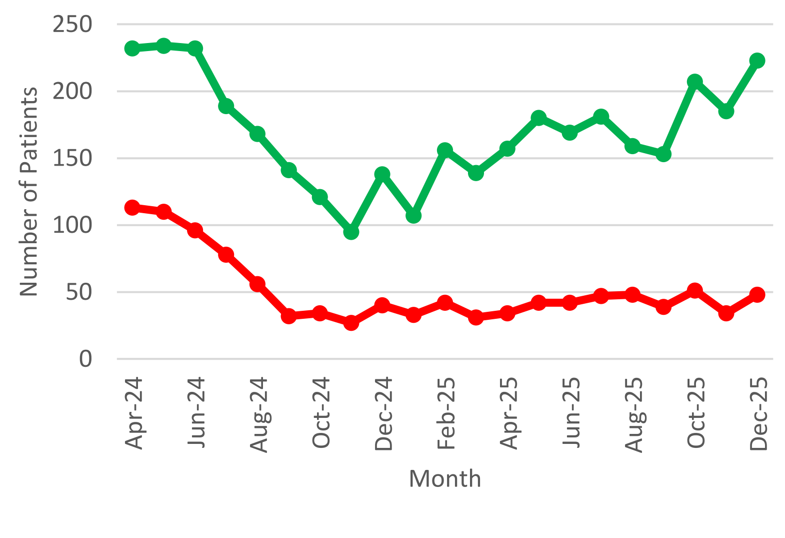
PERFORMANCE OVERVIEW

Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	Red
Latest Performance	n/a
National Benchmark	n/a
National Target	n/a
National Target Achievement	n/a
Benchmarking	n/a







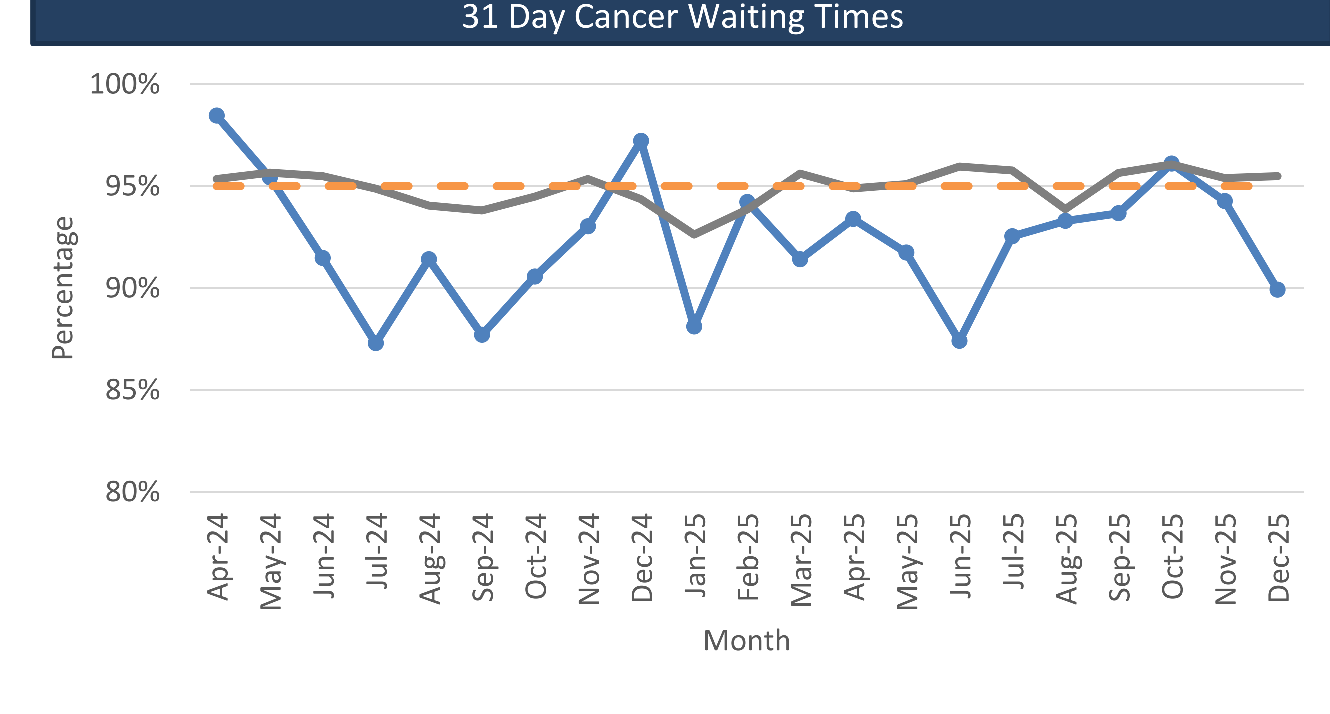
31 Day Cancer Waiting Times

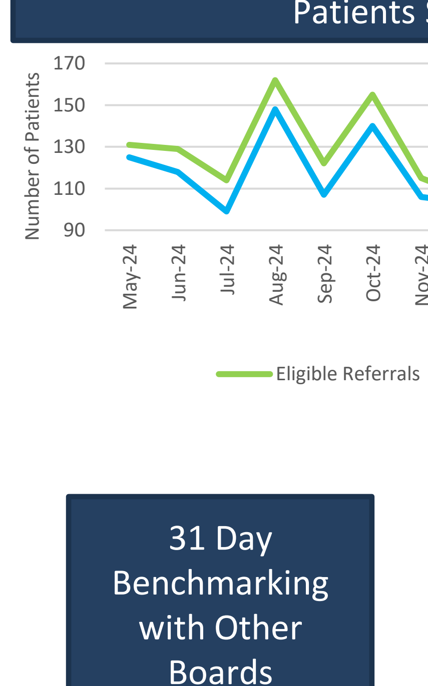
Executive Lead
Katherine Sutton
Chief Officer, Acute

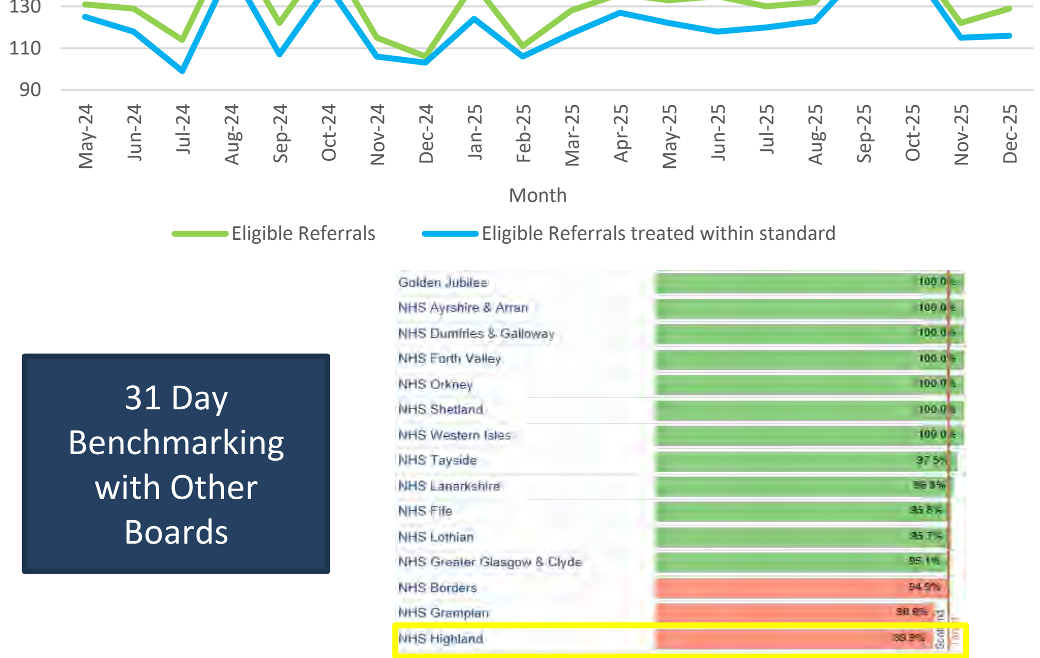
OIP

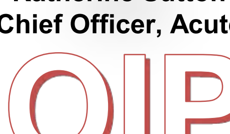
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
95% of patients should begin treatment within 31 days of the decision to treat, regardless of the referral route	• The poor compliance is almost exclusively due to reduced capacity for Breast Surgery following changes in workforce owing to retirement and advertisement of replacement.	• Readvertisment of Breast Surgeon post with interviews scheduled for early March. • Support from NHS Forth Valley as interim measure. • Advancing locum appointment to increase capacity

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	89.9%
National Benchmarking	95.5%
National Target Achievement	95%
Position	15th out of 15 Boards









Executive Lead
Katherine Sutton
Chief Officer, Acute

OIP

62 Day Cancer Waiting Times

Key Performance Indicators

95% of patients referred urgently with a suspicion of cancer (USC) - whether through a GP referral, national screening programme, should be their first cancer treatment within 62 days of receiving the referral.

Reasons for Current Performance

- Compliance within Breast and Colorectal pathways timescales is the most challenged.
- There is a lack of capacity for Assessment & Diagnostics in Breast within staffing gaps
- There is a lack of staff to support a 2-week wait to scope in particular for Colorectal patients.
- Most other patients are above the monthly declared trajectory which aims to be at 80% by 31 March 2026.

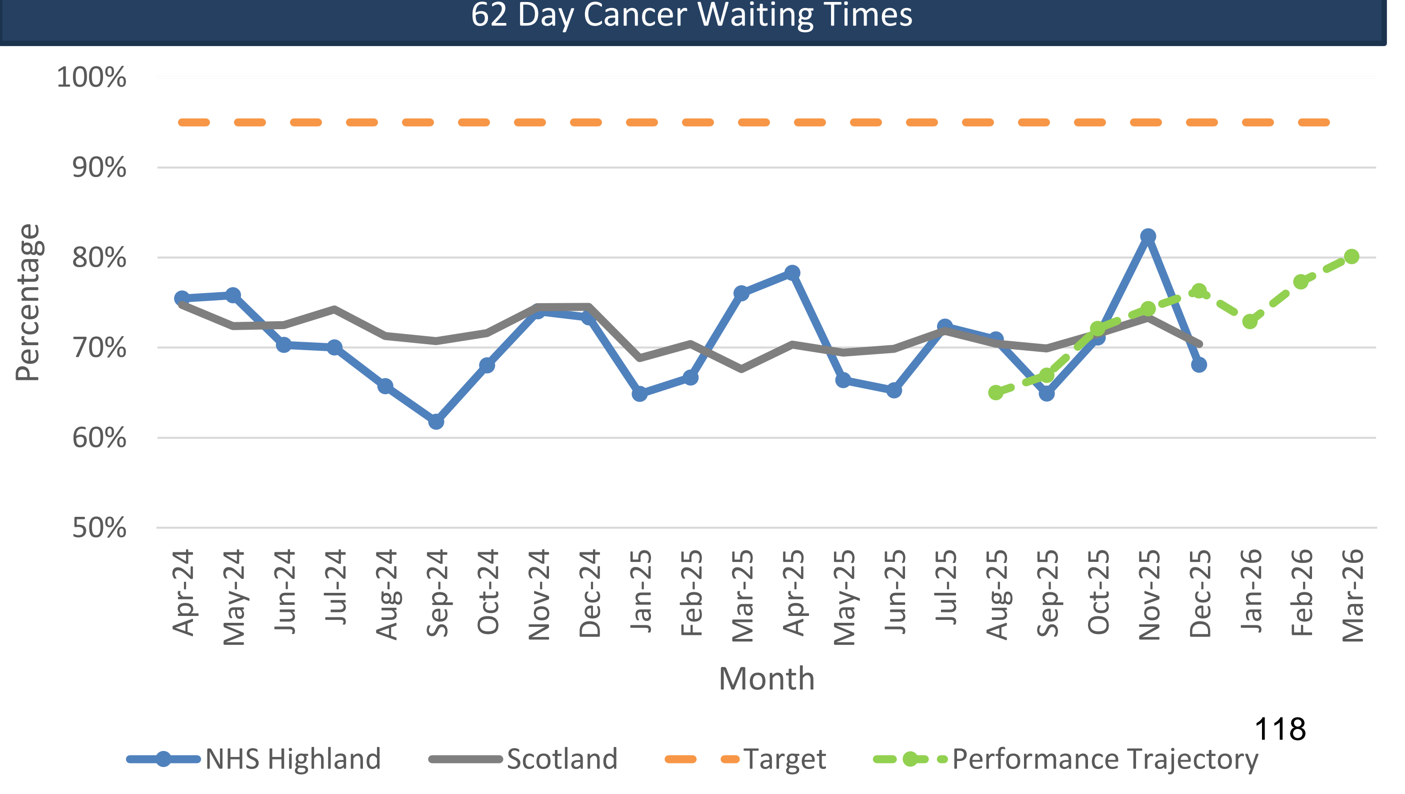
Plans, Mitigations and Actions

- Breast - Continued support from Forth Valley for See and Treat provision.
- Breast – continued recruitment efforts to appoint to vacant posts, include appointment to alternate staffing models using non medical workforce.
- Colorectal – as above with appointment of Nurse Endoscopists
- Continued daily scrutiny and prioritisation of cancer activity to maintain and improve performance in every tumour type

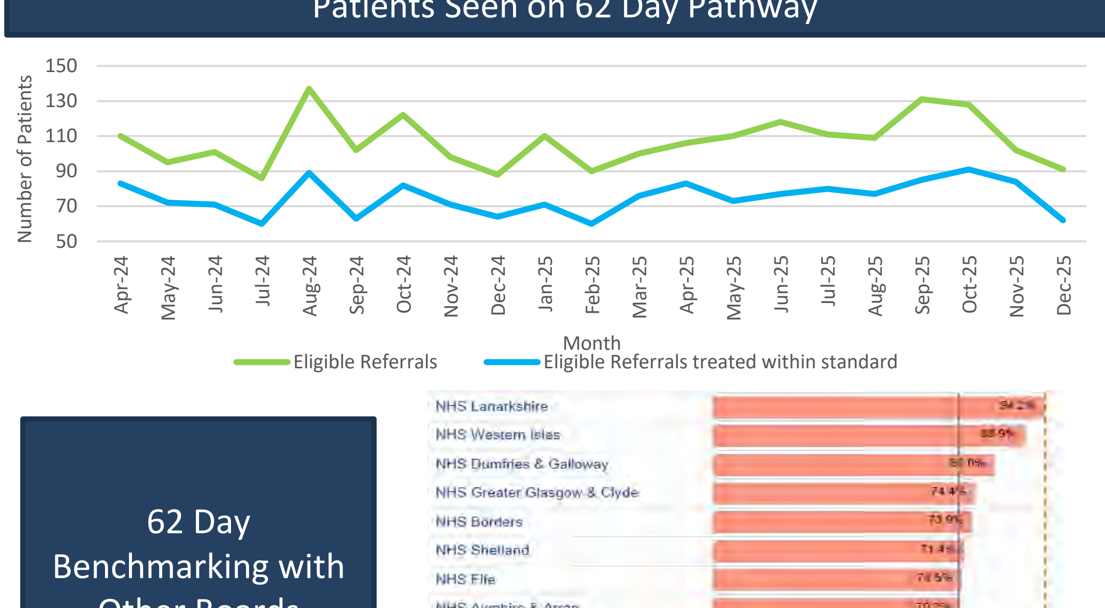
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	68.1%
National Benchmarking	70.4%
National Target	95%
National Target Achievement	Not Achieving
Position	9th Out of 14 Boards

62 Day Cancer Waiting Times



Patients Seen on 62 Day Pathway



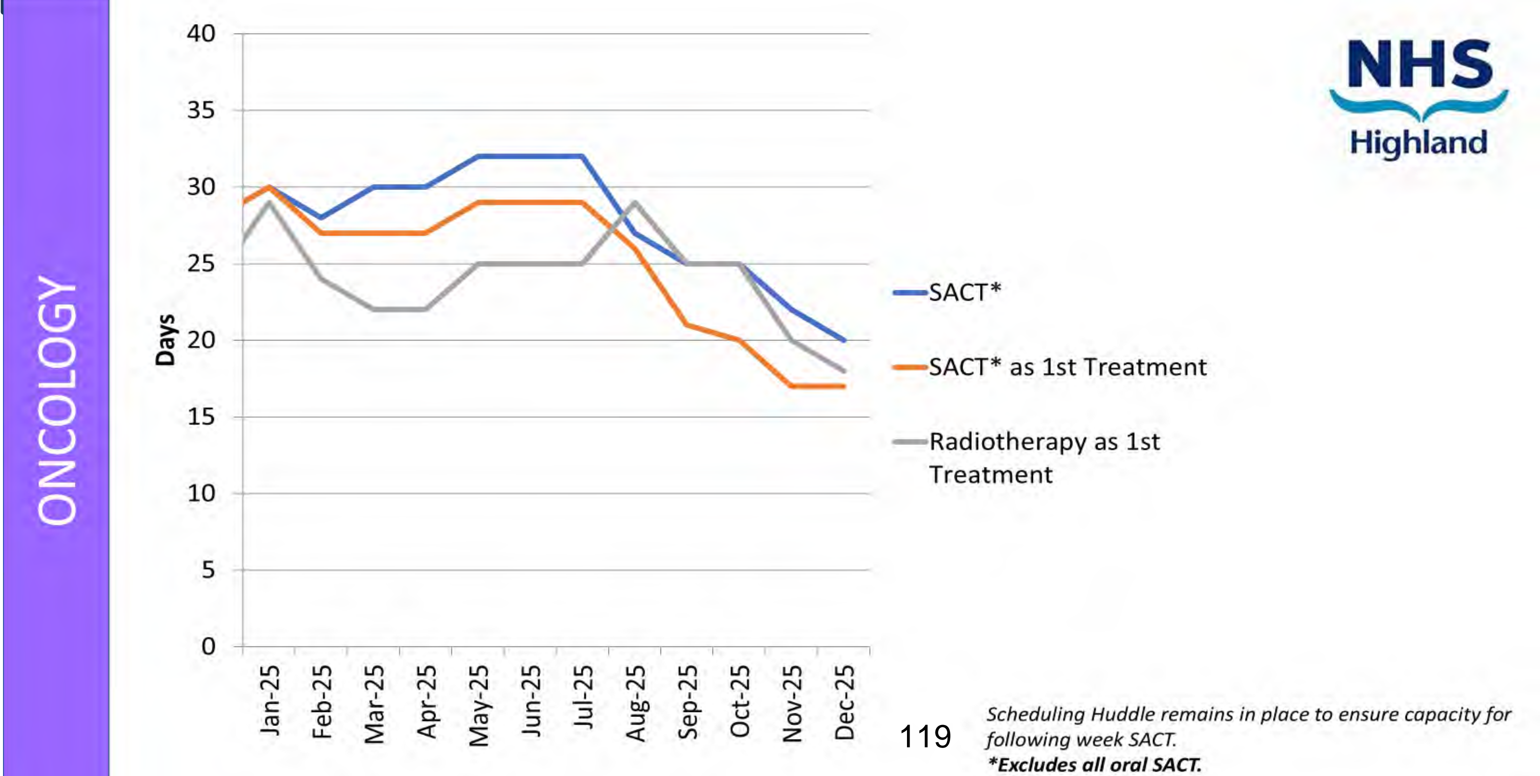
Executive Lead
Katherine Sutton
Chief Officer, Acute

SACT (Systemic Anti Cancer Therapy) and Radiotherapy Access and Benchmarking

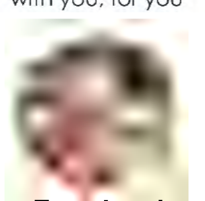
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
The average waiting times for SACT as 1st Treatment, Radiotherapy as First Treatment and ASCT patients overall (new and subsequent) will be no more than 28 days	This is a local standard only. It is expected to be adopted as a national benchmark within the next financial year. Performance is due to a variety of factors such as good prescribing staff capacity (medical and non-medical) together with optimal SACT Nursing staff to support SACT treatments.	We will continue to maximise the resources available to minimise the waiting times to commencement of SACT and Radiotherapy treatments.

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	Average range = 16-20 days to start treatment
National Benchmarking	n/a
National Target	n/a
National Target Achievement	n/a
Position	NHS Highland activity matches national trends

Systemic Anti Cancer Therapy (SACT) and Radiotherapy Average waiting times by month



Scheduling Huddle remains in place to ensure capacity for following week SACT.
Excludes all oral SACT.



Exec Lead
Boyd Peters

Stage 2 Complaint Activity (December 2024 – December 2025)

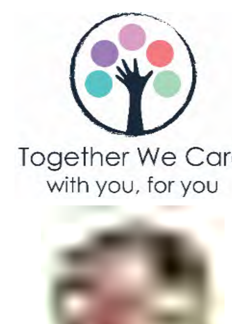
ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
N/A	Continued poor performance against the 20 day working target. This is due to investigations exceeding the expected time, routinely. Feedback Team continue to log and send responses within 24-48 hours of receipt. Whilst the number of complaints closed in November and December exceeded those opened, the previously identified reverse trend continues to reduce efficiency in the Feedback process affecting both Operational Units and the Clinical Governance Team.	Reporting to EDG and escalation to Board Medical Director where required. Weekly and bi-weekly reports to Operational Units. Meetings have been held with SLT. Investigations are the responsibility of the Operational Units.

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	13%
National Benchmarking	None
National Target	60%
National Target Achievement	
Position	

Stage 2 Feedback Cases - Received and closed and working day %

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Working Day Performance	31%	23%	20%	33%	27%	25%	20%	15%	17%	20%	17%	24%	13%

Legend: Working Day Performance; Number of cases received; Number of cases closed



Exec Lead
Boyd Peters

SPSO Activity (January 2025 – January 2026)

ADP Deliverables Progress as at End of Q2 2025/26		Insights to Current Performance	Plans and Mitigations
		The number of cases opened by the SPSO has decreased in the last three months. All cases closed have not been taken forward.	SPSO cases continue to be monitored via the Quality and Patient Safety structure.

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	
National Benchmarking	
National Target	
National Target Achievement	
Position	

Number of SPSO Cases Received / Closed

Month	SPSO Received	SPSO Closed
January/2025	3	3
February/2025	1	4
March/2025	4	2
April/2025	3	4
May/2025	2	4
June/2025	3	3
July/2025	2	2
August/2025	3	1
September/2025	4	1
October/2025	3	4
November/2025	3	3
December/2025	2	1
January/2026	1	3

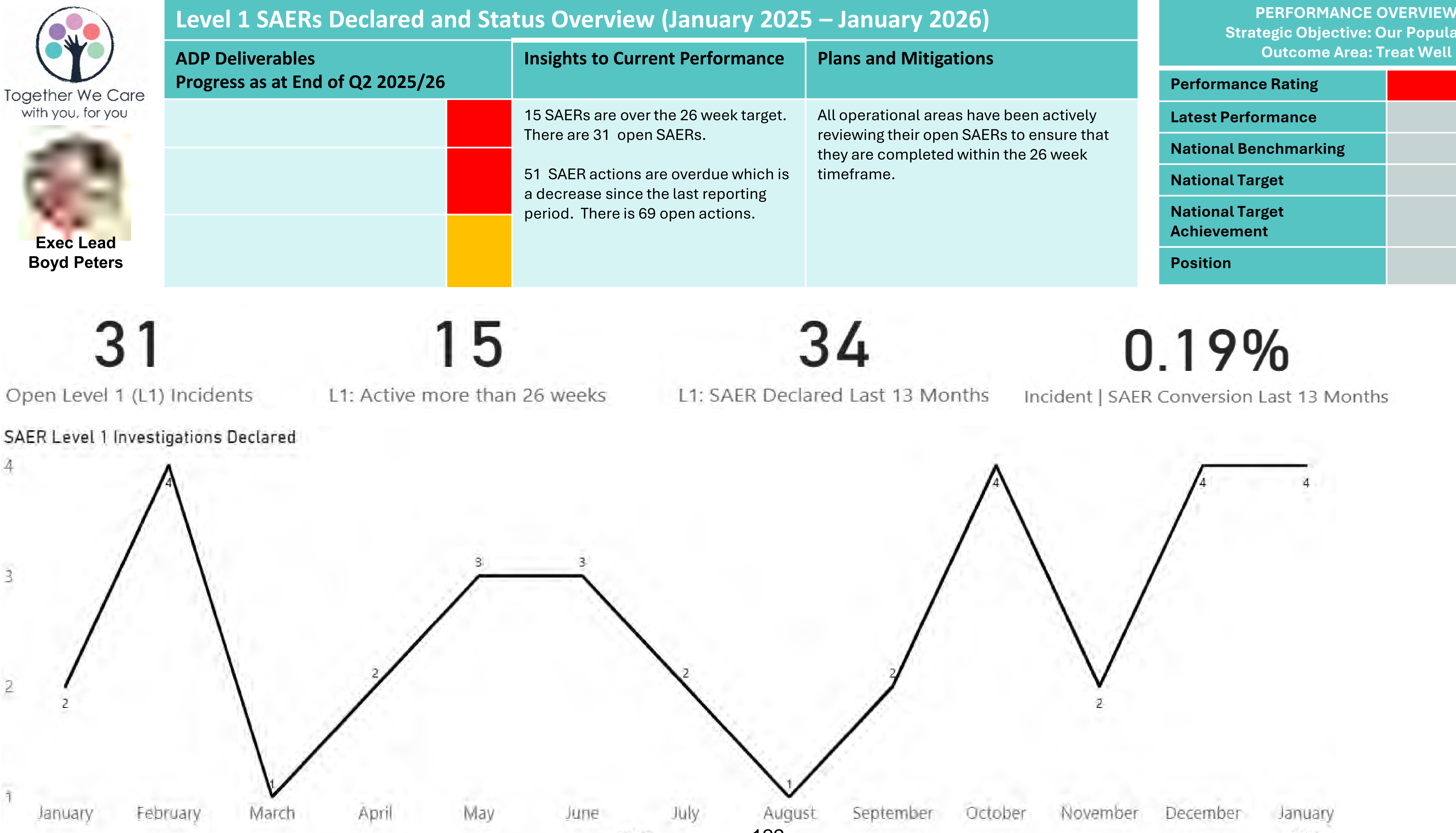
SPSO cases received last 3 months:
6 received:

- 2 x Acute
- 1 x A&B
- 3 x HHSCP

These relate to Mental Health Services - Adult Psychiatry, Surgical - Orthopaedics, Surgical - Urology

SPSO cases closed last 3 months:
7 SPSO enquiries closed

- 7 x not taken forward



Together We Care
with you, for you
Exec Lead
Boyd Peters
Level 1 SAERs Declared and Status Overview (January 2025 – January 2026)
ADP Deliverables
Progress as at End of Q2 2025/26
Insights to Current Performance
15 SAERs are over the 26 week target. There are 31 open SAERs.
51 SAER actions are overdue which is a decrease since the last reporting period. There is 69 open actions.
Plans and Mitigations
All operational areas have been actively reviewing their open SAERs to ensure that they are completed within the 26 week timeframe.
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well
Performance Rating
Latest Performance
National Benchmarking
National Target
National Target Achievement
Position
31
Open Level 1 (L1) Incidents
15
L1: Active more than 26 weeks
34
L1: SAER Declared Last 13 Months
0.19%
Incident | SAER Conversion Last 13 Months
SAER Level 1 Investigations Declared
January 2
February 4
March 1
April 2
May 3
June 3
July 2
August 1
September 2
October 4
November 2
December 4
January 4
2025
2026
Month

Exec Lead
Louise Bussell

Hospital Inpatient Falls (January 2025 – January 2026)

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
	There has been a slight overall increase in inpatient falls rates since last reporting period. Falls with harm rate static, averaging 40 per month across NHSH Multiple bays in Raigmore hospital have had an additional patient in them but this does not appear to have impacted rate of falls.	Improvement work continues at a local level. Good engagement with Falls awareness online event in November

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	
National Benchmarking	
National Target	20% reduction (falls) 30% reduction (falls with harm)
National Target Achievement	
Position	

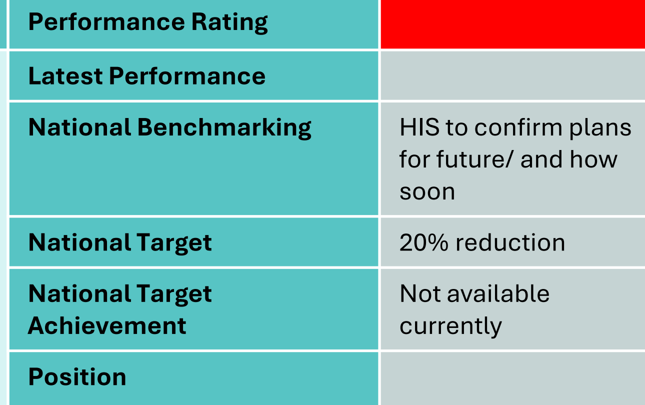
Number of Inpatient Falls | Subcategory

Month	January	February	March	April	May	June	July	August	September	October	November	December	January 2026
Suspected / unwitnessed fall	111	98	107	94	107	80	92	119	89	118	109	119	122

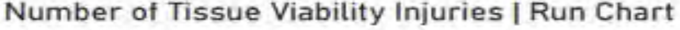
Exec Lead
Louise Bussell

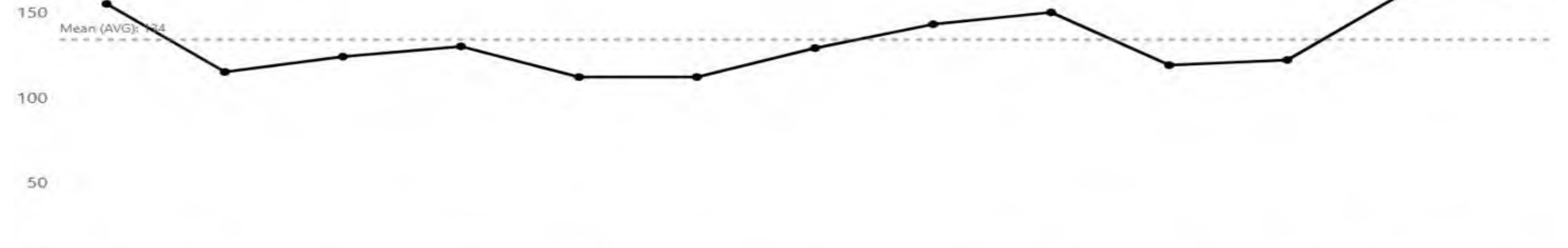
Tissue Viability Injuries (January 2025 – January 2026)

ADP Deliverables Progress as at End of Q2 2025/26		Insights to Current Performance	Plans and Mitigations
-MASD and PU Pathways complete via NATVNS- New Pressure Ulcer Grading Tool Training launched with dates via Teams. Training and Audit to target wards on Datix so that figures are accurate across acute key wards		- IPC unpublishing TURAS modules for Pressure Ulcers (PU). - PUs on feet adding to numbers - developed feet training - SAS discussions ongoing re: frailty pathway and in discussions with Clarie Copeland and Kate Watson from NHS Glasgow for QI - -NHS Grampian/SAS/NHSH PU launch - -MASD and PU Pathways complete via NATVNS-	- -Continue to implement support for high risk areas - -Develop training including for Feet - SLWG set up with NATVNS for pressure ulcer training materials as IPC will be publishing training slides on TURAS - PU Documents ongoing with NES support and NATVNS. Current modules shortened to 2,4,5 and 6 until updated - -There is still discrepancy on community figures due to the nature of the current system, which includes patients NOT known to DNS, but still captured under the headiing of 'developed in community'. Working with MB on this to drive change



PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	
National Benchmarking	HIS to confirm plans for future/ and how soon
National Target	20% reduction
National Target Achievement	Not available currently
Position	





Exec Lead
Louise Bussell

Tissue Viability Injuries | Subcategory (January 2025 – January 2026)

ADP Deliverables Progress as at End of Q2 2025/26		Insights to Current Performance	Plans and Mitigations
		• - QI project started - CPR Feet forms part of lower limb training - At risk ward shows improvement with PUs, but now has increase in number of PUs to feet- ongoing support, and include roll out of CPR Feet - Infection and Biofilm Pathway QI ongoing	- Wards 3A to start project with Podiatry - -Leg Ulcer Audit ongoing - Lower Limb training x1 more for the year successfully ongoing - Infection and Biofilm Pathway QI ongoing

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	
National Benchmarking	HIS to confirm plans for future/ and how soon
National Target	20% reduction
National Target Achievement	
Position	

Number of Tissue Viability Injuries | All Subcategories and Injury grades | Sub-Category

Exec Lead
Louise Bussell

Tissue Viability Injuries | Subcategory by Injury Grade (January 2025 – January 2026)

ADP Deliverables Progress as at End of Q1 2025/26		Insights to Current Performance	Plans and Mitigations
Need to focus on Grade 2 and Grade 1 prevention as these 2 categories still account for the highest incidents of developed PUs.		• To discuss if Grade 1 can continue to be incident reported, as well as Grade 2	• There is a head to toe inspection video that will be used via NATVNS • Requested TURAS share and be made accessible to/including non NHS Highland care homes • Equipment guide being updated as a step up/step down guide for all clinicians across acute and community • Work underway to address Grade 1 and Grade 2 wounds acute/community

PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	
National Benchmarking	HIS to confirm plans for future/ and how soon- ongoing
National Target	20% reduction
National Target Achievement	
Position	

Subcategory | Injury

Injury	Developed in hospital	Developed/discovered in community	Discovered on admission	Known ulcer deteriorating	Total
Mucosal Pressure Damage	10	4	12		**26**
Pressure Ulcer - combination lesions	4	8	7	2	**21**
Pressure Ulcer - deep tissue Injury	27	96	9	10	**142**
Pressure Ulcer - Ungradable	42	136	49	11	**238**
Pressure ulcer (grade not specified)	8	6	12	0	**26**
Pressure ulcer Grade 1	66	145	100	1	**312**
Pressure ulcer Grade 2	196	409	165	17	**787**
Pressure ulcer Grade 3	11	59	23	9	**102**
Pressure ulcer Grade 4	1	17	9	13	**40**
Ulcers	1	5	8	0	**14**
Total	**392**	**885**	**368**	**63**	**1708**

Exec Lead
Louise Bussell

Infection Control - CDI, SAB and ECB Healthcare Associated Infection (HCAI) Reduction aims
1st April 2025 to 31st December 2025

ADP Deliverables: Validated position for 2025/26 reduction aims

The RAG ratings are calculated on the predicted monthly numbers.

Clostridioides difficile (CDI)
2025/2026 reduction aim is 75 HCAI cases. As of 31/12/2025 41 HCAI cases reported.
Currently on track to meet aim (5 cases under trajectory)

Staphylococcus aureus bacteria (SAB)
2025/26 reduction aim is 53 HCAI cases. As of 31/12/2025 41 HCAI cases reported.
Currently on track to meet aim (13 case under trajectory)

Escherichia Coli (ECB)
2025/2026 reduction aim is 75 HCAI cases. As of 31/12/2025 62 HCAI cases reported
This is above predicted trajectory by 8 cases

Insights to Current Performance

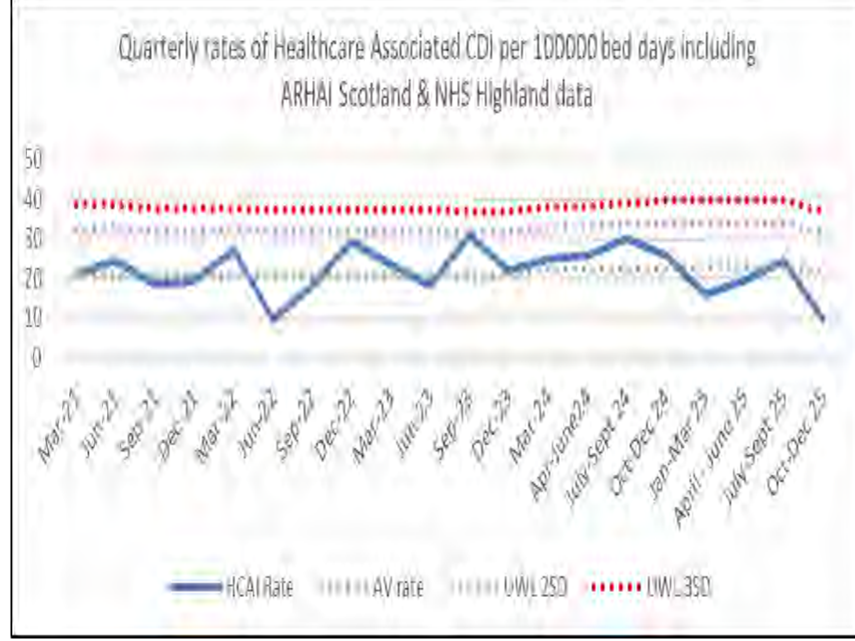
On the 7th of January 2026 National Services Scotland published the report for the Quarterly Epidemiological data on Clostridioides difficile infection, Escherichia coli bacteraemia, Staphylococcus aureus bacteraemia and Surgical Site Infection in Scotland (July- Sept 2025 (Q3) 2025). This data reports that NHS Highland was within normal variation for healthcare associated SAB, CDI and EColi when analysing trends over the past three years, and was not above the 95% confidence interval upper limit in the funnel plot analysis.
It should be noted that we were over the 95% confidence interval for CDI Community cases and have been asked to submit an exception report. These cases are not associated with clusters/outbreaks The following quarter shows the data has returned to within predicted limits.
The next publication is expected April 2026

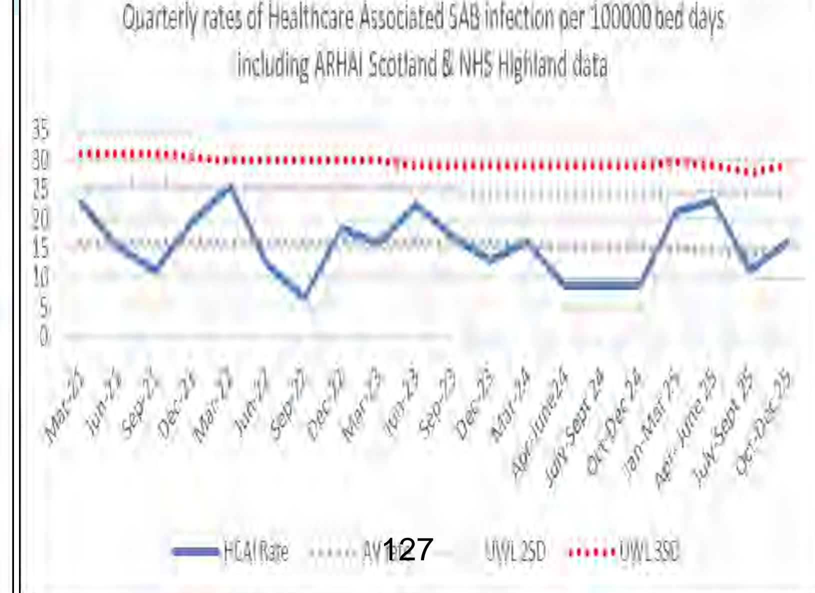
Plans and Mitigations

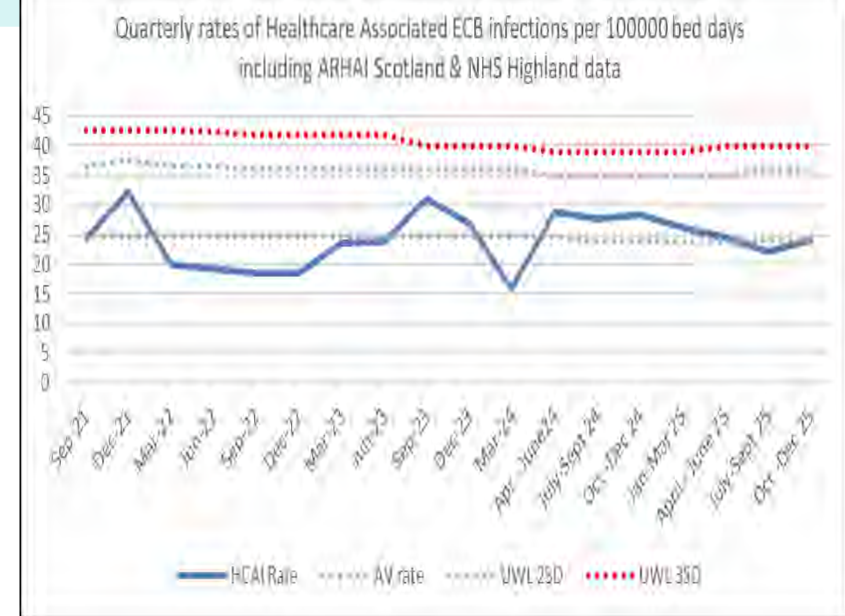
Continue to review individual cases for learning and any subsequent actions.

Targeted work with antimicrobial prescribing continues, The use of faecal microbiota transplant therapy continues to be progressed as a treatment for chronic CDI.

Continue to ensure adherence to national guidance for the management of infections.
Submit the Community associated CDI exception report for Q3 (july-Sept 25) by 13th feb 2026







Integrated Performance & Quality Report: Grow, Listen, Nurture & Plan Well

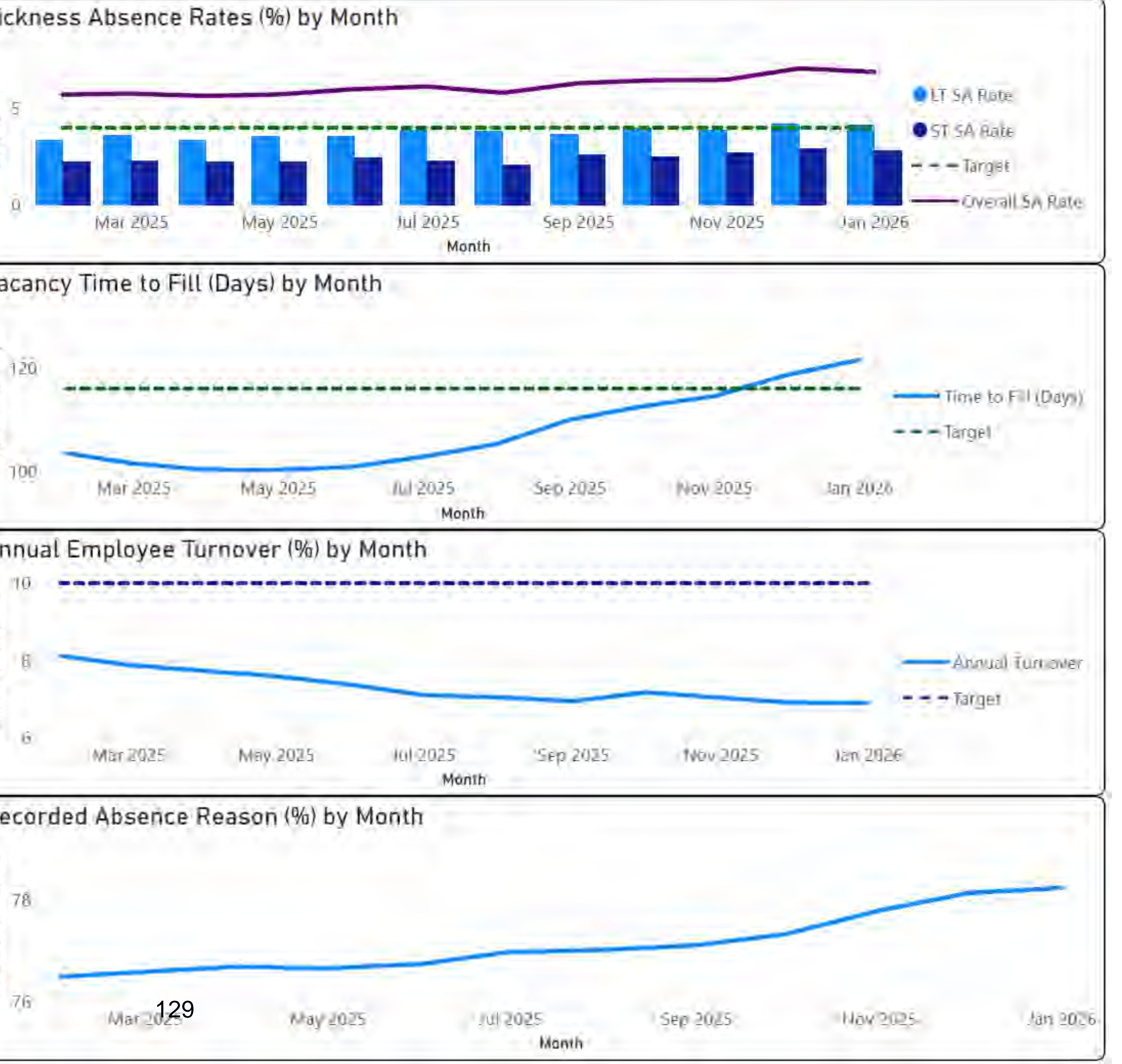
Key Performance Indicators (KPIs)	Rating	Feedback and Summary	Risks
Reduce sickness absence of all staff (long-term and short-term) across NHS Highland to less than 4% of staff being absent at all times.	Red	Remains over 4% and has increased again to 6.9%. 24.9% of Long-term absences are related to anxiety/stress/depression.	Attendance is not managed robustly/consistently and rates remain higher than 4%. Training on policy and process continues. Toolkit and checklist being developed.
Ensure 95% Core Mandatory eLearning compliance across NHS Highland staff (measured through the Core Mandatory eLearning Completion Rate).	Red	Statman compliance is 75.1%, action is required within each area to meet target of 95%	Risk to staff, patients and organisation as staff not appropriately trained. Reports available to managers on TURAS and statman dashboard.
Ensure the annual turnover rate of staff leaving NHS Highland remains below 10% of the total workforce.	Blue	Annual turnover decreased slightly this month to 6.89%	
Ensure the average Time to Fill rate for positions within NHS Highland remains below the 116 day national target.	Blue	Above the national target of 116 days at 121.6 and steadily rising.	Work continues with training for recruiting managers and sustaining lower time to fill period
Ensure 95% of the NHS Highland workforce has a completed TURAS Appraisal within the financial year 2025/26.	Red	Appraisal rate of 29.8% is significantly short of the 95% target. There has been a decrease of 2.9% since last report.	Noncompliance with staff governance standards. All areas asked to develop plans to ensure each employee receives a PDP annually.

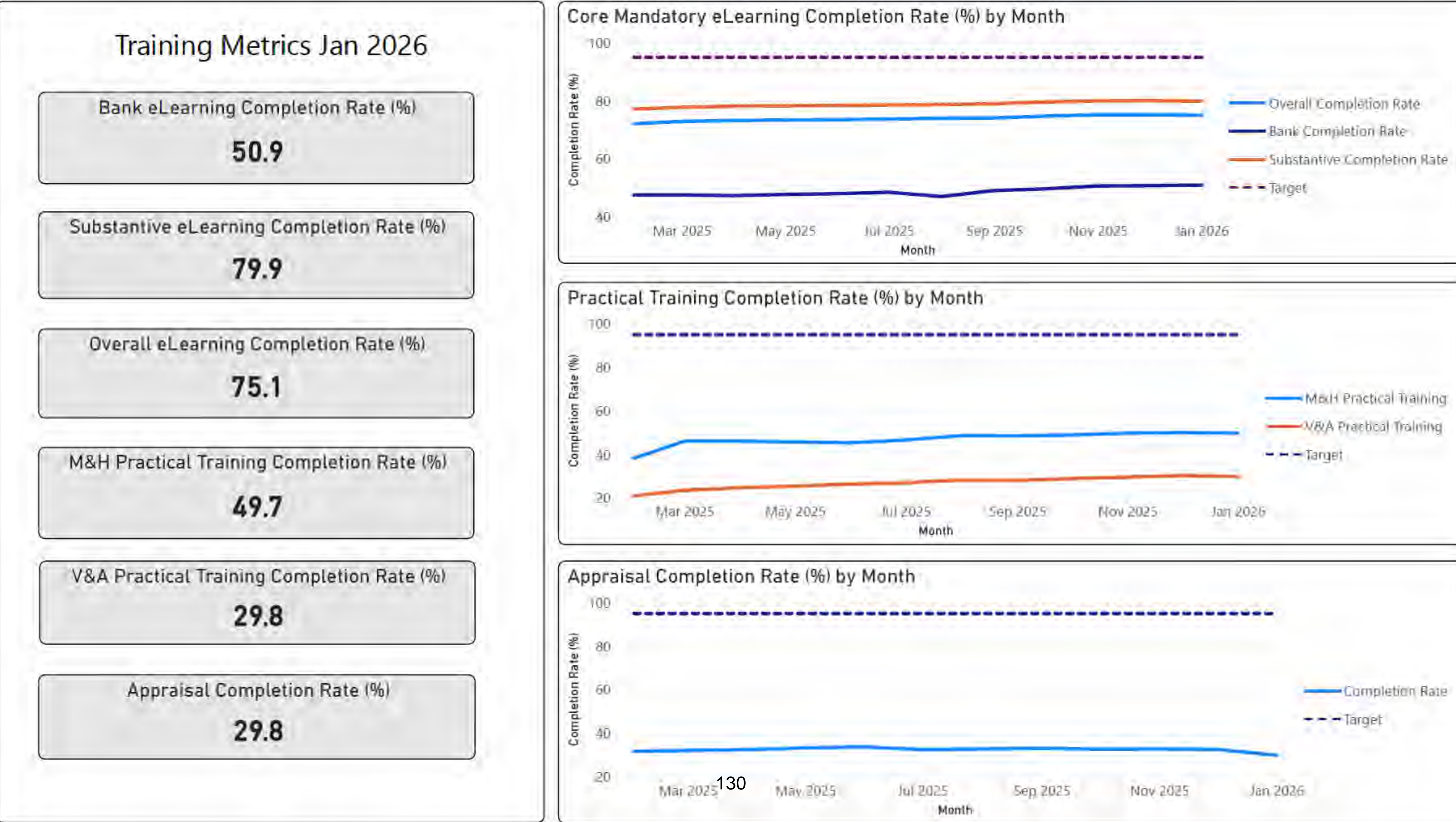
Guide to Performance Rating

Rating	Colour
Meeting Target	Blue
<5% off target	Green
>5% off target	Amber
>10% off target	Red

Organisational Metrics Jan 2026

Metric	Value
Sickness Absence Rate (%)	6.90
Long Term SA Rate (%)	4.15
Short Term SA Rate (%)	2.81
Recorded Absence Reason (%)	78.24
Vacancy Time to Fill (Days)	121.60
Annual Employee Turnover (%)	6.89





Training Metrics Jan 2026
Bank eLearning Completion Rate (%)
50.9
Substantive eLearning Completion Rate (%)
79.9
Overall eLearning Completion Rate (%)
75.1
M&H Practical Training Completion Rate (%)
49.7
V&A Practical Training Completion Rate (%)
29.8
Appraisal Completion Rate (%)
29.8
Core Mandatory eLearning Completion Rate (%) by Month
Completion Rate (%)
100
80
60
40
Mar 2025
May 2025
Jul 2025
Sep 2025
Nov 2025
Jan 2026
Month
Overall Completion Rate
Bank Completion Rate
Substantive Completion Rate
Target
Practical Training Completion Rate (%) by Month
Completion Rate (%)
100
80
60
40
20
Mar 2025
May 2025
Jul 2025
Sep 2025
Nov 2025
Jan 2026
Month
M&H Practical Training
V&A Practical Training
Target
Appraisal Completion Rate (%) by Month
Completion Rate (%)
100
80
60
40
20
Mar 2025
May 2025
Jul 2025
Sep 2025
Nov 2025
Jan 2026
Month
Completion Rate
Target

Organisational Metrics – Glossary

- **Sickness Absence Rate:** The sickness absence rate for the whole organisation, expressed as a percentage of hours lost / total contracted hours, for the specified month. Data is sourced from SWISS.
- **Long Term Sickness Absence Rate:** The long-term sickness absence rate for the whole organisation (long term is defined as 29 days or more), expressed as a percentage of hours lost / total contracted hours, for the specified month. Data is sourced from SWISS.
- **Short Term Sickness Absence Rate:** The short-term sickness absence rate for the whole organisation (short term is defined as 28 days or less), expressed as a percentage of hours lost / total contracted hours for the specified month. Data is sourced from SWISS.
- **Recorded Absence Reason:** This is the percentage of sickness absences where a reason other than 'unknown' is recorded i.e. 100% - the % of sickness absence recorded as 'unknown' reason. Data is sourced from Payroll and the period used is the past 12 months i.e. September 2025 would be looking at sickness absence recorded from Oct 2024 – Sep 2025.
- **Vacancy Time to Fill:** This is the average number of days to fill a vacancy (days between advert live date and candidate start date). Note this therefore does not include any time taken before the vacancy is advertised i.e. approval time, time to enter onto JobTrain etc. Data is sourced from Yellowfin and the period used is the past 12 months i.e. September 2025 would be looking at candidate start dates recorded from Oct 2024 – Sep 2025.
- **Annual Employee Turnover:** This is the turnover for a 12-month period i.e. September 2025 would be looking employee numbers as of 1st October 2024 and 30th September 2025, and the number of leavers during this period. The value is calculated as number of leavers / average number of employees * 100 to express as a percentage. The average number of employees is calculated using the number of employees at the start of the period and the number of employees at the end of the period. For example, 10800 employees as of 1st October 2024, 11400 employees as of 30th September 2025, 780 leavers during that period would give a turnover of 780 / ((10800+11400) / 2) * 100 = 7.03%. Note that Bank staff are excluded from this calculation. Data is sourced from eESS.

Organisational Metrics – Glossary

- **Overall eLearning Completion Rate:** This is the percentage completion rate for all staff for mandatory e-Learning courses within the required time period which varies by course. Courses included are Equality and Diversity, Fire Safety, Hand Hygiene, Information Governance, Moving and Handling Module A, Public Protection, Staying Safe Online, Violence and Aggression, and Why Infection Prevention Matters. Data is sourced from TURAS.
- **Bank eLearning Completion Rate:** As above, for Bank only staff. Data is sourced from TURAS.
- **Substantive eLearning Completion Rate:** As above, for staff who hold a substantive post. Data is sourced from TURAS.
- **M&H Practical Training Completion Rate:** This is the percentage of staff who have completed Moving and Handling (people) practical training within their required time period, which can be 1 year or 2 years depending on department. Only staff who are required to complete this training are included in the calculation. Data is sourced from TURAS.
- **V&A Practical Training Completion Rate:** This is the percentage of staff who have completed Violence and Aggression practical training within their required time period. Only staff who are required to complete this training are included in the calculation. Data is sourced from TURAS.
- **Appraisal Completion Rate:** This is the percentage of staff that have completed an appraisal within the past 12 months i.e. for September 2025, an appraisal with a completion date between 1st October 2024 – 30th September 2025 would be included. Note that Bank and Medical and Dental employees are excluded from this. Data is sourced from TURAS.

Appendix: IPQR Contents

Slide #	Report	Frequency of Update	Last Presented
5	CAMHS Waitlist NHSH	Monthly	January 2026
6	NDAS Total Awaiting 1st App (incl unvetted)	Monthly	January 2026
6	NDAS New + Unvetted Patients Awaiting First Appointment by Wait Band	Monthly	January 2026
7	Vaccinations	Quarterly	January 2026
8	Smoking Cessation	Quarterly	January 2026
9	Breastfeeding	Monthly	January 2026
10	NHS Highland-Alcohol brief interventions 2025/26 Q2	Quarterly	January 2026
11	Drug and Alcohol Recovery Performance Against Standard for Completed Waits	Quarterly	January 2026
12	Psychological Therapy Waiting Times Patients seen <18 weeks.	Monthly	January 2026
13	% of People Seen in ED Within <4 hours Per Month	Quarterly	January 2026
13	Total Patients Waiting >8 hours in ED per Month	Quarterly	January 2026
13	Total Patients waiting >12 hours in ED per Month	Monthly	January 2026
14	Number of People Delayed from Hospital Discharge at Monthly Census Point NHSH	Monthly	January 2026
14	Number of People Delayed from Discharge – Location and Code.	Monthly	January 2026
15	Outpatients (NOP) Seen & Trajectories	Monthly	January 2026
15	Outpatients seen <12 weeks Including Consultant and Nurse Lead Activity	Monthly	January 2026

Slide #	Report	Frequency of Update	Last Presented
16	OP long waits >52 Weeks	Monthly	January 2026
17	Return Outpatients Wait List	Monthly	January 2026
18	TTG <12 Week Target Patients Seen & Trajectories	Monthly	January 2026
18	TTG Seen <12 Weeks (consultant Only).	Monthly	January 2026
19	TTG Long waits >52 Weeks.	Monthly	January 2026
20	Imaging Tests: Maximum Wait Target 6 weeks	Monthly	January 2026
21	CT Patients Seen & Trajectories	Monthly	January 2026
21	MRI Patients Seen & Trajectories	Monthly	January 2026
21	Non Obstetric Patients Seen & Trajectories	Monthly	January 2026
22	Endoscopy Tests: Maximum Wait Target 6 Weeks	Monthly	January 2026
23	Patients Seen & Trajectories Cystoscopy	Monthly	January 2026
23	Patients Seen & Trajectories Colonoscopy, flexi sig & upper GI	Monthly	January 2026
24	ECHO: Total Waiting List Size & Patients waiting >6weeks	Monthly	January 2026
24	ECG Total Waiting List Size & Patients waiting >6weeks	Monthly	January 2026
24	Spirometry Total Waiting List Size & Patients waiting >6weeks	Monthly	January 2026
25	31 Day Cancer Waiting Times	Monthly	January 2026
25	Patients Seen on 31 Day Pathway	Monthly	January 2026

Slide #	Report	Frequency of Update	Last Presented
26	62 Day Cancer Waiting Times	Monthly	January 2026
26	Patients Seen on 62 Day Pathway	Monthly	January 2026
27	SACT Average Waiting Times by Month	Monthly	January 2026
28	Stage 2 Complaint Activity	Monthly	January 2026
29	Number of SPSO Cases Received/ Closed	Monthly	January 2026
30	SAER & Level 1 Volumes: Declared Last 13 Months	Monthly	January 2026
31	Number of Hospital Inpatient Falls by Subcategory	Monthly	January 2026
32	Number of Tissue Viability Injuries	Run Chart	Monthly	January 2026
33	Number of Tissue Viability Injuries	All Subcategories and Injury Grades	Sub-Category	Monthly	January 2026
34	Number of Tissue Viability Injuries	Subcategory by Injury Grade	Monthly	January 2026
35	Infection Control, CDI, SAB and ECB Healthcare Associated Infection (HCAI) Reduction Aims	Monthly	January 2026
36	Integrated Performance & Quality Report : Grow, Nurture & Plan Well	Monthly	January 2026
37	Sickness Absence Rates % By Month	Monthly	January 2026
37	Vacancy Time to Fill Days by Month	Monthly	January 2026

Slide #	Report	Frequency of Update	Last Presented
37	Annual Employee Turnover % by Month	Quarterly	January 2026
37	Recorded Absence Reason % by Month	Quarterly	January 2026
38	Training Metrics January 2026	Quarterly	January 2026
39	Organisational Metrics - Glossary	Bi-monthly	January 2026
40	Organisational Metrics - Glossary	Bi-monthly	January 2026

# NHS Highland	

Meeting:	**NHS Highland Board Meeting**
Meeting date:	**31 March 2026**
Title:	**Finance Report – Month 10 2025/2026**
Responsible Executive/Non-Executive:	**Heledd Cooper, Director of Finance**
Report Author:	**Elaine Ward, Deputy Director of Finance**

Report Recommendation:

The Committee is asked to **Examine** and **Consider** the content of the report and take **Limited Assurance**.

1 Purpose

This is presented to the NHS Highland Board for:

- Assurance

This report relates to a:

- Annual Operating Plan

This report will align to the following NHSScotland quality ambition(s):

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well		Listen Well		Nurture Well		Plan Well	
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well	X	Progress well		**All** Well Themes			

2 Report summary

2.1 Situation

This report is presented to enable discussion on the NHS Highland financial position at Month 10 (January) 2025/2026.

2.2 Background

NHS Highland submitted a financial plan to Scottish Government for the 2025/2026 financial year in March 2025. This plan presented an initial budget gap of £115.596m. When cost reductions/ improvements were factored in the net position was a gap of £55.723m. The Board received feedback on the draft Financial Plan which requested submission of a revised plan with a net deficit of no more that £40m. A revised plan was submitted in line with this request in June 2025 and this revised plan was accepted by Scottish Government.

The Board continues to be escalated at level 3 within the NHS Scotland Escalation Framework. Work continues internally and with the support of SG to improve the financial position by identifying opportunities and implementing new ways of working which will support a move to financial balance.

2.3 Assessment

At the end of January 2026 (Month 10) a year to date overspend of £46.089m is reported. A year end overspend of £44.600m is forecast at this time. An overspend of £25.017 within ASC is included in this forecast. The improvement from Month 9 reflects a reduction in national top slices and the contribution for CNORIS. The overall Board position has been mitigated in part by £10.000m of additional funding received from Scottish Government.

A review of delivery against targets for identified value and efficiency schemes has been undertaken with operational units now forecasting in line with V&E deliverables. Mitigating actions to close the gap between plan and forecast, previously reported, have been factored in to the central position.

2.4 Proposed level of Assurance

Substantial		Moderate	
Limited	X	None	

Comment on the level of assurance

It is only possible to give limited assurance at this time. The position reported aligns with the Scottish Government expected position but still presents a position with is significantly adrift from financial balance.

3 Impact Analysis

3.1 Quality/ Patient Care

The impact of quality of care and delivery of services is assessed at an individual scheme level using a Quality Impact Assessment tool. All savings are assessed using a Quality Impact Assessment (QIA).

3.2 Workforce

There is both a direct and indirect link between the financial position and staff resourcing and health and wellbeing. Through utilisation of the QIA tool, where appropriate, the impact of savings on these areas is assessed.

3.3 Financial

Scottish Government has recognised the financial challenge on all Boards for 2024/2025 and beyond and are continuing to provide additional support to develop initiatives to reduce the cost base both nationally and within individual Boards. NHS Highland continues to be escalated at level 3 in respect of finance.

3.4 Risk Assessment/Management

There is a risk associated with the ongoing delivery of the Value & Efficiency programme. The Board continues to review this position and seeks to develop further plans to generate cost reductions/ improvements and seek mitigating actions which support the current forecast.

3.5 Data Protection

There are no Data Protection risks associated with this report.

3.6 Equality and Diversity, including health inequalities

An impact assessment has not been completed because it is not applicable

3.7 Other impacts

None

3.8 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage both internal and external stakeholders where appropriate through the following meetings:

- Executive Directors Group – via monthly updates and exception reporting
- Monthly financial reporting to Scottish Government

3.9 Route to the Meeting

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

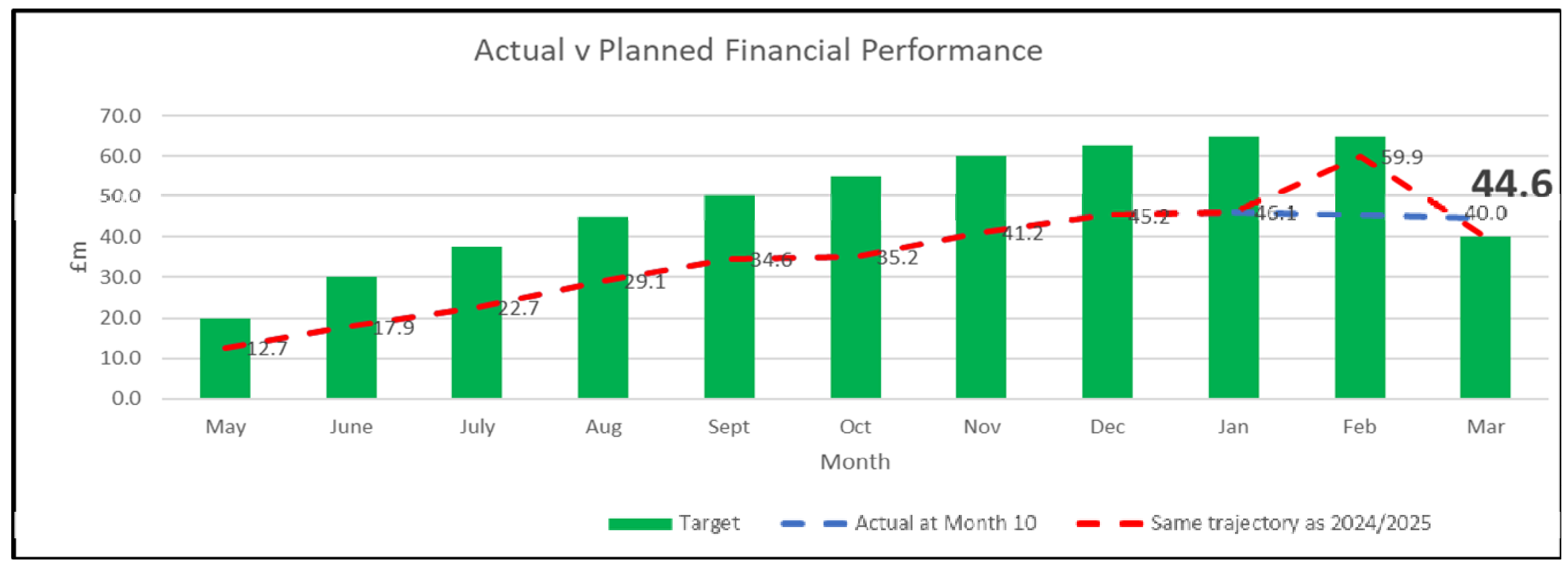
- EDG
- FRPC

4.1 List of appendices

Finance Report – Month 10 (January) 2025/2026

Finance Report –Month 10 (January) 2025/2026

MONTH 10 2025/2026 – JANUARY 2026

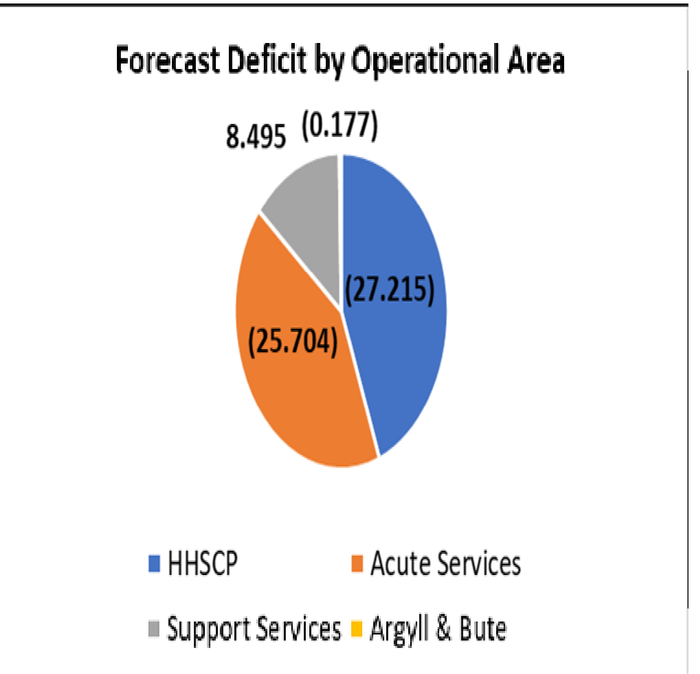


Target	YTD £m	YE Position £m
Delivery against Revenue Resource Limit (RRL) DEFICIT/ SURPLUS	46.1	44.6
Deliver against plan DEFICIT/ SURPLUS	18.9	4.6

- No brokerage available in 2025/2026
- SG requested plan with a deficit no greater than £40m
- SG have previously confirmed that an allocation of £40m (non-repayable) will be made to cover the planned overspend
- Current forecast is £44.6m worse than RRL and £4.6m worse than requested by SG
- SG have agreed to provide a further £10m to support the Board position and this is reflected within the forecast

MONTH 10 2025/2026 – JANUARY 2026

Current Plan £m	Summary Funding & Expenditure	Plan To Date £m	Actual To Date £m	Variance To Date £m	Forecast Outturn £m	Forecast Variance £m
1,353.124	**Total Funding**	1,082.806	1,082.806	-	1,353.124	-
	Expenditure					
512.848	HHSCP	426.499	450.128	(23.630)	540.063	(27.215)
345.065	Acute Services	286.411	307.681	(21.270)	370.769	(25.704)
188.771	Support Services	128.054	129.166	(1.112)	180.276	8.495
1,046.685	**Sub Total**	**840.964**	**886.976**	**(46.012)**	**1,091.108**	**(44.423)**
306.439	Argyll & Bute	241.842	241.920	(0.077)	306.616	(0.177)
1,353.124	**Total Expenditure**	**1,082.806**	**1,128.895**	**(46.089)**	**1,397.724**	**(44.600)**



MONTH 10 2025/2026 SUMMARY

- Year to date overspend of £46.089m reported.
- Year end position of £44.600m overspend forecast
- This forecast includes a further £10m of funding from SG to support the Board position.
- No longer assuming ASC will breakeven in the financial year – full ASC overspend included within position
- Mitigating actions, previously reported will close the gap between planned V&E deliverables and the current delivery forecast
- V&E slippage is now reported within operational areas with adjustment on the central forecast to bring in mitigating actions

MONTH 10 2025/2026 – JANUARY 2026

KEY RISKS/ ISSUES

- ASC – no plan agreed to support delivery of a breakeven position
- Delivery of the Value & Efficiency Cost Reduction/ Improvement programme
- SLA with NHS Greater Glasgow & Clyde
- Supplementary staffing – ongoing reliance due to system pressures and recruitment challenges
- ASC pressures – suppliers continuing to face sustainability challenges, NI impact on independent sector providers
- Potential impact associated with the cost of new drugs
- Financial impact of fragile services
- SLA Uplift
- Allocations less than anticipated

MITIGATIONS

- Ongoing robust governance structures around agency nursing utilisation
- Sustainability funding received from SG
- Funding anticipated from Highland Council in respect of NI rate increase - reflected in Month 10
- SG have confirmed a £40m allocation will be available to enable delivery of a breakeven position at year end – based on delivery of a position in line with the financial plan
- An assessment of the overall position including slippage on the VEAG programme has identified balance sheet adjustments which will cover VEAG scheme slippage
- SG will provide £10.0m of additional support to reduce the forecast year end position – this is reflected in the month 9 position
- Reduced CNORIS contribution, additional New Medicines Funding and reduced top-slices reflected in Month 10 position

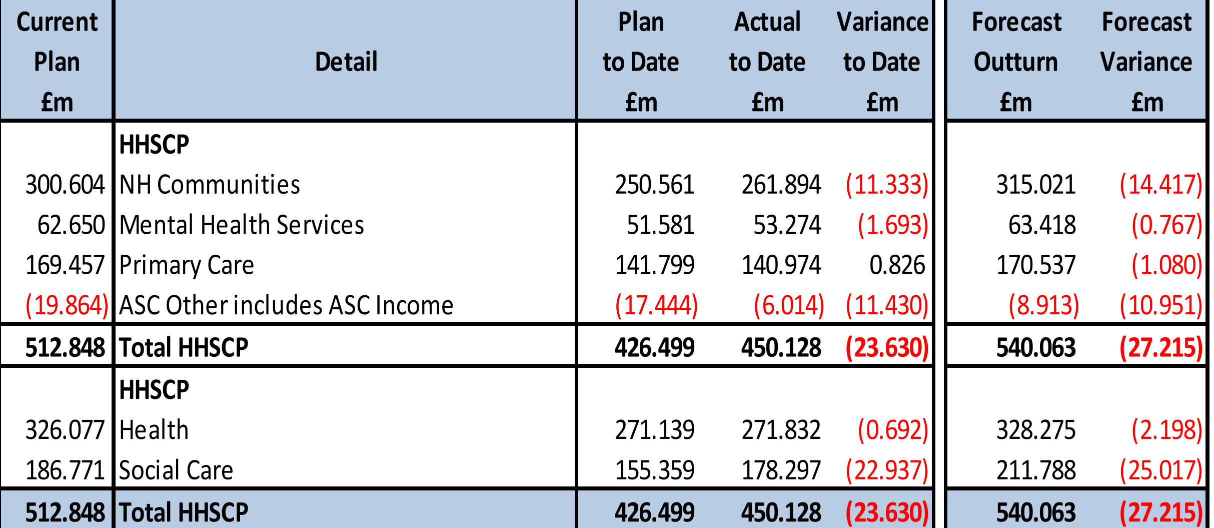
MONTH 10 2025/2026 – JANUARY 2026

Summary Funding & Expenditure	Current Plan £m
RRL Funding - SGHSCD	
Baseline Funding	976.636
Baseline Funding GMS	5.291
FHS GMS Allocation	84.454
Supplemental Allocations	64.211
Non Core Funding	-
Total Confirmed SGHSCD Funding	**1,130.592**
Anticipated funding	
Non Core allocations	81.143
Core allocations	12.061
Total Anticipated Allocations	93.204
Total SGHSCD RRL Funding	**1,223.796**
Integrated Care Funding	
Adult Services Quantum from THC	141.522
Childrens Services Quantum to THC	(12.194)
Total Integrated care	129.328
Total NHS Highland Funding	**1,353.124**

FUNDING

- £1,353.124m of funding confirmed at end of Month 10
- Further Planned Care Funding received (£1.736m) and £10.000m ton improve Board position reflected in Month 10 total

MONTH 10 2025/2026 – JANUARY 2026



Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	HHSCP					
300.604	NH Communities	250.561	261.894	(11.333)	315.021	(14.417)
62.650	Mental Health Services	51.581	53.274	(1.693)	63.418	(0.767)
169.457	Primary Care	141.799	140.974	0.826	170.537	(1.080)
(19.864)	ASC Other includes ASC Income	(17.444)	(6.014)	(11.430)	(8.913)	(10.951)
512.848	**Total HHSCP**	**426.499**	**450.128**	**(23.630)**	**540.063**	**(27.215)**
	HHSCP					
326.077	Health	271.139	271.832	(0.692)	328.275	(2.198)
186.771	Social Care	155.359	178.297	(22.937)	211.788	(25.017)
512.848	**Total HHSCP**	**426.499**	**450.128**	**(23.630)**	**540.063**	**(27.215)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	446	4,080
Agency (Nursing)	545	2,519
Bank	940	9,129
Agency (Non Med)	-108	1,911
Total	**1,822**	**17,639**

HHSCP

- YTD overspend of £23.630m reported with this forecast to increase to £27.215m by the end of the financial year
- ASC overspend forecast at £25.017m – reflects known pressures, slippage on original V&E plan and additional NI funding confirmed from Highland Council
- Locum costs of £1.050m contributing to overspend within Primary Care
- Supplementary staffing costs of £17.639m incurred to date
- High cost out of area placements continue to impact on the Mental Health position

MONTH 10 2025/2026 – ADULT SOCIAL CARE

Services Category	Annual Budget £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Outturn £000's	YE Variance £000's
Total Older People - Residential/Non Residential Care	65.023	54.589	58.097	(3.508)	69.569	(4.546)
Total Older People - Care at Home	40.188	33.585	38.293	(4.708)	45.800	(5.612)
Total People with a Learning Disability	53.448	44.772	48.144	(3.372)	57.942	(4.494)
Total People with a Mental Illness	11.370	9.162	8.133	1.029	9.633	1.738
Total People with a Physical Disability	10.267	8.605	9.450	(0.846)	11.219	(0.952)
Total Other Community Care	13.713	11.428	10.310	1.118	12.512	1.202
Total Support Services	(7.238)	(6.781)	5.468	(12.249)	4.511	(11.750)
Care Home Support/Sustainability Payments	0.000	0.000	0.401	(0.401)	0.603	(0.603)
Total Adult Social Care Services	**186.771**	**155.359**	**178.297**	**(22.937)**	**211.788**	**(25.017)**

ADULT SOCIAL CARE

- YTD an overspend of £22.937m is reported with this forecast to increase to £25.017m by the end of the financial
- No direct support has been provided to cover the ASC deficit this year, but mitigations are in place to reduce the impact.
- NI funding received from Highland Council and reflected in the position
- £4.339m of supplementary staffing costs within in-house care homes are included within the year to date position

MONTH 10 2025/2026 – ADULT SOCIAL CARE

NHSH Care Homes Supplementary Staffing

Care Home	Month 10 Agency £000's	Bank £000's	Total YTD £000's
Ach an Eas	-	33	334
An Acarsaid	6	16	184
Bayview House	3	23	236
Grant House	10	7	255
Home Farm	47	8	644
Invernevis	12	14	286
Lochbroom	-	12	168
Mackintosh Centre	-	1	18
Mains House	38	7	425
Moss Park	61	5	781
Melvich	1	4	59
Pulteney	-	29	279
Seaforth	-	27	246
Strathburn	-	3	11
Telford	19	12	205
Wade Centre	-	22	205
Total	**198**	**223**	**4,339**

- Significant spend across a number of care homes – Home Farm, Mains House and Moss Park remain the highest spend areas
- Spend in Month 10 is £0.012m higher than in Month 9

MONTH 10 2025/2026 – JANUARY 2026

ACUTE

Current Plan £000	Division	Plan to Date £000	Actual to Date £000	Variance to Date £000	Forecast Outturn £000	Forecast Variance £000
94.283	Medical Division	78.451	89.699	(11.247)	107.830	(13.547)
26.436	Cancer Services	21.380	23.297	(1.917)	28.219	(1.783)
79.571	Surgical Specialties	66.118	71.362	(5.245)	85.325	(5.754)
41.814	Woman and Child	35.042	35.701	(0.659)	42.893	(1.079)
50.064	Clinical Support Division	41.537	43.912	(2.375)	52.886	(2.822)
(9.209)	Raigmore Senior Mgt & Central Cost	(7.575)	(7.798)	0.223	(8.961)	(0.248)
30.208	NTC Highland	24.934	23.585	1.348	28.602	1.606
313.166	**Sub Total - Raigmore**	**259.887**	**279.759**	**(19.872)**	**336.792**	**(23.626)**
15.410	Belford	12.830	13.131	(0.301)	15.925	(0.515)
16.489	CGH	13.694	14.790	(1.097)	18.052	(1.562)
345.065	**Total for Acute**	**286.411**	**307.681**	**(21.270)**	**370.769**	**(25.704)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	1,190	10,712
Agency (Nursing)	56	646
Bank	741	7,598
Agency (Non Med)	168	1,274
Total	**2,155**	**20,230**

- £21.270m overspend reported ytd with this forecast that this will increase to £25.704m by the end of the FY
- Supplementary staffing continues to impact the financial position with £20.230m spend at end of Month 10
- £0.516m built into forecast in respect of non-compliant resident doctor rotas
- a further £0.809m of a pressure materialising from resident doctor expansion posts
- £0.481m deterioration in forecast from Month 9 – mainly due to deterioration in resident doctor costs

MONTH 10 2025/2026 – JANUARY 2026

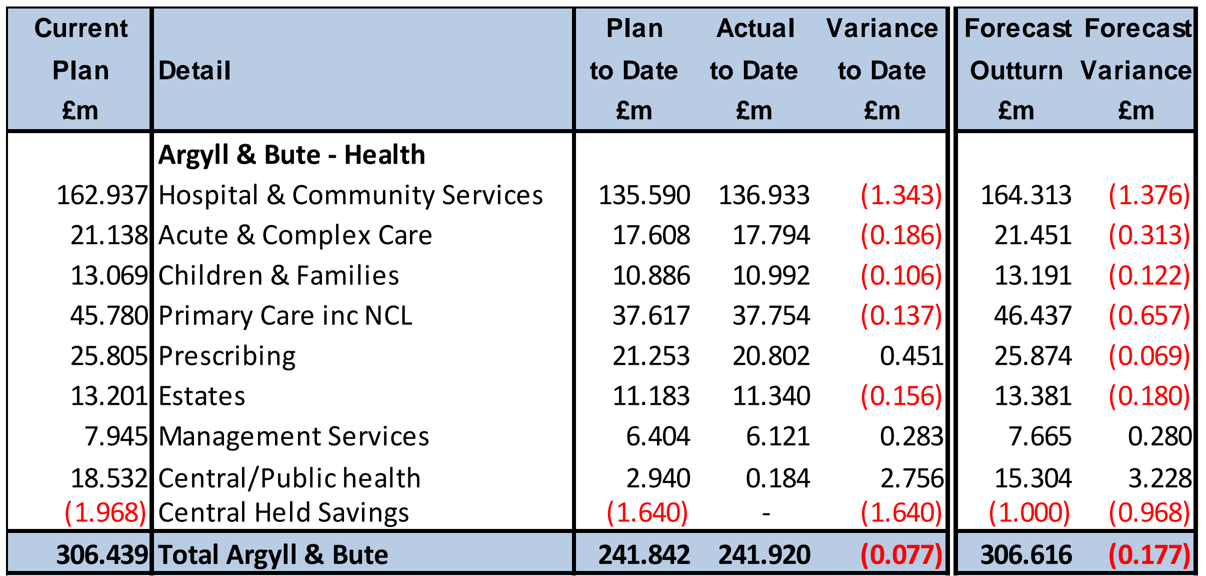
Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	Support Services					
9.765	Central Services	8.989	10.842	(1.853)	12.264	(2.499)
30.503	Central Reserves	0.000	-	0.000	19.723	10.780
46.523	Corporate Services	37.674	34.902	2.772	43.814	2.708
54.833	Estates Facilities & Capital Planning	42.220	40.568	1.652	52.803	2.030
17.597	eHealth	14.545	15.701	(1.155)	19.338	(1.740)
29.551	Tertiary	24.626	27.154	(2.528)	32.335	(2.784)
188.771	**Total**	**128.054**	**129.166**	**(1.112)**	**180.276**	**8.495**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	3	30
Agency (Nursing)	-	(55)
Bank	365	2,735
Agency (Non Med)	87	362
Total	**454**	**3,071**

SUPPORT SERVICES

- YTD overspend of £1.1112m reported with this forecast to improve to a £8.495m underspend by the end of the financial year
- The receipt of ADEL funding and lower than anticipated utility costs continue to mask pressures relating to the cost of provisions within Estates, Facilities & Capital Planning
- Within eHealth further increases in the costs of service contracts continues to be the main driver for the overspend. These increases relate to above inflationary uplifts and increasing activity
- Out of Area Forensic Psychiatry costs, TAVI procedures, rheumatology drugs continue to drive the overspend within Tertiary
- Forecast has improved by £3.325m from Month 9

MONTH 10 2025/2026 – JANUARY 2026



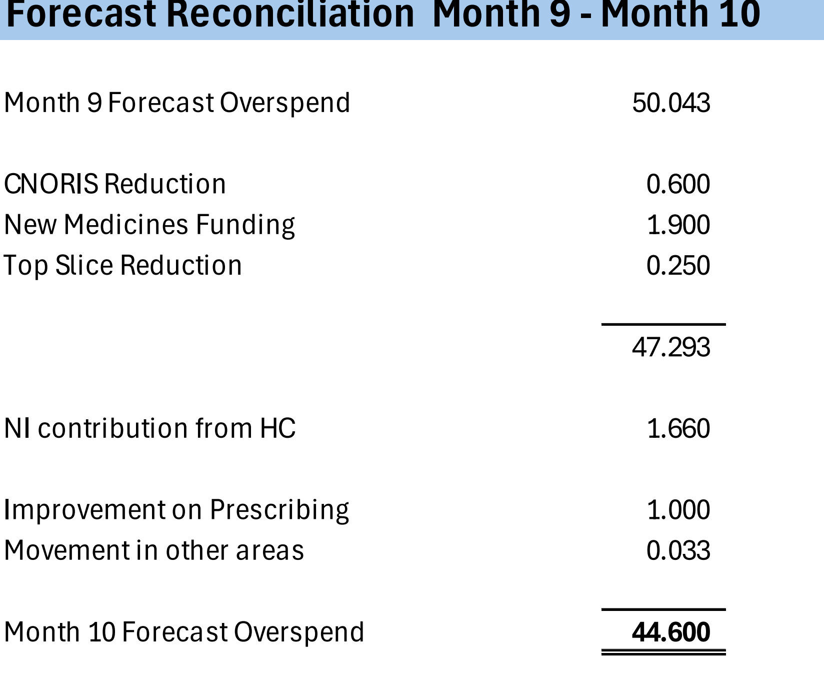
Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	Argyll & Bute - Health					
162.937	Hospital & Community Services	135.590	136.933	(1.343)	164.313	(1.376)
21.138	Acute & Complex Care	17.608	17.794	(0.186)	21.451	(0.313)
13.069	Children & Families	10.886	10.992	(0.106)	13.191	(0.122)
45.780	Primary Care inc NCL	37.617	37.754	(0.137)	46.437	(0.657)
25.805	Prescribing	21.253	20.802	0.451	25.874	(0.069)
13.201	Estates	11.183	11.340	(0.156)	13.381	(0.180)
7.945	Management Services	6.404	6.121	0.283	7.665	0.280
18.532	Central/Public health	2.940	0.184	2.756	15.304	3.228
(1.968)	Central Held Savings	(1.640)	-	(1.640)	(1.000)	(0.968)
306.439	**Total Argyll & Bute**	**241.842**	**241.920**	**(0.077)**	**306.616**	**(0.177)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum & Agency Medical/GP	622	5,610
Agency (Nursing)	69	992
Bank	244	2,897
Agency (Non Med)	74	405
Total	**1,008**	**9,903**

ARGYLL & BUTE

- Year to date overspend of £0.077m reported with this forecast to increase to £0.177m by the end of the financial year
- Supplementary staff continues to be a significant driver for the position – ytd spend £9.903m
- Out of Board cost per case charges and out of area long stay patient treatments continue to impact on the position - £2.807m
- Position does not reflect potential uplift for NHS Greater Glasgow & Clyde SLA
- £0.164m improvement in forecast from Month 9 due to increasing ongoing vacancies

MONTH 10 2025/2026 – JANUARY 2026



Forecast Reconciliation Month 9 - Month 10	
Month 9 Forecast Overspend	50.043
CNORIS Reduction	0.600
New Medicines Funding	1.900
Top Slice Reduction	0.250
	47.293
NI contribution from HC	1.660
Improvement on Prescribing	1.000
Movement in other areas	0.033
Month 10 Forecast Overspend	**44.600**

- Forecast has improved by £5.440m from Month 9
- £4.410m relates to additional unanticipated funding and a reduction in national costs

MONTH 10 2025/2026 – VALUE & EFFICIENCY

In the 2025–26 financial year, savings are reported on a risk-adjusted basis. This approach factors in the probability of risks impacting the achievement of the financial plan. The framework categorises risks into five types: Idea, Opportunity, Plans in Progress, Fully Developed, and Moved to Delivery.

2025-26 Value & Efficiency Plan (£'000)											
Reduction Programmes - Area	100%			Risk Adjusted Forecast (RAF)			Savings Achieved				
	Allocated Target	Current Plan	Plan GAP	Allocated Target	Risk Adjusted Forecast (RAF)	Risk Adjusted Plan GAP	Allocated Target	Budget Savings Achieved	Cost Reductions Achieved	Total Savings Achieved	Current Savings GAP
Value & Efficiency - North Highland	**22,291**	18,881	-3,410	**22,291**	18,445	-3,845	**22,291**	8,851	6,136	14,987	-7,304
Value & Efficiency - Argyll & Bute	**7,852**	7,852	0	**7,852**	6,396	-1,456	**7,852**	5,360	0	5,360	-2,492
Total Value & Efficiency	**30,143**	26,733	-3,410	**30,143**	24,841	-5,301	**30,143**	**14,211**	**6,136**	**20,347**	**-9,796**
Value & Efficiency - ASC	**6,192**	1,632	-4,560	**6,192**	1,407	-4,785	**6,192**	0	1,182	1,182	-5,010
Total Value & Efficiency incl ASC	**36,335**	28,365	-7,970	**36,335**	26,248	-10,087	**36,335**	**14,211**	**7,317**	**21,529**	**-14,806**

The financial plan submitted to the Scottish Government includes a target of achieving 3% efficiency savings across both North Highland and Argyll & Bute.

This equates to a total Value & Efficiency savings goal of **£36.335m** for the FY 2025–26

There is currently a shortfall of **£7.970m** (10.702m in M9) between the 2025–26 savings target and current delivery plan at its 100% value.

MONTH 10 2025/2026 – VALUE & EFFICIENCY RECURRING/ NON-RECURRING BREAKDOWN

2025-26 Value & Efficiency Plan (£'000)										
Reduction Programmes as per Area and Recurrence	Value at 100%			Risk Adjusted Forecast (RAF)			Savings Achieved			
	Current Plan	Recurrent	Non-Recurrent	RAF	Recurrent	Non-Recurrent	Allocated Target	Recurrent	Non-Recurrent	Current Savings GAP
% of the Plan	% Rec/Non-Rec vs Curr Plan	69%	31%	% Rec/Non-Rec vs RAF	71%	29%	% Achieved vs Target	41%	18%	
Value & Efficiency - North Highland	19,247	15,437	3,810	18,445	14,984	3,462	22,291	11,537	3,449	-7,304
Value & Efficiency - Argyll & Bute	7,852	3,384	4,468	6,396	2,646	3,750	7,852	2,610	2,750	-2,492
Value & Efficiency (North Highland)	27,099	18,821	8,278	24,841	17,630	7,212	30,143	14,147	6,199	**-9,796**
Value & Efficiency - ASC	1,632	1,030	602	1,407	891	516	6,192	751	430	-5,010
Total Value & Efficiency incl ASC	28,731	19,851	8,880	26,248	18,520	7,728	36,335	14,899	6,630	**-14,806**

The total planned savings (100% plan) are £28,731m with £19,851m expected to be recurrent.

After adjusting for risk, the total expected savings drop to £26,248m with £18,520m being recurrent.

The savings plans from North Highland currently make up the largest contribution across all areas.

MONTH 10 2025/2026 – JANUARY 2026
SUPPLEMENTARY STAFFING

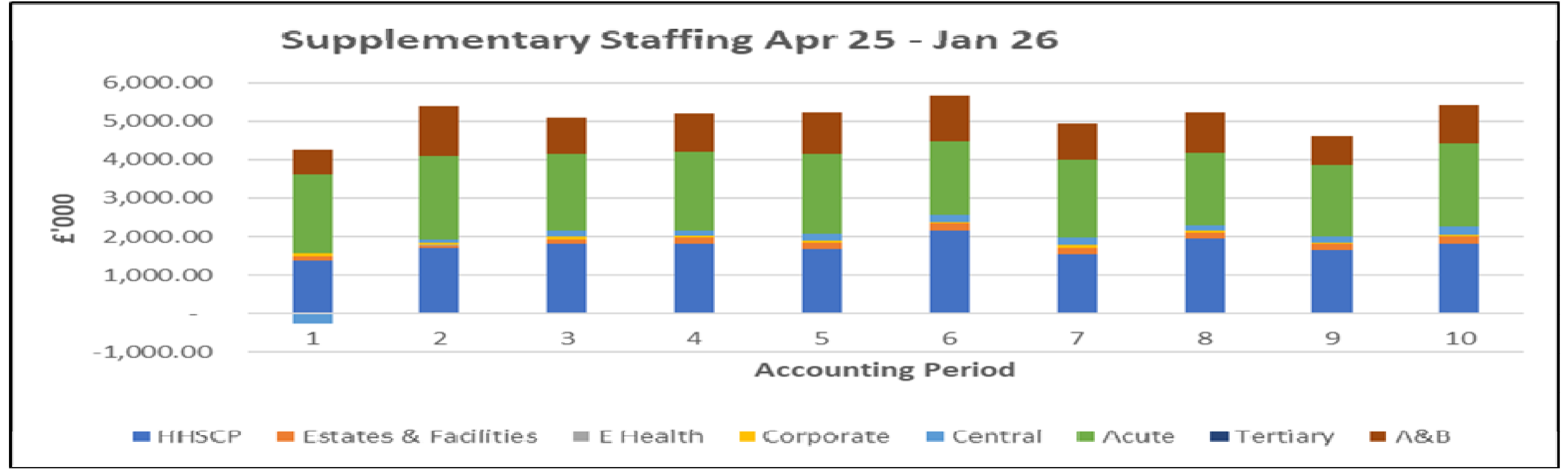
	2025/2026 YTD £'000	2024/2025 YTD £'000	Inc/ (Dec) YTD £'000
HHSCP	17,560	17,307	253
Estates & Facilities	1,396	1,344	53
E Health	2	9.86	(8)
Corporate	555	797	(242)
Central	1,197	1,339	(142)
Acute	20,230	20,405	(175)
Tertiary	-	-	-
Argyll & Bute	9,903	10,794	(891)
TOTAL	**50,844**	**51,997**	**(1,153)**

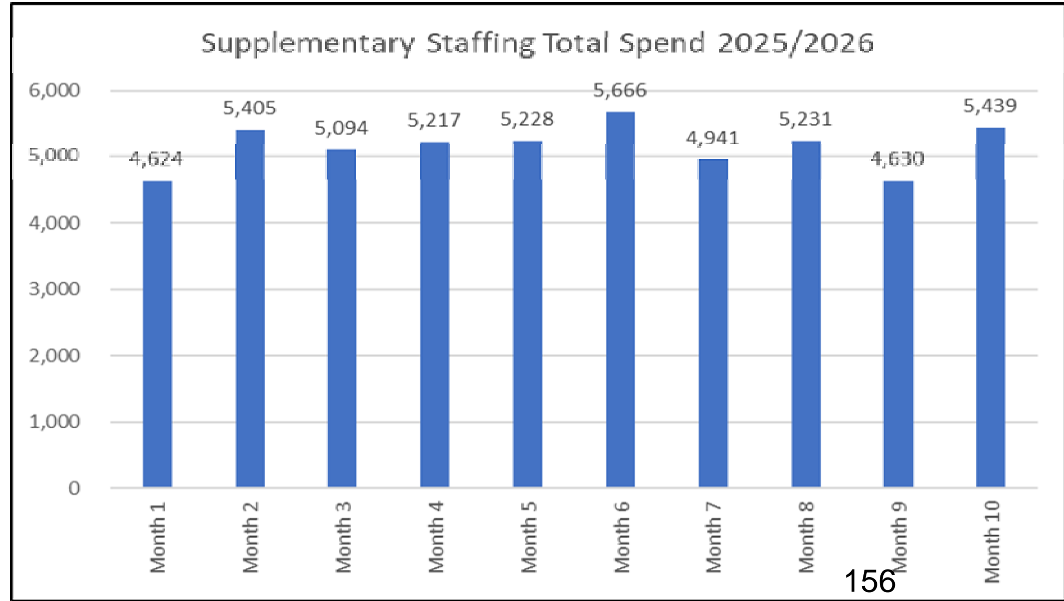
Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Pay			
141.846	Medical & Dental	118.081	123.988	(5.907)
7.628	Medical & Dental Support	6.367	7.957	(1.591)
242.006	Nursing & Midwifery	201.592	201.918	(0.326)
46.524	Allied Health Professionals	38.803	36.078	2.725
18.560	Healthcare Sciences	15.551	15.288	0.263
27.449	Other Therapeutic	22.951	20.897	2.054
53.485	Support Services	44.428	42.066	2.362
95.628	Admin & Clerical	79.253	74.976	4.277
3.367	Senior Managers	2.807	2.718	0.089
66.852	Social Care	55.698	49.986	5.712
1.917	Vacancy factor/pay savings	(5.083)	(2.540)	(2.543)
705.262	Total Pay	580.448	573.332	7.115

SUPPLEMENTARY STAFFING

- Recorded spend at end of Month 10 is £1.153m lower than at same point in 2024/2025
- Pay underspend of £7.115m reported at the end of Month 10 (NI contribution for ASC has increased underspend)

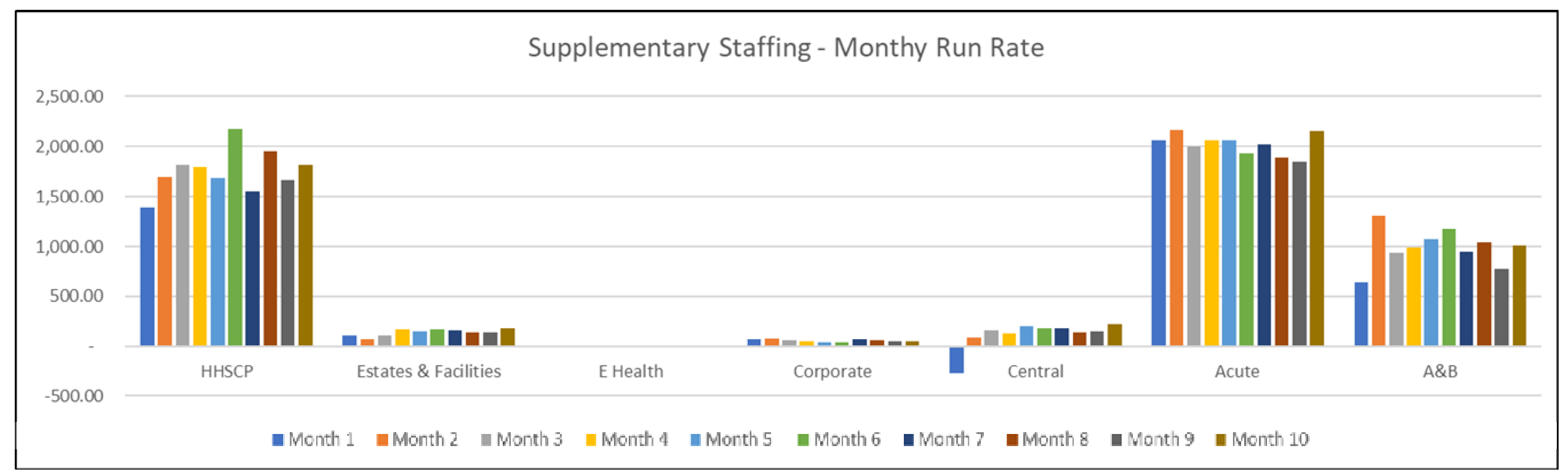
MONTH 10 2025/2026 – JANUARY 2026
SUPPLEMENTARY STAFFING





- Month 10 spend is £0.809m higher than Month 9

MONTH 10 2025/2026 – JANUARY 2026
SUPPLEMENTARY STAFFING



Operational Area Supplementary Staffing Spend by Type
Month 10 - January 2026

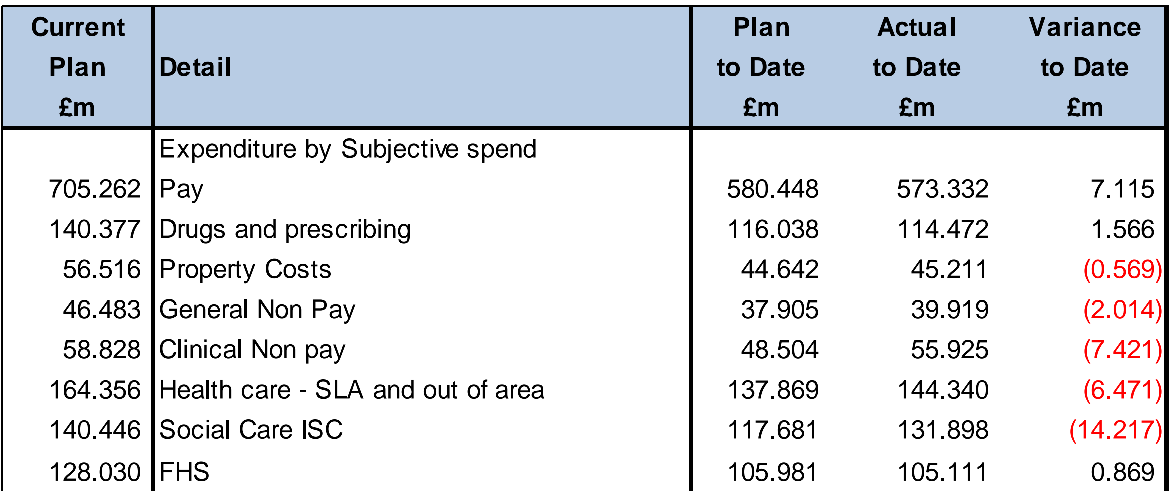
£'000: 25,000 / 20,000 / 15,000 / 10,000 / 5,000 / 0

HHSCP | Acute | A&B

Operational Area

Locum Payroll & Agency | Bank | Agency - Exc Med & Nurs | Agency Nurs

MONTH 10 2025/2026 – JANUARY 2026



Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Expenditure by Subjective spend			
705.262	Pay	580.448	573.332	7.115
140.377	Drugs and prescribing	116.038	114.472	1.566
56.516	Property Costs	44.642	45.211	(0.569)
46.483	General Non Pay	37.905	39.919	(2.014)
58.828	Clinical Non pay	48.504	55.925	(7.421)
164.356	Health care - SLA and out of area	137.869	144.340	(6.471)
140.446	Social Care ISC	117.681	131.898	(14.217)
128.030	FHS	105.981	105.111	0.869

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Drugs and prescribing			
58.211	**Hospital drugs**	**47.890**	**48.453**	**(0.563)**
82.166	**Prescribing**	**68.148**	**66.019**	**2.129**
140.377	**Total**	**116.038**	**114.472**	**1.566**

SUBJECTIVE ANALYSIS

- Pressures continue to be seen within a number of spend categories
- Drugs position has improved this month but is subject to ongong scrutiny
- Vacancies across all staff groups are mitigating the high level of spend on supplementary staffing

MONTH 10 2025/2026

Budget (£000)	Scheme	Actual (£000)	Variance (£000)
	FORMULA		
500	Contingency	(10)	510
1,036	eHealth	351	685
1,786	EPAG	1,289	498
1,972	Estates	894	1,078
1,000	Fire Compliance	200	800
500	PFI - Mid Argyll	326	174
500	PFI - Easter Ross	291	209
7,294	**Total**	**3,341**	**3,953**
	PROJECT SPECIFIC FUNDING		
3,000	Esates - Lochaber	2,477	523
1,291	EPAG - NIB	639	1,291
888	EV Chargers	-	888
400	Raigmore LV infrastructure	-	400
400	CGH Internal Drainage	28	400
80	CGH electrical Infrastructure	7	73
1,700	Raigmore Fire Compliance	1,242	458
400	LIDGH Fire Compliance	-	400
80	Islay Fire Compliance	180	(100)
-	CGH Cladding	32	-
-	ACT Accommodation	24	(24)
3,000	New Craigs Buy Back	3,000	-
11,239	**Total**	**7,628**	**4,310**
18,533	**Total**	**10,970**	**8,263**

CAPITAL

- Formula Capital of £7.294m received in Month 6
- Additional capital allocations received in Month 9
- Expenditure has increased to 59.2% of plan
- Spend is now accelerating as we approach financial year end
- Main areas of spend are on equipment, the Lochaber Redesign project and fire compliance work at Raigmore
- Transfer of New Craigs reflected in position

Agenda Item

NHS Highland

Meeting: NHS Highland Board Meeting

Meeting date: 31 March 2026

Title: 2026/27 Budget offer to Argyll & Bute IJB

Responsible Executive/Non-Executive: Heledd Cooper, Director of Finance

Report Author: Elaine Ward, Deputy Director of Finance

Report Recommendation:

The Board is asked to **Approve** the opening budget offer to the Argyll & Bute IJB in line with the content of this report.

1 Purpose

This is presented to the NHS Highland Board for:

- Decision

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

This report will align to the following NHSScotland quality ambition(s):

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well		Listen Well		Nurture Well		Plan Well	
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well	X	Progress well		**All** Well Themes			

2 Report summary

2.1 Situation

This report sets out the initial budget offer for Argyll & Bute IJB for 2026/2027.

2.2 Background

The Board is required to make an opening budget offer to the IJB in advance of the new financial year. The Director of Finance has been in dialogue with the IJB's Chief Officer and Chief Finance Officer (CFO) and an offer in principle has been made, subject to Board approval.

2.3 Assessment

The funding for Argyll & Bute IJB is largely based on an equivalent NRAC share of overall resource provided to NHS Highland adjusted for ringfenced allocations, i.e. allocations provided out with the NRAC formula, for example the National Treatment Centre. It is the recommendation of this paper that this established method of calculating funding continues.

Initial Offer

NRAC calculations are published by Scottish Government on a 3-year basis and Argyll & Bute's share of the NHS Highland total is 28.58% (28.54% 2025/2026)

On that basis, NHS Highland's offer to the IJB is £331.927m.

Also included within this amount is an estimate of additional in-year allocations. This amount is indicative and will be adjusted throughout the year as resources are allocated to the Board. The basis of the calculation is set out in the table below.

Argyll & Bute 2026-27 Opening offer	£m
2025-26 baseline funding Health	267.514
2025-26 baseline funding IJB	7.451
Estimated Funding Uplifts:	
Health Baseline Uplift	5.350
IJB Baseline Uplift	0.149
Additional Pay 26-27 & AFC Reform Allocation	4.492
NRAC Funding Adjustment	(0.029)
Agreed Anticipated Baseline SG	**284.927**
Further Baseline (funding expected in first letter from SG)	0.061
Expected in-year core allocations	30.784
Expected in-year non core allocations	16.200
Total 2026-27 Opening Offer	**331.972**

2.4 Proposed level of Assurance

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

The assurance being offered is moderate in recognition that the same methodology has been used in previous years, but risks in relation to funding of AFC Reform and changes by other NHS Boards in the methodology for uplifting SLAs; purchase of healthcare from other providers accounts for 37% of the Argyll & Bute Health budget.

3 Impact Analysis

3.1 Quality/ Patient Care

An impact assessment has not been completed because it is not applicable

3.2 Workforce

There is both a direct and indirect link between the financial position and staff resourcing and health and wellbeing. Through utilisation of the QIA tool, where appropriate, the impact of savings on these areas is assessed.

3.3 Financial

This is part of the annual budget setting process for NHS Highland.

3.4 Risk Assessment/Management

Risk management is part of the H&SCP's management process in budgetary management and control.

3.5 Data Protection

There are no Data Protection risks associated with this report.

3.6 Equality and Diversity, including health inequalities

An impact assessment has not been completed because it is not applicable

3.7 Other impacts

None

3.8 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage both internal and external stakeholders where appropriate through the following meetings:

- Executive Directors Group – via monthly updates and exception reporting
- Finance, Resource and Performance Committee
- Monthly financial reporting to Scottish Government

3.9 Route to the Meeting

Annual statutory requirement

4.1 List of appendices

N/A

NHS Highland	

Health and Care (Staffing) (Scotland) Act 2019

Year End Report
Year of Enactment
2024-2025

Covering Quarters 1/2/3
01 April – 30 December 2024

legislative submission and publication timelines necessitate compilation of end of year report at Q3 to allow ratification through NHSH governance structure.
A subsequent Q4 update will be reported to the board in May 2025

NHS Highland

Meeting: Board Meeting

Meeting date: 31st March 2026

Title: Health and Care Staffing Act Implementation

Responsible Executive/Non-Executive: Gareth Adkins, Director of People & Culture

Report Author: Brydie J Thatcher, Workforce Lead, HCSA Programme Manager

1 Purpose

This is presented to the Committee for:

- Noting

This report relates to a:

Annual Operation Plan:
Right Workforce to Deliver Care – Commence implementation of the Health and care (Staffing) (Scotland) Act across relevant areas of the workforce

Government policy/directive:
Health and Care (Staffing) (Scotland) Act 2019

Legal Requirement
Health and Care (Staffing) (Scotland) Act 2019

This report will align to the following NHSScotland quality ambition(s):

Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well		Listen Well		Nurture Well		Plan Well	X
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well	X	Progress well					

2 Report summary

2.1 Situation

Health & Care (Staffing) (Scotland) Act 2019 End of Year Report 2024/25

The provisions set out in the Health & Care (Staffing) (Scotland) Act 2019 (hereafter referred to as "the Act") came into force on 1 April 2024.

The Annual Report reflects on the work undertaken and progress made during the Act's inaugural year, while also outlining key high-level priorities for the 2025/26 period. Given our internal governance timelines, this document focuses on progress up to the end of Quarter 3, with a separate Quarter 4 addendum to be submitted to the Board in Spring 2025.

This report is presented to the APF for noting only, ahead of its submission to the March 2025 Board meeting for approval.

Methodology for Assessing Compliance and Assurance

A combination of board-wide quantitative and qualitative methods has been used to evaluate compliance levels, gather staff perspectives, and gauge implementation progress of the Act.

Our 2024/2025 Year-End Survey was distributed to managers and professional leads in December 2024 and promoted at various professional and senior leadership team meetings. Information was also gathered by our Programme Lead through a series of one-to-one engagement sessions and from HCSA Implementation Group updates provided to NHSH HCSA Programme Board meetings.

This report serves as a comprehensive review of the first year of implementation, reinforcing our commitment to delivering high-quality care and adherence to the statutory requirements of the Act.

2.2 Background

The Health & Care (Staffing) (Scotland) Act 2019 came into force on 1st April 2024. It aims to provide a statutory basis for the provision of appropriate staffing in Health and Social Care services to support the delivery of safe and effective high-quality care. This will be achieved by having the right people with the right skills in the right place at the right time to improve outcomes for people using our services and improve staff wellbeing.

The Act does not prescribe health care staffing levels or planning and instead supports the development of suitable approaches in various health and social care settings.

Implementation of the Act is intended to:

- Assure that staffing is sufficient to support the delivery of high-quality care
- Support a culture of honesty and transparency that engages health and social care staff in the relevant process and ensures they are informed regarding healthcare staffing decisions
- Support further improvements to enhance and strengthen current arrangements in healthcare staffing planning and employment practices
- Risk escalation and mitigation processes to enable health and social care staff to be heard at all levels to inform evidence-based healthcare staffing decision-making
- Ensure professional clinical advice is available when healthcare staffing risks are highlighted

Duties of Healthcare Improvement Scotland (HIS)

HIS have several duties within the Act including, and are described fully within the HIS Healthcare Staffing: Operational Framework:

- HIS: monitoring compliance with staffing duties
- HIS: duty of Health Boards to assist staffing functions
- HIS: power to require information

To assist HIS in their functions, NHSH will share this report to inform further quarterly Board engagement calls. The Q3 Board engagement call is scheduled for March 2025.

Once ratified by the Board, this report will be submitted to Scottish Government, Health Improvement Scotland and published for public information and update, by 30 April 2025.

Legislative Overview

Key Objective	Description
Sufficient Staffing	Ensuring staffing levels support the delivery of high-quality care.
Transparency & Engagement	Encouraging open dialogue and staff involvement in staffing decisions.
Workforce Planning	Strengthening arrangements for effective staffing and employment practices.
Risk Escalation	Implementing processes to identify and mitigate staffing risks.
Clinical Advice	Ensuring professional clinical input in staffing decisions.

The Act does not mandate specific staffing levels but instead supports the development of suitable staffing methodologies tailored to different health and social care settings.

Key Duties Under the Act

Duty	Requirement
12IA: Appropriate Staffing	Ensure suitable staff numbers and competencies for safe, high-quality care.
12IB: High-Cost Agency Staffing	Report agency staff costs exceeding 150% of equivalent NHS staffing costs.
12IC & 12ID: Real-Time Staffing & Risk Escalation	Implement real-time staffing assessments and risk escalation protocols.
12IE: Severe & Recurrent Staffing Risks	Define and manage significant staffing risks at the Board level.
12IF: Clinical Advice on Staffing	Seek and document clinical input in staffing decisions.
12IH: Clinical Leadership	Allocate sufficient time and resources to clinical leaders.
12II: Staff Training	Provide staff with necessary training to implement the Act’s requirements.
12IJ & 12IL: Common Staffing Method	Conduct annual assessments based on validated staffing level tools.

Guiding Principles of the Act

Principle	**Description**
Safe & High-Quality Services	Ensure the best possible care outcomes for service users.
Service Standards & Outcomes	Improve standards while considering diverse user needs.
Respect & Dignity	Uphold service users' rights and involve staff in decision-making.
Transparency	Be open with staff and service users about staffing decisions.
Efficiency & Effectiveness	Allocate staff resources optimally.
Multidisciplinary Collaboration	Encourage teamwork across disciplines where appropriate.

All these principles must be considered holistically when determining staffing levels.

Further details on the Act's statutory duties and guiding principles can be found in the **Health & Care (Staffing) (Scotland) Act 2019: Statutory Guidance Document**

Health and Care (Staffing) (Scotland) Act 2019: overview – gov.scot (www.gov.scot)

2.3 Assessment

The checklist below demonstrates an overall 'moderate' level of assurance regarding compliance with the Act and the progress of HCSA Programme deliverables across the organisation, as referenced by the HCSA annual report RAG status (Appendix 1). Whilst we acknowledge that certain areas of practice exhibit higher levels of assurance, variances persist and, in the meantime, we will continue to adopt a conservative approach to our self-assessment. Concurrently, best practices will be disseminated organisation-wide to support ongoing improvements and learning

	Q1 FY 23/24	**Q2 FY 23/24**	**Q3 FY 23/24**	**Q4 FY 23/24**	**Q1 FY 24/25**	**Q2 FY 24/25**
12IA: Duty to ensure appropriate staffing (Ref to 2IC,12IE,121F,12IL,12IJ)						
Section 12IB: Duty to ensure appropriate staffing: agency workers.						
12IC: Duty to have real-time staffing assessment in place						
12ID: Duty to have risk escalation process in place						
12IE: Duty to have arrangements to address severe and recurrent risks.						
12IF: Duty to seek clinical advice on staffing.						

OFFICIAL

12IH: Duty to ensure adequate time given to leaders						
12II: Duty to ensure appropriate staffing: training of staff.						
12IJ & 12IK relating to the common staffing method						
12IL: Training and Consultation of Staff- Common Staffing Method						
12IM: Reporting on Staffing						
Planning & Securing Services						

Progress Overview

2. Progress Across Quarters 1–3 (2024–2025)

The following section details progress made against each key duty outlined in the Act.

2.1 Guiding Principles: Staffing for Health Care (12IA)

- **Quarter 1:** The Program Board was fully established, and governance structures were put in place.
- Implementation groups for Acute, Health and Social Care Partnership, and Child Health were established with formal reporting structures. Self-assessment returns were used to engage with a range of professional groups, achieving a multifaceted understanding of compliance needs allowing for prioritisation of workstream and areas for targeted improvement.
- **Quarter 2:** These principles became further embedded within workforce planning processes, with governance mechanisms and establishment review processes enhanced to support and drive consistent application.
- **Quarter 3:** Focus has shifted to adopting a revised approach to the establishment review process and further integrating the guiding principles across the organisation into strategic workforce and service planning, thereby ensuring alignment with overall organisational objectives. In addition, we have collaborated with workforce leads from other boards to operationalise the legislation into manageable components, facilitating incremental progress.

2.2 Guiding Principles: Planning and Securing Health Care from Others (12IA)

- **Quarter 1:** Gaps were identified in existing service agreements with third-party providers.
- **Quarter 2:** Governance in contracting processes was improved, aligning agreements with the Act's requirements.
- **Quarter 3:** Standardised procedures for securing third-party services further explored including developed understanding of the legislative requirements. This included direct links with NHSGGC for shared learning and support to progress towards full compliance with the guiding principles.

2.3 Duty to Ensure Appropriate Staffing in Healthcare (12IA)

- **Quarter 1:** Throughout Quarters 1 to 3, our efforts to ensure appropriate staffing have been multifaceted and strategic. In Quarter 1, initial compliance assessments identified significant areas for improvement. An extensive review of the existing E-Rostering system revealed critical issues that have prompted the initiation of a comprehensive rebuild and refresh programme across all e-rostered areas.
- **Quarter 2:** e-Roster 'Review and Rebuild' work carried out across Mental Health
- **Quarter 3: Enhanced Efficiency in Rostering:** The implementation of effective rostering practices across Mental Health services has led to streamlined processes, reducing administrative burdens and minimising the risk of manual errors. The improvements achieved, as outlined below, will provide valuable insights to inform the continued rollout of our 'Review and Rebuild' initiative.

  i **Fair Distribution:** Ensuring equitable allocation of shifts by considering factors such as experience, skills, and availability, thereby promoting a balanced workload.
  ii **Compliance Management:** Maintaining adherence to regulatory guidelines by ensuring the appropriate number of staff are available for each shift.
  iii **Improved Communication:** Facilitating communication between staff, enabling real-time shift swaps, leave requests, and updates.
  iv **Data-Driven Insights:** Providing valuable data and analytics to support informed decision-making regarding staffing requirements
  v **SafeCare** 'Go Live'

- Governance structures strengthened, reporting mechanisms were refined, with increased compliance monitoring was implemented to ensure appropriate staffing levels across Mental Health.

2.4 Duty to Ensure Appropriate Staffing: Agency Workers (12IB)

- **Quarter 1:** A manual tracking system was implemented to monitor and collate data on the usage of agency staff, focus drawn to high costs associated with accommodation and travel.
- **Quarter 2:** Policy revisions were introduced to limit reliance on agency staff and manage associated costs more effectively by ceasing payments for accommodation and travel.
- **Quarter 3:** Enhanced scrutiny processes were established following changes to reporting criteria.

2.5 Duty to Have Real-Time Staffing Assessment in Place (12IC)

- **Quarter 1:** Gaps were identified in real-time staffing assessment processes and recording of data. Many services already had elements of real-time staffing escalation processes, some were not formalised or documented in a way that allowed for easy auditing. Where areas have a strong system in place they were supported in their continued use. The TURAS based RTS tool has been promoted as an interim solution until the implementation of Safe Care. A root cause analysis was conducted to address issues with the quality of information in e-rostering and assessment of the potential impact this sub optimal data would have on the future use of Safe Care.
- **Quarter 2:** Following the completion of the Root Cause Analysis, we agreed to implement a 'Rebuild and Refresh' initiative across all roster locations within Mental Health. This initiative has been highly successful, attributable to the diligent efforts of the e-Rostering Team and robust professional support and leadership. By

reconstructing the underlying shift pattern and staffing infrastructure, we have established a roster that effectively supports the use of Safe Care.

- **Quarter 3:** NHSH reached a significant milestone when the Mental Health directorate became the first areas in NHSH to implement Safe Care. A rollout plan for the further 'Rebuild and Refresh' of the remaining 150 roster locations has been agreed. Work in Acute Services commenced in December 2024. On completion of the 'Refresh and Rebuild' the Raigmore Acute site will follow on as our second area to implement Safe Care. The **roll-out of Safe Care** will further standardise real-time staffing data recording and trend analysis, bridging gaps in the current system.
- The **Turas Real-Time Staffing Tool** continues to be utilised across available areas, supported by local tools in others, with further improvements scheduled for Q4.

Please see Appendix 4 for the corresponding SOP Action Card

2.6 Duty to Have a Risk Escalation Process in Place (12ID)

- **Quarter 1:** Initial evaluations revealed variability in risk escalation processes across different services.
- **Quarter 2:** Efforts were focused on developing Standard Operating Procedures (SOPs) to standardise escalation pathways.

Quarter 3: Formalised SOPs circulated for consultation and consideration for local level interpretation and operationalising to ensure timely escalation and recording of staffing-related risks.

Please see Appendix 5 for the corresponding SOP Action Card

2.7 Duty to Have Arrangements to Address Severe and Recurrent Risks (12IE)

- **Quarter 1:** Scoping identified systems were established to track recurrent risks; however, inconsistent reporting in some areas limited effectiveness.
- **Quarter 2:** Improvements in data collection and thematic risk analysis were promoted as part of the HCSA education and engagement work.
- **Quarter 3:** Formalised SOP circulated for consultation and consideration for local level interpretation and operationalising setting out proactive monitoring mechanisms enhancing the identification and management of severe and recurrent risks.

Please see Appendix 4 for the corresponding SOP Action Card

Duty to Seek Clinical Advice on Staffing (12IF)

- **Quarter 1:** Teams reported generally having access to appropriate clinical advice, with very few exceptions. However, a critical gap was identified: the absence of formalised processes for escalation and regular exception recording (except in cases of significant incidents), which undermines the consistent integration of expert clinical guidance into staffing decisions.
- **Quarter 2:** Efforts focused on developing supporting SOPs and reviewing existing workflows to streamline the process for obtaining and recording clinical advice. These initiatives aimed to enhance access, reduce response times, and generate auditable data.
- **Quarter 3:** The supporting SOP was circulated for consultation, with further local-level reviews underway to assess its impact. It should be noted, the utilisation of SafeCare will enable real-time tracking of clinical decisions, thereby improving communication and the overall quality and timeliness of clinical advice. However, further refinement of interim feedback mechanisms is required. The priority for Quarter 4 is to develop robust systems for gathering, recording, and acting on clinical advice, ensuring that staff at all levels can contribute effectively to real-time workforce planning discussions.

2.9 Duty to Ensure Adequate Time Given to Clinical Leaders (12IH)

- **Quarter 1:** Self-assessments highlighted challenges in balancing clinical responsibilities with leadership duties, underscoring the need for protected leadership time.
- **Quarter 2:** Leadership development programmes were identified as required.
- **Quarter 3:** Refined job planning approaches to ensure that clinical leaders have sufficient time for non-clinical responsibilities, with clear escalation procedures in place for when protected time is compromised have been agreed as a priority area for improvement.

2.10 Duty to Ensure Appropriate Staffing: Training of Staff (12II)

- **Quarter 1:** Baseline training needs assessments were completed alongside initial staff engagement activities, which raised awareness of consultation processes and ensured staff were fully informed of their roles and responsibilities.
- **Quarter 2:** Comprehensive training materials and national framework resources were developed and promoted to support consistent training efforts across all departments.
- **Quarter 3:** Ongoing training and engagement initiatives continued, building on the efforts of the previous quarters.

2.11 Duty to Follow the Common Staffing Method (12IJ)

- **Quarter 1:** Initial planning for the implementation of the Common Staffing Method (CSM) was undertaken.
- **Quarter 2:** CSM preparatory work, education sessions, revision of supporting documents to aid tool runs were scheduled, initiated and shared.
- **Quarter 3:** Tool runs have been conducted with extensive input from individuals and teams responsible for reviewing and collating output data and recommendations. This process included a pilot for five AHAP teams; although these teams are not currently mandated by legislation to conduct tool runs, their inclusion is regarded as a significant development. Workshops are scheduled for Q4 to review outcomes, and the resulting recommendations will be integrated into broader workforce planning strategies to enhance staffing level decision-making processes.

2.12 Training and Consultation of Staff (12IL)

- **Quarter 1:** Initial staff engagement activities were conducted to raise awareness of consultation processes.
- **Quarter 2:** Training materials and additional SOPs were developed.
- **Quarter 3:** Targeted consultation sessions were held to gather feedback and refine development of SOPs based on practical application of the legislation, while ongoing training and engagement sessions were delivered to further enhance staff competencies and ensure a thorough understanding of the Act's requirements.

3. Challenges Identified Across Quarters 1–3

Overall Risk Consideration

The combined effect of these challenges poses a risk to full compliance with the Act's general principles and duties. Addressing these issues will require a concerted effort to standardise processes, enhance data management, improve training and staff engagement, and secure the necessary resources. These targeted actions are essential for mitigating risks and ensuring the effective implementation of the Act across the organisation.

Key Risk/Challenge	Description
Inconsistent Application of Guiding Principles and Policies	Variability exists in how guiding principles and risk escalation processes are applied—particularly in remote areas. Although Nursing and Midwifery have demonstrated strong progress, other services continue to show inconsistency in documenting staffing requirements and escalating risks.

Key Risk/Challenge	Description
Gaps in Service Agreements and Third-Party Processes	The standardisation of service agreements for securing third-party services remains incomplete, necessitating further work to harmonise these processes.
Workforce Shortages and Recruitment Challenges	Staffing shortages, especially in remote areas, present significant challenges in meeting required staffing levels without the use of supplementary staffing
High Reliance on Agency Staff	Despite some improvements, reliance on high-cost agency workers persists in certain areas, leading to elevated expenditure for agency staff.
Variability in OPEL Framework Implementation	The implementation of the Operational Pressures Escalation Levels (OPEL) framework is not uniform across the system, resulting in inconsistent risk escalation processes.
Data Management and Integrity Issues	There is a need for enhanced methods and improved data housekeeping to support accurate data collection and analysis, which are critical for evidence-based decision-making.
Training and Engagement Challenges	Inconsistent delivery and uptake of training programmes, combined with limited staff engagement, have hindered the effective implementation of staffing processes across some groups.
Complexity of E-Rostering Redevelopment	The ongoing e-rostering rebuild is a complex process expected to extend into 2025. Continuous evaluation and validation are essential to ensure the successful implementation of the new system.
Resource Constraints	Limited protected time for clinical leaders and difficulties in balancing clinical and administrative duties have constrained leadership capacity, while overall team engagement in programme initiatives remains limited.
Digital Solution Gaps	The absence or incompleteness of digital solutions hampers the ability to evidence established practices and capture thematic trends. Additionally, the current requirement for SSTS double entry—due to a lack of a payroll interface—prevents rollout to new areas.

4. Planned Work for Quarter 4 (2024–2025)

Key Area	Planned Actions
Embedding Guiding Principles	- Ensure the consistent application of guiding principles across all service and workforce planning activities. - Conduct regular review sessions to monitor adherence.
Standardising Contracting Processes	- Review and standardise third-party contracting processes to achieve full compliance with the Act's requirements.
Strengthening Governance	- Conduct audits and enhance reporting structures to support effective governance and decision-making. - Revise the HCSA Programme Board and supporting Implementation Groups as we transition into a 'business as usual' phase.
Improving Data Management	- Expand the SafeCare system to further enhance real-time staffing assessments. - Refine data collection methods, including enhanced incident reporting via Quality & Patient Safety Dashboards.
Enhancing Risk Management	- Finalise and implement Standard Operating Procedures (SOPs) for risk escalation and the management of recurrent risks. - Deliver comprehensive staff training to support these processes.- Review the effectiveness of the Operational Pressures Escalation Levels (OPEL) framework and supporting clinical structures.
Leadership Development	- Support leadership development programmes. - Refine job planning processes to secure protected non-clinical time for clinical leaders.- Finalise and implement the SOP on "Clinical Time to Lead," accompanied by engagement sessions.

Key Area	Planned Actions
Comprehensive Training and Staff Engagement	- Deliver targeted training programmes to address identified skills gaps and ensure staff are fully equipped to meet the Act's requirements. - Conduct focused consultation sessions to gather feedback and refine training and workforce planning strategies.- Compile and disseminate training materials and videos to support the utilisation of SafeCare.
Common Staffing Method (CSM) Implementation	- Complete the annual run of the CSM tool, analyse outcomes, and integrate findings into workforce and budget planning for the next fiscal year.- Conduct workshops to review outcomes and incorporate learnings into strategic planning.- Collate learnings from the current cycle (24/24) to inform planning for 24/25.
Additional Key Milestones and Actions	- Engage in targeted Medical Staffing Engagement initiatives.- Deliver on the e-Roster 'Rebuild and Refresh' milestone plan for the 24/25 rollout across the remaining rostered areas.- 'Switch on' SafeCare following roster rebuild work.- Initiate the 'switch on' of SafeCare at a test site in non-rostered areas and develop a step-by-step guide based on shared learning from NHSG.- Review and update the Roster Policy and governance structure.- Review Bank/Locum Engagement processes to ensure robust scrutiny and governance.

Key Workforce Planning Work Streams

Work Stream	Description
Workforce Systems Review and Realignment	A systematic review and realignment of workforce systems are underway to create synergy, support real-time data, and enhance decision-making for both operational and strategic workforce planning.
Annual Service Planning	The 2025/26 Annual Service Planning cycle will include budget setting, establishment agreements, and data-driven assessments covering demand, capacity, activity, and quality (DCAQ). Scenario planning will help navigate future complexities and risks.
Service-Based Medical Planning	From April 2025, inclusive service-based medical planning will involve medical staff in workforce decisions, influencing job planning through full engagement with service needs.
Common Staffing Methodology (CSM) and Staffing Level Tools	NHS Highland continues to review and update workforce establishments, informed by CSM tool runs and data from SafeCare. The focus is on ensuring compliance while aligning workforce plans with budgetary considerations.
Workforce Planning for 2025/26	Efforts will focus on evidence-based planning, capacity building, and competency development, while aligning with national strategies. This includes reducing reliance on agency locums through improved recruitment, retention strategies, international recruitment, and enhanced rostering practices.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	x
Limited		None	

Comment on the level of assurance

This report presents a high-level overview of our progress towards compliance with the statutory duties under the Act, outlining systems and processes and work streams which have been established. The HCSA Programme Board continues to maintain a 'moderate' level of assurance.

For the purpose of report submission we apply the Scottish Government's assurance rating system, our current rating is 'reasonable', indicating there are generally sound systems of governance, risk management and controls in place. Some issues, non-compliance or scope for improvement identified which may put at risk the achievement of implementation objectives.

This assessment highlights the need for ongoing, targeted improvements in the formalisation and standardisation of our processes, procedures, governance, risk management, and control frameworks. By strengthening these areas, we will enhance our capacity to mitigate risks and fully discharge the statutory duties and responsibilities mandated by the Act. The HCSA Programme Board is committed to providing robust leadership and strategic direction to address these challenges, and we recognise the continued dedication and collaborative efforts of our teams in advancing this crucial work.

Broadly speaking we have the appropriate mechanisms and governance in place to assess and report on staffing requirements across our organisation needed to deliver care to our population.
We have the appropriate mechanisms and governance in place to assess and report on a routine (day to day) basis:

a. how well we meet the staffing requirements
b. that risks associated with staffing challenges are managed, mitigated and escalated appropriately
c. professional advice is embedded and demonstrable in our day-to-day management of staffing and service delivery

We are able to use the information from assessing staffing requirements and routine assessment of staffing risks and issues 'in practice' to develop short-, medium- and long-term plans to provide appropriate staffing
.

3 Impact Analysis

3.1 Quality/ Patient Care

The HCSA is intended to support delivery of safe, high-quality services.

3.2 Workforce

The HCSA is fundamentally about providing appropriate staffing to deliver services.

3.3 Financial

There are potential financial implications in relation to addressing staffing risks and issues identified through the mechanisms required to demonstrate compliance with the duties of the act. However, it is important to emphasise that the act does not introduce anything new in terms of the principle that services should already be planned and delivered with an appropriate workforce plan in place to deliver the service to the required standards.

3.4 Risk Assessment/Management

This links to board level risk in relation to workforce availability and ensuring we have appropriate mechanisms to manage and mitigate risks associated with staffing issues.

3.5 Data Protection

N/A

3.6 Equality and Diversity, including health inequalities

N/A

3.7 Other impacts

N/A

3.8 **Communication, involvement, engagement and consultation**

This report has been ratified for internal reporting purposes to our Board of Directors by both our Medical Director, Boyd Peters and Executive Nurse Director, Louise Bussell.
NHSH HCSA Programme Board is now well established with professional and staff side involvement for all professional and operational leads across all Board functions.
The programme continues to be supported by a range of, feedback, engagement and briefing sessions.

3.9 Route to the Meeting

N/A

4 Recommendation

The Board is asked to note the requirements placed on the board by the Act
The Board is asked to take moderate/limited assurance and review and scrutinise the information provided in this paper and appendices.

4.1 List of appendices

The following appendices are included with this report:

Appendix 1: HCSA RAG status key

Declaration and level of assurance

When asked to provide declaration of the level of assurance, please use this key.

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

- **Appendix 2 HCSA: End of Year SG Mandated Completed Report Template**
- **Appendix 3: HCSA Quarter 3 External High-Cost Agency Report**
- **Appendix 4: Real-Time Staffing and Risk Escalation Action Card**
- **Appendix 5: Duty to Ensure Adequate Time Given to Clinical Leaders Action Card**

Action Card: Real-Time Staffing and Risk Escalation

Purpose:

Action Card: Real-Time Staffing and Risk Escalation

🔵 **Purpose:**

This Action Card outlines the responsibilities and processes to ensure **NHSH** meets its obligations under the **Health and Care (Staffing) (Scotland) Act 2019 (HCSSA).** The key duties include:

- **12IC:** Real-time staffing assessment
- **12ID:** Risk escalation process
- **12IE:** Addressing severe and recurrent risks
- **12IF:** Seeking clinical advice on staffing

These duties support **safe, high-quality care and staff wellbeing.**

🟡 **Scope:**

Applies to all named professions under the **Act. Clinical leaders and management teams** must implement and maintain these processes.

🔴 **Immediate Actions Required:**

- **Conduct real-time staffing assessments**
- **Escalate and mitigate staffing risks promptly**
- **Maintain records of staffing decisions and mitigations**
- **Seek clinical advice when required**
- **Report quarterly to NHSH Board and annually to Scottish Ministers**

🟡 **Roles and Responsibilities:**

- **All staff covered by the Act:** Escalate staffing concerns to a **Lead Professional (LP)** immediately.
- **Lead Professionals (LPs):** Responsible for **identifying, escalating, and mitigating risks.**
- **Senior Decision-Makers:** Receive risk escalations and determine actions required.

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- **Management Teams:** Ensure **SOPs** align with this **Action Card** and oversee local implementation.

🔴 **Risk Escalation and Mitigation:**

- **Follow local SOPs** to escalate risks up the **chain of command.**
- **Seek appropriate clinical advice** when needed.
- **Notify all relevant staff** of decisions and actions taken.
- **Record severe and recurrent risks** for monitoring and reporting.

🔵 **Incident Reporting & Documentation:**

- **Use Datix Incident Module** for reporting all staffing-related **incidents and near misses.**
- **Maintain local records covering:**
    - **National RAGG status**
    - **Escalations & mitigations**
    - **Clinical advice sought**
    - **Staff notifications**
    - **Disagreements and resolutions**

🟡 **Staffing Meetings:**

- **Daily huddles:** Assess real-time staffing, escalate risks, and discuss mitigations.
- **Monthly senior reviews:** Evaluate severe/recurrent risks based on **Datix reports and staffing records.**
- **Quarterly reporting: Senior Leadership Teams** submit reports on staffing risks and mitigations.

🔴 **Severe and Recurrent Risk Management:**

- **Identify trends** using **Datix and local records.**
- **Manage risks within Division/HSCP,** ensuring visibility across **NHSH.**
- **Escalate where further management is needed,** ensuring documented action plans.
- **Quarterly corporate review of Safe Staffing Risks** to ensure **system-wide oversight.**

🟢 **Compliance & Training:**

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- **Complete essential TURAS learning modules.**
- **Management teams must ensure local training on RTS and Risk Escalation.**

📍 **Reference:** NHSH Risk Management Strategy & Policy
📖 **For full procedural guidance, refer to the NHSH Standard Operating Procedure on Real-Time Staffing and Risk Escalation.**

NHS Highland

Health and Care (Staffing) (Scotland) Act 2019 – Medical FAQs

Q1: Does the Act prescribe minimum staffing levels?
No. The Act does not prescribe minimum staffing levels. It is the responsibility of NHS Highland to establish processes that ensure appropriate staffing levels based on the needs of patients within each clinical area. This may involve multi-disciplinary or multi-professional teams, depending on the service.

Q2: Does this mean there is additional funding for staffing?
No. The Act does not come with specific or additional funding. However, it aims to improve the visibility of staffing issues, enabling senior decision-makers to make informed decisions regarding workforce requirements across all areas.

Q3: What are my responsibilities under the Act?
As a doctor, you already have a professional duty to ensure the delivery of safe, high-quality care to your patients. If a staffing issue arises that impacts patient care and it is within your control to address, you are required to take appropriate action. If you are unable to resolve the issue, you must escalate it through the appropriate management channels.

- **Clinical Leaders** have a real-time view of staffing, with authority to mitigate risks, escalate issues, and communicate decisions to staff.
- **Senior Medical Staff in Management Roles** are responsible for overseeing mitigation efforts, escalating unresolved issues, and ensuring clear communication with teams.
- **Senior Management** holds accountability for accepting and managing risks when mitigation is not possible.
  All incidents related to staffing concerns must be recorded through formal reporting systems such as Datix to ensure accountability and compliance with the Act.

Q4: Who is considered a 'Clinical Leader'?
The definition of a Clinical Leader may vary depending on the service. Generally, this role is held by an individual responsible for rota management, duty allocations, and staffing decisions. They have the authority to redeploy staff or secure additional resources when necessary. Clinical Leaders should have dedicated time in their job plans to fulfil this role and are responsible for ensuring staff awareness of the Act and appropriate training. Responsibilities may be shared within teams—for example, a registrar may manage rotas, while a Clinical Director oversees staff training and authorises agency use.

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Q5: What is meant by 'mitigation'?
Mitigation refers to actions taken to reduce the impact of staffing shortages on patient care. For example, if a doctor calls in sick, the Clinical Leader might:

- Redeploy staff from another well-covered area
- Cancel non-essential activities to prioritise emergency cover
- Engage bank staff or agency staff
- Utilise other members of the multidisciplinary team (MDT)
  The goal is to maintain safe, effective care with minimal disruption to services.

Q6: What if I disagree with the mitigation plans?
If you are directly involved in a staffing issue, the Clinical Leader is required to discuss the proposed mitigation strategies with you. If you believe the mitigation is inappropriate, the Act ensures there is a mechanism to formally record your concerns, with a process for reviewing and reassessing the mitigation plan. Work is ongoing to standardise how such concerns are documented.

Q7: Why are bank/agency costs generally restricted to 150% of the normal rate?
One of the objectives of the Act is to promote cost-effective staffing solutions and reduce reliance on high-cost agency staff. Typically, the cost of additional hours, bank shifts, or agency staff should not exceed 150% of the standard hourly rate for an equivalent employee. However, this is not an absolute limit. If exceeding this threshold is necessary, the circumstances must be clearly documented, and the details included in routine reports submitted to the Scottish Government.

Q8: What should I do if my unit is consistently short-staffed?
You have a duty to mitigate staffing risks where possible and escalate concerns through the appropriate channels. Senior decision-makers are responsible for reviewing data from Datix and other reporting systems to identify persistent or high-risk staffing issues. NHS Highland is then obligated to consider mitigation strategies, which may include service redesign to address ongoing workforce challenges.

Q9: Can non-clinical managers make staffing decisions?
No. The Act mandates that clinical advice must be sought before any staffing-related decisions are made. Non-clinical managers cannot make decisions regarding staffing without appropriate clinical input to ensure patient safety and the delivery of high-quality care.

This FAQ aims to support medical staff in understanding their responsibilities under the Health and Care Staffing (Scotland) Act 2019. Ongoing training, engagement sessions, and operational guidance will continue to support implementation across NHS Highland.

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Action Card: Duty 12IH - Ensuring Time for Clinical Leaders

Background:

Duty **12IH** ensures that **Lead Professionals** have the **time and resources** necessary to manage staffing alongside other professional duties. Within this **Standard Operating Procedure (SOP),** these professionals are referred to as **Clinical Leaders.**

Purpose:

This SOP supports **NHS Highland (NHSH) Health Care Teams** in fulfilling the requirements of the **Health and Care Staffing (Scotland) Act 2019 (HCSSA).**

Key Leadership Roles:

Clinical Leaders must ensure:

- **Supervision of patient care**
- **Management and development of staff**
- **Delivery of safe, high-quality, person-centred care**

NHSH must allocate sufficient **time and resources** for **Clinical Leaders** to fulfil these duties, ensuring alignment with sector-specific **SOPs.**

Scope:

This SOP applies to **Clinical Leaders in NHSH** and **Health & Social Care Partnerships (HSCPs)** covered by the **HCSSA.** It includes **regulated professionals** (e.g., **GMC, NMC, HCPC**) and some **healthcare support workers.**

Definition of a Clinical Leader:

A **Clinical Leader** is an individual with **lead clinical responsibility** for a team. The **HCSSA Leadership Considerations List (Appendix 1)** must be used to determine this role. The term **"clinical"** is broadly applied to all **in-scope professions.**

Time and Resource Allocation:

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NHSH has a duty to provide **adequate time and resources** for **Clinical Leaders.** While the Act does not define **"adequate time,"** it advises using existing **governance** to determine sufficient allocation. Support staff, such as **administrative assistance,** should be available as needed.
Clinical Leaders should also have knowledge of the **Act,** e.g., completing the **TURAS Skilled Level training module.**

🔴 **Protecting and Evidencing Time to Lead:**

Time to lead must be **protected and recorded.** Short-term evidence includes:

- **Nursing staff:** SSTS
- **Other professionals:** E-job planning, work diaries, TURAS appraisals
- **Additional sources:** iMatter surveys, reflective practice, appraisals, and job plan completion rates

🔴 **Escalation procedures must be in place if time to lead is not protected, ensuring senior management intervention and review** (as per **RTS and Risk Escalation SOP**).

🔴 **Severe and Recurrent Risks:**

Severe and **recurrent staffing risks** are defined as **repeated incidents** (severity level **3-5**) or **near misses** due to **staffing issues. Senior Managers** must review **staffing risk reports monthly** and update **Division/HSCP Risk Registers** accordingly.

🟢 **Assurance and Reporting:**

- **Senior Management teams** must submit **quarterly Staffing Risk reports,** detailing **current risk scores and mitigation actions.**
- **Safe Staffing Risks** will be reviewed **quarterly** at the **NHSH senior management and corporate level.**

🟡 **Job Descriptions:**

Any necessary **role adjustments** will follow existing **job planning and evaluation processes.** **Clinical Leader** roles should explicitly reference **HCSSA responsibilities** in **job descriptions and advertisements.**

✅ **Conclusion:**

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This **Action Card** ensures that **Clinical Leaders** are supported with the **necessary time and resources** to uphold **safe staffing standards,** fostering **high-quality patient care** across **NHSH.**

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# NHS Highland	

Meeting:	**Board Meeting**
Meeting date:	**31st March 2026**
Title:	**Quarter 3 Whistleblowing & Confidential Contact Report**
Responsible Executive/Non-Executive:	**Gareth Adkins, Director of People & Culture**
Report Author:	**Dominic Watson, Head of Corporate Governance** **Carolynn Lawrie & Hollie Baxter, Confidential Contact Advisors**

Report Recommendation:

Moderate Assurance – To give confidence of compliance with legislation, policy and Board objectives noting challenges with timescales due to the complexity of cases and investigations.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal requirement

This report will align to the following NHSScotland quality ambition(s):

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well		Listen Well	x	Nurture Well		Plan Well	
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well	x	Progress well		**All** Well Themes			

2 Report summary

2.1 Situation

This report is for Quarter 3 covering the period October to December 2025.

This is provided to give assurance to the committee of our performance against the Whistleblowing Standards which have been in place since April 2021.

2.2 Background

All NHS Scotland organisations including Health and Social Care Partnerships are required to follow the National Whistleblowing Principles and Standards which came into effect from 1 April 2021. Any organisation providing an NHS service should have procedures in place that enable their staff, students, volunteers, and others delivering health services, to access the National Whistleblowing Standards.

As part of the requirements, reports are required to be presented to the Board and relevant Committees and IJBs, on an annual basis, in addition to quarterly reports. The Area Partnership Forum plays a critical role in ensuring the Whistleblowing Standards are adhered to in respect of any service delivered on behalf of NHS Highland. Both quarterly and annual reports are presented at the meetings and robust challenge and interrogation of the content takes place.

The Confidential Contact Service, known as OpenLine, provides our Whistleblowing Standards confidential contacts service. OpenLine will ensure:

- that the right person within the organisation is made aware of the concern
- that a decision is made by the dedicated officers of NHS Highland and recorded about the status and how it is handled
- that the concern is progressed, escalating if it is not being addressed appropriately
- that the person raising the concern is:
  - kept informed as to how the investigation is progressing
  - advised of any extension to timescales
  - advised of outcome/decision made

    - advised of any further route of appeal to the Independent National Whistleblowing Office (INWO)
- that the information recorded will form part of the quarterly and annual board reporting requirements for NHS Highland. Staff can also raise concerns directly with:
    - their line manager
    - The whistleblowing champion
    - The executive whistleblowing lead

Trade union representatives also provide an important route for raising concerns. In the context of whistleblowing standards, the trade union representatives can assist staff in deciding if:

- an appropriate workforce policy process could be used including early resolution
- whistleblowing policy and procedures could be used to explore and resolve concerns that involve wrongdoing or harm

Information is also included in the NHS Highland Induction, with training modules still available on Turas. The promotion and ongoing development of our whistleblowing, listening and speak up services is a core element of the Together We Care Strategy and Annual Delivery Plan.

2.3 Assessment

Summary of Quarter 3 Whistleblowing covering the period October to December 2025:

- No new cases received in the quarter.
- One case has been closed, with the outcome identifying one element partially upheld, and three elements not upheld. 19 recommendations have been identified (see Appendix 1).

Three cases remain under investigation:

- One relates to potential financial mismanagement that has been investigated previously through workforce policies. A whistleblowing investigation is reviewing if there is anything further organisationally that needs to be considered to prevent recurrence.
- Investigation remains ongoing into the case reopened by INWO, as reported in the last quarter.
- One case relates to quality of care concerns.

The table in Appendix 1 summarises the cases with recommendations that are still in progress and the governance arrangements. It is worth noting that recommendations are dependent on the specific context and circumstances and the associated governance arrangements will vary. However, a review date has been set for the whistleblowing function to check with those tasked with the recommendations on progress to date. This will include considering whether the work requires a further review date set.

Summary of Quarter 3 Confidential Contacts covering December 2025 (support formerly provided by the Guardian Service):

- Nine cases received in the month.
  - Three cases relate to line manager issues
  - Two cases relate to unreasonable workload
  - One case relates to discrimination
  - One case relates to line manager issues and lack of communication
  - One case relates to inappropriate staff behaviour
  - One case was a request for information signposting

- All nine cases closed in the month.

2.4 Proposed level of Assurance

This report proposes the following level of assurance

Substantial		Moderate	x
Limited		None	

Comment on the level of assurance

The committee is asked to take moderate assurance on basis of robust process, but noting the challenge of meeting the 20 working days within the standards

3 Impact Analysis

3.1 Quality/ Patient Care

The Whistleblowing Standards are designed to support timely and appropriate reporting of concerns in relation to Quality and Patient Care and ensure we take action to address and resolve these.

3.2 Workforce

Our workforce has additional protection in place under these standards

3.3 Financial

The Whistleblowing Standards also offer another route for addressing allegations of a financial nature

3.4 Risk Assessment/Management

The risks of the implementation have been assessed and included.

3.5 Data Protection

The standards require additional vigilance on protecting confidentiality.

3.6 Equality and Diversity, including health inequalities

No issues identified currently

3.7 Other impacts

None

3.8 Communication, involvement, engagement and consultation

N/A

3.9 Route to the Meeting

N/A

4.1 List of appendices

The following appendices are included with this report:

- Appendix 1 – Case recommendations and Governance Summary Report

Appendix 1 – Case Recommendations and Governance Summary

Case ID	Summary	Recommendations	Actions	Governance Arrangements	Review date	Update
WB19 2025-26	Concerns about impact of staffing shortages on quality and safety of clinical services	**Safe, quality care** • Integrate findings of investigation into service review to ensure the practice model is consistent with national policy • The service review to: o reassess the guidance for future similar situations o discuss the feedback from staff o evaluate the ongoing challenges and any risks associated with paper records and develop plans for transition to electronic records o support the team to ensure that there are effective systems in place for ensuring open lines of communication and feedback • Ensure that staff can access current guidance **Professional Workforce Standards Planning and Development** • Integrate findings and recommendations into the governance systems • Ensure that all staff have undertaken the Health and Care Staffing Scotland (informed level) online training • Ensure that findings of service review: o inform plans for workforce review and address requirements for most efficient use of existing resource o Implement efficient use of existing resources, including skills mix and different roles	• Implement recommendations through senior management team with support from executive team	• Clinical governance	•	N/A

		• Ensure time and resource to fulfil professional and leadership role • Attendance required for all referral discussions **Professional Practice and Accountability** • Compliance with NMC standards with record keeping systems • Safe and effective use of social media platforms for engagement • Implement regular supervision sessions • Review the current model of supervision • Professional collaboration links throughout NHS Highland • Better use of technology to connect teams				

NHS Highland	

Meeting:	**Board Meeting**
Meeting date:	**31st March 2026**
Title:	**Models of Integrations Review – Options Appraisal Phase 1 Outcome Report & Phase 2 Initiation**
Responsible Executive/Non-Executive:	**Gareth Adkins, Director of People and Culture**
Report Author:	**Kate Lackie, Assistant Chief Executive – People, Highland Council**

Report Recommendation:

The Board is asked to:

1. With regard to the options appraisal, it is recommended that Members:
   a) **Note** the outcome of the Phase 1 options appraisal summarised at section 5 and set out in detail at **Appendix 2**;
   b) **Agree** the two options to be taken forward to Phase 2 of the Review: Option A – Lead Agency and Option B – Body Corporate (IJB).

2. With regard to next steps, it is recommended that Members:
   a) **Agree** the draft Phase 2 Programme Plan at **Appendix 3** including timelines for a final decision and recommendation to Highland Council and the Board of NHS Highland by September 2026; and
   b) **Agree** the Communications and Engagement Plan at **Appendix 4**.
   c) **Note** progress with establishing a programme for Phase 2 including initiating appointment of a programme manager.

3. With regard to the NDAS proposal
   a. **Agree** the high level proposal set out in **Appendix 5** and
   b. **Agreed** the work to be further developed by and remitted to the Person Centred Solutions Portfolio Board.

1 Purpose

This is presented to the Board for:

- Decision
- Assurance

This report relates to a:

- Legal Requirement
- Local policy

This aligns to the following NHSScotland quality ambition(s):
- Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well		Listen Well		Nurture Well		Plan Well	
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well		Progress well		All Strategic Outcomes	X		

2 Report summary

2.1 Situation

Highland Council and NHS Highland were the first in Scotland to establish an integrated health and social care partnership. Under the agreement, NHS Highland leads on adult services, while the Council leads on children's services. The intention at that time was to break down barriers between health care and social services for a more seamless experience; and to create a model that focused on prevention and supporting people in their own homes. One of the key drivers was the need to tackle the growing problem of delayed hospital discharge. Two years later, in 2014, the Public Bodies Joint Working (Scotland) Act came into force, making integrated adult services a legal requirement for all councils and health boards in Scotland.

In December 2024/January 2025 the Highland Council and NHS Highland Board agreed to establish a Joint Steering Group to take forward a Models of Integration Review with the potential to change current Lead Agency Integration arrangements to align with the rest of Scotland by establishing a Body Corporate Scheme. Should this ultimately be the approach agreed by the Council and NHS Board it will be the biggest fundamental shift in public sector governance and delivery in the Highlands for over a decade, with potentially major implications for budget, workforce and service users. Whilst some of these aspects are reflected at a high level in this report, the implications still require to be worked through in detail and this will be one aspect of the work that is to be taken forward into the next phase of Review.

The joint Steering Group met on 16th January 2026 to consider the outcomes of the Phase 1 options appraisal; and on 23 February 2026 to consider the Phase 2 Programme Plan. The details and outcomes of both meetings are outlined in this report and the Council is asked to approve the recommendations coming forward from the Steering Group.

The Council is asked to agree that two options are taken forward into Phase 2 of the Review, and that the Senior Officer’s Group continue to develop plans for stakeholder consultation and engagement to commence after the Scottish Parliamentary Elections, with a view to bringing final proposals to the Council and NHS Board by September 2026.

On 5 March 2026 the Council agreed in principle to support a proposal to invest £1.2M in tackling the NDAS waiting list in Highland and work with Glasgow University to develop a new

assessment model to deliver long term improvement. It was agreed that this would be worked up into a more detailed proposal by officers and this is included in Appendix 4. It is not proposed that this piece of work is incorporated into the Models of Integration Review as NDAS is not a function within the Lead Agency Model and so would be outside the scope of the review. Instead, Members are asked to agree to remit the further development of the proposition and subsequent delivery of the project to the Person Centred Solutions Portfolio in the operational Delivery Plan.

2.2 Background

Please see the appendices for the full progress made to date.

2.3 Assessment

Please see the attached appendices for full detail

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	X	Moderate	
Limited		None	

3 Impact Analysis

3.1 Quality/ Patient Care

None arising from this report.

3.2 Workforce

None arising from this report.

3.3 Financial

None arising from this report.

3.4 Risk Assessment/Management

None arising from this report

3.5 Data Protection

Activity is undertaken in line with GDPR regulations.

3.6 Equality and Diversity, including health inequalities

None arising from this report.

3.7 Other impacts

No other impacts.

3.8 Communication, involvement, engagement and consultation

See Appendix 4

3.9 Route to the Meeting

The subject of this report has been considered at the Highland Council and NHS Highland.

4 List of appendices

- **Appendix 1** – Full Draft Report providing additional context and detail
- **Appendix 2** – Phase 1 Outcome Report
- **Appendix 3** – Programme Plan
- **Appendix 4** – MOI Community Engagement Overview

Agenda Item	5
Report No	

The Highland Council

Committee: **Highland Council**

Date: **26 March 2026**

Report Title: **Models of Integration Review – Options Appraisal Phase 1 Outcome report and Phase 2 Initiation**

Report By: **Kate Lackie, Assistant Chief Executive – People**

1. Purpose/Executive Summary

1.1 Highland Council and NHS Highland were the first in Scotland to establish an integrated health and social care partnership. Under the agreement, NHS Highland leads on adult services, while the Council leads on children's services. The intention at that time was to break down barriers between health care and social services for a more seamless experience; and to create a model that focused on prevention and supporting people in their own homes. One of the key drivers was the need to tackle the growing problem of delayed hospital discharge. Two years later, in 2014, the Public Bodies Joint Working (Scotland) Act came into force, making integrated adult services a legal requirement for all councils and health boards in Scotland.

1.2 In December 2024/January 2025 the Highland Council and NHS Highland Board agreed to establish a Joint Steering Group to take forward a Models of Integration Review with the potential to change current Lead Agency integration arrangements to align with the rest of Scotland by establishing a Body Corporate Scheme. Should this ultimately be the approach agreed by the Council and NHS Highland Board it will be the biggest fundamental shift in public sector governance and delivery in the Highlands for over a decade, with potentially major implications for budget, workforce and service users. Whilst some of these aspects are reflected at a high level in this report, the implications still require to be worked through in detail and this will be one aspect of the work that is to be taken forward into the next phase of the review.

1.3 The joint Steering Group met on 16 January 2026 to consider the outcomes of the Phase 1 options appraisal; and on 23 February 2026 to consider the Phase 2 Programme Plan. The details and outcomes of both meetings are outlined in this report and the Council is asked to approve the recommendations coming forward from the Steering Group.

1.4 The Council is asked to agree that two options are taken forward into Phase 2 of the Review, and that the Senior Officer’s Group continue to develop plans for stakeholder consultation and engagement to commence after the Scottish Parliamentary Elections, with a view to bringing final proposals to the Council and NHS Board by September 2026.

1.5 Paragraph 9 and Appendix 4 sets out the approach to utilising the £1.2m investment for NDAS approved at Council on 5 March 2026 for member approval.

2. Recommendations

2.1 1. With regard to the options appraisal, it is recommended that Members:

a) **Note** the outcome of the Phase 1 options appraisal summarised at section 5 and set out in detail at **Appendix 2**;
b) **Agree** the two options to be taken forward to Phase 2 of the Review: Option A – Lead Agency and Option B – Body Corporate (IJB).

2. With regard to next steps, it is recommended that Members:

a) **Agree** the draft Phase 2 Programme Plan at **Appendix 3** including timelines for a final decision and recommendation to Highland Council and the Board of NHS Highland by September 2026; and
b) **Agree** the Communications and Engagement Plan at **Appendix 4**.
c) **Note** progress with establishing a programme for Phase 2 including initiating appointment of a programme manager.

3. With regard to the NDAS proposal
   a. **Agree** the high level proposal set out in **Appendix 5;** and
   b. **Agree** the work to be further developed by and remitted to the Person Centred Solutions Portfolio Board.

3. Implications

3.1 Resource – Current reports to the Joint Monitoring Committee (JMC) demonstrate that the health and social care budgets in NHS Highland and Highland Council have existing pressures for children and adult services. Joint Chairs of the JMC have recently sought bespoke assurance from Chief Executives about resolving these challenges for both organisations. NHS Highland and Highland Council are required to make significant budget savings within the context of wider budgetary pressures. Any model of governance will need to address the significant financial implications, and this requirement will form part of the next stage of the options appraisal process and will be reported back to the Council and NHS Board in September 2026.

The costs of the Independent Advisor, Programme Manager and activities associated with the Communications and Engagement Plan will be met by the Adult Social Care Transformation Earmarked Reserve, with the potential for additional programme resources to be approved if and when required. This is overseen by the Joint Chief Executive's Group which meets fortnightly. There is also a requirement for lead officers in both organisations to identify capacity to take the work forward at pace which will require a re-prioritisation of workload in some cases.

There is engagement with Scottish Government officials to explore whether some or all of the costs of the review can be met through support from government, as is the case with the work being undertake by those authorities who are exploring the single island authority model within public sector reform.

3.2 Legal – At the present time there are no specific legal implications arising directly from the content of this report. However any change to the model of integration in due course would require to be supported by a revised Integration Scheme which is a document that sets out the legal responsibilities and duties of both partners. Both organisations are in the early stages of instructing Legal advisors in this regard.

Public Bodies Joint Working (Scotland) Act 2014 *requires* all health boards and councils to integrate adult services – whether utilising a Lead Agency or a Body Corporate/IJB Model. No other functions are required to be integrated under the legislation, which means that the majority of services currently included in the Lead Agency Model would not automatically be incorporated into a new Integration Scheme. These services, which are wide ranging and include Child Health - an NHS function currently delegated to the Council, Justice Services, Children's Social Work, Educational Psychology, Early Years Education, Young Carers, alongside others (the full list is outlined on pages 19 – 21 of the report at Appendix 1).

Decisions will need to be made regarding each of these functions and the intention is that the Joint Steering Group will be asked to indicate a preference for which functions to include and which to exclude, based on joint work undertaken by the Senior Officers Group. This will then inform the scheme that will go out to stakeholder engagement and feedback the outcome of which will shape the recommendations that will be made to the Highland Council and NHS Board later this year.

3.3 Risk - There are risks regarding the timescales for completing Phase 2 in order to bring final recommendations to Council and NHS Board by September 2026. Mitigating actions will be identified if timescales begin to slip.

The position with regard to financial risk agreement would also need to be set out within any new Integration Scheme arrangements.

A full Risk Assessment of all options will be undertaken as part of the next Phase.

3.4 Health and Safety (risks arising from changes to plant, equipment, process, or people) and Gaelic – There are no such implications arising from this report.

4. Impacts

4.1 In Highland, all policies, strategies or service changes are subject to an integrated screening for impact for Equalities, Poverty and Human Rights, Children's Rights and Wellbeing, Climate Change, Islands and Mainland Rural Communities, and Data Protection. Where identified as required, a full impact assessment will be undertaken.

4.2 Considering impacts is a core part of the decision-making process and needs to inform the decision-making process. When taking any decision, Members must give due regard to the findings of any assessment.

4.3 An impact assessment is not required at this stage. A full screening will be undertaken prior to any options being brought forward for stakeholder engagement, as well as the final recommendations being brought forward for approval.

It is likely that screening will indicate that a full integrated impact assessment will be required at each stage.

5. Summary of progress to date

5.1 Work has been continuing with NHS Highland to review the current lead agency model of integration and consider options for an alternative model based on the body corporate model (Integrated Joint Board). This work has been overseen by a joint Steering Group with councillor and non-executive representatives supported by a Senior Officer's Group with executives from each organisation working in partnership to develop the options appraisal attached in appendix 1.

5.2 At its meeting on 13 November 2025 the Steering Group agreed

- Updated description of options for integration
- Assumptions of associated with employment:
  - initially these will remain unchanged, depending on the preferred option and requirements of the Public Bodies Joint Working act 2014
  - This does not preclude future changes to employment arrangements developed in partnership once a preferred option is agreed
- Some proposed changes to the strategic objectives with final approval agreed to be remitted to Joint Chief Executives Group
- Support for the proposed approach to weighting and scoring
- Agreement to a revised timeline taking into account NHS Board and Council governance requirements:
  - First stage initial appraisal to be completed by workstream leads by end December 2025
  - Steering Group workshop to consider outcomes from workstream activity and to conclude first stage appraisal by end January 2026
  - Reports on stage one outcomes to Health Board and Council by end of March 2026
- Agreement to remit approval of final indicators set associated with strategic objectives to Joint Chief Executives Group.

5.3 The Senior Officer Group completed the first stage of the Options Appraisal process towards the end of last year and the draft report was considered by the Joint Chief Executive's Group on 19 December 2025 with minor adjustments made prior to submitting to the Steering Group in January 2026.

5.4 On 16 January 2026, the Steering Group endorsed 2 Options to go forward to Phase 2 of the Review:

Option 0 – Status Quo; and
Option 3 – Body Corporate with all Lead Agency Functions to be considered.

Option 3 includes all prescribed functions; all current conjoined functions; and all current discretionary delegated functions. The detail of the services included is outlined on pages 19 – 21 of the report at Appendix 1.

In reaching this position, the Steering Group recognised that some aspects of Body Corporate option would be subject to further discussion in Phase 2, including the

range of services to be included or excluded. It was agreed that decisions could not be made ahead of the consultation and engagement phase so any recommendation to exclude certain functions would need to be highlighted as part of the consultation exercise with a rationale provided and feedback invited. This feedback would inform the development of final recommendations to be considered by the Steering Group and presented to the NHS Highland Board and Highland Council for approval.

It was also acknowledged that the Status Quo was not necessarily a 'no change' option, as there could be opportunities to improve the current arrangements sufficient that a change to a different model would not be required. Going forward these 2 options will be referred to as Option A and Option B to avoid conflation with previous options appraisal work.

5.5 On 23 February 2026 the Steering Group considered a Phase 2 Programme Plan (Appendix 2) and a Communications and Engagement Plan (Appendix 3) which takes into account the impact of the Scottish Parliament elections and the pre-election guidance for public sector bodies on public consultation.

The Steering Group considered that the timescale for bringing final recommendations to the Council and NHS Board by September 2026 was very ambitious. However, given the need to maintain momentum, there was a consensus to move forward with the timetable as proposed and to take mitigating action to revise it if the acknowledged risks became a reality.

It was agreed that the two options for the next phase would now be referenced as Option A – Lead Agency, and Option B - Body Corporate (all LAM functions).

6. Phase 1 Assessment – Detail

6.1.1 The senior officer's group has worked collaboratively to progress phase 1 of the options appraisal process with support from the independent external advisor. Appendix 1 contains the Phase 1 Outcome report that was considered by the Joint Chief Executive's Group on 19 December 2025 with minor adjustments made prior to submitting for the Steering Group.

The Senior Officer's Group preferred change option was Body Corporate Option 3 - All current Lead Agency Model functions. This model includes all prescribed functions; all current conjoined functions and all current discretionary delegated functions. (i.e. Option 1 + Option 2 + conjoined Children's and Justice Services).

In reaching this outcome the Senior Officer Group recognised that some aspects of this option would be subject to further discussion in the next stage of consultation, including aspects of the range of services to be included or excluded, but there was a strong endorsement of Option 3 as the preferred direction of travel.

6.1.2 **Outcome**

The full suite of scoring tables from each workstream group is included in the full report in **Appendix 1** with the consolidated scoring shown below showing agreement within the senior officers group on the preferred option for change as Option 3 – Body Corporate with all Lead Agency Model functions (discretionary and conjoined) included. The status quo, i.e. the Lead Agency, was the next highest scoring option. In addition, the professional judgement statements have been included in full in the report with a summary of the key themes below.

Collated scoring

	Option 0	Option 1	Option 2	Option 3
Aggregate scoring Max = 2000	896	615	740	1330
Average scoring Max =500	224	153.75	185	332.5

6.3 Emerging Themes

6.4 A number of key themes became apparent in the scoring discussions. Firstly, the importance of a structural response to assist in service moves towards integration was very evident. There was a recognition that formal organisational boundaries could be an impediment to this goal while acknowledging the commitment and work that would still be required within a fully integrated organisation. This was supported by an understanding of the importance to people who receive support that services should feel coherent and as simple as possible to navigate to help gain assistance.

6.5 It was felt that there was a strong potential for a fully integrated response to further develop early intervention and preventative services. It was also felt that it would assist in wider partnership working across communities particularly in more remote and rural areas and have a greater potential for developing all age responses.

6.6 There was some concern about the risk of smaller services having less prominence in a larger partnership but it was felt that this could be managed if suitable governance and assurance structures were put in place. There was also concern about further distancing education services from children's health and social work.

6.7 The scale of change and potential risks involved in a move to a fully integrated partnership incorporating all current LAM functions was acknowledged but this was potentially offset by the strong rationale behind the change. It was also recognised that some aspects of this option would be subject to further development, including for example the position of functions such as CAMHS/NDAS and early years support.

6.8 It was agreed that the next phase, which included stakeholder consultation and engagement, would allow further consideration of the details of those services for inclusion which might go beyond, or reduce, the functions that are currently included in the Lead Agency Model. Notwithstanding any such work, broadly speaking Option 3 represented the optimum option.

6.9 A number of strengths were noted within current model – Option 0 – although these were set against a range of limitations including the need to further develop and evolve both professional and corporate governance structures and how financial arrangements were managed. It was felt that these could not be easily changed without an element of structural alteration.

6.10 The two remaining options were felt to have a more limited potential for impact with Option 1 being seen as particularly problematic.

6.11 For all options, the continuing pressure on finance/budgets was seen to be a challenging factor and no option had a completely easy response to this. However, it was felt that factors such as clearer governance, coupled with an enhanced ability to make strategic decisions across all ages, along with development of preventative approaches, could contribute to a better response to some of the issues involved.

7. Timelines

7.1 Revised timelines have also been agreed by the Steering Group as follows:

- First phase initial appraisal to be undertaken by workstreams by end December 2025 (completed)
- Steering Group to consider outcomes from workstream activity and to conclude first stage appraisal by end January 2026 (completed)
- Reports on phase one outcomes to Health Board and Council by end of March 2026
- Phase two appraisal completed and reports to Board and Council by end September 2026.
- If decision to move to body corporate model then implementation plan with timescale agreed September 2026
- Full Implementation April 2027

With reference to the timelines for Phase 2, the impact of the Scottish Parliament elections and the pre-election guidance for public sector bodies on public consultation has been taken into account. A detailed communication and engagement plan is provided in **Appendix X.**

8. Communication and Engagement

8.1 The Engagement Plan sets out a number of engagement channels, as follows:

- Targeted engagement with service users
- In person public events
- Partner and stakeholder engagement
- Online engagement hub

The intention is that there will be further engagement undertaken with staff once the Council and Board have agreed the direction of travel.

8.2 Staffside engagement has progressed with trade union representation from the Council and NHS Highland and initial feedback is:

- NHS staffside have welcomed the opportunity to review the lead agency and highlighted the need to comply with NHS Scotland Staff Governance Standards and partnership working principles to develop and agree options in partnership

- Further detail on the potential changes to functions, e.g. any removal of functions from option 3, within the IJB model and the related employment changes has been requested by staffside to enable them to participate in partnership working in relation to a final decision

- It is not possible at this stage for staffside to score the options without further details and engagement. That engagement will take place during phase 2.

- A degree of caution and concern has been expressed regarding the potential for disruption, particularly if all aspects of the current Lead Agency Model are incorporated into a new Corporate Body, with potential resultant changes made to staff employment arrangements.

9. NDAS Investment

9.1 On 5 March 2026 the Council agreed in principle to support a proposal to invest £1.2M in tackling the NDAS waiting list in Highland and work with Glasgow University to develop a new assessment model to deliver long term improvement. It was agreed that this would be worked up into a more detailed proposal by officers and this is included in Appendix 4. It is not proposed that this piece of work is incorporated into the Models of Integration Review as NDAS is not a function within the Lead Agency Model and so would be outside the scope of the review. Instead, Members are asked to agree to remit the further development of the proposition and subsequent delivery of the project to the Person Centred Solutions Portfolio in the operational Delivery Plan.

10. Next Steps

10.1 Subject to the Council supporting the recommendations in this report:

- the next phase options appraisal will be progressed as outlined in **Appendices 2 and 3;** and
- The NDAS Review will be initiated at set out in **Appendix 4** and the work further developed by and remitted to the Person Centred Solutions Portfolio Board.

Designation: Assistant Chief Executive – People, The Highland Council

Date: 16 March 2026

Authors: Kate Lackie, Assistant Chief Executive – People, The Highland Council.

Appendices: Appendix 1 –
Appendix 2 –
Appendix 3 –
Appendix 4 -

Appendix

NHS Highland and the Highland Council

Consideration of future integrated health and social care models

Workstream appraisal scoring outcomes

Introduction

Following discussions in relation to the National Care Service in 2024 the Highland Council and NHS Highland agreed to consider future organisational arrangements for the delivery of health and social care.

A Models of Integration Steering Group (MISG) comprising of Health Board and Council members has been established to oversee this process. This group has considered the potential future models of health and social care arrangements and has asked that a formal options appraisal process is established to assist in determining future arrangements for Highland.

The appraisal process is formed of two stages. The first stage is the consideration of a long list of potential future structures to identify a preferred change option. Following this the second stage is a wider process of engagement and consultation with stakeholders in respect of either maintaining the current arrangements or moving to the preferred option for change.

Senior officers have undertaken an initial evaluation of the options as part of the first stage in the process and this paper collates the outcome of this. It recommends a preferred change option. This appraisal is scheduled to be considered further by the Steering Group with a view to confirming a preferred model that can be recommended to the Highland Council and the NHS Board for further consultation in terms of its potential as set against the current arrangements.

Methodology

To consider the potential models for change the Council and Health Board set up a Senior Officer Group which was supported by four substantive workstreams that would consider the key issues involved. These workstreams are:

- Clinical and care governance and professional assurance
- Corporate governance
- Finance & corporate resources
- Human resources

The appraisal process has involved scoring of the options by the workstreams against five critical success factors. This scoring is accompanied by a professional judgement statement.

The five critical success factors are:

- Strategic fit
- Financial case
- Outcomes/Performance case
- Management case
- Achievability/implementation risk

This work is underpinned by the identified change objectives outlined below. The objectives are linked to associated SMART measures to assist in monitoring success of any change (Appendix 2). These will be developed further as the appraisal process continues.

Objectives

1. That there is a greater range of locally based support, care and treatment provision available that helps people of all ages live longer, healthier and fulfilling lives.
2. That local arrangements maximise early intervention and prevention that can both improve quality of life and assist in easing pressures within key services
3. That when people need to come out of hospital there is a wide range of easily accessible support services that supports timely discharge.
4. Local arrangements have people at the heart of services, empower individuals and support personalised, community-based care
5. That services work well together to provide well-coordinated joined up care

To assist in meeting these goals the organisational changes will:

6. Help to develop services in a financially sustainable manner that manages resources effectively.
7. Implement an effective governance structure that promotes partnership working across services and communities, supports staff in assisting vulnerable people and helps them to manage risk and uncertainty within this.
8. Place organisations in a stronger position to respond to the wider health and social care challenges arising from inequity and equality in Highland.
9. Create opportunities to increase staffing capacity and sustainability in conjunction with local communities and partners.

Outline of options

The four identified options subject to appraisal along with initial comments are:

Option 0 - Retain the Lead Agency Model

This approach would obviously require the least organisational change. However, given the recognition of some of the limitations of the model it would require to be accompanied by a review of how governance arrangements are implemented. There has been some uncertainty expressed as to whether the potential changes needed would be easily achievable without some degree of organisational change.

Body Corporate Option 1 - Legal Minimum

All prescribed conjoined and delegated functions (i.e. Services to Adults as required by the 2014 Act) to be overseen by an Integrated joint Board . The detail of these services is contained within Appendix 2. As noted above however this would require consideration to be given to the governance of delegated children's services separately from an IJB. This would mean the disestablishment of the current integrated children's services with conjoined remaining with Highland council and delegated functions returning the health board.

Body Corporate Option 2 - All LAM delegated functions - Status Quo

All prescribed functions as in Option 1 and additional discretionary delegated functions i.e. Child Health. As with Option 1 this would also mean the disestablishment of the current integrated children's services. In this instance child health would become part of the responsibility of an IJB.

Body Corporate Option 3 - All LAM functions Status Quo

All prescribed functions; discretionary delegated functions *and* some or all of the discretionary conjoined i.e. Option 1 + Option 2 + conjoined Children's Services

This option would maintain children's services within the same organisational structure, but it represents significant organisational change with a higher associated risk of potential disruption.

A full list of services affected in contained within Appendix 3

Workstream scoring outcomes

(i) *Professional leads – scoring and judgement statement*

	Option 0	Option 1	Option 2	Option 3

Critical success factors	Weight	Score	Weighted Score	Score	Weighted score	Score	Weighted score	Score	Weighted Score
Strategic fit	25	3	75	1	25	1	25	4	100
Financial case	25	2	50	2	50	2	50	3	75
Performance case	25	3	75	2	25	1	25	3	75
Management case	15	3	45	2	30	3	45	3	45
Achievability/risk	10	3	30	2	20	2	20	3	30
Total weighted score	**100** Max =500		**275**		**150**		**165**		**325**

Professional judgement statement

Option 3 scored the highest of all the options. It was felt that its structure of including the full range of services within a HSCP/IJB most closely aligned with a vision of developing a fully integrated response to people in need. It was felt to be most beneficial in developing all age support arrangements and being able to help address the multiplicity of issues that may affect families. As part of this it would assist with wider responses to inequities and inequalities.

It was acknowledged that some elements of service such as CAMHS and NDAS remained outwith current scope of integration and it was felt that their position could usefully be considered further as and when new arrangements become established.

It was felt that this option was the least disruptive to integrated arrangements.

In respect of finance it was recognised that there will continue to be challenges of adequate resourcing but that this structure may help with potential cost shunting problems and may assist in a joined up shift towards preventative approaches which may reduce costs on high areas of pressure across the wider system.

This options preserves and extends in instances integrated arrangements and this was felt to be helpful preserving beneficial outcomes for people through joined up responses.

There was some concern expressed that this option created further distance between children's health/social work services and Education. These close links were felt to be very important to maintain and systems to preserve these would need to be clearly reinforced. Links to other social determinants of wellbeing such as housing, employment and welfare support were also felt to be important and these similarly would need to be preserved.

The option would potentially streamline and rationalise some governance issues although care would be needed to ensure that all services/professions received appropriate oversight and support. This was felt to be particularly important for the smaller services such as children's health, children's social work and justice.

In terms of achievability it was recognised this option involved change of organisation location for a significant number of staff but as noted employment status would not be affected. As a strength this option provided a clear rationale for the new arrangements.

The current model Option 0 received the next highest score. This took account of the strength of elements of current integration arrangements particularly regarding children's services and how this reflected the GIRFEC agenda. The range of recent positive developments within adult health and care were also noted.

In respect of finance it was felt that there were some significant issues that remain unresolved within this model and that these continued to affect the ability of services to respond to some key areas of need. Some of the issues with the wider impact of Agenda for Change were also recognised.

Regarding performance there was acknowledgement of how well some services were currently performing and that this was supported by effective performance management systems that were visible and used well by staff. However the organisational boundary between adult and children's services was seen to be potentially difficult in helping to develop joined up whole age responses with transitions given as a particular example.

It was felt that this model had some significant structural issues with governance and that these would not be especially easy to resolve without structural change to support new approaches. Strategic planning was seen as a strength in some areas and under further development in others.

In respect of implementation it was accepted that this option involved the least structural change but there was a view that some of the other changes required within this such as in governance revision may be difficult to achieve without an element of structural change to support it.

Options 1 and 2 scored at similar levels. Both were felt to fall short of supporting a vision for integrated response to communities. Both involved a degree of disaggregation of current integrated arrangements and this was seen as a backward step. In respect of finance it was felt that they may clarify some monitoring and accountability requirements but may create some tensions of funding between relative priorities.

It was unclear how these options would support and enhance greater preventative approaches and impact on wider performance was felt to be uncertain.

It was recognised that all options were evident across Scotland and were feasible but that the history of services in Highland and especially the long standing commitment to integration was an important factor to take into account.

(ii) Corporate Governance – scoring and judgement statement

	Option 0	Option 1	Option 2	Option 3

Critical success factors	Weight	Score 1-5	Weighted Score	Score	Weighted score	Score	Weighted score	Score	Weighted Score
Strategic fit	25	2	50	1	25	1	25	3	75
Financial case	25	2	50	3	75	3	75	4	100
Performance case	25	2	50	1	25	1	25	2	50
Management case	15	2	30	3	45	1	15	4	60
Achievability/risk	10	4	40	2	20	1	10	3	30
	100								
Total weighted score	Max = 500		**220**		**190**		**150**		**315**

Professional judgement statement

Option 0

This retains the status quo and relatively complex arrangements for governance where there are two committees sitting below the JMC: one with responsibilities for children's services and one with responsibilities for adult services. In contrast to an IJB model where the IJB has responsibilities for all services delegated to it the current model does not lend itself well to a holistic view across health and care services and integrating across adult and children's services. This is reflected in two separate strategic plans for adults and children's services in contrast to what might be a single strategic plan for an IJB model.

The current model of integration also separates financial matters into two areas and offers limited opportunities to take a holistic view of resources as the JMC does not hold the budget.

There are opportunities to improve performance through the current model of integration through greater collaboration, however these may be limited by the separation of governance,

strategic planning and financial planning the current model creates as outlined above. In terms of service delivery it may be particularly relevant when considering the transitions between children's and adult services and inter-dependencies that need to be considered when making strategic decisions of the whole of health and social care and the financial implications.

Similarly there are however opportunities to improve operational arrangements and professional governance within the current model, however these may be similarly limited.

This involves minimal change so highly achievable but as outlined offers limited opportunities for improvement.

Option 1

This option would result in integration focussing solely on adult services and the governance arrangements would be simpler in the context of the IJB having sole responsibility for adult services. There would be a single joint strategic plan for integrated services in the context of the public bodies joint working act 2014, however this would obviously be limited to adult services with children's services still required to produce a children's services plan through the community planning partnership arrangements.

So it may be that this option creates simplicity for adult services but continues with complexity for children's services which will be particularly challenging in terms of a move to such a model given that children services are currently integrated within the lead agency model. It also does not enable integration of strategic planning across adult and children's services.

In that context there may be opportunities to improve strategic planning for adult services and financial accountability through the new arrangements that flow from an IJB model. It would not however offer opportunities for a holistic view across childrens and adult services. There would also be an element of unpicking in terms of the current arrangements for children.

This option does offer some opportunities for greater clarity around professional governance and management of adult services. However, this model would lead to dis-integration from a management perspective of children's services which is likely to impact on performance from a children's services perspective compared to other options.

This option would involve significant changes which are achievable but come with risk of disruption.

Option 2

This option would be a mix of focus for the IJB with some of children's service (health functions) being included in its remit and all of adult services. This would potentially offer opportunities to integrate governance, strategic planning and associated financial implications across adult and children's services for the child health elements. This could be considered a step towards a holistic approach but is likely to significantly increase complexity of governance for children's services with some services remaining within council governance and management arrangements. This would essentially dis-integrate children's services and provide only limited opportunities related to integrate some aspects of children's services with adult services. Similar comments would be made as those set out in terms of Option 1

In that context there may be opportunities to improve strategic planning for adult services and financial accountability through the new arrangements that flow from an IJB model. This needs

to be considered alongside the negative impact on current integration arrangements for children's services.

Performance and management arrangements would be simplified for adult services and potentially improved in relation to professional governance. However, professional governance, management and performance of children's services is likely to be negatively impacted.

This model is achievable but probably not practical in relation to a fragmented approach to integration of children's services. It also comes with significant risk of disruption to children's services.

Option 3

If all conjoined and delegated functions are included in the IJB model then this would move strategic planning, performance and financial management along with associated governance into a single integrated arrangement for adults and children's services. This offers opportunities to streamline governance and improve strategic planning across health and care service to improve outcomes in a holistic way.

The requirement for children's services plan would remain but could be integrated/aligned with a single joint strategic plan overseen by the IJB. This is particularly relevant when considering the transitions between children's and adult services and inter-dependencies that need to be considered when making strategic decisions for the whole of health and social care and the financial implications.

This model offers opportunities for greater clarity and transparency of financial accountability by bringing children's and adult services together andthe new arrangements that flow from an IJB model. There would also be an opportunity for more direct financial management.

This model brings clinical and care governance into one place with the governance structure, i.e. under the IJB. Professional leadership and accountability would be clearer in this integrated model

The model would bring management arrangements together under one umbrella for adults and children's services, although one might consider this to be possible under the existing arrangements. This would enable greater consideration of inter-dependencies between adults and children's services and improve performance, particularly in transition areas.

This option is achievable and although there would be some disruption through the transition from the current model it is comparatively low risk if all conjoined and delegated functions are included in the IJB model. Any such change would however require a change to the integration scheme which might take time to negotiate in terms of a move from the current position and associated challenges.

(iii) *Finance workstream - scoring and judgement statement*

	Option 0	Option 1	Option 2	Option 3

Critical success factors	Weight	Score	Weighted Score	Score	Weighted score	Score	Weighted score	Score	Weighted Score
Strategic fit	25	2	50	1	25	2	50	4	100
Financial case	25	2	50	1	25	2	50	3	75
Performance case	25	2	50	2	50	2	50	3	75
Management case	15	1	15	2	30	2	30	3	45
Achievability/risk	10	4	40	2	20	2	20	3	30
Total weighted score	**100** Max =500		**205**		**150**		**200**		**325**

Professional judgement statement

From the scoring exercise Option 3 emerged with the highest score. In respect of strategic fit it was felt that this option most closely aligned with the overall partnership vision of having fully integrated health and social care provision. To support this there was discussion regarding the importance of future arrangements supporting whole family and whole age response to need. This option was felt to have the potential to minimise organisational barriers between services and to have a greater opportunity to produce a whole system type approach.

A possible advantage of this type of fully integrated arrangements was its potential to impact on cost demands and help ease pressure in high cost areas. It was felt that it would also help simplify financial management and monitoring structures. There was a caveat in the financial case regarding potential employment costs arising from this change. This may warrant further more detailed consideration at some point, particularly in relation to the social work service.

It was felt that this option simplified potential arrangements for both corporate and professional governance and helped to clarify the respective responsibilities of the organisations involved taking account of the importance of directions in the governance arrangements for IJB model.

It was recognised that this option presented significant change for staff. However it was also felt that the clear rationale behind the option helped in presenting a "sellable" explanation to staff and wider partners and communities easing the risks in respect of achievability.

Options 0 and 2 scored at similar levels albeit for slightly different reasons. Option 0 was clearly seen as having the highest achievability factor although it was noted that within this option some change would be required to address the some of the difficulties within current corporate and professional governance arrangements. The potential difficulties of this change within existing arrangements was noted and this was the rationale in the low scoring in the management case for this option. Difficulties in current levels of performance in key areas were also recognised and this contributed the scoring in respect of both performance and strategic fit.

Option 2 was recognised as having the potential to resolve many of the current governance issues with child health forming part of a unified community health arrangement within an IJB. This was seen to benefit a greater integrated response to supporting families and vulnerable adults from a health perspective. The major deficit for this option was in the desegregation of integrated children's services and the potential impact this may have on performance in relation to supporting vulnerable families and the further development of preventative responses. From a financial perspective this option may clarify a number of governance and monitoring arrangements but there was uncertainty about its impact in longer term service costs.

Option 1 was clearly seen as the least favoured option. It was felt that this option had a number of distinct disadvantages. This included the disaggregation of integrated children's services and the separation of child health from other community health provision. Impact on performance was felt to be uncertain however there was concern expressed regarding the creation of organisational barriers to integrated support.

Lastly it was recognised that examples of each of the options for change were currently in existence around Scotland and that each of these could be seen to be viable. A key element in decision making was the recognition that Highland was not starting from a blank canvas as partnerships were in 2015 and that any potential change had to take account of the issues involved in current arrangements within Highland.

(iv) HR workstream – scoring and judgement statement

	Option 0		Option 1		Option 2		Option 3	
Critical success factors	Score	Weighted Score	Score	Weighted score	Score	Weighted score	Score	Weighted Score

Critical success factors	Weight	Score	Weighted Score	Score	Weighted score	Score	Weighted score	Score	Weighted Score
Strategic fit	25	2	50	1	25	2	50	4	100
Financial case	25	1	25	1	25	2	50	4	100
Performance case	25	2	50	1	25	2	50	3	75
Management case	15	2	30	2	30	3	45	4	60
Achievability/risk	10	4	40	2	20	3	30	3	30
Total weighted score	**100** **Max =500**		**195**		**125**		**225**		**365**

Professional judgement statement

From the scoring exercise Option 3 emerged with the highest score. In respect of strategic fit it was felt that this option most closely aligned with the overall partnership vision of having fully integrated health and social care provision. It was felt that this option created a good opportunity for developing a collective staffing ethos across the full range of partnership activity. There was some discussion regarding the terms and conditions differential for two sets of social workers within the one organisation. It was felt that this was a relatively small grouping of staff and that the issues involved may not be substantial. However this may benefit from being addressed further at an early stage.

It was recognised that this option benefited from a structural response to whole family/whole age need. This option was felt to have the potential to minimise organisational barriers between services and to have a greater opportunity to produce a whole system type approach.

A possible advantage of this type of fully integrated arrangements was its potential to impact on the development of preventative approaches helping to address pressure in high cost areas.

It was felt that this option gave an opportunity to simplify arrangements for both corporate and professional governance and helped to clarify the respective responsibilities of the organisations involved.

It was recognised that this option presented significant change for the greater number of staff. However, it was also felt that this option had a clear and relatively strong rationale, and this would assist in any further discussion within the next phase of the process. This was particularly noted around the concept of integration reflecting its substantial history within Highland.

Option 2 was the next highest score. This reflected its relatively closeness to the strategic vision of integrated provision with in this instance child health joining other community health provision alongside adult social care within an IJB. The disaggregation of integrated children's services was felt to be a possible concern both in strategic planning areas and in provision of joined up support to families. The inclusion of child health however resolved some of the professional governance issues associated with Option 0 in creating more unified all age community health set of provision with governance of these areas being able to be consolidated within one organisation.

From a financial perspective this option may clarify a number of governance and monitoring arrangements but there was uncertainty about its impact in longer term service costs.

Option 0 was clearly seen as having the highest achievability factor although it was noted that within this option some change would be required to address the some of the difficulties within current corporate and professional governance arrangements. The potential difficulties of this change taking place within existing arrangements was noted and this was the rationale in the low scoring in the management case for this option. Difficulties in current levels of performance in key areas were also recognised and this contributed the scoring in respect of both performance and strategic fit. The current issues in relation to financial monitoring and levels of need were also a factor in the low scoring in the financial case.

Option 1 was clearly seen as the least favoured option. It was felt that this option had a number of distinct disadvantages. This included the disaggregation of integrated children's services and the separation of child health from other community health provision. Impact on performance was felt to be uncertain however there was concern expressed regarding the creation of organisational barriers to integrated support.

Collated scoring

	Option 0	Option 1	Option 2	Option 3
Aggregate scoring Max = 2000	896	615	740	1330
Average scoring Max =500	224	153.75	185	332.5

Key themes

A number of key themes became apparent in the scoring discussions. Firstly the importance of a structural response to assist in service moves towards integration was very evident. There was a recognition that formal organisational boundaries could be an impediment to this goal while acknowledging the commitment and work that would still be required within a fully integrated organisation. This was supported by an understanding of the importance to people who receive support that services should feel coherent and as simple as possible to navigate to help gain assistance.

It was felt that there was a strong potential for a fully integrated response to further develop early intervention and preventative services. It was also felt that it would assist in wider partnership working across communities particularly in more remote and rural areas and have a greater potential for developing all age responses.

There was some concern about the risk of smaller services having less prominence in a larger partnership but it was felt that this could be managed if suitable governance structures were put in place. There was also concern about further distancing education services from children's health and social work.

The scale of change in a move to a fully integrated partnership was acknowledged but again this was potentially offset by the strong rationale behind this arrangement.

It was also recognised that some aspects of this option would be subject to further discussion including for example the position of functions such as CAMHS/NDAS and early years support but there was a strong endorsement of it as the preferred direction of travel.

It was agreed that the next stage would allow further consideration of the details of those services for inclusion which might go beyond, or reduce, those services which are currently included in the lead agency model. Notwithstanding any such work broadly speaking option 3 represented the optimum option for taking forward that work.

A number of strengths were noted within current model – Option 0 – although these were set against a range of limitations including the need to further develop and evolve both professional and corporate governance structures and how financial

arrangements were managed. It was felt that these could not be easily changed without an element of structure alteration.

The two remaining options were felt to have a more limited potential for impact with Option 1 being seen as particularly problematic.

For all options the continuing pressure on finance was seen to be a challenging factor and no option had a completely easy response to this. However it was felt that factors such as clearer governance, coupled with an enhanced ability to make strategic decisions across all ages, along with development of preventative approaches could contribute to a better response to some of the issues involved.

Appendix – Workstream members

Professional leadership

Chief Officer Health and Social Care *H&SCP*

Director of Public Health *NHS Highland*

Executive Chief Officer Health and Social Care/ CSWO *Highland Council*

Head of Child Health *Highland Council*

Chief Nursing Officer *NHS Highland*

Head of Performance and Improvement *Highland Council*

Corporate Governance

Executive Director of People and Culture *NHS Highland*

Chief Officer Integrated People Services *Highland Council*

Head of Corporate Governance *NHS Highland*

Finance

Chief Officer Corporate Finance *Highland Council*

Executive Director of Finance *NHS Highland*

Human Resources

Head of People Planning and Development *NHS Highland*

Head of People *Highland Council*

Appendix 2 – Sample Performance Indicators Aligned with Strategic Objectives

Sample Performance Indicator	Sample Strategic Objective Alignment
Reduction in delayed hospital discharges	Objective 3) That when people need to come out of hospital there is a wide range of easily accessible support services that supports timely discharge.
Care at home capacity (hours available per week)	Objective 1) That there is a greater range of locally based support, care and treatment available that helps people of all ages live longer, healthier and fulfilling lives.
Uptake of Self-Directed Support Option 1	Objective 4)Local arrangements empower individuals and support personalised, community-based care
Recruitment and retention rates in care at home sector	Objective 6) Help to develop services in a financially sustainable manner that manages resources effectively Objective 9) Create opportunities to increase staffing capacity and sustainability in conjunction with local communities and partners.
Use of Independent Service Funds (ISFs)	Objective 6) Help to develop services in a financially sustainable manner that manages resources effectively. Objective 9) Creates opportunities to increase staffing capacity and sustainability in conjunction with local communities and partners.
Technology Enabled Care (TEC) deployment	Objective 1) That there is a greater range of locally based support, care and treatment available that helps people of all ages live longer, healthier and fulfilling lives. Objective 2) Local arrangements maximise early intervention and prevention that can both improve quality of life and assist in easing pressures within key services
Percentage of adults supported at home who agreed they live independently	4)Local arrangements empower individuals and support personalised, community-based care 5) That services work well together to provide well-coordinated joined up care
Percentage of adults who feel health and social care services are well coordinated	5) That services work well together to provide well-coordinated joined up care

	7)Implement an effective governance structure that promotes partnership working supports staff in assisting vulnerable people and helps them to manage risk and uncertainty within this.
Percentage of adults receiving care who rate it as excellent or good	5) That services work well together to provide well-coordinated joined up care 7) Implement an effective governance structure that promotes partnership working supports staff in assisting vulnerable people and helps them to manage risk and uncertainty within this.
Percentage of people with positive experience of GP care	1) That there is a greater range of locally based support, care and treatment available that helps people of all ages live longer, healthier and fulfilling lives. 5) That services work well together to provide well-coordinated joined up care 7)Implement an effective governance structure that promotes partnership working supports staff in assisting vulnerable people and helps them to manage risk and uncertainty within this.
CAMHS waiting times and service transformation	1)That there is a greater range of locally based support, care and treatment available that helps people of all ages live longer, healthier and fulfilling lives. 2)That arrangements maximise early intervention and prevention that can both improve quality of life and assist in easing pressures within key services
Implementation of the Highland Solihull Approach	1) That there is a greater range of locally based support, care and treatment available that helps people of all ages live longer, healthier and fulfilling lives 2)Local arrangements maximise early intervention and prevention that can both improve quality of life and assist in easing pressures within key services 4)Local arrangements empower individuals and support personalised, community-based care
Percentage of children with no developmental concerns at 27–30 month review	2)Local arrangements maximise early intervention and prevention that can both improve quality of life and assist in easing pressures within key services

Appendix – full list of services to be included

1) Services included as a minimum (prescribed services within legislation)

(i) Acute hospital based services

(a) accident and emergency services provided in a hospital;

(b) inpatient hospital services relating to the following branches of medicine—

(i)general medicine;

(ii)geriatric medicine;

(iii)rehabilitation medicine;

(iv)respiratory medicine; and

(v)psychiatry of learning disability,

(c) palliative care services provided in a hospital;

(d) inpatient hospital services provided by general medical practitioners;

(e) services provided in a hospital in relation to an addiction or dependence on any substance;

(f) mental health services provided in a hospital, except secure forensic mental health services.

(ii) Community & Hospital Services

(a) district nursing services;

(b) services provided outwith a hospital in relation to an addiction or dependence on any substance;

(c) services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital;

(d) the public dental service;

(e) primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978

(f) general dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978

(g) ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978;

(h) pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978;

(i) services providing primary medical services to patients during the out-of-hours period;

(j) services provided outwith a hospital in relation to geriatric medicine;

(k) palliative care services provided outwith a hospital;

(l) community learning disability services;

(m) mental health services provided outwith a hospital;

(n) continence services provided outwith a hospital;

(o) kidney dialysis services provided outwith a hospital;

(p) services provided by health professionals that aim to promote public health.

(iii) Social work services

These services are exercisable in relation to persons of at least 18 years of age:

a) Social work services for adults and older people
b) Services and support for adults with physical disabilities and learning disabilities
c) Mental health services
d) Drug and alcohol services
e) Adult protection and domestic abuse
f) Carers support services
g) Community care assessment teams
h) Support services
i) Care home services
j) Adult placement services
k) Health improvement services
l) Aspects of housing support, including aids and adaptations
m) Day services
n) Local area co-ordination
o) Respite provision
p) Occupational therapy services
q) Re-ablement services, equipment and telecare

2) Child health services (discretionary within legislation)

a) Speech and Language Therapy
b) Physiotherapy
c) Occupational Therapy
d) Dietetics
e) Primary Mental Health Workers
f) Public Health Nursing - Health Visiting
g) Public Health Nursing – School Nursing
h) Learning Disability Nurse
i) Child Protection Advisors
j) Looked After Children (as per NHS (Scotland) Act 1978
k) Named Persons Childs Plans
l) Local Carer Strategy (as per S12 Carers (Scotland) Act 2016

3) Children's social work services (discretionary within legislation)

a) Children and families social work teams
b) Residential care workers
c) Fostering/Adoption services
d) Throughcare and aftercare
e) Social work out of hours service
f) Public health improvement
g) Early years and pre school visiting
h) Youth Action Team
i) Additional support for learning

4) Justice social work services (discretionary within legislation)

Appendix

NHS Highland and the Highland Council

Consideration of future integrated health and social care models

Outline Second Phase 2 Programme Plan

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Introduction

The Highland Council and NHS Highland have been considering how best to deliver health and social care. Currently Highland is unique in that it follows a “lead agency” approach in which integrated children’s services are managed by the Highland Council and integrated adult health and social care is managed by NHS Highland.

All other partnerships in Scotland follow a different arrangement in which a single Health and Social Care Partnership manage a combination of health and social care, overseen by an Integration Joint Board.

As background to any proposed change the requirement for Highland to move to an Integration Joint Board (IJB) structure was originally contained in the National Care Service Bill and although this was removed from the bill during parliamentary process partners in Highland agreed to continue to consider the value of changing to an IJB type of arrangement.

The Council and NHS Highland are keen to make sure that any decision about future arrangements is fully informed by the views of people who currently receive any form of care, support or treatment, by residents in local communities and by staff and partner organisations.

To help in this the Council and NHS Highland have done some preparatory work looking at what has worked well in other areas across Scotland and would like to consult more fully on a possible way forward.

This consultation will focus on whether to maintain current arrangements or to move to an IJB type structure within which a Health and Social Care Partnership would oversee health and social care for both adults and children.

To help in this discussion a preferred version of an IJB configuration has been identified. This new arrangement would combine the integrated elements of adult health and social care currently managed by the Health Board along with the children’s health and social care provision including children & families and justice social work services that are currently managed by the Council. A full list of services is outlined within an Appendix attached to this document.

This would create a single organisation that would oversee integrated health and social care for people of all ages in Highland and bring provision closer to the type of arrangements that are in place in different partnerships across Scotland.

As in the rest of Scotland the arrangements would not include elements of health care such as some acute provision and major hospital services.

During the consultation and engagement process the Council and NHS Highland would want to explore the issues involved in more detail with everyone who may be affected by any potential change. This includes details of the scope of services involved in any change.

The work undertaken so far has been assisted by a number of officer led workstreams overseen by a steering group consisting of Council and Health Board members . This framework outlines the scope of activity within these groupings and how these will be taken forward alongside proposals for more detailed engagement with staff and communities

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Phase 2 Activity Framework

The framework notes work to be undertaken across three broad areas of activity along with initial timescales involved in these.

These three broad areas of activity are:

- Workstream developments
- Staffside engagement programme
- Community and partner engagement programme

It is recognised that elements of this activity are interdependent and progress in some areas will rely on decisions within complementary work.

1) Workstream development tasks

Initial developmental work has been undertaken by the workstreams involved and this will now be taken forward alongside wider consultation to consider the issues involved in more detail.

The workstreams involved are:

(i) Clinical and Care Governance/Professional Assurance

Clinical governance

This workstream will develop the new model of clinical and care governance aligned with an IJB model of governance. This will identify the main changes required to establish a joint governance model as utilised in other IJB arrangements. This will enable THC and NHSH accountable officers to work jointly to assure the IJB and both organisations on the clinical and care governance aspects of integrated health and social care services. It will also offer a professional perspective in relation to the scope of services to be included in an IJB model.

Professional Assurance

The THC and NHSH accountable officers for clinical and care governance also have an important role in ensuring appropriate professional assurance arrangements are in place within a new model of integration.

This includes but is not limited to:

- The professional leadership and accountability arrangements to oversee and supervise clinical and care staff
- Training, education and competency assessment of clinical and care staff
- Compliance with professional standards and regulatory/registration requirements

This is closely linked with clinical and care governance, focussing more on the professional management arrangements of service delivery and the staff delivered health and social care.

The workstream members for both activities include:

- Chief Social Work Officer
- Director of Public Health

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- Medical Director
- Director of Nursing, Midwifery and Allied Health Professionals (NMAHP)
- Chief Officer H&SCP
- Strategic Lead Child Health

Workstream leads:

Chief Social Work Officer
Director of Nursing, Midwifery and Allied Health Professionals

Key activities/deliverables:

- Develop joint clinical and care governance model
- Identify key changes required to implement new clinical and care governance model
- Develop options for professional leadership and accountability within IJB model
- Identify key changes required to implement model

(ii) Corporate Governance

The overall governance model will require changes within any move to an IJB model. In particular consideration would need to be given to areas such as: finance; staff governance; strategic and locality planning; commissioning; performance oversight; audit and risk.

It is also recognised that if the outcome is to maintain a variation of a lead agency approach, then this may also require a number of changes to governance arrangements to ensure effective and efficient delivery of services.

Workstream leads:

Executive Director with responsibility for corporate governance (NHS Highland Director of People and Culture)
Chief Officer - Integrated People Services (The Highland Council)

Key activities/deliverables:

- Development of new governance structure and arrangements
- Development of new integration scheme drawing on other workstreams including clinical and care governance and finance
- Identify key changes required to implement new governance model

(iii) Finance

Finance

This workstream will consider the financial implications of moving to an IJB model including:

- Identification and formation of budgets to be transferred resulting from changes to hosting and delivery of services
- Financial requirements to support a change from the current model to an IJB model

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• Budget setting/monitoring arrangements including responding to in year variances/end of year reconciliation
• The financial aspects of the scheme of integration

Workstream leads:

Director of finance – NHS Highland
Director of finance – The Highland Council

Key activities/deliverables:

• Outline briefing on key financial requirements and implications to implement an IJB model
• Draft financial chapter/section of new integration scheme.

Corporate resources

This workstream also leads on consideration of corporate resource issues. This involves addressing any issues in respect of corporate resources including:

- Resources and support to be provided by each partner body for the functions it delivers under direction from the IJB
- Joint or shared resource aligned to the IJB and the new HSCP

This covers functions such as:

- Strategic Planning and Commissioning
- Procurement
- Finance support
- Business support
- Capital asset support
- People services

Key activities/deliverables:

• High level options for provision of corporate services
• Key changes required to implement these options

(iv) Employment

A key task in this activity will be to evaluate options for employment arrangements, working in partnership between THC and NHSH and with staffside colleagues.

An IJB model has consistent employment arrangements across Scotland where the local authority employs staff associated with social care and the NHS employs staff associated with health care. It is acknowledged that Highland is starting from a different point from other partnership areas and at this stage no decisions in respect of employment arrangements have been made.

Workstream leads:

Deputy Director of People – NHS Highland
Head of People – The Highland Council

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Key activities/deliverables:

• Develop options for new models of employment for an IJB model for staff currently employed by THC and NHSH within the lead agency model
• Identify key changes required and develop the framework for agreeing and implementing organisational change between the two employers

(v) Engagement and Consultation

The development of a new model of integration and consideration of all the aspects of this as outlined in the workstreams above will require engagement through a variety of mechanisms.

Key stakeholder groups to be involved are:

• People with lived experience
• Service providers
• Staff
• Professional groups

An overall communications and engagement strategy has been developed for this programme and it is anticipated that leads will be identified at the appropriate time to take forwards engagement activity with stakeholder groups.

Workstream leads:

Chief Officer – Human Resources and Communications (THC)
Head of Communications and Engagement (NHSH)

Key activities/deliverables:

• Communications and engagement strategy

2) Staffside engagement programme

A detailed programme of consultation and engagement with key staff groups and representative organisations is being drawn up. This will inform the activity of the workstreams and be informed by emerging proposals. The discussion in these engagement processes will include consideration of service configurations and include managerial input to provide a fully encompassing perspective.

It was recognised that staff engagement should begin in advance of any wider community engagement and that this phase of work would involve consideration of the scope of integration. This would involve widening participation beyond the existing groups to include relevant subject matter specialists, to ensure that the implications, benefits and risks of including or excluding individual functions were properly understood.

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3) Communities and partner engagement programme

To support and inform the activity of the workstreams a detailed participation and engagement programme for people with lived experience, communities and partner organisations has been drawn up. This details a cross sectional mixed method approach of and engagement utilising in person and online techniques.

4) Initial programme timetable

Activity	**Outline Timings**
Event material to be designed and produced	Feb/March
Pre Council /Board staff engagement	March
Highland Council Meeting	Thursday 26th March
NHS Highland Board Meeting	Tuesday 31st March
Continuing staff engagement	April onwards
Social media ad campaign to go live promoting events	Wednesday 8th April
Start public engagement across 9 localities	Friday 8th May
Conclude public engagement	Friday 10th July (8 weeks)
Analysis of results & report development	Friday 14th August (5 weeks)
Consideration by Senior Officer Group/Steering Group	August/September
Highland Council Board Meeting	Thursday 17th September
NHS Highland Board Meeting	Tuesday 29th September

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5 Next steps

Work is currently underway as part of preparation for the next stage of engagement. This work includes:

- Further consideration of the scope of integration with particular reference to services that would continue to have a close interface with functions that remain in the Council or Health Board. This may include for example services such as early years support and additional support for learning.

- Details of the methodology to be used in the engagement and options appraisal for both staff and community groups/ people with lived experience.

- Coordination of activity across the workstreams

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Appendix - List of services to be included

1) Services included as a minimum (prescribed services within legislation)

(i) Acute hospital based services

(a) accident and emergency services provided in a hospital;
(b) inpatient hospital services relating to the following branches of medicine—
(i)general medicine;
(ii)geriatric medicine;
(iii)rehabilitation medicine;
(iv)respiratory medicine; and
(v)psychiatry of learning disability,
(c) palliative care services provided in a hospital;
(d) inpatient hospital services provided by general medical practitioners;
(e) services provided in a hospital in relation to an addiction or dependence on any substance;
(f) mental health services provided in a hospital, except secure forensic mental health services.

(ii) Community & Hospital Services

(a) district nursing services;
(b) services provided outwith a hospital in relation to an addiction or dependence on any substance;
(c) services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital;
(d) the public dental service;
(e) primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978
(f) general dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978
(g) ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978;
(h) pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978;
(i) services providing primary medical services to patients during the out-of-hours period;
(j) services provided outwith a hospital in relation to geriatric medicine;
(k) palliative care services provided outwith a hospital;
(l) community learning disability services;
(m) mental health services provided outwith a hospital;
(n) continence services provided outwith a hospital;
(o) kidney dialysis services provided outwith a hospital;
(p) services provided by health professionals that aim to promote public health.

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(iii) Social work services

These services are exercisable in relation to persons of at least 18 years of age:
a) Social work services for adults and older people
b) Services and support for adults with physical disabilities and learning disabilities
c) Mental health services
d) Drug and alcohol services
e) Adult protection and domestic abuse
f) Carers support services
g) Community care assessment teams
h) Support services
i) Care home services
j) Adult placement services
k) Health improvement services
l) Aspects of housing support, including aids and adaptations
m) Day services
n) Local area co-ordination
o) Respite provision
p) Occupational therapy services
q) Re-ablement services, equipment and telecare

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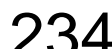

2) Child health services (discretionary within legislation)

a) Speech and Language Therapy
b) Physiotherapy
c) Occupational Therapy
d) Dietetics
e) Primary Mental Health Workers
f) Public Health Nursing - Health Visiting
g) Public Health Nursing – School Nursing
h) Learning Disability Nurse
i) Child Protection Advisors
j) Looked After Children (as per NHS (Scotland) Act 1978
k) Named Persons Childs Plans
l) Local Carer Strategy (as per S12 Carers (Scotland) Act 2016

3) Children's social work services (discretionary within legislation)
a) Children and families social work teams
b) Residential care workers
c) Fostering/Adoption services
d) Throughcare and aftercare
e) Social work out of hours service
f) Public health improvement
g) Early years and pre school visiting
h) Youth Action Team
i) Additional support for learning

4) Justice social work services (discretionary within legislation)

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Models of Integration

Community Engagement Overview

Methodology and Key Messaging

23 February 2026

1. EXECUTIVE SUMMARY

This document outlines the comprehensive approach to engaging Highland communities in the Models of Integration review. Following completion of staff engagement across both NHS Highland and The Highland Council, a public engagement programme will be undertaken to gather community views on two governance models:

- **Current Lead Agency Model** (with improvements)
- **Option 2: Integration Joint Board (IJB) Model** (preferred option identified through internal stakeholder scoring)

The engagement approach recognises that staff engagement should take precedence and commence immediately. Staff views will be incorporated through partnership working with both staff side groups and community engagement messaging will be further refined based on feedback from staff side and wider workforce activity. This ensures that messaging is appropriately nuanced to address the distinct needs and concerns of both internal and external stakeholders before broader community engagement begins in May 2026.

The community engagement will focus on understanding what matters most to communities when services are organised, what information they need to participate meaningfully, and their views on the governance models under consideration.

2. ENGAGEMENT OBJECTIVES

Primary Objectives

1. Inform: Ensure communities understand why the review is happening, what the current model is, and what Option 3 (IJB model) entails
2. Listen: Gather community perspectives on what matters most in how health and social care services are organised
3. Explore: Understand what information communities need to feel informed and able to contribute meaningfully
4. Include: Ensure rural, remote, and urban communities across Highland can participate
5. Comply: Meet statutory duties under NHS (Scotland) Act 1978, Community Empowerment (Scotland) Act 2014, and Public Bodies (Joint Working) (Scotland) Act 2014

Key Questions for Communities

- What works well in current arrangements?
- What could be improved?
- Which model offers the best chance for improved accountability, planning, and outcomes?
- What matters most when services are organised (clarity, communication, local decision-making, efficiency)?
- What additional information is needed to contribute meaningfully?

3. STAFF THEN COMMUNITY ENGAGEMENT

3.1 Rationale for Staff-First Approach

Staff engagement will lead and inform the community engagement programme for several critical reasons:

- **Staff are directly affected:** Any governance changes will impact staff roles, reporting lines, and working arrangements. It is essential that staff have the opportunity to understand, question, and contribute before public engagement begins.

- **Staff are service experts:** Frontline staff and service managers understand the operational realities of current arrangements and can provide valuable insight into what works, what doesn't, and what would improve service delivery under either model.

- **Staff are community ambassadors:** Staff live in Highland communities and interact daily with service users. Their understanding and support is essential for meaningful public engagement.

- **Messaging refinement:** Staff engagement will identify concerns, questions, and issues that need to be addressed in public-facing materials, ensuring community messaging is comprehensive and anticipates key questions.

3.2 Staff Engagement Focus Areas

Staff engagement, led by HR teams across both organisations in partnership with Staff Side representatives, will focus on:

- **Understanding 'why':** Clear explanation of why the review is happening, including feedback from previous staff engagement showing confusion about accountability and decision-making under current arrangements

- **Articulating benefits:** How Option 2 (IJB model) could address current challenges, improve clarity of governance, enhance joint working between health and social care, and create opportunities for service integration. How Option 1 (status quo) could be adjusted to address these issues.

- **Addressing concerns:** Honest discussion about potential impacts on employment, professional accountability, career progression, and service configuration

- **Gathering insight:** Assessment of scope of integration, understanding implications for different staff groups, identifying risks and mitigation requirements

- **Building awareness with Staff Side:** Collaborative work with trade union representatives and professional organisations across both NHS Highland and The Highland Council to ensure staff voices are heard and concerns are addressed throughout the process

3.3 Messaging Alignment and Nuancing

While staff and community engagement share core messages about the review, the emphasis and detail will differ:

Staff Messaging Focus	Community Messaging Focus
How will this affect my role, team, and working arrangements?	How will this affect the services I receive?
Detailed operational implications by service area and staff group	High-level governance changes and service scope
Employment arrangements, professional accountability, career progression	Accountability, decision-making, service coordination
Benefits for staff: clearer governance, better integration, improved support	Benefits for communities: improved outcomes, better coordination, clearer accountability
Opportunity to shape implementation through Staff Side engagement	Opportunity to influence which model is chosen

Key principle: Community messaging will be refined based on staff feedback to ensure it addresses questions and concerns that emerge during staff engagement.

4. COMMUNITY ENGAGEMENT METHODOLOGY

4.1 Timeline

Phase	Activity	Dates
Staff Engagement	Staff-side engagement, service-level discussions and assessment	February – April 2026
Pre-election period	Preparation, material development informed by staff engagement, venue booking	26 March – 7 May 2026
Launch	Engagement Hub goes live, social media campaign begins	8 May 2026
Active Engagement	In-person events, online engagement	18 May – 10 July 2026 (8 weeks)
Analysis	Collation and thematic analysis of feedback from staff and community	11 July – 14 August 2026 (5 weeks)
Reporting	Present findings to Steering Group and both Boards	August – September 2026

4.2 Engagement Channels

A) In-Person Public Engagement Events
Format: Hybrid evening sessions (7:00-8:30pm, Tuesday-Thursday)

Locations:
- Inverness (week commencing 18 May 2026)
- Caithness (TBC)
- Fort William (TBC)

Event Structure:
- Welcome and registration with branded materials
- Presentation loop explaining both models
- Main presentation from NHS Highland and Highland Council executives
- Question and answer session
- 1:1 conversations with staff
- QR codes linking to Engagement Hub and survey
- Paper and digital feedback options
- Light refreshments

Accessibility Features:
- British Sign Language (BSL) interpretation
- Electronic note-taking/transcription
- Facebook Live webcast with recording published on Engagement Hub
- Easy Read materials available
- Venue accessibility confirmed in advance

B) Online Engagement Hub
Platform: NHS Highland Engagement Hub

Features:
- Project overview and timeline
- 60-second explainer video
- Downloadable documents (FAQs, posters, slides)
- Online survey (public and staff versions)
- Regular updates from Steering Group
- Summary of event themes (post-events)
- Contact details for questions

C) Targeted Engagement with Vulnerable Groups
Approach: Commission third-party specialist organisation to undertake targeted engagement with:
- People with lived experience of health and social care services
- People with learning disabilities and physical disabilities
- Mental health service users
- Older people
- Carers
- Children and young people (where appropriate)

Method: Facilitated discussions using accessible formats tailored to each group's needs

D) Partner and Stakeholder Engagement
Direct Outreach To:
• Community Councils
• Third sector organisations
• Advocacy groups
• Health and Social Care Forum members
• Patient participation groups

Method: Written briefings, invitation to events, targeted communications

5. KEY MESSAGING FRAMEWORK (COMMUNITY-FACING)

5.1 Core Narrative
Headline: "Help shape the future of health and social care in Highland"

Why This Matters:
"NHS Highland and The Highland Council are reviewing how health and social care services are organised to ensure the best possible arrangements for people who use services and the staff who deliver them. Feedback has shown that current arrangements can sometimes feel unclear in terms of decision-making and accountability. Your views will help shape the recommendation on which model works best for Highland."

5.2 Explaining the Current Model (Option 1)
"Highland currently uses a Lead Agency model, which is unique in Scotland:
• NHS Highland delivers Adult Social Care on behalf of The Highland Council
• The Highland Council delivers some child health services on behalf of NHS Highland

A Joint Monitoring Committee made up of representatives of both organisations and the third sector oversees this arrangement. This arrangement has provided integrated services but feedback suggests there can be confusion about accountability and decision-making."

5.3 Explaining the IJB Model (Option 2)
"An Integration Joint Board (IJB) is used in all other parts of Scotland. It works like this:
• A formal partnership board is created between the NHS and Council
• The board has representatives from both organisations and community members
• The IJB oversees adult and health and social care services jointly
• An IJB may also oversee the delivery of a range of other functions including child health, children and families social work and justice social work
• There is shared governance and accountability
• This model is designed to improve clarity and collaboration

The proposed Highland IJB would combine:
• Current integrated adult health and social care (currently managed by NHS Highland)
It could also include:
• Children's health and social care, including children and families, justice social work and some education functions (currently managed by The Highland Council)"

5.4 What's In Scope / Out of Scope*

*This will be developed during the staff engagement period.

IN SCOPE (functions an IJB must oversee):
• Community health services (GPs, district nurses, allied health professionals)
• Social care for adults
• Mental health services (non-forensic)
• Addiction services
• Care homes and care at home
• Public health improvement

IN SCOPE (functions an IJB could also oversee)
• Children and families social work
• Justice social work
• Additional Support Needs in Education
• Early Years Education

OUT OF SCOPE (what would NOT change):
• Major hospital services (like Raigmore Hospital acute care)
• Specialist services like cancer treatment
• Ambulance services
• Your GP, dentist, or pharmacist – you would still access these in the same way

IMPORTANT: This review is about governance (how services are overseen and organised), not about:

• Reducing or removing services
• Changing what services you can access
• Creating a new organisation

6. EVALUATION AND REPORTING

6.1 Success Measures

- Participation numbers: Staff and community attendees at events and online survey completions
- Quality of feedback: Depth and relevance of comments and themes
- Demographic representation: Participation from diverse groups including staff and vulnerable populations
- Impact on recommendations: Evidence of staff and community voice in final proposals

6.2 Analysis Approach

- Quantitative analysis of survey responses (staff and public)
- Thematic analysis of qualitative feedback from events and open comments
- Identification of key themes, areas of consensus, and areas of concern across both stakeholder groups
- Assessment of how staff feedback informed and was reflected in community engagement

6.3 Reporting

- Interim updates to Steering Group during engagement period
- Final engagement report (August 2026) including:
    - Participation statistics (staff and community)

- Key themes and findings from both engagement streams
- Staff and community priorities
- Recommendations informed by combined feedback

- Public summary published on Engagement Hub
- Presentation to Highland Council and NHS Highland Boards (September 2026)

Project Initiation Document (PID)/Terms of Reference

Programme Name

Neuro Developmental Assessment Transformation

Draft/Final:	**Version 1**
Date:	**March 2026**

Author:	**Kate Lackie**
Owner:	**Kate Lackie**

Revision date	Summary of Changes

Approvals

Name	Signature	Title	Date of Approval	Version
Corporate Management Team			16 March 2026	1
Highland Council			26 March 2026	

Distribution

Name	Signature	Date of Issue	Version
Corporate Management Team		16 March 2026	1
Person centred Solutions Portfolio Board		March 2026	

SECTION 1: RATIONALE, OBJECTIVES & APPROACH

1.1 Project Rationale

Currently in Highland, over 2,000 young people are awaiting a neurodevelopmental assessment (NDAS). These assessments are vital for a formal medical identification of autism, ADHD, and other neurodevelopmental conditions and, through that diagnosis, the ability to access specialist treatment including medication.

This project is required to provide a programme managed approach to the investment of £1.2M one-off funding approved by the Highland Council in March 2026 to address the long waiting list of children seeking a neurodevelopmental assessment.

The intention is also to innovate a new approach to NDAS, working with system and professional leaders to ensure that, in the future, the process minimises delay and offers a less traumatic approach for children and families. Thereby reducing the potential for waiting lists to build up again and the negative impact to children and families.

This will require a partnership approach with NHS Highland, as the responsible body for NDAS and CAMHs (Child and Adolescent Mental Health Services)

NHS Highland currently does not have a team that is able to undertake ND assessments and so it is proposed that a range of options are explored, including the potential that the funding may have to commission NDAS assessments from the private sector. The costs, speed and number of assessments are some of the aspects that will need to be explored.

The University of Glasgow is at the forefront of research into ND assessment pathways and post diagnosis treatment and support and the potential to partner with UoG will also be considered as part of the approach to establishing a long term approach to improved assessment and outcomes for young people who are not neuro typical.

In addition to the assessment process, the project will look at the treatment and support available post assessment, to ensure that a diagnosis results in appropriate medical and non medical interventions being put in place.

1.2 Project Objectives

This Project will specifically target the following objectives:

- removing or significantly reducing the NDAS waiting list
- improved timescales for ND assessments
- improved outcomes for children with ND
- improved support for children and families impacted by ND

1.3 Project Approach

Appoint a Project Lead and Project Manager to develop a project plan and drive this forward at pace.

With NHSH, identify options for undertaking ND assessments that will be acceptable in terms of formal diagnoses.

Engage with Procurement and Commissioning Team to develop a specification for outsourcing the assessment process and issue a PIN if needed.

Engage with Procurement and Commissioning Team to identify a specialist partner – whether UoG or other appropriately qualified research institute to develop future model of ND assessment.

With NHSH, allied professionals and other partners, develop sustainable post-diagnosis pathways for treatment and support.

Ensure engagement with children and families with lived experience and specialist practitioners in the Council and NHS and learning from best practice elsewhere in the development of a future model.

SECTION 2: SCOPE, DELIVERABLES & EXCLUSIONS

2.1 Project Scope

The approach will be limited to addressing the waiting list and future assessment process and support for children and young people in the Highland Council area.

2.2 Project Deliverables & Expected Benefits

Deliverables	Expected Benefits	Saving
Assessment completed for most or all children on the current NDAS waiting list	Improved treatment and support for those with a confirmed diagnosis. Access to appropriate treatment, including medication, for those with a diagnosis	Difficult to quantify in the short term. Initially likely to be more expensive in terms of medication prescribed by NHSH Long term, benefits as families are better supported and children are more able to thrive,

	Clarity for those who do not receive a confirmed diagnosis Clearer advice for NHS/ Education/Social Work in terms of appropriate support for children and families	therefore putting less pressure on NHS and Council services.
Improved process for future ND assessments	Shorter waiting times for children to receive a diagnosis Earlier diagnosis leading to appropriate supports being in place sooner Children and Young People and their families better able to cope and thrive Transitions into adult services less traumatic and better supported	As above

SECTION 3: GOVERNANCE, ROLES & RESPONSIBILITIES

3.1 Governance

The Project will be directed and overseen by a dedicated Project Board reporting through the Person Centred Solutions Portfolio Board in the operational Delivery Plan to the HSW Committee for Member scrutiny.

3.2 Project Board

Responsibilities of the Board include:

- Direct the Project and the Project Manager
- Delegate appropriate authority to the Project Manager
- Provide required resources / budget for the Project
- Approve the Project Plan, and control/authorise changes to the same
- Ensure Project decisions are made effectively and timeously
- Facilitate communication within the Project and with other stakeholders, both internal and external, e.g. through to the Portfolio Board and Members
- Reporting to the HSW Committee via the Portfolio Board

Role	Name	Designation
Sponsor	Kate Lackie	Assistant Chief Executive - People
Project/Programme Manager	TBC	
Senior Suppliers – THC, NHSH, UoG (or other specialist)	TBC	Child Health Educational Psychology Chief Officer Acute – NHS Clinical Director CAMHs – NHS Procurement Service Etc...
Senior Users – THC and NHSH	Fiona Grant Jack Libby	Chief Officer – Education Head of Service – Children's Services Etc...
Finance Officer	Jennifer McGonagle	Finance Manager
Project Assurance	Fiona Malcolm	Chief Officer Integrated Services
Others to be confirmed where appropriate/relevant		Incl. Corporate Communications, HR

3.3 Project Teams

The composition of the project teams will be drawn from a mix of subject matter expertise, working alongside other specialist resource. Project Manager to coordinate delivery of all work streams required. Post to be funded from the investment budget of £1.2M.

SECTION 4: PLANS & PROGRAMME INTERRELATIONSHIPS/DEPENDENCIES

4.1 Project Plan

The following reflect key dates. These dates are subject to more detailed planning to ensure deliverability, though the approach is to set ambitious timescales. Given the area dimension, a separate plan with specific dates will be required for each area.	Target Date
Preparation work including: Appointment of Project Manager Programme plan to be agreed through Portfolio Board Procurement/commissioning advice secured Specialist partner engaged PIN issued Stakeholder Engagement Plan initiated	 April/May 2026 April/May 2026 August/Sept

4.2 Interrelationships with other Improvement Activity

The Project will have links to and/or dependency on:

- **Learning Without Boundaries** – PCS Portfolio
- **NDAS and CAMHs Project Boards** – NHSH led
- **Children's Services Budget Recovery Plan** – PCS Portfolio
- **ASC Budget Recovery lan** – linkages to Adults with LD
- **Joint Chief Executive's Group**

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**31st March 2026**
Title:	**Review of Argyll and Bute HSCP Integration Scheme 2025**
Responsible Executive/Non-Executive:	**Gareth Adkins, Director of People and Culture**
Report Author:	**Laura Blackwood, Directorate Support Officer A&B Council/HSCP**

Report Recommendation:

The Board is asked to take **substantial assurance** and:

- **Note** that the Integration Scheme has been approved by the SG and that arrangements will now be put in place by the two partner bodies to publish the document.
- **Note** that a similar report will also be tabled at the Argyll & Bute Council and the Integration Joint Board (IJB) to advise of the position.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal Requirement
- Local policy

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

- Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well		Listen Well		Nurture Well		Plan Well	
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well		Progress well		All Strategic Outcomes	X		

2 Report summary

2.1 Situation

NHS Highland Board and Council, at their meetings held on 27th and 29th January 2026 respectively, approved revisions made to the Health and Social Care Integration Scheme following an 8 week consultation process. It was also agreed that the Chief Executives of the two partner bodies would submit the revised Scheme to the Scottish Government (SG) for their consideration and approval.

This report provides detail on the minor revisions made by the SG and confirms that the revised Scheme has now been signed off by Ministers. Arrangements will now be put in place by the two partner bodies to publish the document on their respective websites. A copy of the approved scheme is attached at appendix 2.

2.2 Background

The legal requirement to complete a review of an Integration Scheme is set out in Section 44 of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act). The Scheme must be reviewed each subsequent period of 5 years beginning with the day on which the Scheme was approved.

The current Scheme was approved by Scottish Ministers on 23rd March 2021, therefore there is a statutory responsibility for Argyll and Bute Council and the Board of NHS Highland (the partner bodies) to carry out a review and submit a revised Scheme to Scottish Ministers no later than 23rd March 2026, or a decision taken by the partner bodies that no changes are necessary by that date.

A review of the current Integration Scheme was undertaken and a number of proposed amendments recommended. These changes were considered and approved by both the Council and NHS Highland Health Board at their respective meetings held in June/July 2025. On the basis that both partner bodies agreed the proposed amendments, there was a requirement to undertake a joint formal consultation exercise in accordance with Section 46(4) of the Act.

Arrangements for the joint consultation, which ran from 25th August to 19th October 2025 were put in place, including:-

- Email/postal correspondence issued to all prescribed stakeholders and any others deemed appropriate
- Use of Council ‘Keep in the Loop’ service to promote the consultation to customers who have advised they would like to be engaged in consultation activity
- Details of the consultation uploaded to Council and NHS Highland Websites
- Posts on social media
- Press release issued
- Hard copies issued upon request

A total of 36 responses were received, details of which are attached in appendix 1. The vast majority of responses were received via the online survey (33), with the other responses received via email (2) or letter (1). Two of the 33 responses received online left no comments/detail. As detailed in Appendix 1, and in particular at the final column of that table, a total of seven responses contained comments which did not directly relate to the terms of the Integration Scheme document, and as such, were considered to be outwith the scope of this statutory Review exercise.

Following closure of the consultation period the Working Group, which was established to initiate the 5 year review process, was re-convened on 11 November 2025 to undertake a review of all the consultation responses. The Working Group comprises a range of Senior Officers from both partner bodies, as well as the HSCP. Having considered all feedback received as part of the consultation, the Working Group are recommending a number of further revisions to the content of the Scheme, in addition to those previously agreed by the Council and NHS Highland Board at their meetings in June/July 2025. These are summarised below, and are also highlighted in yellow within the revised Scheme attached at Appendix 2:-

- Section 1.1 has been updated to reflect the current Strategic Plan. The heading changed to "vision and priorities" to reflect changes.
- Duplicate page number 37 corrected
- Link to the Engagement Framework added at section 10.2
- Reference to The Promise at p4 and p8
- Changes to the use of social care/social work terminology throughout the document
- New 6.16 – reference to established Social Work and Social Care Governance Committee

Members are asked to consider the outcome of the consultation exercise, and approve the revised Integration Scheme detailed at Appendix 2. A similar report is also being submitted to the NHS Highland Board scheduled for 28th January 2026. If agreeable, both parent bodies will then arrange for the revised Scheme to be jointly submitted to Scottish Ministers for approval prior to 23rd March 2026 deadline.

Thereafter, the Council and NHS Highland will arrange for the final Integration Scheme to be published on their respective websites as soon as practicable after it takes effect.

On 19th December 2025, the *Public Bodies (Integration Joint Boards) (Scotland) Amendment Order* 2025 was laid before the Scottish Parliament. The effect of that Order is to extend the voting membership of IJBs to include service user, unpaid carer and third sector representatives. The Order, which is subject to the negative procedure, is scheduled to come into force on 1st September 2026 - several months after the revised Scheme requires to be completed and submitted to the Scottish Ministers for approval under Section 46(6) of the 2014 Act. Accordingly, a subsequent review of the Integration Scheme may be required to reflect the changes in voting membership, subject to the Order coming into force on the proposed date, and any further direction or guidance on the matter being issued by the Scottish Government.

2.3 Assessment

Work has continued to progress and the formal submission was made to Scottish Government.

Please see the attached appendices for full detail

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	X	Moderate	
Limited		None	

3 Impact Analysis

3.1 Quality/ Patient Care

None arising from this report.

3.2 Workforce

None arising from this report.

3.3 Financial

None arising from this report.

3.4 Risk Assessment/Management

If the review of the integration is not completed within the designated timescales, there is a risk of non-compliance with statutory measures under the Public Bodies (Joint Working) (Scotland) Act 2014

3.5 Data Protection

Activity is undertaken in line with GDPR regulations.

3.6 Equality and Diversity, including health inequalities

None arising from this report.

3.7 Other impacts

No other impacts.

3.8 Communication, involvement, engagement and consultation

A Communications & Engagement plan has been included as an appendix to this report.

3.9 Route to the Meeting

The subject of this report has been considered at the Argyll & Bute Integration Joint Board, Argyll & Bute Council and NHS Highland.

4 List of appendices

- **Appendix 1** – Full Report providing additional context and detail as of March 2026
- **Appendix 2** – Revised SG Agreed Integration Scheme

ARGYLL AND BUTE COUNCIL **COUNCIL**

LEGAL AND REGULATORY SUPPORT **29TH APRIL 2026**

REVIEW OF THE HEALTH AND SOCIAL CARE INTEGRATION SCHEME

1. EXECUTIVE SUMMARY

1.1 NHS Highland Board and Council, at their meetings held on 27th and 29th January 2026 respectively, approved revisions made to the Health and Social Care Integration Scheme following an 8 week consultation process. It was also agreed that the Chief Executives of the two partner bodies would submit the revised Scheme to the Scottish Government (SG) for their consideration and approval.

1.2 This report provides detail on the minor revisions made by the SG and confirms that the revised Scheme has now been signed off by Ministers. Arrangements will now be put in place by the two partner bodies to publish the document on their respective websites. A copy of the approved scheme is attached at appendix 1.

1.3 Members are invited to:-

- Note that the Integration Scheme has been approved by the SG and that arrangements will now be put in place by the two partner bodies to publish the document.
- Note that a similar report will also be tabled at the NHS Highland Board and the Integration Joint Board (IJB) to advise of the position.

ARGYLL AND BUTE COUNCIL — **COUNCIL**

LEGAL AND REGULATORY SUPPORT — **29TH APRIL 2026**

REVIEW OF THE HEALTH AND SOCIAL CARE INTEGRATION SCHEME

2. INTRODUCTION

2.1 NHS Highland Board and Council, at their meetings held on 27th and 29th January 2026 respectively, approved revisions made to the Health and Social Care Integration Scheme following an 8 week consultation process. It was also agreed that the Chief Executives of the two partner bodies would submit the revised Scheme to the Scottish Government (SG) for their consideration and approval.

2.2 This report provides detail on the minor revisions made by the SG and confirms that the revised Scheme has now been signed off by Ministers. Arrangements will now be put in place by the two partner bodies to publish the document on their respective websites. A copy of the approved scheme is attached at appendix 1.

3. RECOMMENDATIONS

3.1 Members are invited to:-

- Note that the Integration Scheme has been approved by the SG and that arrangements will now be put in place by the two partner bodies to publish the document.
- Note that a similar report will also be tabled at the NHS Highland Board and the Integration Joint Board (IJB) to advise of the position.

4. DETAIL

4.1 The legal requirement to complete a review of an Integration Scheme is set out in Section 44 of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act). The Scheme must be reviewed each subsequent period of 5 years beginning with the day on which the Scheme was approved.

4.2 The current Scheme was approved by Scottish Ministers on 23rd March 2021, therefore there is a statutory responsibility for Argyll and Bute Council and the Board of NHS Highland (the partner bodies) to carry out a review and submit a revised Scheme to Scottish Ministers no later than 23rd March 2026, or a

decision taken by the partner bodies that no changes are necessary by that date.

4.3 Following a joint consultation exercise, which ran from 25th August to 19th October 2025, a number of revisions were made to the Scheme to take account of the feedback received and approved by NHS Highland Board and the Council at their respective meetings in January 2026.

4.4 Thereafter, the Scheme was submitted to the SG for consideration and review, with written feedback provided in February 2026. The proposed amendments were minimal in nature with most comments relating to presentational changes to tidy up the format/layout of the Scheme. On this basis, the Working Group established to oversee the review process agreed to make the changes, with the further revised Scheme being approved by the Chief Executives of the Council and Health Board, and re-sent to the SG early March 2026.

4.5 The SG confirmed via email on 23rd March 2026 that the revised Scheme has now been approved by Ministers. In line with section 8 of the Public Bodies (Joint Working) (Scotland) Act 2014, the two partner bodies will now put in place arrangements to publish the approved Scheme. The legislation is not prescriptive in regard to the specific methods that should be adopted in this regard. It is proposed that both partner bodies, and the HSCP, arrange for the document to be published on their respective websites. Health and Social Care Scotland will also be appraised of the situation to allow them to update their records.

5. CONCLUSION

5.1 Following a period of consultation and review by the SG, the Argyll and Bute Integration Scheme has been approved by Ministers and will now be published in accordance with the requirements as set out in Section 8 of the Act.

6. IMPLICATIONS

6.1 Policy – in line with Scottish Government statutory guidance/policy on improving health and social care outcomes

6.2 Financial – non arising from this report

6.3 Legal - meets the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014

6.4 HR – none arising from this report

6.5 Customer Service - improved outcomes for all customers at core of legislation

6.6 Risk – non-compliance with statutory measures under the Public Bodies (Joint Working) (Scotland) Act 2014

6.7 Climate Change - none

6.8 Fairer Scotland Duty – none arising from this report

6.9 Equalities - protected characteristics – none arising from this report

6.10 Consumer Duty – none arising from this report

6.11 Island Communities – none arising from this report

6.12 Children’s Rights and Wellbeing - improved outcomes for all customers at core of legislation

7. APPENDICES

7.1 Appendix 1 – Approved Integration Scheme as at March 2026

Douglas Hendry
Executive Director with responsibility for Legal and Regulatory Support

Policy Lead for Care Services – Councillor Dougie McFadzean

24th March 2026

For further information, please contact:

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01546 604325

INTEGRATION SCHEME

BETWEEN

ARGYLL AND BUTE COUNCIL

AND

NHS HIGHLAND

Revised March 2026

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1. Introduction

1.1 Vision and Priorities:

The vision of Argyll and Bute Health and Social Care Partnership is that people in Argyll and Bute will live longer, healthier, happier, independent lives. The high level priorities for the area are:-

- Prevention, early intervention and enablement;
- Choice and control and innovation;
- Living well and active citizenship; and
- Community co-production.

1.2 Aims and Outcomes:

The main purpose of integration is to improve the wellbeing of people who use health and social work and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. The Integration Scheme is intended to achieve the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in regulations under section 5(1) of the Public Bodies (Joint Working) (Scotland) Act 2014.

Argyll and Bute Integration Joint Board (IJB) will plan for and deliver high quality health and social care services to, and in partnership with, the communities of Argyll and Bute.

The IJB will set out within its Strategic Plan (defined hereafter) how it will effectively use allocated resources to deliver the National Health and Wellbeing Outcomes, namely that:

- People are able to look after, and improve, their own health and wellbeing and live in good health for longer;
- People, including those with disabilities or long term conditions or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community;
- People who use health and social care services have positive experiences of those services, and have their dignity respected;
- Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services;
- Health and social care services contribute to reducing health inequalities;
- People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing;

- People using health and social care services are safe from harm;
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide;
- Resources are used effectively and efficiently in the provision of health and social care services; and
- Any other National Health and Well Being outcome prescribed in the future will also be adopted.

Argyll and Bute Council and NHS Highland Health Board have agreed that social work services for Children & Families and Justice Services should be included within the functions and services to be delegated to the IJB, therefore The Promise and the specific national outcomes as detailed below for Children & Families and Justice are also included:

The Promise states that 'all Scotland's children and young people will grow up loved, safe and respected so that they realise their full potential'.

The national outcomes for Children & Families are:-

- Our children have the best start in life and are ready to succeed;
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens;
- We have improved the life chances of children, young people and families at risk; and
- Any national outcomes prescribed in the future will also be adopted.

National outcomes and standards for Justice Social Work are:-

- Community safety and public protection;
- The reduction of re-offending;
- Social inclusion to support desistance from offending; and
- Any national outcomes prescribed in the future will also be adopted

1.3 Scope of Integration:

Argyll and Bute Council and NHS Highland Health Board have agreed to delegate to the IJB the following functions:

- All NHS services that the legislation permits for delegation;
- All Adult Social Work and social care services;
- All Children & Families Social Work services; and
- All Justice Social Work services.

1.4 Finance arrangements:

The general principles are agreed as:

- Argyll and Bute Council and NHS Highland Health Board recognise that they each have continuing financial governance responsibilities and have agreed to establish the IJB as a "joint operation" as defined by IFRS 11;
- Argyll and Bute Council and NHS Highland Health Board will work together in the spirit of partnership, openness and transparency;
- The IJB will monitor its financial position and make arrangements for the provision of regular, timely, reliable and relevant information on its financial position which will be shared with Argyll and Bute Council and NHS Highland Health Board. The IJB, Argyll and Bute Council and NHS Highland Health Board will share financial information to ensure all parties have a full understanding of their current financial position, future financial outlook and key planning assumptions; and
- The existing financial regulations of Argyll and Bute Council and NHS Highland Health Board will apply to resources transferred to the IJB.

Integration Scheme

The Parties:

The Argyll and Bute Council, established under the Local Government (Scotland) Act 1994 and having its principal offices at, Kilmory, Lochgilphead, Argyll, PA31 8RT (herein after referred to as "the Council");

And

NHS Highland Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "Argyll and Bute CHP") and having its principal offices at Assynt House, Beechwood Park, Inverness, IV2 3BW (hereinafter referred to as "NHS Highland") (together referred to as "the Parties").

2. Definitions and Interpretation

2.1 "The Act" means the Public Bodies (Joint Working) (Scotland) Act 2014

2.2 "IJB" means Argyll and Bute Integration Joint Board.

2.3 "Outcomes" means the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act.

2.4 "Scheme" means this Integration Scheme.

2.5 "Strategic Plan" means the plan which the IJB is required to prepare and implement in relation to the delegated provision of health and social care services to adults and children in accordance with section 29 of the Act.

2.6 ''Acute Services'' means medical and surgical treatment provided mainly in hospitals and minor injury units.

2.7 "NHS GG&C" means NHS Greater Glasgow & Clyde.

2.8 "Locality Planning Groups" mean local planning groups comprising representatives of local partners and stakeholders who are accountable to the Strategic Planning Group for the

planning and partnership delivery of agreed local health and care service priorities. Their specific purpose is to develop a locality plan, influence priorities for their local area, agree mechanisms for the delivery of actions at a local level and review and report on the locality plan annually.

2.9 "Performance Management Framework" means the quality and performance measures for each service area within Argyll and Bute HSCP and an overview of the HSCPs performance against the National Health and Wellbeing Outcomes.

2.10 "the GDPR" means the UK General Data Protection Regulations

2.11 "the DPA" means the Data Protection Act 2018

2.12 "Annual Budget" – means the annual financial statement prepared setting out the amount the IJB intends to spend to implement its Strategic Plan.

In implementation of their obligations under the Act, the Parties hereby agree as follows:

In accordance with section 1(2) of the Act, the Parties have agreed that the integration model set out in sections 1(4)(a) of the Act will be put in place for the IJB, namely the delegation of functions by the Parties to a body corporate that is to be established by Order under section 9 of the Act. This revised Scheme comes into effect on the date the Parliamentary Order comes into force.

3. Local Governance Arrangements

3.1 The role and constitution of the IJB is established through legislation, with the Parties having agreed that the voting membership will be:

3.1.1 NHS Highland Health Board: 4 members of the NHS Highland Health Board;

3.1.2 Council: 4 Elected Members of the Council nominated by the Council; and

3.1.3 The Parties have agreed that the first Chair of the IJB will be the nominee of the Council. The term of office of the Chair and the Vice Chair will be a period of two years.

3.2 The IJB sets out within its Strategic Plan how it will effectively use allocated resources to deliver the Outcomes prescribed by the Scottish Ministers in regulations under section 5(1) of the Act, namely that:

- People are able to look after and improve their own health and wellbeing and live in good health for longer;
- People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community;
- People who use health and social care services have positive experiences of those services, and have their dignity respected;
- Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services;
- Health and social care services contribute to reducing health inequalities;
- People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing;
- People using health and social care services are safe from harm;
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide;
- Resources are used effectively and efficiently in the provision of health and social care services; and
- Any further Outcomes that may be subsequently prescribed by the Scottish Ministers via Regulations.

3.3 The Parties have agreed that social work services for Children & Families and Justice should be included within the functions and services to be delegated to the IJB. Therefore, The Promise and specific Outcomes as detailed below for Children & Families and Justice are also included:

The Outcomes for Children & Families are:-

- Our children have the best start in life and are ready to succeed;
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens;
- We have improved the life chances of children, young people and families at risk; and

- Any Outcomes prescribed in the future will also be adopted.

Outcomes and standards for social work services in the justice system are:-

- Community safety and public protection.
- The reduction of re-offending.
- Social inclusion to support desistance from offending.
- Any national outcomes prescribed in the future will also be adopted

4. Delegation of Functions

4.1 The Parties agree to delegate a comprehensive range of health, social work and social care functions for adults, children and justice to the IJB.

4.2 The functions that are to be delegated by NHS Highland to the IJB are set out in Annex 1.

4.3 The functions that are to be delegated by the Council to the IJB are set out in Annex 2

5. Local Operational Delivery Arrangements

5.1 The local operational arrangements agreed by the Parties are:

5.1.2 The IJB has responsibility for the planning and delivery of services. This will be achieved through the Strategic Plan.

5.1.3 The IJB will be responsible for the operational oversight of the planning, commissioning and contracting of delegated Acute Services and, through the Chief Officer, will be responsible for the operational management, and budget of Acute Services.

5.1.4 As the majority of Acute Services are contracted from a neighbouring Health Board (NHS GG&C), the IJB will be responsible for the operational oversight of Acute Services. A lead Director for Acute Services in NHS GG&C has been identified as the contract liaison officer who is responsible for the operational management of Acute Services in NHS GG&C.

5.1.5 NHS GG&C will provide information as part of the contract monitoring arrangements on a regular basis to the Chief Officer and the IJB on the operational delivery and performance of these services.

5.2 Support for Strategic Plan

5.2.1 The IJB is required under section 29 of the Act to prepare a strategic plan. All Health and Social Care Partnerships' primary responsibility is the achievement of the Outcomes through the delivery of the principles of integration. A critical element in discharging this responsibility is the production and delivery of a Strategic Plan.

5.2.2 The NHS Board will share with the IJB necessary activity and financial data for services, facilities and resources that relate to the planned use of services by service users within Argyll and Bute for its service and for those provided by other Health Boards.

5.2.3 The Council will share with the IJB necessary activity and financial data for services, facilities and resources that relate to the planned use of services by service users within Argyll and Bute for its services and for those provided by other councils.

5.2.4 The Parties agree to use all reasonable endeavours to ensure that other Integration Joint Boards and any other relevant Integration Authority will share the necessary activity and financial data for Services, facilities and resources that relate to the planned use by service users within the area of their Integration Authority.

5.2.5 The Parties shall ensure that their Officers acting jointly will consider the Strategic Plans of the other Integration Joint Boards or Authorities to ensure that they do not prevent the Parties and the IJB from carrying out their functions appropriately and in accordance with the Integration Planning and Delivery Principles, and to ensure they contribute to achieving the Outcomes. The Integration Authorities that are most likely to be affected by the Strategic Plan are:

- West Dunbartonshire Integration Joint Board; Inverclyde; Renfrew; and East Renfrew Integration Joint Boards share a common acute provider of services (NHS GG&C).

5.2.6 The Parties shall advise the IJB where they intend to change service provision of non-integrated services that will have a resultant impact on the Strategic Plan.

5.2.7 The NHS Highland Board will consult with the IJB to ensure that any overarching Strategic Plan for Acute Services and any plan setting out the capacity and resource levels required for non-delegated budgets for such Acute Services is appropriately co-ordinated with the delivery of services across the NHS Highland area. The parties shall ensure that a group including the Chief Operating Officer, NHS Highland and Chief Officer of the IJB will meet regularly to discuss such issues.

5.3 Corporate Support Services

5.3.1 The Parties will provide corporate support services to the IJB. The Parties will:

- Agree the scope and level of services to be provided to support the IJB in discharging its duties under the Act.

5.4 Performance Targets, Improvement Measures and Reporting Arrangements

5.4.1 The Parties will identify a core set of indicators that relate to services, from publicly accountable and national indicators and targets against which the Parties currently report. A list of indicators and measures which relate to integration functions will be collated in a Performance Management Framework and will provide information on the data gathering and reporting requirements for performance targets and improvement measures. The Parties will share all performance information, targets and indicators from the Performance Management Framework with the IJB. The improvement measures will be a combination of existing and new measures that will allow assessment at local level. The performance targets and improvement measures will be linked to the Outcomes to assess the timeframe and the scope of change.

5.4.2 The Performance Management Framework will also indicate where the responsibility for each measure lies, whether in full or in part. Where there is an ongoing requirement in respect of organisational accountability for a performance target for the NHS Board or the Council, this will be taken into account by the IJB when preparing the Strategic Plan.

5.4.3 The Performance Management Framework will also be used to prepare a list of any targets, measures and arrangements which relate to functions of the Parties, which are not delegated to the IJB, but which are affected by the performance and funding of integration functions, and which are to be taken account of by the IJB when preparing the Strategic Plan.

5.4.4 The Performance Management Framework will be reviewed regularly to ensure the improvement measures it contains continue to be relevant and reflective of the Outcomes to which they are aligned.

5.4.5 The Parties will continue to provide support to the IJB for arrangements regarding performance targets, improvement measures and reporting, including the effective monitoring and reporting of targets and measures for adjoining NHS Boards and Integration Joint Boards.

5.4.6 The IJB will receive performance management information for consideration, approval and agreement, and will act appropriately as necessary, in response to all relevant performance management information, including:-

5.4.6.1 Public Health and Wellbeing Status reports including analysis of Argyll and Bute population, at macro, demographic specific and locality level;

5.4.6.2 Clinical and Care Governance reports to be assured of the quality, safety, risk and effectiveness of services;

5.4.6.3 Staff Governance reports to be assured of compliance and best practice in workforce relations, workforce planning and organisational development;

5.4.6.4 Patients and Users of Care Services; Involvement and Community Engagement reports ensuring their involvement in the shaping, delivery and evaluation of service performance;

5.4.6.5 Financial Governance reports including financial management, budget setting recommendation, expenditure reporting, financial recovery plan and cost improvement plans for consideration and approval;and

5.4.6.6 Performance Management Framework information, to be assured of the performance of services against targets, indicators and outcomes.

6. Clinical and Care Governance

6.1 The Parties and the IJB are accountable for ensuring appropriate clinical and care governance arrangements in respect of their duties under the Act. The Parties will have regard to the principles of the Scottish Government's Clinical and Care Governance Framework, including the focus on localities and service user and carer feedback.

6.2 The Parties recognise that the establishment and continuous review of the arrangements for clinical and care governance and professional governance are essential in delivering their obligations and quality ambitions. The arrangements described in this section are designed to assure the IJB of the quality and safety of services delivered in Argyll and Bute.

6.3 Explicit lines of professional and operational accountability are essential to assure the IJB and the Parties of the robustness of governance arrangements for their duties under the Act. They underpin delivery of safe, effective and person-centered care in all care settings delivered by employees of the Council, NHS Highland, the third and independentsectors, and by informal carers.

6.4 In relation to existing health, social work and social care services, NHS Highland is accountable for health functions and services, whilst the Council is responsible for social work services. Professional governance responsibilities are carried out by the professional leads through to the health, Social Work and social care professional regulatory bodies.

6.5 The Chief Social Work Officer holds professional accountability for Social Work and Social Care services. The Chief Social Work Officer reports directly to the Chief Executive and Elected Members of Argyll and Bute Council in respect of professional Social Work matters. They are

responsible for ensuring that social work and social care services are delivered in accordance with relevant legislation and that staff delivering such services do so in accordance with the requirements of the Scottish Social Services Council.

6.6 Principles of clinical and care governance will be embedded at service user/clinical care/professional interface using the framework outlined below. The IJB will ensure that explicit arrangements are made for professional supervision, learning, support and continuous improvement for all staff.

6.7 The IJB will fulfil its devolved responsibility in terms of overseeing delivery of delegated functions by ensuring that there is evidence of effective performance management systems. Professional and service user networks or groups will inform the agreed Clinical and Care Governance Framework directing the focus towards a quality approach and continuous improvement.

6.8 The Clinical and Care Governance and Professional Governance Framework will encompass the following:

- Measure the quality of integrated service delivery by measuring delivery of personal outcomes and seeking feedback from service users and/or carers;
- Professional regulation and workforce development;
- Information governance; and
- Safety of integrated service delivery and personal outcomes and quality of registered services.

6.9 Each of the four elements, listed at 6.8, will be underpinned by mechanisms to measure quality, clinical and service effectiveness and sustainability. They will be compliant with statutory, legal and policy obligations strongly underpinned by human rights values and social justice. Service delivery will be evidence-based, underpinned by robust mechanisms to integrate professional education, research and development.

6.10 The IJB is responsible for embedding mechanisms for continuous improvement of all services through application of a Clinical and Care Governance and Professional Governance Framework. The IJB will be responsible for ensuring effective mechanisms for service user and carer feedback and for complaints handling.

6.11 NHS Highland Executive Medical Director and Board Nurse Director share accountability for Clinical and Professional Governance across NHS Highland as a duty delegated by NHS Highland. This will include ensuring:

- Quality monitoring and governance arrangements that include compliance with professional codes, legislation, standards, guidance and that these are regularly open to scrutiny;
- Systems and processes to ensure a workforce with the appropriate knowledge and skills to meet the needs of the local population;
- Effective internal systems that provide and publish clear, robust, accurate and timely information on the quality of service performance;
- Systems to support the structured, systematic monitoring, assessment and management of risk;
- Co-ordinated risk management, complaints, feedback and adverse events/incident system, ensuring that this focuses on learning, assurance and improvement;
- Improvement and learning in areas of challenge or risk that are identified through local governance mechanisms and external scrutiny;
- Mechanisms that encourage effective and open engagement with staff on the design, delivery, monitoring and improvement of the quality of care and services; and
- Planned and strategic approaches to learning, improvement, innovation and development, supporting an effective organisational learning culture.

6.12 The Medical Director, or their depute, will be a member of the Clinical and Care Governance Committee and will provide professional advice in respect of the overview and consistency of the Clinical and Care Governance and Professional Governance Framework.

6.13 The Board Nurse Director, or their depute, will be a member of the Clinical and Care Governance Committee and will provide professional advice in respect of the overview and consistency of the Clinical and Care Governance and Professional Governance Framework.

6.14 The Chief Social Work Officer, through delegated authority holds professional and operational accountability for the delivery of safe and high quality social work and social care services within the Council. An annual report on these matters will be prepared for Scottish Government and provided to the Council, NHS Highland and the IJB.

6.15 The Chief Social Work Officer will be a member of the Clinical and Care Governance Committee and will provide professional advice in respect of the delivery of social work and social care services by Council staff and commissioned care providers in Argyll and Bute.

6.16 The Chief Social Work Officer will chair a Social Work and Social Care Governance Committee.

6.17 The Parties, in support of the IJB will put in place structures and processes to support clinical and care governance, thus providing assurance on the quality of health and social care in Argyll and Bute. A Clinical and Care Governance Committee, bringing together senior professional leaders across Argyll and Bute, including the Medical Director, Board Nurse Director, Chief Social

Work Officer, and the Associate Director of Public Health, will be established. This committee, chaired by one of its members, will ensure that quality monitoring and governance arrangements are in place for safe and effective health and social care service delivery in Argyll and Bute. This will include the following:

- compliance with professional codes, legislation, standards, guidance;
- systems and processes to ensure a workforce with the appropriate knowledge and skills to meet the needs of the local population;
- effective internal systems that provide and publish clear, robust, accurate and timely information on the quality of service performance;
- systems to support the structured, systematic monitoring, assessment and management of risk;
- coordinated risk management, complaints, feedback and adverse events/incident system, ensuring that this focuses on learning, assurance and improvement;
- improvement and learning in areas of challenge or risk that are identified through local governance mechanisms and external scrutiny;
- mechanisms that encourage effective and open engagement with staff on the design, delivery, monitoring and improvement of the quality of care and services; and
- planned and strategic approaches to learning, improvement, innovation and development, supporting an effective organisational learning culture.

6.18 The Clinical and Care Governance Committee will provide advice to the IJB, the Strategic Planning Group and to Locality Planning Groups, all of whom may seek relevant advice directly from the Clinical and Care Governance Committee, as required.

6.19 Arrangements will be put in place so that the Area Clinical Forums, Managed Care networks, other appropriate professional groups, and the Adult and Child Protection Committees are able to directly provide advice to the Clinical and Care Governance Committee.

6.20 The Clinical and Care Governance Committee will report directly to the IJB and will provide clear robust, accurate and timely information on the quality of service performance.

6.21 Information will be used to provide oversight and guidance to the Strategic Planning Group in respect of Clinical and Care Governance and Professional Governance, for the delivery of Health and Social Care Services across localities identified in the Strategic Plan.

6.22 Annex 3 provides a schematic to show the systems governance arrangements.

6.23 Annex 4 provides a schematic to show the clinical and care governance arrangements.

7. Chief Officer

7.1 The Chief Officer has both strategic and operational responsibility for the delivery of services. The Chief Officer will be directly responsible to and line-managed by the Chief Executive Officers of both Parties, and via the Chief Executive Officers is responsible to NHS Highland and the Council. The Chief Officer is also accountable to the IJB.

7.2 The Chief Officer will be accountable directly to the IJB for the preparation, implementation of, and reporting on, the Strategic Plan. The Chief Officer will also be responsible for operational delivery of services and the appropriate management of staff and resources.

7.3 The Chief Officer will establish a senior management team, equipped to direct and oversee the structures and procedures necessary to carry out all functions in accordance with the Strategic Plan.

7.4 In the event that there is a prolonged period when the Chief Officer is unable or unavailable to fulfil their functions, interim arrangements will be required to temporarily replace the Chief Officer. The Parties will nominate suitably qualified and experienced senior officers to carry out the functions of the Chief Officer for the duration of the interim period, and submit the said nominations for approval by the IJB.

7.5 The Chief Officer's objectives will be set annually and performance appraised by the Chief Executive Officers of both Parties, in consultation with the Chair and Vice Chair of the IJB.

7.6 The Chief Officer will be a full member of both the Council and NHS Highland's corporate management teams, as well as a non-voting member of the IJB.

7.7 The Chief Officer will ensure the maintenance of an up to date integrated risk register in respect of all functions delegated to the IJB.

7.8 The Chief Officer will routinely liaise with appropriate officers of NHS Highland in respect of the IJB's role in contributing to the strategic planning of acute NHS healthcare services and provision (in accordance with the Act) and delivery of agreed targets that have mutual responsibility. Operational management of integrated services and Acute Services will be the responsibility of the Chief Officer, as detailed in sections 5.1.3, 5.1.4 and 5.1.5.

7.9 The Chief Officer will routinely liaise with the appropriate Officer(s) of the Council in respect of the IJB's role in informing strategic planning for local housing and the delivery of housing support services. Housing functions, apart from equipment, adaptations and aspects that relate to personal support, are outside the scope of the IJB; however, close liaison between the Chief Officer and the appropriate Officer(s) will assist in the strategic planning process.

7.10 The Chief Officer will develop close working relationships with Elected Members of the Council and executive and non-executive members of NHS Highland.

7.11 The Chief Officer will establish and maintain effective relationships with a range of key stakeholders across the Scottish Government, NHS Highland, the Council, Independent and Third sectors, service users, trades unions, professional organisations and informal carers.

7.12 The Chief Officer will ensure appropriate arrangements are in place in respect of information governance and the requirements of the Information Commissioner's Office.

8. Workforce

8.1 The Parties are committed to producing and maintaining a fully integrated Workforce and Organisational Development Plan, relating to the delegated functions, as prescribed in the Act. This will include engagement and learning and development for all staff, to promote the development of a robust organisational structure and healthy organisational culture. The plan will remain under annual review. Chief Officer of the IJB will be responsible for implementation and review of the plan, in conjunction with the implementation of the Strategic Plan.

8.2 The ongoing review of the plan will be remitted to Human Resources and Organisational Development Leads from both Parties, with input from other key stakeholders, as required.

9. Finance

9.1 Roles and Responsibilities

9.1.1 The IJB will make arrangements for the proper administration of its financial affairs by appointing a Chief Financial Officer to discharge the responsibilities that fall within Section 95 of the Local Government (Scotland) Act 1973.

9.1.2 The Chief Financial Officer is accountable for financial management of delegated budgets and overall financial resources of the IJB.

9.1.3 The Chief Financial Officer of the IJB will be responsible for managing preparation of the Annual Budget of the IJB, managing the medium term financial planning process to support the Strategic Plan, and providing financial advice and information to support the planning and delivery of services by the IJB.

9.1.4 The Chief Financial Officer of the IJB will be responsible for producing regular finance reports to the IJB and managers, ensuring that those reports are timely, relevant and reliable.

9.1.5 The Chief Financial Officer of the IJB will be responsible for preparing the IJB's accounts and ensuring compliance with statutory reporting requirements as a body under the relevant legislation.

9.1.6 The Chief Financial Officer of the IJB will work with the Council's Section 95 Officer and NHS Highland Director of Finance to ensure the Council and NHS Highland are kept informed on the financial position, performance and plans of the IJB, at a frequency to be agreed by the parties, in order to inform financial plans and safeguard the financial sustainability of the Council and NHS Highland.

9.1.7 The Chief Executive Officers of the Council and NHS Highland are responsible for the operational delivery of services commissioned by the IJB from their respective organisations.

9.1.8 The Chief Financial Officer will work with the Council's Section 95 Officer and NHS Highland Director of Finance to ensure both organisations work together to develop systems which will allow the recording and reporting of the IJB financial transactions.

9.2 Management of Revenue Budget

9.2.1 The IJB's Strategic Plan will incorporate a medium term financial plan for its resources. On an annual basis the annual financial statement will be prepared setting out the amount the IJB intends to spend to implement its Strategic Plan. This will be known as the Annual Budget. The medium term financial plan will be prepared for the IJB following discussions with the Council and NHS Highland who will provide a proposed budget based on payment for year 1, indicative payments for year 2 and 3 and outline projections for later years. The medium term financial plan will be used in conjunction with the Strategic Plan to ensure the commissioned services by the IJB are delivered within the financial resources available.

9.2.2 The IJB is able to hold reserves. The objectives of the Strategic Plan require to be delivered within agreed resources. The IJB must approve a balanced budget.

9.2.3 The term payment is used to maintain consistency with legislation and does not represent physical cash transfer. As the IJB does not operate a bank account, the net difference between payments into and out of the IJB will result in a balancing cash payment between the Council and NHS Highland. An initial schedule of payments will be agreed within the first 40 working days of each new financial year and may be updated taking into account any additional payments in-year.

9.2.4 The Council and NHS Highland will establish a core baseline budget for each function and service that is delegated to the IJB to form an integrated budget.

9.2.5 The budgets will be based on recurring baseline budgets plus anticipated non-recurring funding for which there is a degree of certainty for each of the functions delegated to the IJB and will take account of any applicable inflationary uplift, planned efficiency savings and any financial strategy assumptions. These budgets will form the basis of the payments to the IJB. These budgets will be reviewed against actual levels of expenditure for the previous 3 financial years. For NHS funding, the starting point will normally be the Argyll & Bute National Resource Allocation Formula (NRAC) share of baseline funding.

9.2.6 For each financial year information will be provided by the Parties on the financial performance of the delegated services against budget in their respective areas to enable all parties to undertake due diligence to gain assurance that the delegated resources are sufficient to deliver the delegated functions.

9.2.7 The Parties will each prepare a schedule outlining the detail and total value of the proposed initial payment in each financial year, the underlying assumptions behind that initial payment and the financial performance against budget for the delegated services in the preceding year for their respective areas. These schedules should be prepared and concluded at least one month before the start of the financial year they relate to. The payment will include funding relating to service level agreements for hospital services provided by other Health Boards to Argyll and Bute residents. The schedules will also identify any amounts included in the payments that are subject to separate legislation or subject to restrictions stipulated by third party funders. These documents must be approved by the Director of Finance for NHS Highland and the Council's Section 95 Officer prior to submission to the IJB.

9.2.8 The IJB Chief Financial Officer will review these documents and reach agreement with both parties on the value of the initial payment. The Chief Financial Officer will then prepare a schedule that describes the agreed value of the payments. The Council's Section 95 Officer, NHS Highland Director of Finance and the IJB Chief Officer must sign this schedule to confirm their agreement.

9.2.9 The process for agreeing the subsequent payments to the IJB will be contingent on the corporate planning and financial planning processes of the Council and NHS Highland. The funding available to the IJB will be dependent on the funding available to the Council and NHS Highland and the corporate priorities of both. Both parties will provide indicative three year allocations to the IJB subject to annual approval through the respective budget setting processes. These indicative allocations will take account of changes in NHS funding and changes in Council funding.

9.2.10 Each year the Chief Financial Officer and Chief Officer of the IJB should prepare a draft budget for the IJB, based on the agreed funding, and present this to the Council and NHS Highland for information within such timescale as may be agreed.

9.2.11 The draft Annual Budget should be prepared to take account of the matters set out above and use the previous year's payment as a baseline that will be adjusted to take account of:

- Activity changes arising from the impact on resources in respect of increased demand (e.g. demographic pressures and increased prevalence of long term conditions) and for other planned activity changes;
- Cost inflation on pay and other costs;
- Efficiency savings that can be applied to budgets;
- Performance on outcomes. The potential impact of efficiencies on agreed outcomes must be clearly stated and open to challenge by the Council and NHS Highland;
- Legal requirements that result in additional and unavoidable expenditure commitments;
- Transfers to/from the budget for hospital services set out in the Strategic Plan; and
- Budget savings required to ensure budgeted expenditure is in line with funding available including an assessment of the impact and risks associated with these savings.

9.2.12 The Director of Finance of NHS Highland, the Council's Section 95 Officer and the Chief Financial Officer of the IJB will ensure a consistency of approach and application of processes in considering budget assumptions and proposals.

9.2.13 Due diligence of the Council and NHS Highland contributions will be undertaken annually and the Chief Financial Officer of the IJB will prepare a schedule outlining the agreed value of the payments. The schedule must be approved by the IJB Chief Officer, the Council's Section 95 Officer and the NHS Highland Director of Finance.

9.2.14 The allocations made from the IJB to the Council and NHS Highland for operational delivery of services will be approved by the IJB.

9.2.15 The annual direction from the IJB to the Council and NHS Highland will take the form of a letter from the Chief Officer referring to the arrangements for delivery set out in the Strategic Plan and will include information on:

- The delegated function/(s) that are being directed;
- The outcomes and activity levels to be delivered for those delegated functions; and
- The amount and method of determining the payment to carry out the delegated functions.

9.2.16 Once issued, these can be amended or varied by a subsequent direction by the IJB.

9.2.17 Any potential deviation from the planned outturn should be reported to the IJB, the Council and NHS Highland at the earliest opportunity.

9.2.18 Where it is forecast that an overspend will arise in the current year, then the Chief Officer and Chief Financial Officer of the IJB will identify the cause of the forecast overspend and prepare a recovery plan setting out how they propose to address the forecast overspend and return to a breakeven position. The Chief Officer and Chief Financial Officer of the IJB should consult the Council's Section 95 Officer and the Director of Finance of NHS Highland in preparing the recovery plan. The recovery plan should be approved by the IJB. The report setting out the explanation of the forecast overspend and the recovery plan should also be submitted to the Council and NHS Highland. The impact on the medium term financial plan, use of reserves balances and financial risks should also be reported, as appropriate.

9.2.19 A recovery plan should aim to bring the forecast expenditure of the IJB back in line with the budget within the current financial year. Progress on the delivery of the recovery plan requires to be monitored and reported upon. Where an in-year recovery cannot be achieved and a recovery plan extends beyond the current year the amount of any shortfall or deficit carried forward cannot exceed the reserves held by the IJB unless there is prior approval of the Council and NHS Highland.

9.2.20 Where recovery plans are unsuccessful and an overspend occurs at the financial year end, and there are insufficient reserves to meet the overspend, the Parties will consider making interim funds available. An analysis will be undertaken to determine the extent to which the overspends relate to either budgets delegated back to or activities managed by the Council or NHS Highland with the allocation of the interim funds being based on the outcome of this analysis. Any interim funds provided by the Council or NHS Highland will be repaid in future years based on a revised recovery plan agreed by both parent bodies, as required by either of the Parties. NHS Highland and the Council will require to be satisfied that the recovery plan provides reasonable assurance that financial balance will be achieved. If the revised recovery plan cannot be agreed by the Parties or is not approved by the IJB, the dispute resolution mechanism in clause 14 hereof, will be followed.

9.2.21 Subject to there being no outstanding payments due to the partner bodies, the IJB may retain any underspend to build up its own reserves and the Chief Financial Officer will maintain a reserves policy for the IJB.

9.2.22 There will be arrangements in place to allow budget managers to vire budgets between different budget heads set out in the financial regulations.

9.2.23 Redeterminations to payments made by the Council and NHS Highland to the IJB would apply under the following circumstances:

- Additional one off funding is provided to partner bodies by the Scottish Government, or some other body, for expenditure within a service area delegated to the IJB. This would include in year allocations for NHS and redeterminations as part of the local government finance settlement. The payments to the IJB should be adjusted to reflect the full amount of these as they relate to the delegated services. The Parties agree that an adjustment to the payment is required to reflect changes to demand and activity levels; and/or
- Where either Party requires to reduce the payment to the IJB, any proposal requires a justification to be set out and then agreed by both Parties and the IJB.

9.2.24 Where payments by the Council and NHS Highland are agreed under paragraphs 9.2.3 to 9.2.23 above, they should only be varied as a result of the circumstances set out in paragraphs 9.2.16, 9.2.22 and 9.2.23. Any proposal to amend the payments outwith the above, including any proposal to reduce payments as a result of changes in the financial circumstances of either the Council or NHS Highland requires a justification to be set out and the agreement of both Parties.

9.3 Financial Systems

9.3.1 The Chief Financial Officer will work with the Council's Section 95 Officer and Director of Finance of NHS Highland to ensure appropriate systems and processes are in place to:

- Allow execution of financial transactions;
- Ensure an effective internal control environment over such;
- Maintain a record of the income, expenditure, assets and liabilities of the IJB;
- Enable reporting of the financial performance and position of the IJB; and
- Maintain records of budgets, budget savings, forecast outturns, variances, variance explanations, proposed remedial actions and financial risks.

9.4 Financial reporting to the IJB:

9.4.1 The Chief Financial Officer will provide comprehensive financial monitoring reports to the IJB. These reports will set out information on actual expenditure and budget for the year to date and forecast outturn against Annual Budget together with explanations of significant variances and details of any action required. These reports will also set out progress with action required with achievement of any budgetary savings required. The Chief Financial Officer will also report to the IJB as appropriate in relation to:

- Developing a medium and longer term financial strategy to support delivery of the Strategic Plan;
- Preparation and review of the Annual Budget and medium term financial plan;
- Cost and demand pressures impacting current and future years;
- Collating and reviewing budget savings proposals;
- Identifying and analysing financial risks, and identifying mitigating actions to manage those risks; and
- Policy in relation to reserves, with regular updates on the use of reserves and the impact of the current financial monitoring position on available reserve balances.

9.4.2 On a monthly basis the Parties will provide comprehensive financial monitoring reports to the Chief Financial Officer. The reports will set out information on actual expenditure and budget for the year to date and forecast outturn against Annual Budget together with explanations of significant variances and details of any action required. These reports will also set out progress with achievement of any budgetary savings required.

9.5 Financial reporting to management:

9.5.1 The Chief Financial Officer will work with the Council's Section 95 Officer and Director of Finance of NHS Highland to ensure:

- Managers are consulted in preparing the budget of the IJB;
- Managers are supported in identifying budgetary savings;
- Managers are made aware of the budget they have available;
- Managers are provided with information on actual income and expenditure;
- Managers are provided with information on previous forecast outturns;
- Managers are supported to provide up to date information on forecast outturns;
- Managers are supported to provide explanations of significant variances;
- Managers are supported to identify action required;
- Managers are supported to identify and assess financial risks; and
- Managers are supported to identify and assess future medium to longer term budget implications.

9.6 Financial Statements:

9.6.1 The Chief Financial Officer of the IJB will supply any information required to support the development of the year-end financial statements and annual report for both the Council and NHS Highland.

9.6.2 The Council's Section 95 Officer and the Director of Finance of NHS Highland will supply the Chief Financial Officer of the IJB with any information required to support the development of the year-end financial statements and annual report of the IJB.

9.6.3 Prior to 31 January each year, the Chief Financial Officer of the IJB will agree with the Council's Section 95 Officer and the Director of Finance of NHS Highland a procedure and timetable for the coming financial year end for reconciling payments and agreeing any balances.

9.7 Capital Expenditure and Non-Current Assets

9.7.1 The IJB will not receive any capital allocations, grants or have the power to invest in capital expenditure nor will it own any property or other non-current assets. The Council and NHS Highland will:

- Continue to own any property or non-current assets used by the IJB;
- Have access to sources of funding for capital expenditure; and
- Manage and deliver any capital expenditure on behalf of the IJB.

9.7.2 The Argyll & Bute IJB does not have responsibility for Capital Investment in, or ownership of, the assets it requires to deliver its delegated operational responsibilities. Therefore, it is the responsibility of both parties to ensure that their capital planning and funding allocations are informed by the strategic and operational infrastructure requirements of the IJB, having regard to their available resources. In doing so, both parties will also have regard to the IJB's Joint Strategic Plan, Service Plans, Health and Safety, and Regulatory requirements. This will be undertaken in consultation with the Argyll & Bute Health and Social Care Partnership Management Team.

9.7.3 The Chief Financial Officer of the IJB will be required to work with the relevant officers in the Council and NHS Highland to extract details of the asset registers of property and noncurrent assets used by the IJB.

9.7.4 The Chief Officer of the IJB will work with the relevant officers in the Council and NHS Highland to prepare an asset management plan for the IJB to be approved by the

IJB within a timescale to be agreed annually by the Council and NHS Highland (it is expected this would normally be 30 September). The asset management plan will set out suitability, condition, risks, performance and investment needs related to existing property and other non-current assets identifying any new or significant changes to the asset base.

9.7.5 Alongside the asset management plan, the Chief Officer of the IJB will work with the relevant officers in the Council and NHS Highland to prepare a bid for capital funding for property and other non-current assets used by the IJB. This should be approved by the IJB within a timescale to be agreed annually with the Council and NHS Highland. A business case approach should be adopted to set out the need and assess the options for any proposed capital investment. Any business case will set out how the investment will meet the strategic objectives of the IJB and set out the associated revenue costs.

9.7.6 Whilst responsibility for managing and delivery of capital expenditure remains the responsibility of the Council or NHS Highland, the relevant officers in the Council and NHS Highland will work with the Chief Officer of the IJB to report quarterly on progress with capital expenditure related to property or other non-current assets used by the IJB.

9.7.7 The IJB, the Council and NHS Highland will work together to ensure capital expenditure and property or other non- current assets are used as effectively as possible and in compliance with the relevant legislation on use of public assets.

9.7.8 Depreciation of NHS Highland owned property and other non-current assets used in the services within the scope of the IJB will be charged to the accounts of the IJB and incorporated in the budgets and payments to the IJB.

9.7.9 Revenue costs from property and other non-current assets used in the services within the scope of the IJB will be charged to the accounts of the IJB and incorporated in the budgets and payments to the IJB.

9.7.10 Any gains or losses on disposal of property and other non-current assets used in the services within scope of the IJB will be retained within the accounts of the Council or NHS Highland and not charged to the IJB.

9.7.11 Capital receipts will be retained by the Council or NHS Highland.

9.8 VAT

9.8.1 The IJB will not be required to be registered for VAT, on the basis it is not delivering any supplies that fall within the scope of VAT. The actual delivery of functions delegated to the IJB will continue to be the responsibility of the Council and NHS Highland.

9.8.2 Both the Council and NHS Highland will continue to adhere to their respective VAT arrangements which will be accounted for through respective financial ledgers and statements. The IJB will consult HMRC regarding any VAT issues arising from proposed transfer of services between the Parties (e.g. VAT leakage) taking specialist external VAT advice beforehand if necessary.

10 Participation and Engagement

10.1 In line with the provisions of section 44 of the Act , the Scheme will be reviewed every 5 years.

The parties will undertake a formal consultation exercise in accordance with section 46(4) of the Act, where changes are proposed to the Scheme. This will include the prescribed stakeholders, as set out in the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014:-

- Health professionals (GPs, management teams, clinical groups including nursing staff and allied health professionals);
- Users of health care;
- Carers of users of health care;
- Commercial providers of health care;
- Non-commercial providers of health care;
- Social care professionals;
- Users of social care;
- Carers of users of social care;
- Commercial providers of social care;
- Non-commercial providers of social care;
- Staff of NHS Highland and the Council who are not health professionals or social care professionals;
- Non-commercial providers of social housing;
- Third sector bodies carrying out activities related to health or social care;
- Highland Council; and
- NHS GG&C.

Other, local specific stakeholders include:-

- The Council's employees / elected members
- Staff side/trade unions
- Argyll and Bute Public Partnership Forums
- Scottish Ambulance Service
- NHS 24
- Scottish Health Council
- MPs/MSPs
- Dentists
- Pharmacists
- Police Scotland
- Scottish Fire and Rescue
- Argyll and Bute Advice Network
- Lomond and Argyll Advocacy Service
- Argyll and Bute Citizens Advice Bureau / Patient Advice and Support Service
- Argyll and Bute Community Planning Partnership

10.2 The format of the consultation exercise, including the type of methodologies to be adopted when engaging with stakeholders, will be in accordance with the adopted Argyll and Bute HSCP Engagement Framework, which has been developed in line with national guidance and standards for community engagement.

10.3 The Parties will carry out Equality and Socio-Economic Impact Assessments, to ensure that services and policies do not disadvantage communities and staff.

10.4 The Parties will continue to allocate responsibility to senior managers and their teams to support local public and staff involvement and communication.

11 Information Sharing and Data Handling

11.1 The Parties agree to be bound by the Information Sharing Agreement and to continuance of the existing agreement to use the Scottish Information Sharing Toolkit and guidance from the Information Commissioners Office, in respect of information sharing.

11.2 The Parties have developed an Information Sharing Agreement which covers guidance and procedures for staff for sharing of information.

11.3 All staff managed within the delegated functions will be contractually required to comply and adhere to respective local information security policies and procedures including data confidentiality policies of their employing organisations and the requirements of the IJB's agreed Information Sharing Agreement.

11.4 The Data Protection Officers of NHS Highland and theCouncil, acting on behalf of the Parties, will meet every two years, or more frequently, if required, to review the Information Sharing Agreement and will provide a report detailing recommendations for amendments, for the consideration of the IJB.

11.5 With regard to individually identifiable material, data will be held in both electronic and paper formats and only be accessed by authorised staff, in order to provide the patient or service user with the appropriate service.

11.6 In order to provide fully integrated services it will be necessary to share personal information between the parties and with external agencies. Where this is the case, the IJB will apply a legal basis contained in Article 6 of the General Data Protection Regulations ('the GDPR'). Generally this will be either public task or legal obligation but, where appropriate, any of the other legal bases contained in Article 6 will be used.

11.7 Where the sharing consists of 'special category' information the legal basis for sharing will be consistent with the requirements of Article 9 of the GDPR and schedule 1 of the Data Protection Act 2018 ('the DPA').

11.8 In order to comply with the requirements of the DPA and the GDPR, the IJB will always ensure that personal data it holds will be processed in line with the Data Protection Principles contained within Article 5 of the GDPR and section 35- 40 of the DPA.

12 Complaints

The Parties agree the following arrangements in respect of complaints on behalf of, or by, service users.

12.1 Both Parties will retain separate complaints policies reflecting the distinct statutory requirements.

12.1.1 There will be a single point of contact for complainants. This will be agreed between the Parties to co-ordinate complaints specific to the delegated functions to ensure that the requirements of existing legal/prescribed elements of health and social care complaints processes are met.

12.1.2 Staff within the delegated functions will apply the complaints policy of the relevant Party, depending on the nature of the complaint made. Where a complaint could be dealt with by the policies of both Parties, the appropriate manager will determine whether both need to be applied separately, or a single joint response is appropriate. Where a joint response to such a complaint is not possible or appropriate,

the material issues will be separated and progressed through the respective Party's procedures.

12.2 In the first instance all complaints will be handled by front line staff. If they are unresolved, they will then be passed to a relevant senior manager and thereafter to the Chief Officer.

12.3 If the complaint remains unresolved, the complainant may refer the matter to the Scottish Public Services Ombudsman for health or for social care, as appropriate.

12.4 All complaints procedures will be clearly explained, well publicised, accessible, will allow for timely recourse and will sign-post independent advocacy services.

12.5 The person making the complaint will always be informed which policies are being applied to their complaint.

12.6 The Parties will produce a quarterly joint report, outlining the learning from upheld complaints. This will be provided for consideration by the IJB.

13 Claims Handling, Liability & Indemnity

The Parties agree the following arrangements in respect of claims handling, liability and indemnity:

13.1 The IJB, whilst having a legal personality in its own right has neither assumed nor replaced the rights or responsibilities of either NHS Highland or the Council as the employers of staff who are managed within the delegated functions, or for the operation of buildings or services under the operational remit of those staff.

13.2 The Parties will continue to indemnify, insure and accept responsibility for the staff that they employ; their particular capital assets that the IJB uses to deliver services with or from; and the respective services themselves, which each Party has delegated to the IJB.

13.3 Liabilities arising from decisions taken by the IJB will be shared between the Parties.

14 Risk Management/Internal Audit

14.1 The Parties will develop a shared risk management strategy that will identify, assess and prioritise risks related to the delivery of services under integration functions, particularly any which are likely to affect the IJB's delivery of the Strategic Plan.

14.2 The risk management strategy will identify and describe processes for mitigating those risks and set out and agree the reporting standard, which will include:

- Risk management process;
- Escalation of risks;
- Risk register and action plans;
- Risk tolerance; and
- Training.

14.3 The risk management strategy will be approved by both Parties. The risk management strategy will allow for any subsequent changes to the strategy to be approved by the IJB.

14.4 The risk management strategy will include an agreed risk monitoring framework and arrangements for reporting risks and risk information to the relevant parties from the date of inception of the IJB.

14.5 The Parties will develop an integrated risk register that will set out the key risks for the IJB. Risk officers from each of the Parties will review respective procedures and formulate revised procedures which will allow associated risks, scoring and mitigations to be identified for inclusion in the integrated risk register.

14.6 The Integrated Risk Register will be reported to the IJB on a timescale and format agreed by the IJB, but this will not be less that once per year.

14.7 The risk integrated management strategy will set out the process for amending the integrated risk register.

14.8 The Parties will make appropriate resources available to support the IJB in its risk management.

14.9 The IJB is responsible for commissioning an independent internal audit function, as part of an effective system of internal control.

14.10 Establishing the Internal Audit Plan and monitoring its implementation and management progress sits with the IJB, and its Audit and Risk Committee, who take ownership for the IJB's consideration and approval of the annual accounts including the annual governance statement and associated assurances. Both partners may also include pieces of internal audit work that overlap with, or relate to, responsibilities delegated to the IJB within their internal audit, risk management, and assurance processes.

14.11 To maximise the added value from the Internal Audit Service, the IJB will normally appoint the same internal auditor as either Argyll & Bute Council or NHS Highland. If this is not possible or appropriate for any reason, the IJB has authority to procure its own Internal Audit Service using an appropriate public procurement framework, as an alternative.

15 Dispute Resolution Mechanism

15.1 Where either of the Parties fails to agree with the other on any issue related to this Scheme, they will follow a process which comprises:

15.1.1 A representative of NHS Highland and the Council will meet to resolve the issue, supported by appropriate Officers;

15.1.2 In the event that the issue remains unresolved, the Chief Executive Officers of NHS Highland and the Council, and the Chief Officer, will meet to resolve the issue, supported by appropriate Officers;

15.1.3 In the event that the issue remains unresolved, the Chair of NHS Highland and the Leader of the Council will meet to resolve the issue, supported by appropriate Officers;and

15.1.4 In the event that the issue remains unresolved, NHS Highland and the Council will proceed to mediation with a view to resolving the issue.

15.2 With regard to the process of appointing a mediator, a representative of NHS Highland and a representative of the Council will meet with a view to appointing a suitable independent mediator. If agreement cannot be reached, a referral will be made to the President of The Law Society of Scotland inviting the President to appoint a mediator. The Parties agree to share the cost of appointing a mediator.

15.3 Where an issue remains unresolved following the process of mediation, the Chief Executive Officers of NHS Highland and the Council will communicate in writing with Scottish Ministers, on behalf of the Parties, informing them of the issue under dispute and that agreement cannot be reached.

Annex 1

Part 1

Functions delegated by NHS Highland to the IJB

Functions prescribed for the purposes of Section 1(6) of the Act

Column A	*Column B*
The National Health Service (Scotland) Act 1978	
All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of section 2(7) (Health Boards); section 9 (local consultative committees); section 17A (NHS contracts); section 17C (personal medical or dental services); section 17J (Health Boards' power to enter into general medical services contracts); section 28A (remuneration for Part II services); section 48 (residential and practice accommodation); section 57 (accommodation and services for private patients); section 64 (permission for use of facilities in private practice); section 79 (purchase of land and moveable property); section 86 (accounts of Health Boards and the Agency); section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services); paragraphs 4, 5, 11A and 13 of Schedule 1 (Health Boards); and functions conferred by – The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000; The Health Boards (Membership and Procedure) (Scotland) Regulations 2001; The National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004; The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018 The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006;

The National Health Service (Discipline Committees) (Scotland) Regulations 2006;

The National Health Service (Appointment of Consultants) (Scotland) Regulations 2009;

The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009; and

The National Health Service (General Dental Services) (Scotland) Regulations 2010.

Disabled Persons (Services, Consultation and Representation) Act 1986

Section 7 (persons discharged from hospital)

Community Care and Health (Scotland) Act 2002

All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.

Mental Health (Care and Treatment) (Scotland) Act 2003

All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and and Treatment) (Scotland) Act 2003.

Except functions conferred by section 22 (approved medical practitioners).

Education (Additional Support for Learning) (Scotland) Act 2004

Section 23 (other agencies etc. to help in exercise of functions under this Act).

Public Health etc. (Scotland) Act 2008

Except functions conferred or by virtue of –

Section 2 (duty of Health Boards to protect public health)

Section 7 (joint public health protection plans)

Public Services Reform (Scotland) Act 2010

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010.

Except functions conferred by—

Section 31 (Public functions: duties to provide information on certain expenditure etc.); and

Section 32 (Public functions: duty to provide information on exercise of functions).

Patient Rights (Scotland) Act 2011

All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011.

Carers (Scotland) Act 2016

Section 12 (duty to prepare young carer statement)

Section 31 (duty to prepare local carer strategy)

Functions Prescribed for the purposes of Section 1(8) of the Act

Column A *Enactment conferring function*	*Column B* *Limitation*
The National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of - section 2(7) (Health Boards); section 2CB (functions of Health Boards outside Scotland); section 9 (local consultative committees); section 17A (NHS contracts); section 17C (personal medical or dental services); section 17 (use of accommodation); section 17J (Health Boards' power to enter into general medical services contracts); section 28A (remuneration for Part II services); section 38 (care of mothers and young children); section 38A (breastfeeding); section 39 (medical and dental inspection, supervision and treatment of pupils and young persons); section 48 (residential and practice accommodation); section 55 (hospital accommodation on part payment); section 57 (accommodation and services for private patients); section 64 (permission for use of facilities in private practice); section 75A (remission and repayment of charges and payment of travelling expenses); section 75B (reimbursement of the cost of services provided in another EEA state); section 75BA (reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013); section 79 (purchase of land and moveable property); section 82 use and administration of certain endowments and other property held by Health Boards); section 83 (power of Health Boards and local health councils to hold property on trust); section 84A (power to raise money, etc., by appeals, collections etc.);

section 86 (accounts of Health Boards and the Agency); section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);

section 98 (charges in respect of nonresidents); and paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);

and functions conferred by—

The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989;

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001;

The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000;

The National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004;

The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018; The National Health Service (Discipline Committees) (Scotland) Regulations 2006;

The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006;

The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009;

The National Health Service (General Dental Services) (Scotland) Regulations 2010; and

The National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Regulations 2011

Disabled Persons (Services, Consultation and Representation) Act 1986

Section 7
(persons discharged from hospital)

Community Care and Health (Scotland) Act 2002
All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.

Mental Health (Care and Treatment) (Scotland) Act 2003

All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— section 22 (approved medical practitioners) section 34 (inquiries under section 33: co-operation); section 38 (duties on hospital managers: examination, notification etc.); section 46 (hospital managers' duties: notification); section 124 (transfer to other hospital); section 228 (request for assessment of needs: duty on local authorities and Health Boards); section 230 (appointment of patient's responsible medical officer); section 260 (provision of information to patient); section 264 (detention in conditions of excessive security: state hospitals); section 267 (orders under sections 264 to 266: recall); section 281 (correspondence of certain persons detained in hospital); and functions conferred by— The Mental Health (Safety and Security) (Scotland) Regulations 2005; The Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005; The Mental Health (Use of Telephones) (Scotland) Regulations 2005; and The Mental Health (England and Wales Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008.

Education (Additional Support for Learning) (Scotland) Act 2004

Section 23 (other agencies etc. to help in the exercise of functions under this Act)

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Public Services Reform (Scotland) Act 2010

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010.	Except functions conferred by— section 31 (public functions: duties to provide information on certain expenditure etc.); and section 32 (public functions: duty to provide information on exercise of functions).

Patient Rights (Scotland) Act 2011

All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36.

Part 2

Services provided by NHS Highland which are to be integrated

- Hospital inpatient (scheduled and unscheduled)
- Rural general hospitals
- Mental health
- Pediatrics
- Community hospitals
- Hospital outpatient services
- NHS community services (nursing, allied health professionals, mental health teams, specialist end of life care, homeless service, older adult community sychiatric nursing, re-ablement, geriatricians community/ccute, learning disability specialist, community midwifery, speech and language therapy, occupational therapy, physiotherapy, audiology
- Community children's services - child and adolescent mental health service, primary mental health workers, public health nursing, health visiting, school nursing, learning disability nursing, child protection advisors, speech and language therapy, occupational therapy, physiotherapy and audiology, specialist child health doctors and service community pediatricians
- Public health
- GP services
- GP prescribing
- General dental, opticians and community pharmacy
- Support services
- Contracts and service level agreements with other NHS boards covering adults and children

Annex 2

Part 1

Functions delegated by the Council to the IJB

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A *Enactment conferring function*	*Column B* *Limitation*
National Assistance Act 1948	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958	
Section 3 (Provision of sheltered employment by local authorities)	
The Social Work (Scotland) Act 1968	
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.
Section 13A (Residential accommodation with nursing.)	
Section 13B (Provision of care or aftercare.)	
Section 14 (Home help and laundry facilities.)	
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.

Column A *Enactment conferring function*	*Column B* *Limitation*
The Local Government and Planning (Scotland) Act 1982	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly)	
Disabled Persons (Services, Consultation and Representation) Act 1986	
Section 2 (Rights of authorized representatives of disabled person.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000	
Section 10 (Functions of local authorities)	
Section 12 (Investigations.)	
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions.
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions.
The Housing (Scotland) Act 2001	
Section 92 (Assistance to a registered for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002	
Section 5 (Local authority arrangements for residential accommodation outwith Scotland.)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	
The Mental Health (Care and Treatment) (Scotland) Act 2003	
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire.)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 34 (Inquiries under section 33: Co-operation)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards)	
Section 259 (Advocacy)	
The Housing (Scotland) Act 2006	
Section 71(1) (b) (Assistance for housing purposes)	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007	
Section 4 (Council's duty to make inquiries)	
Section 5 (Co-operation)	
Section 6 (Duty to consider importance of providing advocacy and other)	
Section 11 (Assessment Orders)	
Section 14 (Removal orders)	
Section 18 (Protection of moved persons property)	
Section 22 (Right to apply for a banning order)	
Section 40 (Urgent cases)	
Section 42 (Adult Protection Committees)	
Section 43 (Membership)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Social Care (Self-directed Support) (Scotland) Act 2013	
Section 5 (Choice of options: adults)	
Section 6 (Choice of options under section 5: assistances)	
Section 7 (Choice of options: adult carers)	
Section 9 (Provision of information about self-directed support)	
Section 11 (Local authority functions)	
Section 12 (Eligibility for direct payment: review)	
Section 13 (Further choice of options on material change of circumstances)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Section 16 (Misuse of direct payment: recovery)	
Section 19 (Promotion of options for self-directed support)	
Carers (Scotland) Act 2016	
Section 6 (Duty to prepare adult carer support plan)	
Section 21 (Duty to set local eligibility criteria)	
Section 24 (Duty to provide support)	
Section 25 (Provision of support to carers: breaks from caring)	
Section 31 (Duty to prepare local carer strategy)	

Column A *Enactment conferring function*	*Column B* *Limitation*

Section 34
(Information and advice service for carers)

Section 35
(Short breaks services statements)

The Community Care and Health (Scotland) Act 2002

Section 4

The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002

Additional Functions delegated by the Council to Argyll and Bute Integration Joint Board

Column A *Enactment conferring function*	*Column B* *Limitation*
National Assistance Act 1948	
Section 45 (Recovery in cases of misrepresentation or non-disclosure)	
Matrimonial Proceedings (Children) Act 1958	
Section 11 (Reports as to arrangements for future care and upbringing of children)	
The Social Work (Scotland) Act 1968	
Section 5 (Powers of Secretary of State)	
Section 6B (Local authority inquiries into matters affecting children)	
Section 27 (Supervision and care of persons put on probation or released from prisons etc)	
Section 27ZA (Advice, guidance and assistance to persons arrested or on whom sentence deferred)	
Section 78A (Recovery of contributions)	
Section 80 (Enforcement of duty to make contributions)	
Section 81 (Provisions as to decrees for ailment)	
Section 83 (Variation of trusts)	
Section 86 (Adjustment between authority providing accommodation etc., and authority of area of residence)	
The Children Act 1975	
Section 34 (Access and maintenance)	

Column A *Enactment conferring function*	*Column B* *Limitation*

Section 39
(Reports by local authorities and probation officers)

Section 40
(Notice of application to be given to local authority)

Section 50
(Payments towards maintenance of children)

Health and Social Services and Social Security Adjudications Act 1983

Section 21
Recovery of sums due to local authority where persons in residential accommodation have disposed of assets)

Section 22
(Arrears of contributions charged on interest in land in England and Wales)

Section 23
(Arrears of contributions secured over interest in land in Scotland)

Foster Children (Scotland) Act 1984

Section 3
(Local authorities to ensure well-being of and to visit foster children)

Section 5
(Notification by persons maintaining or proposing to maintain foster children)

Section 6
(Notification by persons ceasing to maintain foster children)

Section 8
(Power to inspect premises)

Section 9
(Power to impose requirements as to the keeping of foster children)

Section 10
(Power to prohibit the keeping of foster children)

The Children (Scotland) Act 1995

Section 17
(Duty of local authority to child looked after by them)

Column A *Enactment conferring function*	*Column B* *Limitation*

Section 20
(Publication of information about services for children)

Section 21
(Co-operation between authorities)

Section 22
(Promotion of welfare of children in need)

Section 23
(Children affected by disability)

Section 25
(Provision of accommodation for children etc.)

Section 26
(Manner of provision of accommodation to child looked after by local authority)

Section 26A
(Provision of continuing care: looked after children)

Section 27
(Daycare for pre-school and other children)

Section 29 (Aftercare)

Section 30
(Financial assistance towards expenses of education or training and removal of power to guarantee indentures etc.)

Section 31
Review of case of child looked after by local authority)

Section 32
(Removal of child from residential establishment)

Section 36
(Welfare of certain children in hospitals and nursing homes etc.)

Section 38
(Short term refuges for children at risk of harm)

Section 76 (Exclusion orders.)

Criminal Procedure (Scotland) Act 1995

Section 51
(Remand and committal of children and young persons)

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 203 (Reports)	
Section 234B (Drug treatment and testing order)	
Section 245A (Restriction of liberty orders)	
The Adults with Incapacity (Scotland) Act 2000	
Section 40 (Supervisory bodies)	
The Community Care and Health (Scotland) Act 2002	
Section 6 (Deferred payment of accommodation costs)	
Management of Offenders etc (Scotland) Act 2005	
Sections 10 (Arrangements for assessing and managing risks posed by certain offenders)	
Section 11 (Review of arrangements)	
Adoption and Children (Scotland) Act 2007	
Section 1 (Duty of local authority to provide adoption service)	
Section 5 (Guidance)	
Section 6 (Assistance in carrying out functions under sections 1 and 4)	
Section 9 (Assessment of needs for adoption support services)	
Section 10 (Provision of services)	
Section 11 (Urgent provision)	
Section 12 (Power to provide payment to person entitled to adoption support service)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 19 (Notice under Section 18 local authorities duties)	
Section 26 (Looked after children - adoption is not proceeding)	
Section 45 (Adoption support plans)	
Section 47 (Family member's right to require review of plan)	
Section 48 (Other cases where authority under duty to review plan)	
Section 49 (Re-assessment of needs for adoption support services)	
Section 51 (Guidance)	
Section 71 (Adoption allowance schemes)	
Section 80 (Permanence Orders)	
Section 90 (Precedence of certain other orders)	
Section 99 (Duty of local authority to apply for variation or revocation)	
Section 101 (Local authority to give notice of certain matters)	
Section 105 (Notification of proposed application for order)	
The Adult Support and Protection (Scotland) Act 2007	
Section 7 (Visits)	
Section 8 (Interviews)	
Section 9 (Medical examinations)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 10 (Examination of records etc.)	
Section 16 (Right to remove adult at risk)	
Children's Hearings (Scotland) Act 2011	
Section 35 (Child assessment orders)	
Section 37 (Child protection orders)	
Section 42 (Parental responsibilities and rights directions)	
Section 44 (Obligations of local authority)	
Section 48 (Application for variation or termination	
Section 49 (Notice of an application for variation or termination)	
Section 60 (Local authorities duty to provide information to Principal Reporter)	
Section 131 (Duty of implementation authority to require review)	
Section 144 (Implementation of a compulsory supervision order; general duties of implementation authority)	
Section 145 (Duty where order requires child to reside in a certain place)	
Section 166 (Review of requirement imposed on local authority)	
Section 167 (Appeal to Sheriff Principal: section 166)	
Section 180 (Sharing of information: panel members)	
Section 183 (Mutual assistance)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 184 (Enforcement of obligations of health board under section 183)	
Social Care (Self-directed Support) (Scotland) Act 2013	
Section 8 (Choice of options; children and family members)	
Section 10 (Provision of information; children under 16)	
Carers (Scotland) Act 2016	
Section 12 (Duty to prepare a Young Carer Statement)	
Children's Hearings (Scotland) Act 2011	
Section 153 (Secure accommodation: regulations)	

Part 2

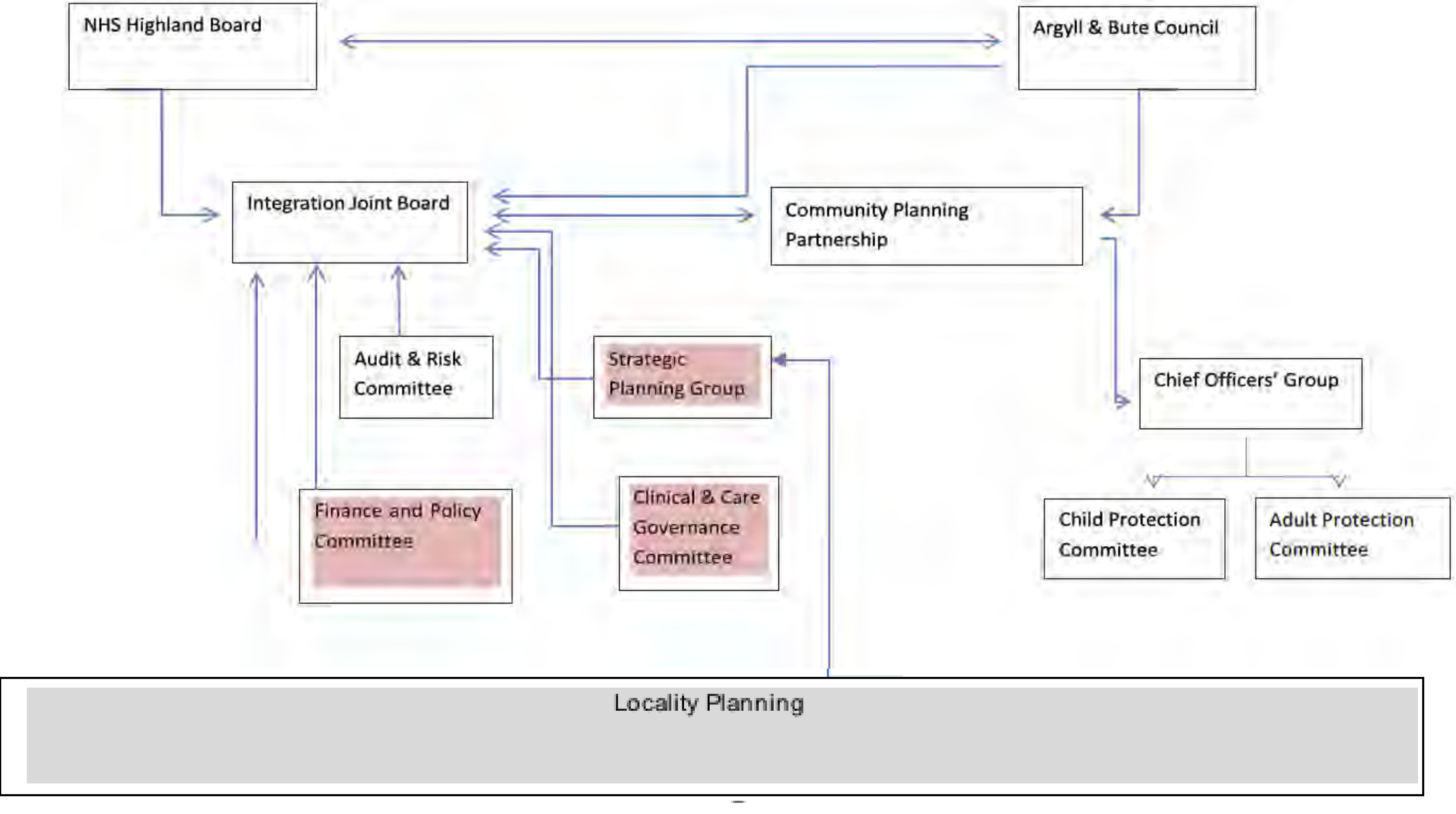
Services provided by the Council which are to be integrated:

All permitted Council functions apart from housing and housing support services, other than aids and adaptations aspects of housing support.

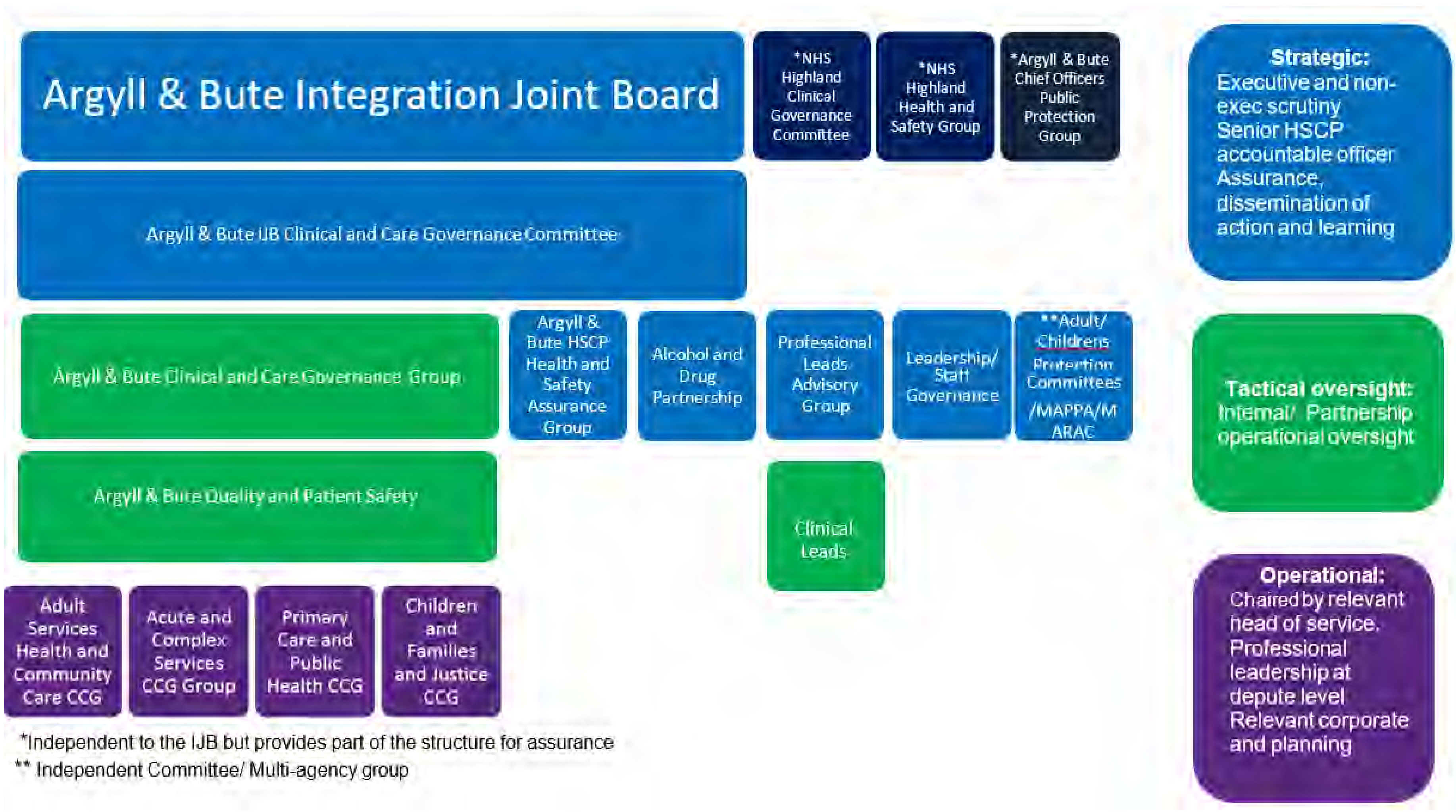
- Social care services for adults and older people
    - Services and support for adults with physical disabilities and learning disabilities
    - Mental health services
    - Drug and alcohol services
    - Adult protection and domestic abuse
    - Carers support services
    - Community care assessment teams
    - Support services
    - Care home services
    - Adult placement services
    - Health improvement services
    - Housing support including aids and adaptions
    - Day services
    - Local area co-ordination
    - Self-directed support
    - Respite provision for adults and young people
    - Occupational therapy services
    - Re-ablement services, equipment and telecare
- Social care services for children and young people
    - Child care assessment and care management
    - Looked after and accommodated children
    - Child protection
    - Adoption and fostering
    - Special needs/additional support
    - Early intervention
    - Through-care services
    - Youth justice services
- Social care justice services
    - Services to courts and parole board
    - Assessment of offenders
    - Diversions from prosecution and fiscal work orders
    - Supervision of offenders subject to a community based order
    - Through care and supervision of released prisoners
    - Multi agency public protection arrangements

Annex 3: Systems Governance.

System Governance Schematic



Annex 4: Clinical and Care Governance structure.



# NHS Highland	

Meeting:	**NHS Highland Board Meeting**
Meeting date:	**31 March 2026**
Title:	**NHS Highland Board Risk Register**
Responsible Executive/Non-Executive:	**David Park, Deputy Chief Executive Officer**
Report Author:	**Gil Paget, Project Manager – Strategy & Transformation**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal requirement

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

- Safe
- Effective
- Person Centred

This report relates to the following Corporate Objective(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well		Listen Well		Nurture Well		Plan Well	
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform Well		Progress Well		All Well Themes	X		

2 Report summary

This report is to provide Board with an overview extract from the NHS Highland Board risk register, awareness of risks that are being considered for closure and/or additional risks to be added. This report covers board risks that are reported through Finances, Resources and Performance Committee (FRPC),

Staff Governance Committee (SGC) and Clinical Governance Committee (CGC) for governance and oversight.

2.1 Situation

This paper is to provide Board with assurance that the risks currently held on the NHS Highland Board risk register are being actively managed through the appropriate Executive Leads and governance structures within NHS Highland and to give an overview of the current status of the individual risks.

All risks in the NHS Highland Board Risk Register have been mapped to the Governance Committees of NHS Highland and they are responsible for oversight and scrutiny of the management of the risks. An overview is presented to the Board on a bi-monthly basis.

The Audit Committee is responsible for ensuring we have appropriate risk management processes in place.

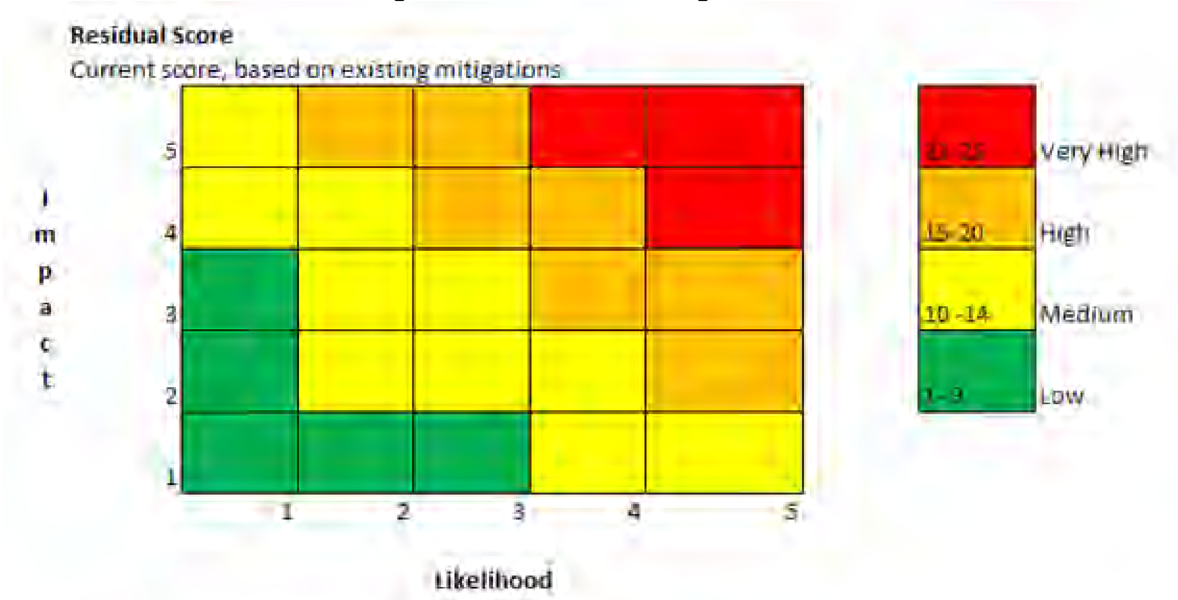
For this meeting, this summary paper presents a summary of the risks identified as belonging to the NHS Highland strategic risk register and recorded on Datix.

2.2 Background

Risk Management is a key element of the Board’s internal controls for Corporate Governance and was highlighted in the 2022 publication of the “Blueprint for Good Governance.” The Audit Committee provides assurance to the Board that risk management arrangements are in place and risks are managed effectively.

2.3 Assessment

The following section is presented to Board for an overview of the risks contained within the NHS Highland Board Risk Register.



Risk ID	CTTEE	Title	Risk Description	Mitigating Actions	Progress	Initial Grade	Target	Sept 25	Nov / Dec 25	Jan 26	Mar 26	Completed Actions	Live Actions	Executive Lead	Opened	Review Date	Trend	Strategic Objective
632	SGC	Culture across NHS Highland	There is a risk of a poor culture in some areas within NHS Highland due to inadequate leadership and management practice and inappropriate workplace behaviours, resulting in poor organisational performance including colleague and patient experience, staff retention, staff wellbeing and quality of care.	Cohort training for key groups of managers being explored. Staff engagement action plan	Cohort training being presented at next people and culture portfolio board. Action plan will review in Spring 2026 with a view to next steps for imatter and for further staff engagement sessions.	160	90	160	120	120		14	3	Gareth Adkins	Oct 19	May 26	↔	Listen Well Nurture Well Plan Well
706	SGC	Workforce availability	There is a risk of insufficient workforce to deliver our strategic objectives due to a shortage of available workforce and failure to attract and retain staff, resulting in failure to deliver new	Board Learning and Development group established and has proposed review of approach to appraisals. Plans in place to refresh 3 year workforce plan. An integrated service	Appraisal review is linking to work ongoing to establish career development frameworks as well as refreshing knowledge and skills framework. Intention is to	200	90	200	200	200		14	3	Gareth Adkins	Aug 20	May 26	↔	Plan Well

			models of health and social care, reduced services, lowered standards of care and performance and increased costs as well as a negative impact on colleague wellbeing, morale and increased turnover levels.	planning framework has been developed which is to be introduced to annual planning process in latter part of the year.	develop a people strategy rather than workforce plan and incorporate all aspects of people and culture strategic objectives including workforce planning and development.													
1056	SGC	Statutory Mandatory Training Compliance	There is a risk of poor practice across cyber-security, information governance, health and safety and infection control due to poor compliance with statutory and mandatory training requirements resulting in possible data breaches, injury or harm to colleagues or patients, poor standards of quality and care, reputational damage, prosecution or enforcement	New national statutory and mandatory training modules.	These will be launched in February 2026	200	80	150	150	150		3	1	Gareth Adkins	Jul 22	Apr 26	↔	Nurture Well Perform Well

			action.															
1375	FRPC	25/26 Financial Risk	There is a risk that NHS Highland will not deliver its planned financial position for 2025/26 and that the maximum deficit of £40m agreed with SG will not be achieved. There is currently no brokerage confirmed for 2025/26 therefore there is a risk of a section 22 report may be issued.	- A&B recovery plan submitted June 25 - STAG financial assessment completed Sept 25 - Non-recurrent recovery plan Q2 report to FRPC to update on actions Nov 25 - Monthly reporting – ongoing	The position is being monitored carefully as we move into the final months of the financial year. At month 10 the forecast is £44.6m deficit and additional £5m funding has been requested from THC towards the ASC gap, which would align the forecast with the £40m deficit funding available. The NHS GGC SLA vale of £8m is not included within the forecast and remains a significant risk	160	120	160	160	120		4	1	Heledd Cooper	Jul 25	Mar 26	↓	Perform Well
666	FRPC	Cyber Security	There is a risk that: NHS Highland could experience a cyber incident that results in loss of access to all or part of the digital infrastructure, devices, systems or data that	-Varonis Software purchased, initial scoping meeting held National OH support process to be fully implemented - Initial discussions taken place re NHSH early adopter of Horizon3.ai tool - NHSH Security	Risk reviewed and actions updated, risk level remains unchanged The results of the NIS 2025 audit provides assurance that NHSH continues	200	150	160	160	160		24	4	David Park	Oct 19	Mar 26	↔	Progress Well

			makes up its digital estate. Such an incident could occur at a board, regional or national level.	Management System doc set to be drafted - MS365 security features are being implemented - Trend Deep Security Tool network configuration required to extend to A&B	to operate at a level that exceeds the Scottish Governments SLA for cyber security and the SHCA expectations regards NIS compliance. Outstanding actions are on track for completion by delivery dates.													
1097	FRPC	Strategic Transformation	NHS Highland will need to redesign to systematically and robustly respond to challenges faced. If transformation is not achieved this may limit the Board's options in the future regarding what it can and cannot do for our population. The ability to achieve financial balance and the focus on the current operational challenges may leave insufficient capacity for the long-term	-reprioritisation of STAG programmes underway aligned to ADP 25/26 and OIP - Focus of leadership to be on key strategic transformation aligned to Together We Care - Structure for strategic transformation programme reporting portfolios to be established - Engagement with Exec Leads to define roles and responsibilities of programme management, clinical leadership and SROs	While programmes are reporting within a structure of portfolios, this action requires to extend to ensure a replacement for the previous STAG assurance reporting is stood-up. Proposal on the refocussing of strategic transformation programmes between planning priorities and Value & Efficiency	160	60	160	160	160		0	4	Bryan McKellar	May 23	Mar 26	↔	Perform Well

			transformation, which could lead to us unable to deliver a sustained strategic approach leading to an inability to deliver the required transformation to meet the health and care needs of our population in a safe & sustained manner and the ability to achieve financial balance.		programmes is progressing. Left-over planning programmes are being reviewed in terms of the deliverables for 26/27 as part of development of our Annual Delivery Plan Left-over planning programmes are being reviewed in terms of the deliverables for 26/27 as part of development of our Annual Delivery Plan													
1376	FRPC	Adult Social Care Financial Risk 25/26	There is a risk that NHS Highland will not deliver its planned position of financial balance within the Adult Social Care delegated budget for 2025/26.	-Expectation of a contribution towards eNIC for directly employed staff as a min – initial discussion with CO for Finance, THC - ASC recover plan and long term sustainable financial plan needed and in progress	The ASC forecast has reduced slightly in month 10 to £25.017m which is fully reflected within the NHSH position. Additional funding of £5m has been requested from The Highland Council to mitigate the overall NHSH position but will	160	120	160	160	160		4	1	Arlene Johnstone, Heledd Cooper	Jul 25	Mar 26	↔	Perform Well Care Well

					not offset the full ASC gap..													
1388	FRPC	ADP 25/26 Delivery	There is a risk that the Annual Delivery Plan for 2025/2026 will fail to deliver the outcomes of improving patient quality, care delivery and efficiency due to fragility of services and reliance on additional/ unfounded resource to cope with current levels of demand activity resulting in lack of compliance with Scottish Government Objectives.	-Quarterly reporting of ADP deliverables to EDG and monthly reporting of OIP deliverables established -Review of escalation process for ADP deliverables and documentation - Reprioritisation of STAG programmes to focus leadership on key transformation programmes	Actions in relation to the audit of ADP reporting are on track for completion by 31/3/25. FRPC continue to receive bi-monthly reporting on OIP deliverables. Quarterly ADP progress continues to be reported on EDG with escalation of any At Risk (red) deliverables Development of the 26/27 ADP has begun – this will carry over any incomplete ADP 25/26 actions.	160	80	160	160	160		1	2	Bryan McKellar	Sept 25	Mar 26	↔	All Well Themes
714	FRPC	Backlog Maintenance	There is a risk that the amount of funding available to invest in current backlog maintenance will not reduce the overall backlog figure. Continuing to work with SG where able when extra capital	Risk methodology in place to prioritise investment.	All backlog maintenance risks are prioritised through the BCIP risk assessment programme. This is reviewed throughout the financial year.	160	80	120	120	120		3	1	Richard MacDonald	Aug 20	Mar 26	↔	Perform Well

			funding is provided to remove all high-risk backlog maintenance.															
1353	CCGC	Sustainability	This risk articulates that the sustainability of clinical and social care services across the system may be compromised, impacting the ability of professionals to meet their responsibilities and uphold standards of care reflecting a recurring theme raised through the Clinical Governance Committee.	Re-configure service deliver, in line with regional or national work Assistance/pathways from other boards view service level agreements and mutual aid arrangements Digital solutions to allow remote/ virtual care Maintain service through locum cover where necessary	Risk description was amended to better define risk. No change	160	120	160	160	160		No individual actions recorded	0	Boyd Peters	May 25	July 26	↔	Progress Well
959	CCGC	COVID and Influenza Vaccines	Uptake rates for vaccination across NHS Highland for the winter COVID and influenza programmes have been reasonable with overall uptake in line with the national average. Staff uptake has tended to be slightly higher	Actions to increase uptake rate and other quality improvement in place Implementation of autumn/ winter 2025 COVID and influenza vaccinations	Vaccination funding with reduced allocation from last year and significant workforce issues remain – peer review complete and implementation group with action plan in place	160	90	120	120	120		4	6	Jennifer Davies	Nov 21	Mar 26	↔	Stay Well

			than national rates. Rates for some groups were low and Highland HSCP tends to have a lower uptake than Argyll and Bute. Highland HSCP remains in performance escalation with SG. Improving children's vaccination has been a major focus of work including peer review, vaccination improvement group and plans for a new model of delivery.		Effective delivery model in place across Highland HSCP												

Removed Risks:

ID	Title	Risk Description	Reason for removal
877	SGC	There is a risk of services being designed and delivered in ways that make them unsuitable or inaccessible to some people; because of lack of resourcing of, or commitment to, partnership working and engagement, leading to poorer health outcomes and reduced wellbeing for people in Highland and Argyll & Bute, and damaging the performance and reputation of NHS Highland.	The engagement framework has been developed and rolled out. This risk is no longer relevant
1182	FRPC	There is a risk that the transfer of New Craig site does not progress to timescale or concluded effectively due to the tight timescale. This could result in reputational/ service risk is the transaction is not completed or financial impact - through either financial penalties or inability to maximise the estate for future service delivery and estate rationalisation.	Removed from Risk Register. PFO Handback has now been concluded
1101	SGC	There is a risk of our workforce being impacted by the current social, political and economic challenges resulting in added financial pressures of pay uplifts, impact on colleagues being able to attend work and stay healthy due to personal financial pressures, direct and indirect impact of strike action on workforce availability and increased absence due to physical, emotional and mental health impacts of the wider situation as well as potential supply chain and energy shortages, increased turnover to higher paid employment and pressure on office capacity due to expense of working from home over winter. Demand for services will also increase creating further pressure on resources.	Risk related mainly to a period of time when strike action was imminent. This risk is no longer relevant.

1254	FRPC	Failure to Deliver ADP for 2024/2025	Although NHSH did not meet the initial brokerage cap set, the amended brokerage cap, which was in line with the proposed budget, was delivered
1352	FRPC	Timely Care: There is a risk that access to timely and appropriate investigations, care or treatment as required in the ADP will not be achieved or fully available in a timely fashion. Access to Treatment: There is a significant risk that NHS Highland will fail to achieve all waiting time standards for community and hospital services. This will lead to delay in diagnosis and potential progression of disease/symptoms and hence poorer experience and outcomes for our population.	Risk – rejected as reflected elsewhere and in Performance finance Resource Committee

Assessment – NHS Highland Risk Management Framework

NHS Highland currently faces several key risks in relation to its risk management arrangements, primarily arising from the absence of a designated department, team or manager with formal responsibility for risk management. This has led to vulnerabilities in compliance, oversight, engagement, and systems use, as outlined below.

1. **Ownership and Accountability**
   Without a designated risk management function, there is a risk of poorly managed or unidentified risks, leaving the organisation exposed to non-compliance with the Orange Book requirements. While Strategy & Transformation Project Management has supported risk owners and champions by embedding risk processes within operational divisions, a dedicated risk manager is required to provide consistent leadership, accountability, and compliance assurance.

2. **Staff Engagement and Capability**
   Risk management may be undermined by limited staff engagement, as those required to manage risks often lack the necessary skills, tools or support. Although learning materials and resources have been developed and shared via the Risk Champions Teams channel, these are interim measures. Sustainable improvement requires a central function to coordinate training, build capability, and maintain consistent standards across the organisation.

3. **Oversight and Integration**
   The lack of central oversight across corporate, divisional, and operational risks has created duplication, additional workload, and missed opportunities to align risks across levels. Interim support has been provided by Strategy & Transformation Project Management and risk champions, but formalised oversight must be built into NHS Highland's corporate governance framework to ensure risks are consistently captured, escalated, and monitored.

4. **Link Between Risks and Adverse Events**
   Opportunities to proactively identify risks and reduce adverse events are currently constrained, as risk and adverse event management are managed separately in a closed-loop process. Limited oversight restricts the ability to identify themes and learning across both domains. Incorporating regular review of adverse events into the risk governance system will strengthen proactive risk reduction and patient safety outcomes.

5. **Systems and Technology**
   Sub-optimal use of risk management applications (Datix) and delays in implementing a new software (InPhase) are significant risks.

Overall, the assessment highlights a pressing need for NHS Highland to establish a dedicated risk management function, supported by a commissioned and organisation-owned Risk Improvement Plan. Interim measures have maintained progress, but the recommended actions set out above are essential to embed risk management within corporate governance and to strengthen the organisation's ability to manage risks proactively and effectively.

A timeline to refresh risk was taken to the Audit Committee on 14 March 2026 who supported the proposed actions. This timeline includes the full review of all risk registers by 17 April 2026 as well as implementing a training programme for the management of risk.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	x	Moderate	
Limited		None	

While the proposed level of assurance is substantial for level 1 risks, the proposed level of assurance is moderate for the Board's Risk Assurance Framework.

3 Impact Analysis

3.1 Quality/ Patient Care

A robust risk management process will enable risks to quality and patient care to be identified and managed. Assurance for clinical risks will be provided by the Clinical and Care Governance Committee.

3.2 Workforce

A robust risk management process will enable risks relating to the workforce to be identified and managed. Assurance for these risks is also provided by the Staff Governance Group and where appropriate to the Staff Governance Committee.

3.3 Financial

A robust risk management process will enable financial and performance risks to be identified and managed. Assurance for these risks will be provided by the Finance, Resources and Performance Committee.

3.4 Risk Assessment/Management

This is outlined in this paper.

3.5 Data Protection

The risk register does not involve personally identifiable information.

3.6 Equality and Diversity, including health inequalities

An impact assessment has not been completed because this is a summary report.

3.7 Other impacts

No relevant impacts.

3.8 Communication, involvement, engagement and consultation

This is a publicly available document. We aim to share this more widely internally and externally to develop understanding of risks within the system in in line with our strategic objectives and outcomes once strategy is approved.

3.9 Route to the Meeting

Through EDG, FRPC, SGC, CGC and Board.

4 Recommendation

- **Assurance** – To give confidence of compliance with legislation, policy and Board objectives.

4.1 List of appendices

N/A

NHS Highland Chief Executive's Update

March 2026

Fiona Davies,
Chief Executive NHS Highland

Managing Winter Pressures

Like many health systems across Scotland, NHS Highland has been navigating significant winter pressures over recent months. In particular, Raigmore and Caithness General Hospitals has been operating at elevated escalation levels, with high occupancy, delayed discharges, and demand on our urgent and unscheduled care pathways all contributing to system-wide pressure. I want to acknowledge the exceptional effort of our staff across acute and community services who have worked tirelessly to maintain safe, high-quality care throughout this period.

In response, we established an Incident Management Team to provide frequent executive oversight of patient flow and discharge activity across the system. This structured approach has helped us to better understand and manage the pressures we face coordinated discharge processes are now in place, community pathway capacity is being identified daily, and we have strengthened the working relationship between our acute and community services. While we are seeing some encouraging progress in discharge activity, this remains work in progress. Winter pressures of this scale do not resolve quickly, and there is more to do to achieve the sustained improvement our patients and staff deserve. What the IMT has given us is valuable operational learning and a clearer picture of where the systemic barriers lie and that foundation will inform how we continue to develop our approach.

Alongside this operational response, I am pleased to report the introduction of two important new initiatives that are already supporting our system. NHS Highland and the Scottish Ambulance Service have strengthened our long-standing collaborative relationship through the introduction of Hospital Ambulance Liaison Officers (HALOs) at Raigmore, funded through the SAS winter pressures programme. Bev MacKenzie and Blair Gordon are embedded within our Flow Team, providing seven-day cover and acting as a dedicated point of contact for complex discharges and patient handovers, making a tangible difference to both patient safety and staff experience.

In addition, our new Hospital at Home service launched in North Highland in January and is steadily building capacity. Currently providing the equivalent of five beds, the service enables patients to receive acute-level care in their own homes and is already contributing meaningfully to system flow. We have every reason to be optimistic about its potential, our Hospital at Home service in Oban has been transformative for the Argyll and Bute population it serves, with patients, families and clinical colleagues across the system all speaking powerfully to its impact on outcomes, independence and system pressure.

That experience gives us a strong foundation and genuine confidence as we develop the North Highland service. Recruitment is ongoing and we anticipate reaching the equivalent of 15 beds later in the year. Together, these developments reflect the kind of whole-system, partnership-based approach that I believe is essential to building a more resilient service for the future.

Cross Leadership Development Session

I was pleased to host our first Cross Leadership Development Session on 5 March, bringing together approximately 40 senior managers for a full day of structured dialogue focused on connecting purpose, people and pathways forward. I opened the session by reflecting on what matters most to us as an organisation, our purpose, our values and our commitment to quality set against the very real backdrop of financial tension and the need to work more sustainably and differently than we have before. Rather than presenting a single vision from the top, I was clear that shaping our collective future needs to be a shared endeavour, and that this gathering was about creating the space for our senior leadership community to contribute to that.

The day was shaped around seven themes including what we are doing well, how we better meet community needs, opportunities for a prevention-focused whole system approach, cross-system collaboration, innovation, future challenges, and how we take our staff with us through change. These were not rigid separate discussions but interconnected areas that naturally overlapped and influenced conversations throughout the day, with similar themes emerging across the group alongside new ideas and approaches that we will continue to develop.

I was struck by the quality of engagement and the commitment in the room to doing things differently. My intention is for this to become a quarterly meeting that will rotate in location around the Board area, with smaller groups taking focused pieces of work forward as we shape our new population health strategy and build the relationships needed to create genuine and lasting change.

Sub-National Planning – Scotland West

As part of the Scottish Government-directed sub-national planning structure, I continue to co-chair the Finance, Planning, Performance and Workforce (FPP&W) Delivery Group within Scotland West, alongside the interim sub-national finance lead. This group is working at pace to develop the Scotland West contribution to the national sub-national plan, with a focus on achieving financial balance by March 2029, establishing a Scotland West performance framework with clear KPIs and trajectories, and coordinating sustainable plans for regional and vulnerable services. A skeleton plan outline was shared in early February, and a first full draft was submitted at the end of the month. The draft plan will be considered by the Scotland West Strategic Planning and Delivery Committee, before being submitted to Scottish Government by 31 March 2026 for review and feedback. It is anticipated that the plan will subsequently be returned to boards for formal approval.

More broadly, the Scotland West structure which brings together seven territorial boards including NHS Highland is making good progress in establishing its three delivery groups covering Planned Care (orthopaedics), Improving Flow (urgent care and digital front door), and the FPP&W group. A sub-national handbook is being developed to set out governance, leadership and performance monitoring arrangements, and a Programme Management Office approach is being established to provide consistent oversight. The golden threads of inequalities, rural and island communities, digital transformation and innovation run throughout all of this work, which is directly relevant to NHS Highland's population and geography. I have been asked to co-chair the Rural and Island group

with James Goodyear, Interim CEO of NHS Orkney to take a pan-Scotland approach to that Golden Thread. Initially this will focus on synthesising the Joint Strategic Needs Assessments of these areas so that the health needs of rural and island communities are evidenced and understood.

Renal Service: 50th Anniversary and Endowment Fund Project

This month marks a significant milestone for NHS Highland's Renal Service, as we celebrate the 50th anniversary of the first kidney dialysis treatment in the Highlands, carried out at Raigmore Hospital in March 1976. In the decades since, the service has grown considerably and now includes renal units in Fort William, Wick, and Broadford, enabling patients across our dispersed geography to access treatment closer to home.

Photo caption: Staff past and present at 50th celebration

Over one thousand patients have received regular dialysis since the service began, and several hundred have gone on to receive kidney transplants. To mark this landmark anniversary, the team hosted an informal gathering for current and former patients, transplant recipients, and staff past and present providing a wonderful opportunity to reflect on the service's history and the many lives it has touched.

Alongside this celebration, I am pleased to share news of an exciting new initiative for the Renal Unit at Raigmore, made possible through a generous legacy donation entrusted to NHS Highland Charity and given specifically to support the service. Around 100 patients currently attend Raigmore for haemodialysis, with sessions lasting up to five hours several times each week, a demanding and at times isolating experience.

The legacy gift has enabled the development of a year-long pilot project, designed with direct patient input and in partnership with High Life Highland it will introduce creative activity to the unit during treatment time. The project has been developed to support emotional wellbeing, self-expression and connection and will culminate in a public exhibition celebrating the work produced by patients and staff together.

This initiative is a fine example of how philanthropy, partnership and clinical care can come together to enrich the patient experience, and I am proud that it has been developed in direct response to feedback from our patients about what matters to them.

CGI Conference

Photo caption: CGI Conference Discussion

I was pleased to join Pippa Milne, Chief Executive of Argyll & Bute Council, in presenting at the CGI Conference last week, where together we shared our joint learning on public service reform across our two organisations. The session drew on the key factors in Argyll & Bute, such as complex geography, workforce pressures, and constrained resources, to make the case that sustainable reform requires planning at the right scale, building trusted relationships, and designing services around the communities they serve rather than the structures that deliver them. Between us, we covered a range of interconnected themes: the behavioural and cultural shift required under a Single Authority Model; how sub-national planning enables both regional consistency and local flexibility; and the importance of collective sense-making, analysing problems jointly before negotiating solutions. We were clear that integration remains critical but must be held lightly, with governance that is proportionate and accountable without becoming an end in itself.

The opportunity to present alongside Pippa reinforced for me the value of cross-boundary leadership, and to hear from colleagues in other sectors including a presentation from NHS National Education for Scotland on the Digital Front Door being developed in partnership with CGI

Hospital Visits

Caithness General Hospital

In early February, I was pleased to visit Caithness General Hospital in Wick, where I had the opportunity to meet with staff across the hospital including our midwifery team. It was wonderful to see first-hand the dedication of colleagues working in such a remote and rural setting, and to hear directly about both the challenges and the pride they take in serving their local community.

As part of the visit, I met with representatives of the Caithness Health Action Team (CHAT), joined by our Chair, Sarah Compton-Bishop, and Eddie Gilmartin, our Rural General Hospital Manager. This was the latest in a series of regular and constructive meetings with CHAT, and I value the open and professional relationship we have developed with this community group.

Photo Caption: *Fiona Davies, NHSH Chief Executive with Donna Firth, Team Lead Midwifery and Sarah Compton-Bishop, NHSH Chair at Caithness General Hospital*

Photo caption L-R: *Eddie Gilmartin, Rural General Hospital Manager; Iain Gregory CHAT; Ron Gunn CHAT; Sarah Compton-Bishop, Chair NHSH; Fiona Davies, CE NHSH; CHAT members Elizabeth More, Gill Arrowmsith, Derek Bremner, Marlene MacDonald, Susan Sutherland and Elspeth Husband.*

Our discussions ranged across a broad spectrum of local health priorities, including palliative and end of life care, maternity services, A&E bed capacity, GP pressures, care at home provision, and access to appointments at Raigmore for Caithness patients. We also had a useful conversation about staff accommodation and the very real recruitment challenges facing remote and rural areas and CHAT indicated a willingness to support incoming staff in finding suitable housing locally, which I welcomed. Meetings like this are an important part of how I stay connected to the communities we serve, and I came away with a clear sense of the commitment of both our local teams and our community partners to achieving the best possible outcomes for people in Caithness.

New Craigs Hospital
I recently visited New Craigs Hospital, where I met with the leadership team to hear about their vision for mental health services in Highland and had the opportunity to walk several of the wards.

Having known the hospital well from my own time working there, it was particularly meaningful to see at first hand the continuing improvements in culture, patient safety and quality assurance, a real testament to the dedication of the team.

Photo Caption L-R: *Tom McGreavy, Charge Nurse, Morar Ward at New Craigs and Fiona Davies, Chief Executive*

Aviemore Community Hospital
I also visited Aviemore Community Hospital, where staff shared with me the realities of delivering district-based services from a relatively new building, including the ongoing recruitment challenges that continue to affect their capacity. These conversations are invaluable in helping me understand the pressures our teams are navigating day to day.

Photo Caption L-R: *Tony Powell, Senior Charge Nurse; Fiona Davies, Chief Executive and Kenny Rodgers, District Manager at Aviemore Community Hospital*

The Moorings, Muir of Ord
I recently visited Katie at her new home at The Moorings in Muir of Ord, and I wanted to share something of her story with the Board. Katie is a young woman with complex autism who, following a difficult period without the right community support in place, spent a number of years in a hospital setting including 7 years in New Craigs Hospital that, while providing clinical care, was never the right long-term environment for her. I want to be honest with the Board that finding the right local solution took longer than it should have, and that is something we must learn from. The development of The Moorings, though delayed further by the pandemic, ultimately provided the answer Katie and others with similar specialist support requirements needed, her story is a reminder of what is at stake when the right housing and support is not in place. Good transition planning for children and young people with complex needs will need to be a focus of our integrated health and social care, as discussed at our recent Joint Monitoring Committee.

The Moorings is a purpose-built core and cluster development, delivered by NHS Highland in partnership with Key Community Supports, providing six individual tenancies in Muir of Ord for

people with complex needs. Integrated staffing accommodation enables 24-hour support on site, allowing individuals to live as independently as possible within their community. The development directly supports the Scottish Government's ambition to reduce out-of-area placements and delayed hospital discharges, and reflects what can be achieved when health, housing and the independent sector work with genuine shared purpose.

Katie moved into her new home in January 2025 and is flourishing. When I visited, I was struck by how settled and content she is, taking part in activities she loves and beginning to engage with life in her local community in Muir of Ord. Hearing first-hand what this independence means to her was a genuinely moving experience, and a powerful reminder of why getting these solutions right matters so much. The Moorings is a happy ending, but it is also a prompt to ensure we continue to develop the range of specialist housing and community support that enables people to live well, and close to home from the outset.

I want to be honest with the Board that finding the right local solution took much longer than it should have, and this delay had a significant negative impact on both Katie and her family. This is something we must learn from.

Fiona Davies, Chief Executive NHS Highland