NHS HIGHLAND BOARD	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk/
DRAFT MINUTE of BOARD MEETING Virtual Meeting Format (Microsoft Teams)	**27 May 2025 – 9.30am**

Present

Dr Tim Allison, Director of Public Health & Policy
Alexander Anderson, Non-Executive
Emily Austin, Non-Executive
Graham Bell, Non-Executive
Elspeth Caithness, Employee Director (until 12pm)
Sarah Compton-Bishop, Board Chair
Louise Bussell, Nurse Director
Garret Corner, Argyll & Bute Council stakeholder Non-Executive
Alasdair Christie, Non-Executive
Muriel Cockburn, Highland Council stakeholder Non-Executive
Heledd Cooper, Director of Finance
Albert Donald, Non-Executive
Fiona Davies, Chief 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
Catriona Sinclair, Non-Executive & Chair of ACF
Steve Walsh, Non-Executive
Dr Neil Wright, Non-Executive

In Attendance

Gareth Adkins, Director of People and Culture
Dr Heather Bain, University of the Highlands and Islands
Evan Beswick, Chief Officer, Argyll & Bute Health & Social Care Partnership
Rhiannon Boydell, Head of Service
Andrew Devlin, Interim Head of Communications & Engagement
Kristin Gillies, Interim Head of Strategy & Transformation
Liz Humphreys, Non-Executive, Scottish Ambulance Service (Observing)
Richard MacDonald, Director of Estates, Facilities and Capital Planning
David Park, Deputy Chief Executive
Katherine Sutton, Chief Officer, Acute
Nathan Ware, Governance & Corporate Records Manager
Dominic Watson, Incoming Head of Corporate Governance (Observing)

1.1 Welcome and Apologies for absence

The Chair welcomed attendees to the meeting, especially members of the public and press.

The Chair paid tribute to Catriona Sinclair whose term as Area Clinical Forum was coming to an end, highlighting her dedication, leadership and the positive impact she has had on strengthening engagement between the Forum and Board.

The Chair also expressed gratitude to Nathan Ware, Governance and Corporate Records Manager for maintaining continuity of Board business following the departure of the Board Secretary, ahead of the new Head of Corporate Governance joining in June.

Additionally, the Chair welcomed new Board Member Dr. Neil Wright, alongside Liz Humphries, who was attending as part of the Aspiring Chairs Programme.

Apologies for absence were received from Brian Williams and Pamela Stott.

1.2 Declarations of Interest

Alasdair Christie stated he had considered making a declaration of interest in his capacity as a Highland Council Councillor, but felt this wasn't necessary after completing the Objective Test.

Steve Walsh stated he had considered making a declaration of interest in his capacity as an employee of Highlife Highland, but felt this wasn't necessary after completing the Objective Test.

1.3 Minutes of Previous Meetings and Action Plan

The Board **approved** the minutes as an accurate record of the meeting held on 25 March 2025.

The Board **noted** the Action Plan and **agreed** to keep Actions 33, 35, and 42 open, as they were dependent on matters expected to be addressed through the proposed Population Health and Planning Committee, which was due for discussion later in the agenda. The Board **approved** the closure of the remaining six actions.

1.4 Matters Arising

2 Chief Executive's Report – Update of Emerging Issues

The Chief Executive provided updates on the Cabinet Secretary for Health and Social Care visit to Raigmore and the National Treatment Centre. Further updates on the Sutherland Care at Home Improvement Notice, Vascular procedures, Integration with The Highland Council, and the Hospital Electronic Prescribing and Medicines Administration (HEPMA) roll out.

She also took the opportunity to congratulate Lochardil Pharmacy, who won Community Pharmacy of the Year and KinWell Pharmacy in Nairn, who won the Innovation in Community Pharmacy Practice at the Scottish Pharmacy Awards 2025.

During discussion the following points were raised:

- The Chair extended her congratulations to the two pharmacy teams and welcomed the continued rollout of the HEPMA programme.
- Board Members acknowledged the challenges surrounding Sutherland Care at Home and appreciated immediate remedial actions were being prioritised. However, they expressed concern about the communication process, particularly around why information was shared out of sequence; They requested clarity on how this occurred and what steps would be taken to prevent a recurrence. The Deputy Chief Executive confirmed that it will form part of the large-scale investigation, and an action plan would be developed once the formal recommendations were received.
- The Chair highlighted a concern around support for staff during this difficult period, particularly as they were working extremely hard to deliver the Care at Home services under such challenging circumstances. The Deputy Chief Executive provided assurance that support for staff was an essential element in the review process, but work had already taken place by way of a recruitment fair and additional training provided to line managers to assist them in supporting their staff directly.
- Board Members asked whether the additional funding given to the National Treatment Centre was recurrent. The Director of Finance confirmed it was recurrent but was subject to delivering on some key metrics.

The Board **noted** the update.

3 Governance and other Committee Assurance Reports

a) Finance, Resources and Performance (FRP) Committee agreed minute of 14 March and 4 April 2025, and summary of meeting of 9 May 2025

The Chair of FRP highlighted that committee had received updates on the financial position at each meeting which were discussed in detail and would be revisited later in the Board agenda. The Committee also reviewed a letter from the Scottish Government regarding the financial plan; and discussed Scottish Government's challenging 75% decarbonisation target particularly around feasibility and investment required.

Updates were also provided on the IPQR, digital healthcare strategy and financial risk. He noted that while financial risks had decreased, work would be needed to manage them in the next financial year.

b) Staff Governance Committee agreed minute of 4 March 2025 and summary of meeting of 6 May 2025

The Vice Chair of Staff Governance reflected positively on the meeting. The Committee discussed the draft Annual Delivery Plan (ADP) and welcomed the staff governance deliverables.

A spotlight session on employability in acute services highlighted the operational implementation of the employability strategy and NHS Highland's role as an anchor institution.

The Committee also reviewed the Medical Education, and the Education, Learning and Organisational Development (ELOD) annual reports. It was noted that the integration of ELOD work had delivered efficiencies and effective working across NHS Highland. Following discussion, the committee agreed to raise the level of assurance on the Medical Education annual report to substantial.

c) Highland Health & Social Care Committee (HHSCC) agreed minute of 5 March 2025 and summary of meeting of 7 May 2025

The Chair of HHSCC highlighted Committee received the Annual Care Home Collaborative Report, which provided a reassuring overview of the care home sector across North Highland but referenced the sector's ongoing fragility primarily driven by financial pressures. He noted the issue had been escalated to the Executive Directors Group.

He added it was positive to see the planned opening of up to 78 new care home beds over the course of 2025/26.

The Committee also reviewed progress against the vaccination options appraisal nd noted that work had been divided into two main workstreams, children and adults with both progressing steadily. An update was also received from dental services and work continued to address the ongoing service provision challenges.

The Chair of HHSCC welcomed Dr Neil Wright as Non-Executive Director alongside Dr Tom Brown as the new lead GP.

d) Clinical Governance Committee agreed minute of 6 March 2025 and summary of meeting of 1 May 2025

The Chair of Clinical Governance Committee highlighted a rich discussion around the vascular service, care at home services, and the ongoing challenges with the Care at Home service in Sutherland.

These areas continued to face pressure and work was underway to address those but acknowledged the broader national issue which contributed to the challenges. It was confirmed the Chief Officer for Acute would provide an executive summary in due course.

She noted that staff continued to input a considerable amount of effort to maintain these essential services but the demand on staff and impact on service users was clearly noted.

e) Audit Committee agreed minute of 11 March 2025 and summary of meeting of 13 May 2025

The Chair of Audit Committee highlighted there had been positive news regarding children's services, as fieldwork for the internal audit had now commenced and an update on progress was expected in June with an aim to present findings at the September meeting.

She noted Committee focused on the management actions and all items were on track for closure. Concerns remained in adult social care and complex care with a comprehensive update planned for the June meeting.

f) Argyll and Bute Integration Joint Board (IJB) Minute 26 March 2025

The Chair of the IJB highlighted financial challenges continued to be a focus and the end-of-year financial position was reviewed which indicated reserves were utilised to achieve balance.

He noted that in an effort to strengthen local engagement the IJB bimonthly meetings would be held in various locations across Argyll and Bute to assist board members gain a deeper appreciation of local issues. He noted resourcing remained a major concern but focused work was underway on long-term sustainability of the workforce.

The Board:

- **Confirmed** adequate assurance had been provided from Board governance committees.
- **Noted** the Minutes and any agreed actions from the Argyll and Bute Integration Joint Board.

4 Draft Annual Delivery Plan 2025-26

The Board received a report from the Interim Head of Strategy and Transformation outlining the draft Annual Delivery Plan (ADP) for 2025-26, which was submitted to Scottish Government in March 2025. The report provided an Executive Summary across each Well theme and will be subject to quarterly reporting to EDG and Scottish Government, with 6-monthly progress updates planned for Finance Performance and Resources Committee (FRP). Once approval from Scottish Government is received, a final version of the ADP 25/26 will be shared with FRP for assurance prior to progression to NHS Highland Board.

The Board was asked to take substantial assurance as the plan provides confidence and compliance with legislation, policy and Board objectives in development of the Annual Delivery Plan and Medium-Term Plan.

The Interim Head of Strategy and Transformation spoke to the circulated report and highlighted the ADP was awaiting final approval from Scottish Government and included medium-term priorities for 2027–2028, key performance indicators, and proposed success measures which would be integrated into the next version of the Integrated Performance and Quality Report (IPQR).

She added that final feedback from government was expected imminently, with the aim of presenting the final version for board approval in July.

During discussion the following points were raised:

- Board Members sought clarity on whether delays in receiving Scottish Government approval had impacted progress, potentially affecting the ability to meet KPIs due in June 2025 or whether work had already commenced. The interim Head of Strategy and Transformation confirmed the work was ongoing and didn't envisage any concerns from Scottish Government as early feedback had been positive.
- The Board Chair asked whether the delay was due to NHS Highland being an outlier by comparison to other Boards. The interim Head of Strategy and Transformation confirmed that wasn't the case and the delay revolved around the ADP's alignment to NHS Highland's financial plan which was under review.
- Board Members asked whether the First Minister's commitment to eliminating waits beyond 52 weeks by 26 March 2026 would be reflected in the final trajectories in the ADP, particularly given the strong performance NHS Highland's Treatment Time Guarantee had this year. They also sought clarity around the rationale behind the projected trajectory for delayed discharges.
- The interim Head of Strategy and Transformation advised the trajectories were being actively reviewed following confirmation of planned care funding and the team remained in close dialogue with government colleagues should the trajectories require adjusted if further funding was secured.
- The Chief Officer for Acute added that delayed discharges had reduced slightly, with further improvement expected through new frailty pathways alongside a dedicated unit at Raigmore and targeted Hospital at Home services in high-impact areas.
- Board Members welcomed the inclusion of the easy read section, noting that it had made the content more accessible and digestible. They commended the effort involved in condensing complex information and highlighted the importance of presenting key priorities in a way that supported public understanding and transparency.

The Board **noted** the content of the report and took **substantial assurance** it provided confidence and compliance with legislation, policy and Board objectives in development of the Annual Delivery Plan and Medium-Term Plan.

5 Finance Assurance Report – Month 12 Position

The Board received a report from the Director of Finance which detailed the financial position as at Month 12, 2024/2025. The Board were invited to take moderate assurance as the board delivered a balanced position within the agreed brokerage, although the final accounts position was still subject to audit.

The Director of Finance advised the draft Month-12 financial position remained subject to external audit and final sign-off. She confirmed the Board's original plan presented a budget gap of £112.491m. With a brokerage cap of £28.400m which meant savings of £84.091m were required, but an agreed plan of £50.6m deficit. At the end of March 2025 (Month 12) an underspend of £0.206m was reported. This position had been delivered following the receipt of £49.700m of brokerage and additional funding from the Highland Council Transformation Fund to support the Adult Social Care position. This results in a cumulative brokerage position of £106.5m.

The Highland Health and Social Care Partnership (HSCP) reported an improved position at year-end, although Adult Social Care recorded an overspend. This was reduced through additional support from The Highland Council's transformation fund, and the remainder offset through slippage in non-recurrent funding in Health budgets. The Argyll and Bute HSCP achieved a balanced position by utilising reserves to offset reported pressures. The financial position for Acute services had improved, with cost reductions across specialties and services in the Belford and Caithness Hospitals.

It was highlighted that £30.4m savings had been delivered, representing a 2.7% saving against a 3% target. Supplementary staffing costs increased in Month 12 due to prior period adjustments and a provision for a potential future claim. The Board had worked with Scottish Government to maximise the use of available funding to deliver an on-target position at financial year end.

Board members queried whether the rollout of HEPMA would help reduce overspending on drugs and prescribing. The Director of Finance advised that the programme is expected to support improved governance and reporting, which may contribute to better cost control.

Having **examined** the draft Month 12 financial position for 2024/2025, the Board **considered** the implications and **agreed** to take **moderate assurance** from the report.

6 NHS Highland 2025/26 Budget Update

The Board received a report from the Director of Finance detailing the 3-year financial plan 2025/26 to 2027/28 setting out the process to identify and deliver further actions required to reduce the financial gap to the SG requirements.

The Board was invited to take Limited Assurance that NHS Highland would deliver the level of savings required by SG and the delivery of a plan that reduces the gap further in year. The report noted assurance should be taken from the robust approach and identification of pressures and mitigations.

The Director of Finance spoke to the circulated report and highlighted the following:

- The budget presented was interim and subject to change whilst discussions continued with Scottish Government prior to formal agreement.
- The plan included a 3% recurrent savings target, consistent with the previous financial year and an opening deficit of £115.6 million for 2025/26 with planned outturn position of £55.7million deficit.
- Argyll and Bute also faced a 3% efficiency target, but actions were yet to identified to achieve the full amount.
- Adult Social Care has been set a 3% recurrent savings target but further actions would be needed to reduce the full funding gap.
- There were no new investments beyond agreed allocations, but funding had been received for 60% of employer National Insurance contributions and a sustainability payment to support the financial position. However, no allocation had been assumed for national insurance contributions within adult social care.
- She noted Scottish Government expected the board to limit the deficit to £40 million despite a confirmation that there would be no brokerage for 2025/26. Further work was underway to identify non-recurrent savings and accelerate the efficiency programmes.
- She highlighted that risk remained in delivering the adult social care position and there was an emerging risk from the new planned care funding, which is conditional on achieving core activity first.

During discussion the following points were raised:

- The Chair asked what the £40 million figure, mentioned by Scottish Government was based on and whether discussions had been held around that figure. The Director of Finance explained that there had been no prior discussion with Scottish Government before the letter was issued. She noted that based on verbal feedback, the £40 million figure appeared to factor in sustainability allocations but did not fully account for rising cost pressures and lacked a clear, evidence-based calculation.
- Board Members sought clarity around the specific proposals that would deliver the required level of savings in adult social care and asked if the final version of the budget proposal could be shared with members. The Director of Finance explained that the adult social care position remained unchanged from previous plans and reflected similar assumptions to last year, where a comparable funding gap existed. While some significant transformation programmes had been proposed and supported by council funding, detailed improvement trajectories were not yet available. She confirmed the final submission would be scrutinised by the Finance, Resources and Performance committee (FRP) prior to submission given the tight timelines involved.
- The Chair added that Non-Executive Members were welcome to attend the FRP meeting should they wish.
- Board Members asked whether the full impact of the National Insurance increase had been included in the budget under national policy decisions or pay pressures. They also queried if the same assumption applied to adult social care and whether partial funding such as 60% had been assumed.
- The Director of Finance confirmed that the full National Insurance cost for directly employed staff was included in the budget with 60% funded by Scottish Government, the rest was offset through sustainability funding. In adult social care, the full £1.3 million cost was assumed for directly employed staff without confirmed Council funding, although some funding is anticipated.
- Board Members questioned whether the Board should actively challenge or seek clarification from Scottish Government around the £40 million deficit target, rather than passively accepting it without clear justification. The Director of Finance explained that whilst the ministerial letter offered little context, there had been ongoing dialogue with them and discussions revealed a more flexible stance. She added that work was underway to develop realistic, supported plans that would not compromise the Annual Delivery Plan (ADP).
- The Chair proposed that the FRP Committee on 6th June finalised a cover letter to accompany the financial plan submission to the Scottish Government. She suggested it incorporated key points raised, particularly around the £40 million target and the Board's position.

The Board **examined** and **considered** the content of the report and **agreed** to take **limited** assurance.

The Board took a break at 11.30am and the meeting resumed at 11.45am

7 Integrated Performance and Quality Report

The Board received a report from the Deputy Chief Executive that detailed current Board performance and quality across the health and social care system. The Board was asked to take limited assurance due to the continued and sustained pressures facing both NHS and commissioned care services, and to consider the level of performance across the system.

The Deputy Chief Executive spoke to the circulated report and highlighted:

- Waiting list numbers continued to reduce and the Treatment Time Guarantee (TTG) remained slightly ahead of ADP target.
- Vaccination uptake had declined but work was under way to drive improvement.
- Delayed Discharges have reduced from a peak of 220 to 208
- 31-day and 62-day cancer performance had improved and increased to 94% and 78% respectively in April.
- Vacancy time to fill has continued to improve alongside absence rates which have continued to reduce since November 2024.

During discussion the following points were raised:

- Board Members sought clarity on whether previously advised complaints training had helped to improve overall performance. They also asked how learning from Significant Adverse Event Reviews (SAER's) was applied.
- The Medical Director explained that the complaints training had focused on improving the quality of responses rather than response times, so it had not impacted the performance metric. He added that learning from SAERs

had occurred both locally and at an organisational level, with clinical governance managers using the insights to inform training.

- Board Members asked if the cancer performance figures reflected the Argyll and Bute locality or only Highland. The Interim Head of Strategy and Transformation confirmed they only represent the Highland locality as any cancer pathways in Argyll and Bute were tracked through NHS Greater Glasgow and Clyde.
- Board Members sought clarity on the appraisal completion rates and whether any further progress had been made. The Director of People and Culture noted that completion rates had improved from 28.1% to 32%, though progress remained slow. A short-life working group had been formed to support improvement, with challenges such as high manager-to-staff ratios; he highlighted some were managing 20 direct reports.
- The Board Chair asked whether any remedial work was underway to identify why 31-day and 62-day cancer performance had fluctuated regularly. The Chief Officer for Acute confirmed that had taken place and resourcing challenges had been the underlying factor and work was underway to maintain improvements, particularly around the creation of a resilience plan.
- Board Members expressed concern over virtual appointment performance at 36% against a 95% national target, suggesting NHS Highland should lead due to its rural geography. The Chief Officer for Acute noted NHS Highland was outperforming other Boards but explained many appointments were unsuitable for virtual delivery. Work was underway to explore alternatives, such as locating practitioners closer to patients when appointments couldn't be virtual.

The Board:

- Took **limited assurance** from the report.
- **Noted** the continued and sustained pressures facing both NHS and Commissioned Care Services.
- **Considered** the level of performance across the system.

8 Corporate Risk Register

The Board received a report from the Medical Director which provided an overview of the NHS Highland corporate risk register. The Board was invited to examine and consider the evidence provided and make final decisions on those risks and take substantial assurance.

The Medical Director spoke to the circulated report and highlighted work was underway to improve how clinical risks across the organisation were articulated and confirmed this would be reported through Clinical Governance Committee.

The Board **noted** the content of the report and took **substantial** assurance on compliance with legislation, policy and Board objectives.

9 Board Strategy Update

The Board had received a report from the Interim Head of Strategy and Transformation outlining the initial considerations for the development of NHS Highland's future Strategy to iterate Together We Care by 2026.

The Board were invited to take **moderate assurance** to the Board regarding the development of a refreshed strategic approach to NHS Highland's Strategy encompassing population health and proposing an early update to the current "Together We Care" strategy by 2026.

The Interim Head of Strategy and Transformation spoke to the circulated report and highlighted that the work of the recent Board development session had been incorporated into the report which outlined the future direction of NHS Highland's strategy. She noted the revised strategy would focus on prevention, improving population health outcomes and reducing health inequalities. A new Population Health and Planning Committee was proposed to oversee the development and delivery of the refreshed strategy.

During discussion the following points were raised:

- Board Members asked whether the planned approach would incorporate the community planning partnerships alongside other public authorities. The Interim Head of Strategy and Transformation confirmed that was the intention whilst taking cognisance of NHS Highland being an Anchor institution and had an Anchor strategy which would be part of the development.

- The Director of Public Health added that it was vital to work closely with the Community Planning Partnerships to address health inequalities and noted ongoing efforts underway to develop metrics for monitoring inequalities and highlighted this would present opportunities to align the work with NHS Highland's strategic priorities.
  The Board:

- Took **moderate assurance** from the report.
- **Approved** the requirement for a refresh to the TWC strategy (2022-2027) a year earlier than planned – 2026
- **Approved** the outline and approach to the development of a refreshed NHS Highland strategy
- **Approved** the proposed Population Health and Planning Committee.

10 Governance Committees Annual Reports

The Board had received a report from the Chief Executive and Board Chair on the Annual Governance Committee Reports for the period 1 April 2024 to 31 March 2025 which had been endorsed by the Audit Committee on 13 May 2025.

The Board were invited to take substantial assurance from the reports, noting that the Governance Committee Annual Reports formed a key part of the evidence in support of the Board's Annual Accounts Governance Statement.

The Board:

- **Agreed** to take **substantial assurance** from the report.
- **Noted** that the Governance Committee Annual Reports for financial year 2024- 25 were considered by the Audit Committee on 13 May 2025.
- **Approved** the Annual Reports which form a key part of the evidence in support of the Board's Annual Accounts Governance Statement.

11 Community Empowerment Act – Annual Reports

The Board had received a report from the Chief Executive detailing the NHS Highland Annual Reports dealing with Asset Transfers and Public Participation Requests for the period 2024/25. The Board were invited to take substantial assurance and approve the Annual Reports.

The Governance & Corporate Records Manager presented the circulated report and noted that there had been no public participation or asset transfer requests during 2024/25. He highlighted that work had been ongoing in relation to a previous asset transfer request, with further details included in the report. Although there had been no new public participation requests, he emphasised that other engagement activities had been underway, including the launch of NHS Highland's Engagement Hub.

During discussion the following points were highlighted:

- The Chair reflected on the value of the recent development session on community empowerment and emphasised the importance of embodying the spirit of the Community Empowerment Act, not just fulfilling formal reporting requirements and suggested adding more narrative and meaning to future reports to reflect broader engagement work.
- Board Members agreed, particularly around the contrast of the current report by comparison to the rich, engaging discussion in the development session. The Director of People and Culture suggested a review of which committee should take ownership of the statutory reporting to ensure alignment with the broader strategic work taking place, he confirmed he'd discuss this with the incoming Head of Corporate Governance.
- The Director of Finance added that the expanded reporting could be integrated into the annual accounts report which incorporates performance and governance statements.

The Board **agreed** to take **substantial assurance** and **approved** the annual reports.

12 Register of Members Interests

The Governance and Corporate Records Manager provided a verbal update, confirming that the register was accessible via the link in the Board Agenda. He also reminded members to notify him within 30 days of any changes to their declarable interests

The Board **noted** the 2025-26 Register of Member Interests.

13 Any Other Competent Business

No items were brought forward for discussion.

Date of next meeting – 24 June 2025
The meeting closed at 12.57pm

NHS Highland Chief Executive's Update

June 2025

Fiona Davies,
Chief Executive NHS Highland

Waiting Times Reduction Initiative

In 2025, NHS Boards across Scotland committed to reducing the longest waits in their systems, ensuring no patient waits more than 52 weeks for an appointment. NHS Highland is fully engaged with this critical work through weekly assurance meetings where operational leads and executives report on performance and trajectories. Our teams actively participate in national meetings to implement all appropriate quality improvement actions.

I have been consistently impressed by the commitment demonstrated by everyone involved locally. This initiative represents exactly the right approach, and I welcome the challenge set across the country. While operational pressures are inherent in any healthcare system, the enthusiasm and determination for continuous improvement shown by our teams as they address these challenges has been genuinely inspiring. We will continue to report progress on this work in future Board meetings through our IPQR.

Vascular Service Provision

As previously discussed with the Board, we continue to face significant challenges with our vascular service provision due to a national shortage of vascular surgeons and interventional radiologists—two specialist groups we have been unable to recruit in recent years. I am deeply grateful for the support provided to our vascular patients by larger centres across Scotland, as well as our locum surgeons who are seeing and assessing patients at Raigmore alongside our vascular specialist nurse.
I would like to pay special tribute to our former vascular surgeons, particularly Mr Bernhard Wolf, who recently retired after providing unstinting service for several decades in the Highlands as both a general surgeon and vascular specialist.

The current arrangements are not a permanent solution. Active discussions are ongoing at regional and national level to create a sustainable long-term solution which will give NHS Highland the service which our population needs. The Medical Director and I remain actively engaged in these discussions.

Lochaber Service Redesign Update

I am pleased to report that the Lochaber Redesign Programme Board has re-commenced monthly meetings, reporting through NHS Highland Board to the Scottish Government Capital Investment Group. I have established two key delivery groups to drive this vital project forward.

The Service Delivery Group is focusing on comprehensive service and workforce planning across both acute and community settings, with the primary purpose of ensuring we design care pathways that meet the evolving health needs of the Lochaber population while optimising our workforce deployment and skills mix. This group will develop models of care that could result in enhanced

integration between hospital and community services, improved patient flow, and more sustainable staffing arrangements.

The Infrastructure Delivery Group is ensuring the new hospital build meets the specific needs of patients, staff and our communities, with the purpose of translating clinical service requirements into functional design specifications. This group's work will result in a state-of-the-art facility that incorporates the latest healthcare design principles, provides flexible spaces that can adapt to future service needs that support both patient recovery and staff wellbeing.

We have commenced work on RIBA Stage 3 and the Outline Business Case for completion in July 2026, with RIBA Stage 4 and the Full Business Case programmed for August 2026 to November 2027. Construction is planned to commence in November 2027 with the building handover programmed for Q3 2029.

I am personally committed to developing a comprehensive people and culture plan to support our workforce through this significant transition. Enhanced communications and engagement plans will ensure meaningful involvement of all Lochaber communities as we shape this transformational project together. The Lochaber Health and Social Care Redesign Stakeholders Group continues monthly meetings, and I am pleased to welcome new community representatives to these important discussions.

New Craigs Hospital PFI Handover

On 14 June 2024, I had the privilege of attending the official handover of New Craigs Hospital to NHS Highland, concluding its 25-year Private Finance Initiative contract with Dalmore Investments and Robertsons Facilities Management. Since opening in 2000, the site has evolved from providing inpatient mental health and learning disability services to become a comprehensive health hub offering urgent assessment, dementia care, drug and alcohol recovery services, and integrated physical health provision.

Partnership working with local housing associations has enabled thoughtful redevelopment of original hospital buildings into residential housing for people with learning disabilities, supporting community inclusion as part of wider Estates Transformation works. I was pleased to see that the building has been handed over in excellent condition, with 65 staff successfully transferring to NHS Highland through TUPE arrangements. There will be no impact on service delivery during this transition.

Capital Investment and Estates Strategy Update

Following the Scottish Government review of NHS Capital Allocation, I have been working closely with Richard MacDonald, Deputy Director of Estates Facilities to submit a Business Continuity Capital Investment Plan detailing estates backlog maintenance, EPAG medical equipment replacement, and eHealth requirements. For 2025/26, we have received Formula Capital Allocation of £7,294,000 plus an additional £2,180,000 for Fire Compliance works at Oban, Islay and Raigmore Hospitals. While backlog maintenance funding remains challenging, the BCIP process enables me to formally identify highest risk priorities with our estates team and make additional submissions as risk profiles change.

As part of Scottish Government's sustainability agenda for public sector estates, all Boards are reviewing assets for co-location opportunities. NHS Highland participates in the Highland Property Partnership and Argyll & Bute Place Board to deliver optimal property solutions. Master Planning exercises are underway in Inverness, Dingwall and Thurso to identify co-location and joint investment opportunities, with the Estates team working with partners over the next 12 months.

Scottish Government's "Whole System Infrastructure Plans" will require Strategic Assessments from Health Boards covering infrastructure investment implications from national/regional service changes, national primary care investment programmes, and up to three local investment priorities per Board. Discussions on submission format and content are ongoing, with proposals progressing through Board Committees as requirements evolve.

Nursing Support Worker of the Year

As a mental health nurse myself, I am particularly delighted to see one of our nurses nationally recognised. Congratulations to Chelsey Main, one of our nursing support workers from the Forensic Service, who was recently announced as the 2025 Nursing Support Worker of the Year at the Royal College of Nursing Scotland Nurse of the Year Awards.

Chelsey was nominated for the profound impact she has had on the lives of forensic inpatients and community patients; she offers tailored 1:1 activity, supporting patients with practical life skills to foster independence, confidence, and helps patients re-engage with the community, encouraging transitions to more independent living.

The judges praised Chelsey's enthusiasm and inspiring commitment to delivering exemplary care.

UNICEF Gold Award Recognition

I am immensely proud to announce that our Neonatal Unit has achieved the prestigious UNICEF Gold Award through the Baby Friendly Initiative. This full unit accreditation signifies that our neonatal team has met the most rigorous national standards in supporting breastfeeding, building close parent-infant relationships, and valuing parents as true partners in their baby's care.

This award is a nationally recognised mark of quality that reflects our unwavering commitment to family-centred care during some of the most vulnerable moments in our patients' lives. I am particularly delighted that both our Maternity Unit and Neonatal Unit have now achieved this distinguished recognition, demonstrating our integrated approach to supporting families from birth through their neonatal journey.

I want to personally thank all the dedicated staff who have been instrumental in achieving this award. Their compassion, expertise, and commitment to excellence in neonatal care exemplifies the values we strive for across NHS Highland, and I could not be more proud of their outstanding achievement.

Fiona Davies, Chief Executive NHS Highland

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MINUTE of MEETING of the NHS Board Audit Committee Microsoft Teams	**13 May 2025 9.00 am**

Present:

Emily Austin, Non-Executive (Chair)
Alasdair Christie, NHSH Board Non-Executive
Heledd Cooper, Director of Finance
Bert Donald, NHSH Board Non-Executive
Gerry O'Brien, NHSH Board Non-Executive

In Attendance:

Gareth Adkins, Director of People and Culture
Louise Bussell, Board Nurse Director
Garret Corner, NHSH Board Non-Executive
Charlotte Craig, Argyll and Bute IJB
Claire Gardiner, Audit Scotland, External Auditors
Stephanie Hume, Azets, Internal Auditors
Stephanie Innes, Assistant Financial Accountant
Brian Mitchell, Board Committee Administrator
David Park, Deputy Chief Executive
Dr Boyd Peters, Board Medical Director
Liz Porter, Assistant Director of Financial Services
Iain Ross, Head of eHealth
Nathan Ware, Corporate Governance and Records Manager
Dominic Watson, Head of Corporate Governance (Observing)

1.1 WELCOME, APOLOGIES AND DECLARATION OF INTERESTS

Apologies were noted from A Anderson and F Davies.

The Chair welcomed G O'Brien to the meeting, noting his attendance, for the purposes of ensuring meeting quoracy.

1.2 DECLARATION OF INTERESTS

A Christie advised that, as a Highland Councillor, he had applied the objective test outlined in paragraphs 5.3 and 5.4 of the Code of Conduct in relation to Items on the Agenda and concluded that these interests did not preclude his involvement in the meeting.

1.3 MINUTE AND ACTION PLAN OF MEETING HELD ON 11 MARCH 2025

The Minute of the meeting held on 11 March 2025, and Committee Work Plan were **Approved.**

In relation to the Committee Action Plan, the following was **Noted:**

Action 5 – Confirmed relevant Plan in place, with update included in Internal Audit Actions update under 2.2 on agenda. **Agreed** Action can be **closed.**
Action 6 – To be discussed later on agenda.

The Committee:

- **Approved** the draft Minute and Committee Work Plan.
- **Agreed** in relation to Rolling Action Plan, Action 5 be **closed.**

1.4. MATTERS ARISING

There were no matters discussed in relation to this Item.

2 INTERNAL AUDIT PROGRESS REPORT AND INDIVIDUAL REPORTS

2.1 Internal Audit Progress Report

S Hume spoke to the report, advising as to the position as at 2 May 2025 and indicating a follow up exercise had been completed since the previous meeting. Work remained on track to deliver the Internal Audit Plan for 2024/25 by the June 2025 Audit Committee. It was noted the scope of the Children's Services review had been formally agreed, fieldwork had commenced, and the final report would now form part of the 2025/26 Internal Audit Plan and be reported to the September 2025 Audit Committee meeting. The plan for the following quarter was outlined as relating to submission of the 2024/25 Internal Audit Report. Internal audit themes identified as part of the 2024/25 audit process were indicated as relating to aligning financial and performance data, policies and procedures, and roles and responsibilities. An overall update on progress against the 2024/25 audit plan was provided along with an indication of the relevant audit outcomes to date and relevant Key Performance Indicator (KPI) status. The Committee was invited to note the circulated report, endorse the plan for the next quarter and provide any relevant comment.

The following was discussed:

- Children Services Review. Advised initial assessment of original audit questions received, with discussion to be held with relevant teams. A sample had been selected of individuals who had transitioned from Children's Services into Adult Services, for appropriate review. Overall, relevant fieldwork was continuing and not subject to pause. Highland Council had indicated their associated activity was progressing well, the findings of which would be shared. An update was also provided in relation to the process for obtaining relevant information and how this had been formally progressed.

The Committee:

- **Noted** the content of the circulated report.
- **Noted** the Children's Services report would be submitted to the September 2025 meeting.

2.2 Internal Audit Actions Update

There had been 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 49 actions identified, some progress had been made in relation to each. It was reported management had made with the completion of actions, with no outstanding actions where no progress had been made. Of the 32 actions assessed as 'Action on track of being progressed with revised completion date', 24 had had their due dates moved on at least one occasion from that set at the time of finalising the original report. There had been provided a note of the number of times all actions which remained open had had their

due date moved. Members again acknowledged the progress made since the last Committee meeting, and recognised the efforts of all involved.

There was discussion of the following, relating to actions associated with reviews involving the following areas:

- Cyber Security (Network Controls). Advised all relevant delivery dates had been met, with remaining actions on track for completion through May/June 2025 as agreed. Progress was monitored on a weekly basis. Action relating to Policy development had been moved. An update was also provided in relation to associated audit activity undertaken with the external national standards group. Organisational risk was assessed as low.
- Adult Complex Care Packages. Noted number of actions listed as complete, pending internal audit review. Advised outstanding work related to the development of a framework for the allocation and monitoring of high cost care adult social care packages, further detail in relation to which had been requested.
- Adult Social Care Services. Noted a management representative would be requested to provide an update on actions at the next meeting.

After discussion, the Committee

- **Noted** the circulated report.
- **Noted** the updates provided in relation to Cyber Security (Network Controls) and Adult Complex Care Review actions.
- **Noted** an update on completion of Adult Social Care Services Review actions would be provided at the next meeting, including in relation to CM2000.

3 LOSSES AND SPECIAL PAYMENTS – NSS APPROVED WRITE-OFF

H Cooper spoke to the circulated report, advising an advance payment had been made by NHS National Services Scotland (NSS) to Community Pharmacies in January 2023 along with cumulative overpayments to Pharmacies during the implementation of a new system throughout 2023. Lloyds Pharmacy, who had received part of these advances had since gone into liquidation. The Committee was asked to approve the write-off of £1,078,898.11 due to NHS Highland from Lloyds Pharmacy. Detail of the associated process, including relevant action at national level was provided. There was discussion of the lessons learned from this case, noting advance payments were not a common approach within NHS processes.

After further discussion of reporting aspects, the Committee Agreed to **Approve** the requested financial write-off.

The following Item was taken later in the meeting.

4 ARGYLL AND BUTE IJB AUDIT COMMITTEE 6 MONTH UPDATE

C Craig spoke to the circulated report, providing an update on the scope and detail of the recent activity of the Argyll and Bute Integrated Joint Board Audit and Risk Committee and advising this had met twice since the last update provided to this Committee. The report proposed the Committee take **Moderate** assurance.

The Committee:

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

5 BLUEPRINT FOR GOOD GOVERNANCE 6 MONTHLY UPDATE (IMPLEMENTING SELF-ASSESSMENT FINDINGS)

N Ware spoke to the circulated report, providing an update on the delivery of longer-term actions contained within the NHS Board's agreed Blueprint for Good Governance Improvement Plan 2023 with relevance to this Committee. It was reported the outstanding actions relating to the Audit Committee's remit were focused on reviewing and revising organisational controls in line with risk appetite and that the cascading of associated organisational training would be ongoing activity extending beyond the end of 2024. Specific updates were provided in relation to the resetting of NHS Board Risk Appetite activity; translation of revised risk appetite into workable processes for colleagues; and upskilling of the workforce in risk management knowledge and methodology. The Report proposed the Committee take **Moderate** assurance.

In relation to the stated periodic review of risk appetite, members were advised this was expected take place annually, with no set dates yet agreed.

The Committee:

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

6 GOVERNANCE COMMITTEE ANNUAL ASSURANCE REPORTS 2024/25

N Ware spoke to the circulated report, advising all Governance Committees were required to provide an Annual Statement of Assurance on their activities throughout the financial year to the Audit Committee and NHS Board. The report included the Annual Governance Committee Reports for the period 1 April 2024 to 31 March 2025 in relation to the Clinical Governance; Finance, Resources and Performance; Highland Health and Social Care; Pharmacy Practices, Remuneration and Staff Governance Committees. It was reported Governance Committees had reviewed their Terms of Reference during November 2024 and January 20205, with agreed documents being endorsed by the Audit Committee in March 2025 and incorporated into a refreshed Code of Corporate Governance approved by the NHS Board in March 2025. The report proposed the Committee take **Substantial** assurance.

The Committee:

- **Noted** the content of the circulated report.
- **Agreed** to **Approve** and **Recommend** to the NHS Board the circulated Governance Committee Annual Reports 2024/25, as evidence in support of the Annual Accounts Governance Statement.

7 RISK MANAGEMENT UPDATE

B Peters spoke to the circulated report providing a detailed update on risk systems and improvement work to ensure NHS Highland was aligned with best practice across Scotland and with national guidance on governance and risk management including the Blueprint for Good Governance document and the Scottish Government's Orange Book. The report proposed the Committee note the continuing work on risk management processes in NHS Highland including Board level risk register; development work on linking this to risk appetite; oversight via the risk dashboard; and work underway in operational units around training and use of methodology in business-as-usual activities. It was proposed the Committee also take **Moderate** assurance.

He went on to give a short presentation to members, providing an overall summary of Risk Management in NHS Highland and indicating the existing position, including associated reporting and governance arrangements; providing an overview of the detail included within Risk Dashboard; detail of qualitative sampling undertaken at Levels 2 and 3; training provision by NHS Providers and the cascade of learning activity; and an outline of current and future actions. Additional presentation content related to aspects concerning risk appetite and the NHS Highland Board Strategic Risk Register including Risk Appetite Statement; associated risk appetite assessment criteria and grading activity; risk appetite scales by risk type considerations. An indication was also provided on activity planned for the upcoming year.

After discussion, the Committee:

- **Noted** the content and detail of the circulated report and associated presentation.
- **Agreed** to take **Moderate** assurance.
- **Agreed** Risk Management be maintained as a Standing Item on future agendas.

The Committee adjourned at 9.55am and reconvened at 10.05am.

8 COUNTER FRAUD

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; Counter Fraud Services (CFS); current cases and recent events; the NHS National Services Scotland/CFS Annual Delivery Plan 2025/26; NFI exercise activity; and relevant training actions. The report proposed the Committee take **Substantial** assurance.

In relation to translating the NHS National Services Scotland/CFS Annual Delivery Plan 2025/26 into specific actions for NHS Highland, it was advised relevant detail would be considered in terms of identifying specific risk analysis areas, dissemination of the same as appropriate and development of a local action plan.

There was discussion of the following:

- Progress on Counter Fraud Standards Components. Advised progress continued in nine component areas, remained on track and would be reported on later in 2025.
- TURAS Training Completion Rate for Finance Staff. Advised detail monitored by Counter Fraud Services, with future reporting detail being actively considered. An update would also be provided to a future Committee meeting on actions arising from an associated earlier Internal Audit Review.

After discussion, the Committee:

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

9 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.

10 ITEMS ESCALATED FROM OTHER COMMITTEES

Members **Agreed** to provide the NHS Board with a current update in relation to position regarding delays around the Internal Audit of Children's Services.

The Committee so Noted.

11 ANY OTHER COMPETENT BUSINESS

There were no matters discussed in relation to this Item.

12 DATE OF NEXT MEETING

The next meeting was to be on **Tuesday 24 June 2025** at **9.00 am** on a virtual basis.

The meeting closed at 10.15am.

HIGHLAND NHS BOARD	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk
MINUTE of MEETING of the NHS Board Audit Committee Microsoft Teams	**19 June 2025 9.00 am**

Present:
Emily Austin, Non-Executive (Chair)
Heledd Cooper, Director of Finance
Bert Donald, NHSH Board Non-Executive

In Attendance:
Sarah Compton-Bishop, NHSH Board Chair
Garret Corner, NHSH Board Non-Executive
Fiona Davies, Chief Executive
David Eardley, Azets, Internal Audit
Patricia Fraser, Snr Audit Manager, Audit Scotland, External Auditors
Stephanie Innes, Assistant Financial Accountant
Arlene Johnstone, Interim Chief Officer, HSCP
Jo McBain, Director of Allied Health Professions
Brian Mitchell, Board Committee Administrator
Gerry O'Brien, NHSH Board Non-Executive (from 9.30am)
David Park, Deputy Chief Executive
Dr Boyd Peters, Board Medical Director
Liz Porter, Assistant Director of Financial Services
Simon Steer, Head of Adult Social Care
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 Committee members A Anderson and A Christie.

1.2 DECLARATION OF INTERESTS

There were no Declarations made.

1.3 MINUTE AND ACTION PLAN OF MEETING HELD ON 13 MAY 2025

The Minute of the meeting held on 13 May 2025 was **Approved.**

The Committee Approved the draft Minute.

1.4. MATTERS ARISING

There were no matters discussed in relation to this Item.

2 INTERNAL AUDIT PROGRESS REPORT AND INDIVIDUAL REPORTS

2.1 Adult Social Care Services

The Chair advised as to the reason for inclusion of this item on the agenda, with the Committee seeking an update on completion of Adult Social Care Services Review actions. A Johnstone advised that in relation to Adult Complex Care Case actions work was underway in relation to improving the relevant governance framework and funding approval arrangements and ensuring increased early support for front line workers developing appropriate care packages. With regard to Adult Social Care actions, S Steer advised as to work in relation to implementing a Single Escalation Policy and relevant oversight arrangements; actions relating to the CM2000 project and the review and allocation of packages as well as associated compliance; planned service redesign aspects; establishment of a professional audit process and review of Standard Operating Procedures. On the matter of the future of the CM2000 service it was advised eHealth support was in place, leading to an upcoming review of the digital health of Adult Social Care Services overall and consideration of relevant associated aspects.

During discussion, the Chair requested A Johnstone and S Steer liaise with Internal Audit colleagues to update relevant target completion dates for actions, where appropriate.

The Committee:

- **Noted** the updates provided.
- **Agreed** A Johnstone and S Steer liaise with Internal Audit colleagues to update relevant target completion dates for actions, where appropriate.

2.2 Internal Audit Annual Report 2024/25 (Incl. Status Update on Management Actions)

D Eardley spoke to the circulated report, advising as to the overall internal audit opinion that NHS Highland had a framework of governance, risk management and controls that provided reasonable assurance regarding the effective and efficient achievement of objectives; the internal audit work performed across the reporting period and associate scope and responsibilities; conformance with Global Internal Audit Standards; relevant planning process; cover achieved and summary of reports by control assessment and action grade; progress in implementing previous internal audit actions; key themes from audit work across 2024/25; and a summary of performance against Key Performance Indicators.

There was discussion of the following:

- Children's Services Review. Advised as to position in relation to ongoing review activity and timescale for associated reporting.
- Key Themes. Advised these were broadly in line with those for other NHS Boards in Scotland.
- Actions With Revised Completion Dates. Questioned if indicator of multiple date changes available. Advised a mixed position was being presented, with further detail provided within individual follow up reports and tracker updates. Internal audit also held regular scheduled progress update meetings with relevant Lead Officers. Confirmed any formal concerns in relation to this point would be raised at Committee level.
- Progress Monitoring on Completion of Management Actions. Update sought. Advised progress monitored through relevant follow up activity and tracker document.

After detailed discussion, the Committee Noted the circulated report.

3 DRAFT AUDIT ASSURANCE REPORT ON EXTERNAL SYSTEMS

L Porter spoke to the circulated report which asked the Committee to note and take assurance from the Service Audit reports from NHS National Services Scotland covering Practitioner and Counter Fraud Services; National IT Services for the NHS in Scotland; NHS Ayrshire & Arran covering the National Ledger System (NSI – National Single Instance Financial Ledger Services; and NHS Scotland National Payroll System ePayroll updates report T28/25. Each of the relevant individual reports were also circulated. A detailed assessment of the reports was provided, with the report proposing the Committee take **Substantial** assurance.

During discussion, members were provided with an update on in-year reporting and update arrangements for relevant external systems.

After detailed discussion, the Committee Noted the circulated report and took **Substantial** assurance.

4 AUDIT COMMITTEE ANNUAL REPORT 2024/25

The Chair spoke to the circulated Audit Committee Annual Report and sought the agreement of Committee members for the approval of the report, subject to update of the attendance detail for this meeting. The NHS Board Chair took the opportunity to reflect on a positive year for the Audit Committee and provided an update in relation to recruitment of a committee member to fill the existing formal membership vacancy.

After detailed discussion, the Committee Noted the circulated report and **Agreed** to **Approve** the same for onward submission to the NHS Board.

5 DRAFT LETTER OF REPRESENTATION FROM NHS HIGHLAND TO AUDIT SCOTLAND

Members **Noted** consideration of this Item would be deferred to the next meeting.

6 EXTERNAL AUDIT - DRAFT FINAL ANNUAL AUDIT REPORT 2024/25

P Fraser advised activity remained on track for the signing of the Annual Accounts, with an unqualified audit opinion expected to be provided. An update was provided in relation to current ongoing activity and findings to date and the annual audit report clearance process. It was advised there had been no significant matters raised during the process, with strong progress noted on matters raised in previous reports. Members were also requested to formally raise any matters relating to suspected fraudulent activity that required to be noted. The work of all involved in the formal process to date was acknowledged.

The Committee otherwise Noted the update provided.

7 DRAFT ANNUAL REPORT AND ACCOUNTS 2024-25 FOR NHS HIGHLAND

L Porter gave a presentation to members and spoke to the circulated draft annual report and accounts highlighting detail in relation to the overview of the Financial Statements; gross expenditure movement across the financial year; other operating expenses; other operating income; the Statement of Financial Position, associated balance sheet aspects; and Losses

and Special Payments. Members acknowledged the work of all involved in contribution to a positive report.

There was discussion of the following:

- Minor Amendments. Agreed minor formatting requirements in relation to Names and Titles, typographical errors, update of Overall Performance data detail, population data detail, presentation detail and target definition, and information relating to Governance Committee membership.
- Future Reporting. Requested consideration of reporting on impact of improvement actions, and GP practice size detail context provision.
- Public Consumption Aspects. Members reflected on the report detail and accessibility of the annual report to members of the public.

The Committee otherwise Noted the report and updates provided and **Agreed** to recommend the Annual report and Accounts for approval by the NHS Highland Board.

8 PROPOSED DEVIATION FROM STANDING FINANCIAL INSTRUCTIONS – HIGHLAND ALCOHOL AND DRUGS PARTNERSHIP

H Cooper spoke to the circulated report, advising as to the position in relation to Third Sector payment arrangements within the Highland Alcohol and Drugs Partnership. It was recommended the Committee approve a move to a system of payment for a small number of Third Sector organisations that would include payment one month in advance over the 2025/26 financial year, and that the same organisations be formally advised this was to be a time limited option to support transition to payment in arrears from 1 April 2026. This option would require the issuing of monthly purchase orders to facilitate efficient processing of payments. The report proposed the Committee take **Moderate** assurance.

The following was raised in discussion:

- Governance Aspects. Suggested Finance colleagues work with Head of Corporate Governance to ensure consideration of any associated impacts relating to being an anchor organisation within the community whilst minimising financial risk. Members noted relevant national guidance on making advance payments, and the ability of NHS Boards to consider relevant exceptions where appropriate. On the matter of potentially raising suggested changes to existing Standing Financial Instructions at Scottish Government level, it was noted this would require further discussion in an appropriate forum.

After further detailed discussion, the Committee:

- **Agreed** to **Approve** the requested changes to financial payment arrangements for a small number of Third Sectors organisations, and associated communication requirements.
- **Agreed** to take **Moderate** assurance.

9 PATIENT AND CLIENT FUNDS

L Porter spoke to the circulated formal Audit Report by Thomson Cooper Accountants, associated Letter of Representation and relevant Accounts for the year ended 31 March 2025. The nature of the funds held, and audit work undertaken was outlined, with members advised a clean audit had been found. A small number of recommendations had been received as part of the audit process in relation to banking reconciliation arrangements, and the arrangements for holding cash sums on site including co-signatory verification of the same.

After discussion, the Committee Approved the circulated Accounts and associated documentation for submission to the NHS Board, subject to change of existing references to Borders Health Board to NHS Highland Board.

10 REVIEW OF COMMITTEE TERMS OF REFERENCE

N Ware spoke to the circulated report, recommending the Committee approve the proposed changes to the Terms of Reference of the Highland Health and Social Care Committee for inclusion in the Code of Corporate Governance. It was noted the proposed change related to quorum requirements, reflecting the actual number of active members. The report proposed the Committee take **Substantial** assurance.

The Committee:

- **Agreed** to **Approve** the recommended change.
- **Agreed** to take **Substantial** assurance.

12 ANY OTHER COMPETENT BUSINESS

The Chair took the opportunity to seek the view of members as to the value of holding relevant additional meetings at this time, given the context of the overall Annual Accounts process and time commitment involved. All present agreed there was benefit derived from such meetings, in relation to a number of aspects, and these should be continued. Meeting arrangements for June 2026 would be progressed in early course.

13 DATE OF NEXT MEETING

The next meeting was to be on **Tuesday 24 June 2025** at **9.00 am** on a virtual basis.

The meeting closed at 10.25am.

HIGHLAND NHS BOARD	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk
MINUTE of MEETING of the NHS Board Audit Committee Microsoft Teams	**24 June 2025 1.11pm**

Present

Alexander Anderson, Non-Executive
Dr Tim Allison, Director of Public Health
Emily Austin, Non-Executive (Chair)
Graham Bell, Non-Executive
Elspeth Caithness, Employee Director
Alasdair Christie, Non-Executive
Sarah Compton Bishop, Chair
Heledd Cooper, Director of Finance
Garret Corner, Non-Executive (Argyll and Bute Council Stakeholder)
Fiona Davies, Chief Executive
Albert Donald, Non-Executive
Karen Leach, Non-Executive
Boyd Peters, Medical Director
Janice Preston, Non-Executive
Philip Macrae, Non-Executive
Gerry O'Brien, Non-Executive
Steve Walsh, Non-Executive
Neil Wright, Non-Executive

In Attendance

Gareth Adkins, Director of People and Culture
Andrew Devlin, Interim Head of Communications and Engagement
David Eardley, Internal Auditor, Azets
Patricia Fraser, Audit Scotland
Claire Gardiner, Audit Scotland
Kristin Gillies, Interim Head of Strategy and Transformation
Jo McBain, Director of Allied Health Professionals
Liz Porter, Assistant Director of Financial Services
Nicki Sturzaker, Incoming Head of Communications and Engagement
Katherine Sutton, Chief Officer, Acute
Nathan Ware, Governance and Corporate Records Manager
Dominic Watson, Head of Corporate Governance

The meeting was preceded by a meeting of the Trustees of the Endowment Fund for NHS Highland and followed immediately by an In Committee meeting of the NHS Highland Board.

1.1 Welcome and Apologies

Apologies were received from Joanne McCoy, Catriona Sinclair, Muriel Cockburn, Arlene Johnstone and Louise Bussell with Jo McBain deputising.

1.2 Declarations of Conflict of Interest

Alasdair Christie stated he had considered making a declaration of interest in his capacity as General Manager of Inverness, Badenoch and Strathspey Citizens Advice Bureau and as a Highland Council Councillor, but felt this was not necessary after completing the Objective Test.

1.3 Minute of Previous Audit Committee Meeting, 19 June 2025 and Action Plan

The Committee **approved** the minute of the meeting held on 19 June 2025 and **noted** the rolling action plan.

1.4 Matters Arising

None

2 Assurance for the Consolidation of Endowment Fund Accounts

The Committee **noted** that the Endowment Fund Accounts had been approved and that it could take assurance that having been audited, with an unqualified opinion, that they could be consolidated within NHS Highland's Accounts.

3 Draft Final External Audit Annual Report

C Gardiner spoke to the circulated report and advised the letter confirmed that the audit opinion for the year was unqualified, as disclosed.

She also highlighted:

- Audit Scotland had concluded their work, subject to the final review of the annual report and accounts by NHS Highland.
- The appendices included a letter of representation from the Chief Executive covering key areas such as fraud, contingent liabilities, and compliance with laws and regulations.
- A minor issue was identified in the draft accounts relating to the title of the Independent Auditor's Report which required to be corrected to reflect the appropriate addressees.
- She added that the full annual audit report provided an overview of the 2024/25 accounts and audit process and all audit opinions were unqualified, with no significant findings or adjustments above the £0.7 million reporting threshold.
- Audit Scotland were satisfied that all audit risks had been addressed with adequate assurance and the finance team were commended for delivering high-quality accounts on time.
- Members were reminded that they were obligated to confirm there were no known instances of fraud, legal non-compliance, or post-balance sheet events Audit Scotland were not aware of.

She confirmed that in terms of the wider scope work:

- NHS Highland ended the year with a small surplus, a significant improvement from the initially projected £120 million deficit which was achieved through £49.7 million in brokerage and £43.1 million in savings.
- It was noted the board remained heavily reliant on non-recurring measures, with a cumulative brokerage of £106 million and a starting deficit of £40 million for 2025/26.
- On governance and transparency, arrangements were found to be effective and improving, with a strong commitment to good governance.
- Regarding performance and best value, performance against national standards had been mixed, but there was a clear commitment to improvement. It was noted that NHS Highland has well established arrangements in place for securing best value.

The auditors concluded that the board's financial position was not sustainable, though this was consistent with sector-wide challenges.

The Committee **considered** the report of the External Auditor and **noted** the content.

4 Letter of Representation from NHS Highland to Audit Scotland

The Committee **noted** the content of the letter.

5 Draft Annual Report and Accounts 2024/25 for NHS Highland

The Chair introduced the report and thanked Board Members Gerry O'Brien and Neil Wright for their support in ensuring the Audit Committee meeting held on 19 June was quorate, enabling a full and timely review of the 2024/25 Annual Report and Accounts.

During discussion the following points were highlighted:

- The Chair sought clarification regarding the level of personal detail included in the write-off reports, questioning whether such detail was necessary or if anonymisation could have been considered. The

Assistant Director of Financial Services confirmed that the level of detail provided was required to ensure full transparency in the reporting process.

- Committee Members sought clarity on the term ‘going concern’ and its context. The Director of Finance confirmed it was a term used for all NHS Boards as there was nothing in legislation that would suggest the services provided would cease.
- Committee Members expressed appreciation to all those involved in the preparation of all the component parts of the Annual Accounts for 2024/25.

The Committee:

- Took **Substantial Assurance** from the Annual Report and Accounts.
- **Noted** the submission of the NHS Highland Annual Report and Accounts including the Summary of Losses.
- **Noted** and **Agreed** the recommendations for the Debt Adjustments (Write Off’s) over £15,000 and took **Moderate Assurance** from those reports and;
- **Recommended** the Annual Report and Accounts for **Approval** by the NHS Highland Board.

6 Any Other Competent Business

None

7 Date of Next Meeting

The next meeting will be on **9th September 2025**.

The meeting closed at **1.25pm**

HIGHLAND NHS BOARD	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk
MINUTE of the FINANCE, RESOURCES AND PEFORMANCE COMMITTEE TEAMs	**6 June 2025 at 2.00pm**

Present	Alexander Anderson, Chair Graham Bell, Non-Executive Director Louise Bussell, Board Nurse Director Heledd Cooper, Director of Finance Garret Corner, Non-Executive Director Fiona Davies, Chief Executive Gerard O'Brien, Non-Executive Director David Park, Deputy Chief Executive Dr Boyd Peters, Board Medical Director
In Attendance	Rhiannon Boydell, District Manager (Community) Kristin Gillies, Interim Head of Strategy and Transformation Brian Johnstone (Facilities, Estates and Capital Planning) Brian Mitchell, Committee Administrator Katherine Sutton, Chief Officer (Acute) Elaine Ward, Deputy Director of Finance Nathan Ware, Governance/Corporate Records Manager (from 2.20pm) Dr Neil Wright, Non-Executive Director

1 STANDING ITEMS

1.1 Welcome and Apologies

Apologies for absence were received from Committee members R MacDonald and S Walsh. Apologies were received from non-Committee members E Beswick, S Compton-Bishop and P Stott.

1.2 Declarations of Interest

There were no formal Declarations of Interest.

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

The draft Minute of the Meeting held on 9 May 2025 was **Approved.** The Committee further **Noted** the Rolling Action Plan, subject to the closure of Actions 19 and 20 and **Noted** the Committee Work Plan 2025/26.

It was confirmed Action 15 would remain on the Action Plan at this time.

2 FINANCE

2.1 NHS Highland Budget 2025/26 Update

H Cooper spoke to the circulated report outlining the current position in relation to the process for agreement of the NHS Highland budget for 2025/26; the Scottish Government response to the initial finance plan submitted and assessment of the potential actions required to meet relevant asks. Detail of the key points of the outlined draft response to Scottish Government were provided along with an indication of the wider background activity already in place and underway, including in relation to value and efficiency, and strategic transformation. The report proposed the Committee take **Moderate** assurance, recognising the remaining risk relating to delivery of the required 3% cost reductions and a balanced Adult Social Care and Integrated Joint Board position.

There was discussion of the following:

- Funding Support for a Public Health Centred Approach. Advised associated specific spend to save proposals had been encouraged by Scottish Government, in the context of wider national Public Health and Service Renewal Frameworks considerations. The position in relation to potential financial assistance for bids was unclear. There remained discussion ongoing at national level in relation to a number of associated investment and funding aspects across a number of areas. Population health was not solely an NHS matter.
- New Craigs (RAAC) Position. Confirmed funding for future work was unaffected.
- Impact of Annual Leave Accrual and Future Years. Advised related to annual leave outstanding at end of financial year. Appropriate guidance had been provided to managers and staff in relation to ensuring allocations were fully utilised in-year, subject to exceptional circumstance arrangements.

After discussion, the Committee:

- **Examined** and **Considered** the content of the circulated report.
- **Agreed** to **Endorse** the revised NHS Highland Financial Plan 2025/26 and onward submission to Scottish Government.
- **Agreed** to take **Moderate** assurance.

2.2 Update on 2024/25 Financial Position and Audit Process

H Cooper advised the relevant audit process remained on track, and the external audit opinion having been the subject of ongoing discussion between relevant parties. A clearance meeting had been held with Audit Scotland the previous day, with no adjusted or unadjusted errors having been raised in relation to the Annual Accounts. Updates were also provided in relation to aspects including risk and associated material statement. There had been no formal Matters to Report. Matters relating to controls (Payroll and Care First Income systems), had been highlighted, actions in relation to which were being taken forward as part of the routine Internal Audit process. Overall progress in relation to the Annual Accounts audit process was positive.

After further discussion, the Committee Noted the reported position.

3 ANNUAL DELIVERY PLAN 2024/25 – Q4 UPDATE

K Gillies spoke to the circulated report, providing an update on submission of the Quarter 4 update of the 2024/25 NHSH Annual Delivery Plan (ADP) to Scottish Government. The submission was part of the evolution of the national planning process, was in line with expectations and continued to be monitored through programme management performance monitoring and assurance reporting processes. The ADP tracker detail had been circulated,

with further detailed updates provided in relation to process matters; transformation activity progress and outstanding deliverables; and associated risks and challenges. The report proposed the Committee take **Moderate** assurance.

The following was discussed:

- Outstanding Deliverables. Questioned how many were related to national transformational activity and how best to ensure movement in those specific areas. Aspects relating to governance were also raised. Advised strong system processes in place within NHSH to drive activity forward, recognising the wider national challenges being presented. The importance of integrated practice and wider partnership approaches was recognised.
- Progress Actions Status Definition. Suggested greater focus on the levels of progress being made would be welcome. Further consideration would be given to this aspect.

After further detailed discussion, the Committee:

- **Noted** the circulated report content.
- **Agreed** to **Endorse** the Quarter 4 update for onward submission.
- **Agreed** to take **Moderate** assurance.

4 INTEGRATED PERFORMANCE AND QUALITY REPORT

K Gillies spoke to the circulated report and gave a brief presentation to members on performance detail, noting discussion was underway in relation to development of the next iteration of future reporting. The Executive Summary provided an outline of relevant performance indicators and continuing challenges were noted in relation to CAMHS, NDAS, Delayed Discharges, 62 Day Cancer target and SACT Access/Benchmarking.

A specific update was provided in relation to Outpatients and Treatment Time Guarantee (TTG) performance, noting national weekly scrutiny in relation to reducing long waits. There was a request to focus on aspects relating to efficiencies. TTG, Delayed Discharge and Emergency Access performance in NHSH was noted as improving. An update was also provided in relation to associated funding elements. Members were further advised as to matters relating to wider access targets and national consideration of potential capacity available across NHS Boards to bring down long waits. The report proposed the Committee take **Limited** assurance.

There was discussion of the following:

- Future Reporting Detail on Outpatients and TTG Performance. View expressed Committee required data from a Specialty level in future reports. Advised level of detail requested would be available as part of reporting to Scottish Government moving forward, with national discussion on the relevant dataset requirements being taken forward. Recent TTG performance improvement was acknowledged.
- Delayed Discharges. Update sought on position regarding relevant target and associated internal trajectories. Advised activity being taken forward in relation to medium- and long-term plans in this area including appropriate data capture requirements. Noted a range of activity being taken forward at that time, including in relation to Care at Home and associated frailty pathways etc.
- Potential Service Capacity Utilisation. Questioned if internal progress could be impacted by providing services to external NHS Boards. Advised the focus across individual NHS Boards would be on meeting the 52-week target and considering what they can do to achieve this. Wider process detail remained in development. The potential service change implications and impact on relevant clinical teams and patients having to travel for

appointments was recognised. Aspects relating to prioritisation of clinical need were highlighted in discussion. Future updates would be provided to Committee.

After further detailed discussion, the Committee:

- **Noted** the circulated report content.
- **Agreed** to take **Limited** assurance.

5 STRATEGY AND TRANSFORMATION ASSURANCE GROUP UPDATE

K Gillies spoke to the circulated report providing an update on the strategic transformation model and the associated A and B programmes aligned in that framework and outlining the requirement to further align the STAG priorities to the financial plan. It was reported the ABC change framework had commenced in each level and programme management resource had been assigned to support Senior responsible Officers. The report proposed the Committee take **Limited** assurance.

There was discussion of the following:

- Future Programme Progress Reporting. Questioned level of detail relating to efficiency delivery. Advised as to the development of detail requirement considerations underway in that area. The need for STAG to continue to focus on longer term strategic approach and associated potential service change considerations was emphasised.

After further discussion, the Committee:

- **Noted** the circulated report content.
- **Agreed** to take **Limited** assurance.

6 ENVIRONMENT AND SUSTAINABILITY UPDATE

B Johnstone gave a presentation to members and spoke to the circulated report, advising as to how NHS Highland was proposing to move towards Scottish Government Net Carbon Zero targets and demonstrating the progress made in relation to the NHS Highland Environment and Sustainability agenda at June 2025. Specific detailed updates were provided in relation to carbon emissions; power consumption; utilities finance; waste and resources; current projects, including Capital Plan and EV infrastructure; and wider environment and sustainability activity. The report proposed the Committee take **Moderate** assurance.

The following was discussed:

- Financial Impact of Change of Fuel Usage. Advised as to current wide-ranging considerations, with intended aim of any change being to reduce associated cost. The future availability of a Hydrogen option was under active consideration, further technical detail in relation to which was discussed.
- Achievement of 2030 Targets. Relevant challenges both locally and nationally were acknowledged. Recent discussion with national colleagues was noted as positive.

After further detailed discussion, the Committee:

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

7 2025/26 and 2026/27 Meeting Schedules

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

11 July 2025
1 August 2025
12 September 2025
3 October 2025
14 November 2025
5 December 2025
9 January 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
8 January 2027
5 February 2027
12 March 2027

The Committee Noted the meeting schedules for 2025/26 and 2026/27.

8 ANY OTHER COMPETENT BUSINESS

There were no matters raised.

9 DATE OF NEXT MEETING

The next meeting of this committee was to be held on Friday 11 July 2025.

The meeting closed at 3.35pm

NHS Highland	NHS Highland na Gàidhealtachd

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name of Committee	**Finance, Resources and Performance Committee**
Date of Meeting	**11 July 2025**
Committee Chair	**Alex Anderson**

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

None.

ASSURE

- **Draft NHS Highland Financial Position 2025/26 Update and Value and Efficiency Update** – Limited.
- **Capital Asset Management Plan Update** – Moderate.
- **Digital Health and Care Update** – Substantial.
- **Business Continuity/Resilience Update** – Substantial.
- **NHS Highland Board Risk Register** – Substantial
- **Finance Risks 2025/26** - Substantial

ADVISE

- **NHS Highland 2025-28 Financial Plan Addendum Letter** – Noted.
- **Operational Improvement Plan** – Advised Item to be included on next agenda.

RISKS

- **Strategic Transformation** – Advised risk may require to be revisited in due course.

ACTIONS

None.

LEARNING

None.

HIGHLAND NHS BOARD	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk
MINUTE of MEETING of the STAFF GOVERNANCE COMMITTEE	**6th May 2025 at 10.00 am**

Present

Elspeth Caithness, Employee Director
Bert Donald, Whistleblowing Champion
Kate Dumigan, Staffside Representative
Claire Laurie, Staffside Representative
Dawn MacDonald, Staffside Representative
Gerry O'Brien, Board Vice Chair
Janice Preston, Non-Executive Director
Steve Walsh, Non- Executive (Chair)

In Attendance:

Michielle Abraham, Organisational Development Manager
Gareth Adkins, Director of People and Culture
Evan Beswick, Chief Officer, Argyll and Bute Health and Social Care Partnership
Gaye Boyd, Deputy Director of People
Natalie Booth, Board Governance Assistant
Louise Bussell, Nurse Director
Heledd Cooper, Director of Finance
Arlene Johnstone, Head of Mental Health, Learning Disabilities and Drug & Alcohol Recovery Services
David Park, Deputy Chief Executive
Katherine Sutton, Chief Officer, Acute
Simon Steer, Director of Adult Social Care
Nathan Ware, Governance and Corporate Records Manager

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. It was noted that Steve Walsh would be recommended as the new Vice Chair for Staff Governance Committee from May 2025, this was agreed by the committee.

Apologies were received from Philip MacRae, Sarah Compton-Bishop and Pamela Stott, with Arlene Johnstone deputising.

1.2 Declarations of Interest

There were no declarations of interest.

2 ASSURANCE REPORTS & COMMITTEE ADMINISTRATION

2.1 MINUTES OF MEETING HELD ON 1st March 2025

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

2.2 **ACTION PLAN**

The Director of People and Culture confirmed that both outstanding actions would be closed as they will be discussed item three on the agenda.

2.3 **COMMITTEE WORKPLAN 2025-2026**

Committee Members noted the workplan.

3. MATTERS ARISING NOT ON THE AGENDA

3.1 **Appraisal and PDP Improvement Plan Update**

The Director of People and Culture confirmed a new Head of People Planning and Development had been confirmed in post. He noted this piece of work sat within their remit and staffside had provided nominees for participation in the Short Life Working Group to drive progress in this area.

3.2 **Health and Safety Reporting Argyll & Bute Update**

The Director of People and Culture noted there had been some adjustments in senior management teams but work was underway on health and safety assurance but highlighted some reporting had been delayed. The committee were assured that the work is continuing and the Argyll and Bute Interim Head of Strategic Planning was working closely with him to ensure the appropriate reporting was consistent.

The Director of People and Culture confirmed that whilst this topic had been discussed at Staff Governance Committee, the correct governance route was the Health and Safety Committee.

4. Spotlight Session

4.1 **Acute**
Katherine Sutton, Chief Officer, Acute

The Chief Officer for Acute spoke to the circulated presentation and noted:

- 23% of the workforce over 55
- 10% were over 60 and largely female
- 50% were currently working on a part time basis.
- The Chief Officer highlighted the importance of supporting the workforce but noted significant challenges as absence rates remained high across acute hospitals. She added that the causes consisted of anxiety, stress, depression and other psychiatric illnesses.

Mandatory Training

- Acute held a completion rate of 62.67%.
- Belford Hospital had an 80% compliance rate.
- The National Treatment Centres compliance rate was very good with a comprehensive people plan in place.
- Appraisal Completion rates continued to be low, but renewed focus was underway to improve this.
- The Acute Partnership Forum was now meeting regularly; and communication had been issued so managers understood how they could utilise the forum
- The Management Development Forum had been working with the Acute Medical Director and Associate Nursing Director to identify how multidisciplinary working could be improved.
- Committee Members sought clarity around the sickness levels and whether the failure to conduct appraisals could contribute to this and whether senior managers had not recognised this. The Chief Officer agreed that it may be a contributory factor.

- Committee Members highlighted a lack of communication, particularly around the TARA group, the use of Artificial Intelligence (AI) alongside concerns raised by members in relation to vacancy levels in Fort William causing burnout. The Chief Officer suggested this point was discussed in further detail out with the meeting
- The Director of People and Culture highlighted the need to embrace the use of technology to assist colleagues and relieve additional pressures.
- Committee Members asked whether the removal of some management posts had resulted in increased pressure for existing colleagues. The Chief Officer confirmed the change in structure had enabled closer collaborative working within the teams but any highlighted pressures were being monitored.

4.2 **Employability**
Megan Glass, Employability Lead

The Employability Lead spoke to the circulated presentation and confirmed there was a focus on delivery and planning over the next 3 years. She confirmed the strategy had been pulled together by working closely with partners and considered the wider health inequalities challenges.

It was noted, NHS Highland should consider how it engages with younger generations and their career aspirations. Currently only 3.5% of NHS Highlands workforce is under 25, 0.4% were under 18. She added that a secondary school engagement plan had been developed in partnership with Highland Council and Argyll and Bute Council.

There had been a number of work experience opportunity enquiries which was an area of work moving forward. 15 different workshops took place across Highland and a total of 80 pupils attended, she confirmed this would now take place annually in Inverness, Wick and Fort William.

Discussions had taken place with UHI to increase the number of apprenticeships across NHS Highland and some awareness sessions were conducted during National Apprentice Week with Skills Development Scotland.

5.

Items for Review and Assurance

5.1

People and Culture Portfolio Board Update
Report by Gaye Boyd, Deputy Director of People

The Director of People and Culture spoke to the circulated report and highlighted:

- Assurance levels were good indicating positive progress against expected milestones for each workstream.
- Workforce transformation and planning has been discussed at committee for some time but no decision had been made in terms of deliverables. It was highlighted the Portfolio Board would be refreshing the 3-year workforce plan.

The Committee **noted** the report and agreed to take **moderate** assurance.

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

The Director of People and Culture spoke to the circulated paper:

- Statutory/Mandatory training completion numbers had increased.
- Appraisal completion figures had increased but it was noted improvements were still required.
- Committee members sought clarity on whether there had been any particular reasoning around recent voluntary departures and had an exit interview been completed. The Director of People and Culture confirmed there were a variety of

reasons including retirement and fixed term contracts but highlighted a more robust exit interview process was required to provide additional insight.

The Director of People and Culture also indicated that a review around the quantity of training NHS Highland asks of its management teams was required as it had increased and could become unmanageable.

The Committee **noted** the report and agreed to take **moderate** assurance.

5.3 **Education, Learning and Organisational Development (ELOD) Annual Report**
Report by Gaye Boyd, Deputy Director of People

The Organisational Development (OD) Manager explained the Learning and Development team merged with the Organisational Development team to form ELOD, with the focus of aligning goals with the organisation's aim to embed a culture that encourages interpersonal working and compassion. She provided an overview of the recent activity conducted by the ELOD team and explained that further detail was contained in the circulated report. The Director of People and Culture advised the report aimed to provide assurance across educational activities and identify areas for improvement.

Committee Members inquired about aligning OD with future priorities and the demand for coaching and mentoring within NHS Highland. The OD Manager advised they were progressing proactively with OD themes and addressing the high demand for coaching. Members emphasised the importance of measuring outcomes and evaluating success, and the need to balance proactive and reactive efforts given limited resources.

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

5.4 **Medical Education Annual Report**
Report by Helen Freeman, Director of Medical Education

The Medical Director highlighted that the report provided an overview of last year's activities, regulatory compliance, and stakeholder involvement, noting that inspections and reviews ensured quality and addressed any concerns raised. It was noted there was a national aim to increase medical student numbers to fill workforce gaps, with current challenges including accommodation for trainees. Despite these challenges, the medical education team performed well, providing high-quality education and meeting standards.

Members highlighted concerns about staff workload and burnout, access to staff accommodation, and the need for other onsite facilities. He also sought clarity on the term "ACT" referenced in the report. The Medical Director suggested consulting the Director of Medical Education for issues related to hospital facilities. He noted the "additional cost of treating" (ACT) fund was central funding for medical education, highlighting the need for a balanced approach between service commitment and education. It was noted that plans were being reviewed to increase accommodation capacity in Highland, with alternative funding methods being sought.

The Director of People and Culture noted that traditional staffing models might no longer be sustainable or attractive due to changes in medical jobs. Exploring different roles and staffing mixes was necessary to support junior doctors and the medical workforce, while addressing challenges and adapting to modern expectations.

Members queried the reason for the low number of doctors proceeding to specialty training after their foundation year. The Medical Director emphasised that national and international data on workforce changes should guide the creation of future jobs and services, with medical education serving as an early warning system to shape policy and adapt working conditions.

Members questioned the removal of FY1s from trauma and orthopaedics and the ability of senior clinical supervisors to deliver quality education. The Medical Director explained that GPs and consultants were responsible for teaching and emphasised the importance of ring-

fencing time for medical education. It was noted that the decision to remove FY1s was necessary due to repeated poor feedback, with ongoing improvements to reintroduce them with better support. Additionally, the Director of People and Culture highlighted collaboration on medical leadership development, aiming to integrate it into overall learning and development offerings, addressing the need for leadership skills beyond technical expertise.

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

5.5 **Annual Delivery Plan**
Report by Gareth Adkins, Director of People and Culture

The Director of People and Culture highlighted that feedback on the Annual Delivery Plan was still under review by the Scottish Government. The plan aimed to focus on workforce elements, ensuring clear deliverables within the People and Culture portfolio, which aligned with strategic work. The circulated report provided a comprehensive overview of workforce priorities across different services and areas, reflecting corporate workforce development and specific deliverables for various organisational areas.

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

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

The Director of People and Culture advised there were no updates on the actions from June, but completed actions had been integrated into risk controls. It was highlighted that progress on Level 2 corporate risks was pending with further work being required.

Members queried protected learning time for statutory training and its national implementation. The Director of People and Culture advised that the national working group aimed to define protected learning time as part of the non-pay aspects of the Agenda for Change. He advised the working group also focused on creating a consistent approach to statutory and mandatory training across the organisation, understanding the time required and how to incorporate it.

Members highlighted risk of poor culture querying the controls in place to address this and enquired about the effectiveness of the leadership and management development, and corporate induction programmes. The Director of People and Culture advised of the need to identify gaps in the strategic approach to ensure controls are effective. He noted the leadership and management development provided updates through the portfolio board and people were actively participating in the Corporate Induction programme.

The Committee **noted** the report and agreed to take **moderate** assurance.

5.7 **Staff Governance Monitoring 23/24**
Report by Gareth Adkins, Director of People and Culture

The Director of People and Culture advised that the paper had followed the correct governance routes in response to a Scottish Government request. The government had paused staff governance submissions but had requested an assurance statement, with clarity provided in national discussions. The submission had focused on continuous improvement, highlighting areas of success and needed improvement based on government feedback.

Ongoing discussions with staff side colleagues regarding issues raised at the 2024 Annual Review had yet to reach an agreement. Communication had been provided to the Scottish Government outlining negotiation steps. Further discussions had been held with relevant unions and staff side to ensure a clear working process and address disagreements. There would be a review of whether a staff governance monitoring group with staff side

representation could be created to proactively resolve disagreements and ensure good governance.

Members emphasised the importance of reaching agreement with staff side colleagues and ensuring smooth approval processes. The Director of People and Culture suggested that majority decisions might be necessary when consensus was not possible and highlighted the need for clear, transparent processes.

The Committee:

- **Agreed** to take **moderate** assurance
- **Noted** the request from Scottish Government to provide an update on the assurance request in September 2024 against the staff governance standard
- **Noted** the response to Scottish Government including:
    - Unable to reach a consensus agreement with staff side to date
    - Further discussions are required with relevant unions to identify additional actions or areas of focus that could be included and this can then be discussed with the wider staff side group
    - Draft letter to be submitted to Scottish Government

6. Items for information and noting

6.1 **Area Partnership Forum update of meeting held on** 4 April 2025

The Committee **noted** the Area Partnership Forum update of meeting held on 4 April 2025.

6.2 **Health and Safety Committee Minutes of meeting held on** 1 April 2025

The Committee **noted** the Health and Safety Committee Minutes of meeting held on 1 April 2025.

7. Any other Competent Business

7.1 **Review / summary of meeting for Chair to highlight to Board**.

The Chair noted that it was his first time chairing the Committee. He highlighted the quality of the two spotlight sessions and the Education reports, which were very informative and high quality. He also mentioned the staff governance monitoring and the commitment to avoid future disagreements.

8. Date & Time of Next Meeting

The next meeting is scheduled for Tuesday 1st July 2025 at 10 am via Microsoft Teams.

9. Future Meeting Schedule

The Committee Noted the remaining meeting schedule for 2025 as follows:

2 September 2025
4 November 2025
13 January 2026
3 March 2026

Close of Meeting 12.35 pm

NHS Highland	NHS Highland na Gàidhealtachd

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name of Committee	**Staff Governance Committee**
Date of Meeting	**01 07 2025**
Committee Chair	**Philip MacRae**

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

The Chair would highlight to the board:

- the Staff Governance Monitoring Group Update
- Ongoing regular review of Strategic Risks
- the improvements in relation to the Statutory and Mandatory training.
- The positive performance of the Finance Directorate In relation to workforce metrics and staff governance standards

ASSURE

Assurances taken on:

- Staff Governance Monitoring Group Update
- People and Culture Portfolio Board Update
- Integrated Performance and Quality Report
- Strategic Risk Review
- Health & Safety Annual Report
- Health & Safety Strategy and Plans
- Whistleblowing Q4 Report
- Whistleblowing Annual Report
- Guardian Annual Report
- Workforce Monitoring Report 2025
- Health & Care Staffing Act Q4 Report

ADVISE

RISKS

The committee discussed the appropriateness of the risk reporting frequency, ultimately deciding to maintain regular updates at every meeting due to the importance of tracking risk progression. It was noted that high-level risks should be escalated to Board level, and with the appointment of a new Head of Corporate Governance, a refresh of risk management was planned. Additionally, a workshop on operational risks, including health and safety, had been held, and a review process was underway.

ACTIONS

- **Statutory mandatory training:** review the process of providing updates to the committee on progress with compliance in context of regular updates provided through the integrated performance report
- **Whistleblowing:** Review future Non-Executive Whistleblowing executive lead visit locations and provide further updates on progress with actions arising from whistleblowing investigations

LEARNING

The Finance spotlight session highlighted recent developments as teams from the People and Culture Directorate transitioned into the Finance Directorate. Key updates included workforce demographics, training and appraisal completion, and improvements in operational areas such as procurement and travel. The presentation also covered initiatives in organisational development, employee engagement, and internal communications aimed at supporting staff and enhancing service delivery.

The Health and Wellbeing lead outlined the work of the Health and Wellbeing Oversight Group, which was established in 2023 and now oversees the 2025–2027 Health and Wellbeing Strategy, focusing on wellbeing, leadership, and equality. Key initiatives included the launch of the Employee Assistance Programme, a Wellbeing Roadshow, and a Leadership and Management Conference, all receiving positive engagement. Further developments included Occupational Health support enhancements, staff network launches, and ongoing analysis of key wellbeing themes such as anxiety and addiction.

HIGHLAND HEALTH & SOCIAL CARE GOVERNANCE COMMITTEE
Report by Committee Chair

The Board is asked to:

- **Note** that the Highland Health & Social Care Governance Committee met on Wednesday 7 May 2025 with attendance as noted below.
- **Note** the Assurance Report and agreed actions resulting from the review of the specific topics detailed below.

Present:
Gerry O'Brien, Committee Chair, Non-Executive
Tim Allison, Director of Public Health and Public Relations
Thomas Brown, Lead Doctor (GP)
Louise Bussell, Nursing Director
Cllr Muriel Cockburn, Non-Executive
Claire Copeland, Deputy Medical Director (until 3.31 pm)
Fiona Duncan, Chief Social Work Officer, Highland Council
Julie Gilmore, Nurse Lead and Assistant Nurse Director
Cllr Ron Gunn, Highland Council
David Park, Deputy Chief Executive
Fiona Malcolm, Highland Council Executive Chief Officer for Health & Social Care
Joanne McCoy, Non-Executive
Kaye Oliver, Staffside Representative
Simon Steer, Director of Adult Social Care
Elaine Ward, Deputy Director of Finance (until 3.00 pm)
Neil Wright, Non-Executive

In Attendance:
Rhiannon Boydell, Head of Integration, Strategy and Transformation, HHSCP
Paul Chapman, Associate Director AHP (until 3.31 pm)
Jennifer Davies, Deputy Director of Public Health (from 2.30 pm)
Kristin Gillies, Interim Head of Strategy and Transformation
Gillian Grant, Interim Head of Commissioning (until 3.38 pm)
Arlene Johnstone, Head of Service, Mental Health, Learning Disability and DARS
John Lyon, Client Dental Director
Karen-Anne Wilson, Area Manager for Skye, Lochalsh and Wester Ross (until 3.35 pm)
Natalie Booth, Board Governance Assistant
Dominic Watson, Head of Corporate Governance (until 3.35 pm)
Nathan Ware, Governance & Corporate Records Manager

Apologies: Cllr Christopher Birt, Philip MacRae, Catriona Sinclair, and Pamela Stott.

1.1 Welcome

The meeting opened at 1pm, and the Chair welcomed the attendees. He advised the committee that the meeting was being recorded and would be publicly available to view for 12 months on the NHSH website.

The meeting was quorate.

1.2 Declarations of Interest

There were no declarations of interest.

1.3 Assurance Report from 05 March 2025, Action Plan and Workplan

The draft minute from the meeting of the Committee held on 5 March 2025 was **approved** by the Committee as an accurate record.

The Committee

- **APPROVED** the Assurance Report, and
- **NOTED** the Action Plan and Work Plan.

1.4 Matters Arising From Last Meeting

There were no matters arising from the last meeting raised.

2 FINANCE

2.1 Year to date Financial Position at Month 11 & the 2025/26 financial year ahead

Report by Deputy Director of Finance

The Head of Finance for HHSCP presented the report and a PowerPoint which summarised the financial position for NHS Highland at Month 11 with further detail presented on the HHSCP position. The forecast year end deficit £44.792 million with the assumption that additional action was taken to deliver breakeven Adult Social Care (ASC) position. The forecast is £4.9 m better than the revised brokerage limit set by Scottish Government and £5.8 m better than the target agreed with the Board in May 2024. £4.225 m of funding was confirmed in Month 11, with the most significant elements being the junior doctors pay award funding and additional allocation for AfC non-pay costs.

Key risks included, ongoing to deliver a breakeven position for ASC, the potential that spend on supplementary staffing continued to fluctuate, that prescribing and drugs costs could see increases in volume and cost, that ASC suppliers could continue to face sustainability challenges, the Health and Care Staffing Act. Corresponding mitigations were outlined which included, that Adult Social Care had received a higher than anticipated allocation from SG, that robust governance structures around agency nursing utilisation continued to progress, that additional New Medicines funding had been received, and that MDT funding had been reinstated by SG following productive discussions.

A year-to-date (Month 11) overspend of £19.982 m was reported within the HHSCP, and it had been forecast that this would decrease to £2.481 m by the end of the financial year based on the assumption that further action would enable delivery of a breakeven ASC position. A £2.736 m overspend had been built into the forecast to acknowledge the continuing pressures around prescribing and drugs. A high risk was noted around the assumed delivery of £2.319 m of ASC value and efficiency cost reductions and improvements in the forecast. Further detail was provided in a slide presentation circulated to the members around North Highland Communities; Mental Health Services; Primary Care; ASC; Cost Reduction/Improvement Target; Value and Efficiencies; HHSCP Supplementary Staffing.

In discussion, the following topics were discussed:

- The Deputy Director of Finance highlighted the gap between the month 11 forecast and the brokerage position close to the forecast, with transformation funds assisting to close the adult social care position.

- The Deputy Director of Finance attributed the primary cause of the underspend in the Dental department to challenges in filling certain vacancies.
- The Deputy Director of Finance Elaine noted additional Scottish Government funding had been provided for an ASC service in Skye and ongoing recruitment efforts for house care homes. K Wilson reported progress in recruiting for Home Farm, reducing agency reliance, and integrating workers, with the Skye working group aiding these efforts, though full local staffing remains incomplete.
- Members highlighted ongoing challenges in controlling prescribing costs, despite various efficiency schemes and control processes, noting the need for further examination of specific drug categories. The Deputy Director of Finance confirmed that the efficiency schemes, including a new addressing medicines wastage scheme, would continue into 2025/2026.

The Committee:

- **NOTED** from the report the financial position at month 11 and the associated mitigating actions, and
- **ACCEPTED limited** assurance.

3. PERFORMANCE AND SERVICE DELIVERY

3.1 Care Home Oversight Board Annual Report 24/25

Report by Pamela Stott, Chief Officer Highland Health and Social Care Partnership

The Interim Head of Commissioning highlighted the circulated report included the Independent Sector Care Home Overview that provided an overview of commissioned independent sector care home issues as of April 2025. It was noted that there were 1,856 care home beds commissioned or delivered in Highland, with an 84 per cent commissioned from independent providers. Key issues in the independent sector care home delivery were highlighted in relation to the National Care Home contract, financial viability, recruitment and Moss Park. Further updates were provided on the quality-of-Care Home Services; Market and Service Changes; and Strategic Direction.

The Interim Head of Commissioning noted that the second section of the circulated report provided an update on Collaborative Support and arrangements to support independent sector care home delivery. It also covered the achievement of good outcomes for residents across Highland during the 2024/25 period. It was highlighted that the Collaborative Care Home Support Team had received baseline funding for 2025/26 and plans were being developed to ensure continuity. This had included the implementation of a comprehensive work plan to enhance training delivery to care homes.

In discussion,

- It was highlighted that training was an ongoing programme with no end date set due to the nature of ASC and could provide assurance to staff and service users that training focused on key areas of risk based on feedback from the collaborative team and care homes.
- It was confirmed that both virtual and in-person training methods were being used to efficiently engage staff, acknowledging the challenges of coordinating in-person training.
- Committee Members queried whether there was a significant short fall of potential beds. It was noted the forward strategy supported by the transformational programme was addressing the medium to long-term bed requirements and planned actions around the issue.
- Committee Members noted that overspending makes increased care home capacity unaffordable and destabilises existing homes. The financial implications of the National Care Home Contract were queried, and it was highlighted that the strategy focuses on balancing demand and supply by promoting independent living.
- The Chair highlighted a development session would be held to discuss the Care Home strategy further.

- Following Committee members wishing to clarify timescales for the delayed Care Home Strategy Commissioning Plan, it was noted that there were no defined timescales, but work progressed and would consider key data and models.
- Committee Members raised concern of care homes not meeting patients' needs and highlighted staffing issues. The Director of Adult Social Care highlighted the main challenge in the care home sector was ensuring that care homes meet the complex needs of residents, while balancing security, dignity, and rights. This included addressing concerns about staff groups and ensuring a good skillset to provide care for patients.
- Committee Members noted concerns about recruitment and retention, particularly regarding shift changes leading to staff turnover. Gathering data on staff turnover was suggested to understand issues in more detail.

.

The Committee:

- **NOTED** the report and
- **ACCEPTED moderate** assurance

3.2 Vaccinations Update

Report by Tim Allison, Director of Public Health

The Director of Public Health spoke to the circulated report which focused on progress with vaccination uptake and the rollout of a new delivery model. The Vaccination rates at 12 months had improved significantly in the Highland HSCP, while uptake remained below the World Health Organisation target of 95 per cent, the trend remained positive. Rotavirus uptake remained lower due to strict timing requirements, but overall, quality improvement efforts over the past year had been effective.

It was highlighted that the adult vaccination rates were reasonable and broadly aligned with national figures. A new delivery model, involving general practice or a mixed approach, had been approved and was in early stages. Progress was being monitored, but caution was advised to ensure services remained safe, effective, and efficient.

In discussion,

- Following Committee members querying whether GPs and frontline staff had been actively involved in vaccination planning. The Director of Public Health confirmed strong GP engagement during the options appraisal, though acknowledged some communication gaps remained, with efforts ongoing to improve information flow and collaboration.
- Committee Members questioned whether the timeline for implementing the new vaccination model was realistic. The Director acknowledged the growing complexity of vaccine delivery and stressed the importance of collaboration and quality assurance to ensure a safe, effective service with high uptake.
- Committee Members raised concerns about unresolved IT issues in vaccine data sharing between GP systems and public health databases, especially compared to the smoother COVID-19 process. The Director of Public Health noted ongoing challenges with childhood vaccination data and noted that national efforts were underway to source initial fixes.
- Committee Members queried the reliance on manual data entry, citing negative GP feedback and potential friction with health boards. The Director of Public Health clarified this was not a long-term solution but a temporary measure until better IT systems were in place.
- The Deputy Medical Director reassured the committee of strong GP involvement through leadership roles and acknowledged the need to improve communication and digital solutions, while also recognising concerns about manual data handling.

The Committee Chair summarised that the committee had reviewed the vaccination update, , and agreed to a follow-up in September.

The Committee:
- **CONSIDERED** and **DISCUSSED** the report.
- **ACCEPTED limited** assurance.

3.3 Fees and Charges 25/26

Report by Pamela Stott, Chief Officer Highland Health and Social Care Partnership

The Interim Head of Commissioning spoke to the circulated paper that outlined the implementation of a government directive requiring all adult social care providers to pay staff a minimum of £12.60 per hour. The process involved engagement with relevant stakeholders and financial planning to assess the impact and identify a funding shortfall. The report confirmed that the required steps were followed, including collaboration with finance colleagues to manage the funding gap.

The Committee:
- **NOTED** the report.
- **ACCEPTED substantial** assurance.

3.4 Dental Services Update

Report by John Lyon, Clinical Dental Director

The Clinical Dental Director noted access to NHS dental services had partially stabilised following the national payment reform. Workforce challenges continued, included recruiting dentists willing to provide NHS services and job postings attracting fewer applicants. The Scottish Dental Access Initiative (SDAI) grants were one of the few tools available to improve access; three had been awarded, with one new practice expected to open in the summer. Sustainability concerns were noted, with at least one practice requesting direct financial support to avoid closure, highlighting the need for a national strategy for rural dental services.

In discussion,

- Committee Members queried whether there had been any changes to NHS dental registration issues since the last update received by the Committee. The Clinical Dental Director advised exact figures were unavailable due to fragmented data sources. He noted a new mapping tool was being developed to link registrations to specific areas.
- Committee Members queried the number of people involved in the Highland Dental Plan (HDP) and how oral health data can be better captured. The Clinical Dental Director noted the HDP were not required to share data with NHS Highland. He noted that data previously shared may be outdated or incomplete and capturing accurate oral health data remained challenging.
- Committee Members requested clarification on how dental care how local dental care for young children in the region compares to the rest of Scotland, particularly regarding programmes like oral health programmes. The Clinical Dental Director noted NHS Highland actively participates in five national oral health programmes. He highlighted strong engagement and positive feedback with the Board performing above national average in providing oral health support to young children.

- The Clinical Dental Director advised while cross-border patient movement was common, registration data did not include patients receiving treatment in other Board areas. Capturing data on the new mapping tool for cross-border patient movement would require further coordination with planning colleagues to ensure a more complete picture.
- Committee members queried whether young people from the Highlands pursue dental training and noted limited course availability. The Clinical Dental Director noted no specific data on local students entering dental school and highlighted the BSc Oral Health Sciences programme (via UHI) was highly oversubscribed. He advised planning for a dental school was in the early stages, but development of the plan was dependent on funding and national alignment.
- Committee members sought clarity on the impact reduced dental services has on oral health. The Clinical Dental Director noted it was too early to assess long-term impacts as national data reflects trends over five years. He highlighted there had been no increase in A&E visits or hospital admissions for dental issues, suggesting urgent care was being managed.

The Committee:
- **NOTED** the update.
- **ACCEPTED limited assurance** from the report.

The Committee took a Break between 15.02 pm and 15.12 pm

3.5 Joint Strategic Plan Implementation

Report by Rhiannon Boydell, Head of Integration, Strategy and Transformation, HHSCP

The Head of Integration, Strategy and Transformation presented a paper outlining three main implementation routes: the Strategic Planning Group (SPG) and District Planning Groups (DPG), oversight by the Strategic and Transformation Accountability Group (STAG) within NHS Highland, and the Partnership Transformation Programme, which formed part of Highland Council's Delivery Plan.

The SPG and DPG met quarterly throughout the year. Despite some delays due to attendance, progress was steady with updates from workstreams to align with the bimonthly meetings. There had been discussions across all areas highlighted local issues, with recurring themes of workforce, sustainability, access, and service-specific concerns. The SPG and DPG focused on local engagement, involving NHSH partners, strategic stakeholders, the independent sector, third sector providers, and unpaid carers. STAG supported understanding and implementation of the plan's aims.

The various workstreams supported the Joint Strategic Plan (JSP), aiming to deliver care close to home, reduce hospital admissions, and avoid long stays. Emphasis was placed on the role of Community Integrated Teams and clarity was provided on how the Delivery Plan and SPG/DPG activities aligned with NHS Highland's planning processes. The Adult Social Care Transformation Programme, a three-year initiative backed by a £20 million Transformation Fund, focused on two main areas: shifting the balance of care and improving transitions. A target operating model had been developed, with initial work underway in Lochaber, including Moss Park Care Home. This work was integrated with STAG and the HHSCP senior leadership team.

In discussion, the Interim Head of Strategy and Transformation advised further information could be shared with Committee Members to help provide further detail on the governance structures and escalation processes. Committee Members sought clarity and transparency on the coordination of the multi-agency partnership, along with the measurement and assurance on possible risks. The Deputy Chief Executive highlighted the main challenge to coordination was determining the correct sequence for implementing the change.

The Committee:
- **NOTED** the update and
- **ACCEPTED moderate** assurance.

3.6 Chief Officer's Report

Report by Pamela Sott, Chief Officer for the Highland Health and Social Care Partnership

The Deputy Chief Executive highlighted the success of the AHPs in the Emergency Department of Raigmore as the results of this had been positive and measurable, positively impacting admissions.

The Director of Adult Social Care gave an update on the required improvement enforcement requirements at Sutherland Care Home which need to be made by 25 May 2025. The included a new scheduler, including a complete revision and review of visits; a changed management arrangement to be used longer term whilst the service was stabilised; Increased training, including the use of the improved CM2000 system for assurance of scheduled visits, and further training in pharmacy and engagement with the community nursing team.

He also advised there was concern regarding provision of weekend cover being put in place across the Highlands, with a permanent resolution across the Highlands for Care at Home provision being put to an oversight group meeting once a week.

In discussion,

- Committee members asked what steps had been taken to ensure issues in Sutherland were not present elsewhere in care-at-home services. The Adult Social Care Director confirmed that more robust, planned assurance visits were underway across all in-house services as part of an existing improvement plan.
- The Committee Chair requested a formal close-off report be shared with the committee, outlining the actions taken and evidence of progress.
- The Adult Social Care Director provided assurance to the Committee that the service standards surrounding the Adult Protection Element Process were being followed appropriately.

The Committee:
- **CONSIDERED** the Chief Officers Report and
- **IDENTIFIED matters** requiring further assurance / escalation.

3.7 Sir Lewis Ritchie Report Update

Report by Pamela Stott, Chief Officer Highland Health and Social Care Partnership

The Area Manager for Skye, Lochalsh and Wester Ross advised the final report remained in draft but was expected to be finalised shortly. The final report would outline the work NHS Highland had undertaken to act upon the 15 recommendations from the original Sir Lewis Ritchie report in 2018. She provided a brief update on work undertaken in conjunction with the recommendations noting Portree Out of Hours Service had received additional funding from Scottish Government and was in place.

She provided a brief update to the Committee on the position of the Community bed and care provision related to Care Homes and Portree Hospital; Closer Inter-Agency and Public Participation; Collaboration with Scottish Ambulance Service; Collaboration with NHS 24; First Responders; Workforce Capacity and Capability; Housing Solutions; Road Issues; Transport and Accessibility; Digital Innovation; Specific Localities; Centre for Excellence; Best Use of Resources; and Making it Happen.

The Committee Chair report noted that Sir Lewis had now completed his final report, with the work being integrated into the work of the Skye, Lochalsh and Wester Ross District Planning Group. Governance would continue under a new independent chair, as Sir Lewis Ritchie would be stepping back from the process.

The Deputy Chief Executive acknowledged the emotional and practical challenges of implementing change, and praised the those involved for their efforts in progressing the work.

The Committee:

- **NOTED** the update and
- **ACCEPTED moderate** assurance.

4 COMMITTEE FUNCTION AND ADMINISTRATION

4.1 Blueprint for Good Governance Improvement Plan Progress Update

Report by Nathan Ware, Governance and Corporate Records Manager

The Governance and Corporate Records Manager advised the Board approved its Blueprint Improvement Plan on 25 July 2023 and agreed that Governance Committees should provide informal oversight of progress and delivery of elements relevant to their functions. He highlighted that from the original 17 actions, nice had been completed and open actions had longer-term completion dates and had an organisation-wide focus.

He explained the quality framework was progressing following an April 2025 EDG discussion, with plans to recruit a quality lead and involve senior clinical staff once funding is secured. Efforts to embed Care Opinion were ongoing, supported by the clinical governance manager, with over 250 instances recorded in the past year, providing assurance that actions are actively being addressed.

On behalf of F Duncan, the Director of Adult Social Care requested clarification on where Social Work and Social Care would sit within that structure. The quality of services across the full integrated world in relation to the role of Chief Social Work Officer when associated with the Medical Director and Nurse Director, also needed consideration.
Committee Members sought clarity on the figure of 250 was requested, in relation to it being an increase or decrease. The Governance and Corporate Records Manager advised it would be tracked from hereon, enabling 6-monthly comparisons to be made at future Committee Meetings.

The Committee:
- **NOTED** the progress update, and
- **ACCEPTED moderate** assurance.

4.2 Committee Self-evaluation results
Excel Spreadsheet

The Chair picked the following key themes from the results and proposed the points below were put forward to a future development session, for discussion and improvement options:

- The role of the Committee and its Members.
- The ability for lay members to have more effective inputs.
- Moving from a Lead Agency to an IJB and how the new governance framework would affect the Committee.
- Agenda items and time allocated versus papers and time allocated for discussion.

The Chair highlighted the potential transitioning to an alternative governance model and would consider further committee discussions in a development session.

The Committee:
- **DISCUSSED** and **NOTED** the Committee Self-evaluation results.

5 AOCB

A proposal was made by the Chair to make a temporary change for the quorate rules and terms of reference, to quoracy being granted for one out of three of the occupied pool, rather than one out of three of the membership. The Committee agreed this was to be put through the appropriate governance routes as quickly as possible.

DATE OF NEXT MEETING
The next meeting of the Committee will take place on **Wednesday 2nd July 2025** at **1.00 pm** on a virtual basis.

The Meeting closed at 4pm

NHS Highland	NHS Highland na Gàidhealtachd

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name of Committee	**Highland Health and Social Care**
Date of Meeting	**02 July 2025**
Committee Chair	**Gerry O'Brien**

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

The IPQR highlighted that while delayed discharge figures have improved, they remained a significant pressure point linked to care home and care-at-home service delays with concern being raised about potential unmet need in the community.

ASSURE

Assurances taken on:

- Annual Delivery Plan 2025/26 Update (Substantial)
- Finance Report – Month 12 2024/2025 Year End position & 2025/2026 Financial Plan Summary (Limited)
- Highland Health and Social Care Partnership - Integrated Performance and Quality Report (IPQR). (Limited)
- Transformation Overview 2025/26. (Moderate)
- Learning Disability Services. (Moderate)
- Primary Care Services Update, including an update on the current position on the Primary Care Improvement Fund. (Moderate)
- Sutherland Care at Home (Moderate)
- Sir Lewis Ritchie Report Final Report. (substantial assurance that report identified the current position and the actions and moderate assurance that the Board will continue to make progress in line with the outcomes.)

ADVISE

The Sir Lewis Ritchie Final Report was received by the Committee and they were advised of the Boards plans for continued implementation of the original report recommendation and response to additional points referenced by Sir
Lewis Ritchie

RISKS

In relation to the Financial Plan for 2025/26, the Head of Finance for HHSCP advised funding allocation short fall risks were being monitored at both Board and National levels.

ACTIONS
It was noted that the Committee would receive further updates on Highland at Home and the Care Home Commissioning Report later in the year. A Development session on enhanced services in General Practice would be planned prior to December 2025, after highlighting the complexity and opportunities within the current commissioning framework.
LEARNING
The Committee received an overview of learning disability services in NHS Highland and including the range of support available, including community nursing teams, specialist medical staff, and a joint transition social work team for young adults. A Primary Care update was received from the Head of Primary Care to highlight progress made in Community Optometry, Dentistry and General Practice.

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/
MINUTE	**1 May 2025 – 9.00am (via MS Teams)**

Present
Karen Leach, In the Chair
Tim Allison, Director of Public Health
Emily Austin, Non-Executive Board Director (Substitute Attendance)
Louise Bussell, Board Nurse Director
Muriel Cockburn, Non-Executive Board Director
Alasdair Christie, Non-Executive Board Director
Liz Henderson, Independent Public Representative
Dr Boyd Peters, Medical Director/Lead Officer

In attendance
Gareth Adkins, Director of People and Culture (Item 8)
Isla Barton, Director of Midwifery
Duncan Clark, Clinical Director (CAMHS) and Interim Lead for NDAS
Kristin Gillies, Interim Head of Strategy and Transformation
Stephanie Govenden, Consultant Community Paediatrician
Evelyn Gray, Associate Nurse Director (from 9.05am)
Rebecca Helliwell, Depute Medical Director, Argyll and Bute HSCP
Elaine Henry, Deputy Medical Director (Acute)
Jo McBain, Director of AHPs
Brian Mitchell, Board Committee Administrator
Mirian Morrison, Clinical Governance Development Manager
Elise Murray, Medical Secretary (from 9.25am)
Heather Richardson, Head of Operations
Leah Smith, Complaints Manager
Tracey Sturgeon, Consultant, Obstetrics and Gynaecology (from 9.10am)
Katherine Sutton, Chief Officer (Acute)
Nathan Ware, Governance and Corporate Records Manager
Dr Neil Wright, Non-Executive Board Director (Observing)

1.1 WELCOME AND APOLOGIES

Formal Apologies were received from Committee members S Compton-Bishop, D MacDonald, J McCoy and C Sinclair.

1.2 DECLARATIONS OF INTEREST

A Christie advised that being a Highland Councillor he had applied the objective test outlined in paragraphs 5.3 and 5.4 of the Code of Conduct in relation to Items on the Agenda and concluded that these interests did not preclude his involvement in the meeting.

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

The Minute of Meeting held on 6 March 2025 was **Approved.** The Committee Work Plan would continue to be iteratively developed on a rolling basis. The following was **Noted** in relation to the Rolling Action Plan:

- **Live Actions** – Advised actions would be discussed with relevant Lead Officers, including due dates, and the Plan updated for the next meeting.

The Committee:

- **Approved** the draft Minute and Committee Work Plan 2025/26.
- **Noted** the update provided in relation to the Rolling Action Plan.

1.4 MATTERS ARISING

1.4.1 Neurodevelopmental Assessment Service (NDAS) Update

D Clark and H Richardson spoke to the circulated report, advising the service remained under significant pressure. There were a number of children and young people on the waiting list, with some waiting years to access services. It was stated the service was unable to meet existing service demands or address the growing legacy waiting list. Clinical capacity had been further reduced in 2024/25 due to a decrease in the core central NDAS team, placing the service at risk of further deterioration in access and quality of care. The service was operating with a lone clinician, impacting the delivery of timely and safe assessments. The staffing situation did not meet standards for effective multidisciplinary assessment as recommended in national guidelines. As a result, there was an increasing backlog leading to growing frustration and distress within relevant families and referrers. There was increasing public and political scrutiny regarding delays in neurodevelopmental assessments, reflected in rising complaints from families, attention from elected members, and interest from the wider media. The Board Medical Director further advised as to the detail and requirements of relevant associated government scrutiny of services. It was noted an associated financial Business Case was being developed for submission to the Executive Directors Group for consideration in relation to securing ongoing service sustainability. Discussion was also being held with Scottish Government in relation to potentially securing additional financial resource. The report outlined a series of recommendations and proposed the Committee take **Limited** assurance.

There was discussion of the following:

- Service Sustainability. Noted stated concern relating to safely continuing services in their existing form and questioned the applicability of recommendations contained in the report. The ability of the Committee to take the level of assurance proposed was highlighted.
- Wider Local and National Position. Advised as to the challenges across Argyll and Bute and in relation to wider national service provision concerns being highlighted at governmental level. Recruitment challenges were highlighted alongside the impact of movement of individual patients from Children's Services into Adult Services. NHS Highland Services continued to be delivered at the time of discussion. The need to focus on population need was recognised.
- Provision of Executive Overview Summary Statement. Agreed any Statement being developed include an update in relation to Argyll and Bute, recent activity since the report to Committee in March 2025, and provide an explicit outline of any associated asks of this Committee and other groups. D Clark provided general updates on aspects relating to funding, recruitment and staffing, Highland Council position and existing capacity within the wider multidisciplinary team. Work on pathway development was ongoing in association with Highland Council.
- Escalation Process to NHS Board. Noted overall meeting Summary would be provided to next Board meeting as part of the normal governance reporting process.

After discussion, the Committee:

- **Noted** the reported position.
- **Agreed** an additional Executive Summary be prepared for the consideration of members, including an update on any recent or potential changes to the associated risk level.
- **Agreed** to take **Limited** assurance, subject to recognition of the current service position; improvement plan development; associated risk level statement and the highlighting of relevant aspects at NHS Board level. This would be dependent on receipt of the Executive Summary and further assurance relating to ongoing service sustainability.
- **Agreed** this subject remain on the agenda for future meetings.

1.4.2 Vascular Services Update

B Peters advised the mutual aid arrangement with four other NHS Boards in Scotland was continuing. It was advised locum cover was in place, with additional cover being pursued. Relevant pathways for patients requiring interventions were maturing, with both national and regional activity being taken forward with a view to seeking an improved interim and longer-term solution. It was confirmed patient outcomes and associated adverse events were being actively monitored and investigated, in association with partner NHS Boards. The Director of Public Health took the opportunity to highlight an increase in Aortic Aneurysm screening activity, with discussion taking place with NHS Lothian in relation to associated treatment service requirements.

The Committee:

- **Noted** the reported position.
- **Agreed** this subject remain on the agenda for future meetings.

2 SERVICE UPDATES

2.1 Primary Care Workforce Survey Update

It was agreed consideration of this Item be deferred to the next meeting.

2.2 Adult Social Care/Commissioned Services Update

It was agreed consideration of this Item be deferred to the next meeting.

2.3 Women's Services (incl. Maternity Services) Six Monthly Update

I Barton spoke to the circulated report, giving an update on National strategic priorities and how these were translated into local governance and operational priorities along with an overview of some key governance data pertaining to workforce, morbidity and mortality, and service targets. There was significant National focus from Scottish Government and Healthcare Improvement Scotland on Perinatal (Maternity and Neonatal) services. The level of scrutiny for these services over the coming year, through a variety of different channels, including strategies, standards, inspections and improvement guidance was unprecedented. The wider Women's Service agenda was to focus on a second phase of the Women's Health Plan along with services specific focus for Gynaecology and associated services. Women's Services required to be able to provide evidence of assurance both locally and nationally, and to be able to respond to the scrutiny and changing demands. All NHS Boards across Scotland were working to enhance the current position. National workstreams will support this activity. The improvement programmes would focus on quality with a strong emphasis on safety within Maternity and Neonatal services. From an NHS Highland Perspective, there was positive engagement across the national and local workstreams. Specific updates were provided in relation to National Neonatal Redesign activity; Moray Maternity collaboration with NHS Grampian; National HIS Standards for Maternity Services; National Policy; Midwifery, Medical Workforce and

partnership matters; clinical governance, quality improvement and patient safety oversight structures; Gynaecology and the Women's Health Plan; and scanning and screening activity. The report proposed the Committee consider a series of levels of assurance on varying aspects, all as indicated further.

There was discussion of the following:

- Facilities and Physical Infrastructure. Advised as to discussion regarding the upgrading of facilities at Raigmore Hospital and the Lochaber area. A position statement would be prepared for members.
- Cancer Services Reporting. Stated reporting, including relevant data and service provision aspects should be more prominent in future updates. An update in relation to late abortions would also be beneficial for members. Further updates on greater system oversight, system quality and future improvement activity would also be welcomed.
- Team Function and Development. Requested greater detail in the next update. Advised HIS Standards included Leadership and Culture.
- HIS Unannounced Visits to Maternity Units. Advised NHS Highland would be subject to review, with a focus on risk, associated systems and NHS Board level monitoring and reporting. Relevant governance aspects would be a key element.
- Caithness Services. Advised factual service position statements continued to be developed. Regular meeting held with CHAT representatives, including on a face-to-face basis.

The Committee:

- **Noted** the reported position.
- **Agreed** a statement on facilities be provided for members.
- **Agreed** an update on Team function and development be included in the next update.
- **Agreed** to take the levels of assurance proposed.

2.4 Long Wait Performance Report

K Gillies spoke to the circulated update, providing a dashboard report on Long Waits across NHS Highland Services as previously reported to, and considered by, the Executive Director's Group (EDG). Specific detail was provided in relation to Outpatients and Treatment Time Guarantee activity across relevant Specialties, and associated conclusions. She went on to advised as to relevant National target requirements, associated planned care submission and resource bids, administrative challenges relating to data cleansing activity, Local Access Policy training for relevant staff, funding to support planned care activity, and continued EDG reporting and oversight.

The following was discussed:

- Associated Treatment Impact on Waits. Noted waits for specific treatment can be reliant on service provision elsewhere in the system thereby impacting stated overall wait position. Confirmed consideration was being given to these aspects and associated reporting.
- Patient Waits and Treatment Outcomes. Advised clinicians highlight particular cases of clinical priority at an early stage, such as in relation to Oncology and Orthopaedic services. This enabled the specific targeting of resource where appropriate.
- Intersectional Waiting Lists. Advised related activity ongoing in relation to identifying those patients waiting for multiple services and potential service profiling to address those cases.
- Areas of Challenge. Advised as to level of discussion within relevant Scottish Government Access Team, bids for additional funding resource, impact of the National Treatment Centre and the levels of support offered to and from other NHS Boards across Scotland.
- Wider Data Consideration Requirements. Advised data for all patient waits would enable further consideration of aspects relating to productivity and efficiency. The role of the Centre for Sustainable Delivery was highlighted. Further government direction was expected in this area. It was stated there would be need for greater clarity on associated Governance Committee

consideration of relevant data aspects. This was being taken forward at NHS Board level, including by Chairs of relevant Governance Committees.

After discussion, the Committee otherwise Noted the circulated report.

The meeting adjourned at 10.30am and reconvened at 10.40am.

3 EMERGING ISSUES/EXECUTIVE AND PROFESSIONAL LEADS REPORTS BY EXCEPTION

3.1 Highland Care at Home Service

L Bussell advised a briefing had been provided to NHS Board members the previous week in relation to Care at Home Service provision, a wider communication in relation to which had followed. She advised as to specific challenges being faced in the Sutherland area, relevant recent inspection results and a series of actions requiring to be taken by 25 May 2025. An Action Plan had been developed and was being taken forward. It was reported an investigation was being taken forward under Adult Protection legislation, in relation to which there would be a number of associated learning matters to be considered relating to both issue escalation and overall governance arrangements.

The Committee Noted the reported position.

4 PATIENT EXPERIENCE AND FEEDBACK

The Chair introduced the circulated Case Studies, documenting both positive and negative patient experiences, which had been produced by the Clinical Governance Team Complaints Manager and in relation to which detail of relevant learning opportunities and outcomes had been indicated. An update was provided in relation to the potential for wider publication of such reports. The report proposed the Committee take **Moderate** assurance.

The Committee:

- **Noted** the detail of the circulated Case Study documents.
- **Agreed** to take **Moderate** assurance.

5 CLINICAL GOVERNANCE QUALITY AND PERFORMANCE DATA

M Morrison spoke to the circulated report, advising as to detail in relation to performance data; associated commentary; and an indication of key risks and mitigations around Complaints activity; Scottish Public Services Ombudsman activity; Listening and Responding to Patients (Emergency Department); Level 1 (SAER) and Level 2A incidents; Hospital Inpatient Falls, Tissue Viability and Infection Control. The report highlighted performance over the previous 13 months and was based on information from the Datix risk management system. It was stated performance against the 20-day working target for Complaints had decrease and there had been a decrease in both the number of falls with harm and tissue viability injuries. The report proposed the Committee take **Moderate** assurance.

There was discussion of the following:

- Reporting Detail. Advised consideration being given as to future reporting on quality markers and associated data. Noted Quality Strategy development activity continuing.

After discussion, the Committee

- **Noted** the report content.
- **Agreed** to take **Moderate** assurance.

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 key clinical governance topics from each service area within the Argyll and Bute Health and Social Care Partnership and providing assurance of effective clinical governance frameworks being in place. Specific updates were provided in relation to Health and Community Care, including recent inspection activity; Primary Care, including an update on Sexual Health Services, CTAC and general medical services; Children, Families and Justice; and Acute and Complex Care, including Mental Health Oban Rural General Hospital. Other updates were provided in relation to Tissue Viability, Adverse Events and Significant Adverse Events activity. There was reference to SPSO Investigations; Mental Welfare Commission, Fatal Accident Inquiry, and HSE Inquiry activity; unannounced HIS inspection of Oban General Hospital. The report proposed the Committee take **Moderate** assurance.

After discussion, the Committee:

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

6.2 Highland Health and Social Care Partnership

B Peters introduced the circulated report providing a summary of the governance structure for the Highland Health and Social Care Partnership (HSCP), advising an iterative process of embedding a refined structure based on the Vincent Framework was continuing. Links to performance data were provided in relation to Violence and Aggression, Tissue Viability, Falls and Medication Issues. Detail was provided in relation to relevant Statutory and Mandatory training activity, staff sickness levels, and complaints activity. Updates were also provided in relation to SPSO activity and the weekly review of the Datix system to identify key issues for presentation at weekly QPS meetings. An overview of SAER activity was provided. Current issues being highlighted were in relation to communication of medication changes from Secondary to Primary Care; and bed capacity within Mental Health Services and associated inpatient aspects. Updates were also provided in relation to progress on previous matters highlighted to Committee. It was noted relevant First Contact Physiotherapy digital successes were to be reported to a forthcoming Digital and Healthcare Conference. The report proposed the Committee take **Moderate** assurance.

The following was discussed:

- Mental Health Service Option Appraisal. Advised engagement processes being finalised for early issue and consultation.

After further detailed discussion, the Committee:

- **Noted** the report content.
- **Agreed** to take **Moderate** assurance.

6.3 Acute Services

E Henry spoke to the circulated report in relation to Acute Services, providing an Executive Summary in relation to Vascular Services; recent HIS Inspection results relating to Raigmore Hospital; water system concerns; Front Door Allied Health Professions (AHPs) Initiative; concerns relating to wheelchair services; Colorectal MDT and Medical Oncology Attendance and support arrangements; infection prevention and control matters; performance reporting focus on Emergency Department access and Scottish Cardiac Audit Programme; and wider data trend analysis activity. An update was provided on mortality data received across the reporting period. Updates in relation to Hospital Acquired Infection (HAI) and emergency access were also provided. The report included a whole system pressure dashboard. The main points emerging from the recent Scottish Cardiac Audit Programme Annual Report 2024 were outlined. Other aspects relating to quality and patient care were also highlighted, including development and testing of a new CPR Case Review governance structure; HEPMA rollout; new biochemistry, haematology and coagulation platforms; work on relocation of the General Admission entrance; a diabetic nurse quality improvement project; Stoma Nurse of the Year Award; preparation for a HIS Maternity Service inspection; review of stillbirths; outstanding SAER actions; Caithness General Hospital Open Day arrangements and the Belford Hospital redesign programme progress. Data was provided in relation to Datix's, SAERs, inpatient falls; tissue viability; violence and aggression; Outpatient performance, training activity compliance, workforce and financial performance. There had also been circulated Minute of Meeting of the Acute Services Division Clinical Governance Committee on 18 March 2025, and other associated appendices. The report proposed the Committee take **Moderate** assurance.

The following points were raised in discussion:

- Year on Year Infection Control Trend Analysis. Advised as to proactive monitoring and isolation arrangements for patients with infection. Activity increased over the winter period. Active learning approach taken.
- Reporting Detail. Welcomed Executive Summary approach. Requested, where additional appendices included members are advised as the reason for these being presented. Noted a more data focussed approach to be adopted for future reporting. Feedback from non-executive members on reporting detail arrangements referenced, welcomed and encouraged.
- Scottish National Audit Programme. Suggested Committee members would benefit from additional information, potentially through a Development Session. Further consideration would be given to this point. The need for positive shared learning from this and other activity, including HIS was highlighted.

After further detailed discussion, the Committee:

- **Noted** the report content, associated Appendices and circulated Minute.
- **Agreed** to take **Moderate** assurance.

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

S Govenden spoke to the circulated report, advising recent child death reviews and the child death review annual report had been considered and the recommendations of the annual report accepted. Examples of positive actions and outcomes were referenced. It was stated there was a desire for all child deaths investigated by the board go to ICYPCGG for wider discussion. It was reported staff vacancies within the team providing care to children with complex and exceptional needs had led to a reduction in hours provided for all families currently receiving support. There had also been circulated minute of meeting of the ICYPCGG held on 19 March 2025 and one Child Death Review Report. The report proposed the Committee take **Moderate Assurance.**

The Committee:

- **Noted** the report content and associated circulated minute.

- **Noted** the position in relation to services for patients with complex needs and recognised the work of all staff members involved.
- **Agreed** to take **Moderate** assurance.

7 INFECTION PREVENTION AND CONTROL REPORT

The Board Nurse Director spoke to the circulated report and advised NHS Scotland published data for quarter 4 (Oct – Dec 2024) in April 2025 identified NHS Highland was within the normal variation for healthcare associated CDI, EColi,and SAB when analysing trends over the past three years, and was within expected rates across all three delivery targets. Validated and provisional data for April 2024 to March 2025 calculated the reduction aim for SAB would be met. The reduction aims for CDI and ECOLI would not be met but remained within predicted limits. ARHAI Scotland and UKSHA had noted an increase in the incidence of CDI across the 4 nations and were undertaking a review, any outcomes from which would be adopted by NHS Boards. NHS Boards had been informed that there should be no increase in the incidence (number of cases) of CDI, ECB, and SAB by March 2026 from the 2023/2024 baseline. ARHAI Scotland would be providing Boards with the 2023/2024 baseline number of CDI, ECB and SAB cases to enable local monitoring. Whilst clarification was awaited NHS Highland would continue to utilise the previous reduction aims, with the Infection Prevention and Control Annual Work Plan reflecting this. Once received this would be updated. Aspects relating to quality and patient care, workforce matters, finance and risk assessment/management activity were also highlighted. There had also been circulated a six-monthly updates in relation to the NHS Highland Infection Prevention and Control Annual Work Plans 2024/25 and 2025/26. The report proposed the Committee take varying levels of assurance across a number of areas, as indicated in the report.

The Committee:

- **Considered** the report content.
- **Agreed** to accept the levels of assurance being offered in the circulated report.

8 HEALTH AND SAFETY COMMITTEE - 6 MONTHLY UPDATE BY EXCEPTION

G Adkins spoke to the circulated report providing an update on the activities of the Health and Safety Committee over the previous six months. The Committee had met three times during the reporting period as indicated, with issues of note for the Clinical Governance Committee including development of a 3-Year Health and Safety Strategy and 2025-2026 Health and Safety Plan; activity relating to Managing Inpatient Suicide in Mental Health; and Managing Inpatient Suicide in General Hospital Settings. The report proposed the Committee take varying levels of assurance across a number of areas, as indicated in the report.

The Committee:

- **Noted** the report content.
- **Agreed** to accept the levels of assurance being offered in the circulated report.

9 RADIATION SAFETY COMMITTEE ANNUAL REPORT 2024

B Peters introduced the circulated report providing an annual update on the status of radiation safety and compliance within NHS Highland. Specific updates were provided in relation to Service Lead reporting to the Radiation Safety Committee, IRR 2017 Compliance (Health and Safety Scope) and exceptions, IR(ME)R 2017 Compliance (Clinical Governance Scope) and exceptions, and challenges relating to replacement of equipment and staffing. The report proposed the Committee take **Moderate** assurance.

There was discussion of the following:

- Comment on the Level of Assurance. Wider governance role of Committee, and the associated content generally provided in this reporting template element, was discussed. Noted the expressed concern in relation to a reduced capital budget for equipment.

The Committee:

- **Noted** the report content.
- **Agreed** a revised report, based on discussion relating to wider governance considerations and the level of assurance reporting aspect, be brought back to the next meeting.

10 PHARMACY SERVICES ANNUAL REPORT AND STRATEGIC PLAN

The Committee **Noted** consideration of this Item had been deferred to the next meeting.

11 RISK REGISTER – CLINICAL RISK AND WAY FORWARD

B Peters spoke to the circulated report, which had been issued to members for comment prior to the meeting. The report outlined two risks relating to access to timely investigation and treatment, and service delivery risk related to sustainability challenges. Assessments were provided for each of the stated risks, including detail of associated mitigating actions. It was recommended the Committee approve the addition of these risks to the Clinical Governance Committee Risk Register and take **Limited** assurance.

There was discussion of the following:

- Level of Risk Presented at Committee Level. Advised, from governance perspective, a wide and high-level expression of risk and oversight in relation to all service areas is presented.
- Impact on Existing Risks. Advised consideration was being given to this aspect with regard to potential impact of new risks on known and previously identified Risk Register entry detail.
- Service Sustainability. Referenced potential for inclusion of a patient expectation aspect, and the ability of individual NHS Boards to deliver ever more complex care in line with those.

After discussion, the Committee:

- **Noted** the report content.
- **Agreed** to **Approve** the addition of the stated risks to the Clinical Governance Committee Risk Register.

12 PUBLIC HEALTH UPDATE

T Allison spoke to the circulated report outlining the public health function within NHS Highland and setting out the role in the context of the new NHS Highland Population Health Committee and the relationship of public health with clinical governance. Detail was presented with regard to aspects including strategic and individual advice provision; direct provision of services; commissioning of services; coordination of services; partnership working and overall responsibilities. The report proposed the Committee take **Substantial** assurance in relation to associated governance aspects.

B Peters took the opportunity to reflect on the imminent retiral of Dr T Allison, from the role of NHS Highland Director of Public Health and Policy, recognising and thanking him for the significant contribution made in the sphere of public health activity in general and in the facilitation of discussion

of key clinical governance aspects in this forum. All Committee members echoed the sentiments expressed.

After discussion, the Committee:

- **Noted** the report content.
- **Agreed** to continue to receive future Public Health updates.
- **Agreed** to take **Substantial** assurance.

13 COMMITTEE SELF-ASSESSMENT OUTCOMES

There had been re-circulated detail of the Committee Sel-Assessment exercise and associated results. The Chair outlined relevant key strengths, and highlighted negative comment received in relation to the late submission of Committee reports. She advised discussion was ongoing at non-executive level as to the results of all governance committee self-assessment exercises and how best to improve existing governance arrangements.

After discussion, the Committee otherwise Noted the circulated report.

14 DATE OF NEXT MEETING

The Chair advised the Members the next meeting would take place on 3 July 2025 at 9.00am.

15 REPORTING TO THE NHS BOARD

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

The Committee so Noted.

16 ANY OTHER COMPETENT BUSINESS

There was no discussion in relation to this item.

The meeting closed at 12.00pm

NHS Highland	NHS Highland na Gàidhealtachd

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name of Committee	**Clinical Governance Committee**
Date of Meeting	**3 July 2025**
Committee Chair	**Karen Leach**

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

- **NDAS Service –** Continuing challenging position recognised. Agreed future reports include detail of activity to reduce waiting lists, and update on national position. Matter to remain on future agendas.

ASSURE

- **Revised Radiation Safety Committee Annual Report 2024** – Moderate.
- **Patient Experience and Feedback –** Moderate.
- **Clinical Governance Quality and Performance Data –** Moderate.
- **Argyll and Bute Update –** Moderate.
- **Highland HSCP Update –** Moderate.
- **Acute Update –** Moderate, noting aspects relating to Diabetes Services.
- **ICYPCGG –** Moderate.
- **Infection Prevention and Control –** varying levels of assurance outlined taken.
- **Annual Delivery Plan Update** – Substantial.
- **Area Drug and Therapeutics Committee Six Monthly Update** – Moderate.
- **Information Assurance Group Six Monthly Update** – Substantial.

ADVISE

- **Rolling Action Plan –** Noted to be discussed with Lead Officers and updated.
- **Vascular Services Update** – Noted reported position.
- **Pharmacy Services Strategic Plan** – noted updated Strategy and associated summary document to be circulated to members after the meeting.

RISKS

- **NDAS Service –** acknowledged continuing risk to service sustainability.
- **Diabetes Services** – noted ongoing discussion, including enhanced services aspects relating to GP contract.

ACTIONS

- **NDAS Service -** Agreed additional aspects be included in future reports as indicated.
- **Primary Care Workforce Survey –** Agreed update to next meeting.
- **Adult Social Care/Commissioned Services -** Agreed update to next meeting.

- **Diabetes Services** – agreed there be discussion at next Argyll and Bute Clinical and Care Governance Group meeting.
- **Subject Access Requests** – Agreed further detail be provided in future Information Assurance Group reports.

LEARNING

- No matters highlighted.

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MINUTE of MEETING of the AREA CLINICAL FORUM	**9 January 2025 – 1.30pm** **Microsoft TEAMS**	

Present

Catriona Sinclair (Chair)
Alex Javed, Area Healthcare Science Forum
Annette Grier, Area Optometric Committee
Calum Fraser, Area Optometric Committee
Eileen Reed-Richardson, NMAHP Advisory Committee
Kara McNaught, Team Manager, Adult Social Care
Malcolm Mathieson, Area Pharmaceutical Committee
Peter Cook, Area Healthcare Science Forum

In Attendance

Boyd Peters, Medical Director (from 1.45pm)
Fiona Davies, Chief Executive (Item 4.1)
Gareth Adkins, Director of People and Culture (Item 4.2)
Tim Allison, Director of Public Health
Karen Doonan, Committee Administrator (Minutes)

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting, apologies were received from Paul McMullan, Kitty Millar, Helen Eunson, Linda Currie, Grant Franklyn, Andrew Strain.

1.1 DECLARATIONS OF INTEREST

There were no declarations of interest.

2. DRAFT MINUTE OF MEETING HELD ON 29th August 2024 and 31st October 2024

The minutes were taken as accurate and correct.

The Forum **noted** and **approved** the minutes.

3. MATTERS ARISING

There were no matters arising.

4. ITEMS FOR DISCUSSION

4.1 **Fiona Davies** – Chief Executive

F Davies introduced herself to the forum and thanked the chair for inviting her to speak to the forum. She went on to explain what she had taken from the recent Annual Review that had taken place which was that the Forum would like to have sight of planned pieces of

work that was ongoing within the organisation and how the work would feed into the wider workplan.

There were various pressures within the system caused by patients who were not being cared for in the most appropriate places e.g. patients who remained in a hospital setting where a community setting would be more appropriate. This had resulted in many services under intense pressure and becoming more fragile as a result. Many of the specialist services were having challenges recruiting to posts and this was adding to the system pressures. Focus had been placed on these areas to address the pressures being experienced.

There had been challenges to the vaccination delivery model and there had been a lot of work done over the course of 2024 to ensure that the service was able to deliver where it was most needed by the public.

F Davies went on to explain how the Together We Care Strategy was being utilised to help by focusing in on areas to address the pressures without adding to them. Lots of discussion had taken place regarding the seven areas that were being focused upon. Work was also ongoing regarding the process required to develop the next strategy to tackle health inequalities and the health outcomes of the population.

Focus had also been put on the Integrated Health and Social Care services in North Highland with a paper having gone to the Highland Council and also the Joint Monitoring Committee in December which would be discussed in the Board Meeting later in January as there would be a change to the governance model used in NHS Highland, a move away from the Lead Agency model

The Chair highlighted the challenges to the Forum in what to look at and advise upon due to the changes that were occurring within the organisation. Some changes were happening very fast whilst others were happening at a very slow pace. She queried how to the flow of information going through the Forum could be managed more effectively.

F Davies agreed that one of the ongoing challenges was communication however, work was underway to address this, she cited the work that the Director of People and Culture had undertaken around Corporate Governance.

K McNaught queried the work that had been done by Meridian and stated that whilst not all work being done could go through the Forum awareness of the work would be beneficial. F Davies stated that the organisation itself was complicated but co-ordination across the organisation was vital.

G Adkins explained that Meridian sat within the value efficiency workstreams and there were conversations regarding productivity and efficiency taking place. He went on to explain Engagement HQ, a platform that the organisation had recently invested in to assist in improving communication across the organisation and suggested the Head of Communications and Engagement could attend a future meeting to provide and update.

Action: Ruth Fry and the Chair to discuss the Engagement HQ platform offline.

The Forum **noted** the update.

4.2 Confidential Contacts – Gareth Adkins, Director of People and Culture

G Adkins outlined the discussions that had taken place over the last year in relation to the Confidential Contacts and the Guardian Service which provides and independent and neutral service for staff who wish to raise concerns. Discussions had taken place around moving to a different model, moving the service inhouse or a blend of both.

A short life working group (SLWG) which included staffside representatives looked at the options with moving the service inhouse being the preferred option. This paper was brought to the Forum for awareness. As the Area Partnership Forum formally represented all staff the decision would be signed off at that Forum.

K McNaught queried the end date of the Guardian Contract (25th July) and whether there would be any gaps whether there would be no service available to staff. G Adkins agreed that the timescales were short and explained that whilst there was a potential risk work was being done to mitigate this, there was potential to negotiate with the Guardian Service to extend the service.

The Forum **noted** the update.

4.3 Integrated Patient Record Systems – Iain Ross, Head of e-Health

I Ross spoke to a short presentation wherein it was highlighted:

There was concern around a lack of single clear access to patient records across many contracted groups with variations appearing between North Highland and Argyll and Bute. There are various timescales involved when addressing the access required by the different contracted groups and a need to be aware of the risks involved in the sharing.

There had been various work done over the past two years including:

- Workshops led by different groups within clinical and non clinical staff in order to identify and understand the concerns
- There had been a Visioning event held last May
- A visit to Dr Grays Hospital to understand the approach that NHS Grampian had taken
- Discussions had taken place with many different groups and individuals across the organisation.

It was noted that there was no proposal to replace what already exists with one digital system that covered all care settings. What was proposed was to improve on the existing single digital record systems within a care setting which would all be linked by a patient centric information repository which would be Care Portal. It was noted that Care Portal may be replaced by the National Unified Record solution once this was available.

The focus of work being done at present was in Acute Care with it being noted:

- NHS Highland would adopt TrakCare Electronic Patient Records (EPR) across all hospitals over the next 18 – 24 months across all clinical staff
- Patient contexts links would be added for HEPMA and Care Portal
- NHS Highland would establish a digital skills programme across all staff groups
- NHS Highland would adopt a TrakCare first policy to avoid non integrated being procured.
- Morse Acute would be removed at the correct time.

Regarding Dentistry and Optometry access to Care Portal could be provided under the right controls which would be:

- Caldicott – what clinical information should be accessed
- Senior Information Risk Owner (SIRO) – what safeguards were in place to protect the information

It was noted that work was ongoing with Pharmacy with the correct access controls to be put in place, this model would now be used for both Dentistry and Optometry. C Fraser queried how this would be progressed for Optometry and I Ross explained that a named person from the management team was required in order that the processes could be mapped out to obtain permission from SIRO.

The Chair highlighted that frustration may have grown due to the lack of communication to those who would be using the systems and I Ross explained that once Pharmacy access had been trialled across a couple of sites more communication would be sent out

however it was challenging to put timescales within said communication. C Fraser queried whether I Ross would be available to come to the next Area Optometric Committee to discuss further and this was agreed.

Action: C Fraser to invite I Ross to the next Area Optometric Committee meeting.

M Mathieson queried the connectivity and the amount of digital transformation and whether the network was strong enough to cope with the delivery of the digital platforms. I Ross stated there was work going on in the background to upgrade the network within the budget provided. It was noted that having the staff updated in digital skills prior to the roll out of the digital solutions across the network.

Action: any advisory committee wishing more information to contact I Ross directly.

The Forum **noted** the update.

4.4 Wheelchair Service Continuity – Peter Cook, Head of Medical Physics and Bio Engineering

P Cook spoke to the circulated update and explained issues were being experienced as the wheelchair and specialist seating service, part of assistive technology services was based at the Longman Industrial Estate. They had received a notice to quit by the end of May 2025, necessitating action as detailed in the circulated paper which was first reviewed by the senior leadership team.

He highlighted that the wheelchair service faced significant challenges and a paper is planned for the executive director's group for assistance whilst seeking input from professional advisory groups including the Area Clinical Forum. He emphasised the service's continuity was crucial, given its impact on around 4,000 patients in Highland, including those with complex conditions like multiple sclerosis and cerebral palsy.

He noted the service faced workflow issues due to the separation of wheelchair clinics and the storage area and a recent service evaluation recommended co-locating services for better accessibility. However, lease negotiation led to the current landlord issuing a notice to quit. Options for continuity included another commercial site or storage at the back of Raigmore.

He also indicated that a service interruption or suspension was likely, as early as the end of February, lasting around two months which would affect the supply and assessment of wheelchairs.

Forum members shared the concerns highlighted and sought clarity on whether any work had been undertaken to identify whether the alternate sites would be suitable, P Cook confirmed nothing had been scoped out and formalised at this stage.

The Forum **noted** the Update

5 MINUTES FROM PROFESSIONAL ADVISORY COMMITTEES AND EXCEPTION REPORTS

5.1 Area Dental Committee meeting – 24 September 2024 and 27 November 2024

There were no additional comments.

5.2 Adult Social Work and Social Care Advisory Committee meeting - 5 September 2024

The Chair noted that the last meeting had been cancelled due to quoracy issues and the next meeting is planned for February 2025 where a review around the agenda content

and membership would be discussed.

5.3 Area Pharmaceutical Committee meeting –7 October 2024 and 9 December 2024

There were no additional comments.

5.4 Area Medical Committee meeting – 15 October 2024 and 17 December 2024

There were no additional comments.

5.5 Area Optometric Committee meeting – 28 October 2024

The Chair highlighted that committee had spent some time discussing the Care Portal and its implications alongside any concerns which the Head of eHealth alleviated earlier in the meeting.

5.6 Area Nursing, Midwifery and AHP (NMAHP) Advisory Committee meeting – 26 September 2024 and 21 November 2024

The representative for NMAHP highlighted that committee had continued to discuss the Health and Social Care Staffing act and its wider implications on the sector alongside the ongoing challenges in recruitment and retention of staff.

5.7 Psychological Services Meeting – **no meeting held.**

5.8 Area Health Care Sciences meeting

The representative highlighted there were positive scoping discussions around the governance framework for life sciences where recruitment and retention noted as a continued challenge in biomedical science. He noted that a job description was being reviewed for the post of training manager and the role would cover all laboratories across NHS Highland which aimed to improve training structure and staff development.

The Forum **noted** the circulated committee minutes and feedback provided by the Chairs.

6 ASSET MANAGEMENT GROUP

There were no additional comments

7 HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE – Minute of meeting held on 26 September 2024 and 6 November 2024
Kara McNaught, Team Manager, Adult Social Care

There were no additional comments

The Forum **noted** the circulated minutes.

8 Argyll and Bute IJB minutes

There were no additional comments.

9 Dates of Future Meetings 2025

13 March
1 May
3 July
4 September
9 November

10 FUTURE AGENDA ITEMS

Leadership and Culture Framework update
Update on the Meridian Improvement/Efficiency Work

11. ANY OTHER COMPETENT BUSINESS

None

12 DATE OF NEXT MEETING

The next meeting will be held on 13 March January 2025 at **1.30pm on Teams.**

The meeting closed at 4.10pm

MINUTES of MEETING of ARGYLL AND BUTE HSCP INTEGRATION JOINT BOARD (IJB) held ON A HYBRID BASIS IN THE STUDIO THEATRE, CORRAN HALLS, OBAN AND BY MICROSOFT TEAMS on WEDNESDAY, 28 MAY 2025

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 Gary Mulvaney, Argyll and Bute Council
Karen Leach, NHS Highland Non-Executive Board Member
Janice Preston, NHS Highland Non-Executive Board Member

Evan Beswick, Chief Officer, Argyll and Bute HSCP
Fiona Broderick, Staffside Lead, Argyll and Bute HSCP (Health)
Linda Currie, Associate Director AHP, NHS Highland
James Gow, Head of Finance, Argyll and Bute HSCP
Rebecca Helliwell, Depute Medical Director, Argyll and Bute HSCP
Elizabeth Higgins, Associate Nurse Director, NHS Highland
Julie Hodges, Independent Sector Representative
Kenny Mathieson, Public Representative
Angus MacTaggart, GP Representative, Argyll and Bute HSCP
Alison McGrory, Associate Director of Public Health, Argyll and Bute HSCP
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
Tracey White, Carers Representative, NHS Highland

Attending: Gaye Boyd, Deputy Director of People, NHS Highland
Charlotte Craig, Interim Head of Strategic Planning, Performance and Technology, Argyll and Bute HSCP
Nikki Gillespie, Interim Head of Service – Mental Health, Disability and Dementia Services, Argyll and Bute HSCP
Hazel MacInnes, Senior Committee Officer, Argyll and Bute Council
Angela Tillery, Principal Accountant, Argyll and Bute Council
Donald Watt, Interim Head of Service – Acute and Community Care, Argyll and Bute HSCP

Prior to the commencement of Business, the Chair accepted a box of papers from a range of Bute Residents in relation to Thomson Court.

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Ross Moreland, Emily Austin, David Gibson and Fiona Thomson.

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 26 March 2025 were approved as a correct record.

4. MINUTES OF COMMITTEES

(a) **Argyll and Bute HSCP Clinical and Care Governance Committee held on 1 May 2025**

The Minutes of the meeting of the Argyll and Bute HSCP Clinical and Care Governance Committee held on 1 May 2025 were noted.

(b) **Special Argyll and Bute HSCP Finance and Policy Committee held on 19 May 2025**

The Minutes of the Special meeting of the Argyll and Bute HSCP Finance and Policy Committee held on 19 May 2025 were noted.

Kenny Mathieson advised that he had raised a point of order during the meeting and that it had not been included in the Minutes. The Senior Committee Officer advised that normal procedure was that the Minutes of these meetings only recorded the decisions of the meeting and did not record any discussion, and that was why his point of order had not been included.

5. CHIEF OFFICER'S 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 March 2025.

Decision

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

(Reference: Report by Chief Officer dated 28 May 2025, submitted)

6. FINANCE

(a) **Social Work / Social Care Financial Recovery**

The Board gave consideration to a report outlining a specific recovery plan to address the Social Work / Social Care element of the HSCP budget shortfall of £500k in 2025/26.

Decision

The Integration Joint Board –

1. endorsed the recovery actions outlined in the submitted report;

2. noted that the submitted report sat alongside other work on the delivery of approved savings and development of further options;

3. requested integrated impact assessments and that appropriate community

engagement be carried out in respect of relevant proposals; and

4. noted that a further report would be provided to the September meeting of the Board.

(Reference: Report by Head of Finance dated 28 May 2025, submitted)

7. Q4 WORKFORCE REPORT (2024/25)

The Board gave consideration to a report detailing the workforce data of the HSCP as at 31 March 2025 and providing the current democratic position, highlighting trends and advising of changes and progress made, as well as actions taken to address areas of concern.

Decision

The Integration Joint Board -

1. noted the workforce data contained within the submitted report; and

2. agreed that staff appraisal and training were business critical areas for the Integration Joint Board and requested the Chief Officer to seek substantial progress in these areas and report back to the meeting on 17 September 2025.

(Reference: Report by Deputy Director of People dated 28 May 2025, submitted)

8. ARGYLL AND BUTE HSCP EQUALITIES MAINSTREAMING PROGRESS REPORT 2021-2025 AND EQUALITIES OUTCOMES 2025-2029

The Board gave consideration to a report setting out Argyll and Bute Integration Joint Board's continued commitment to advancing equality through the implementation of its statutory duties under the Equality Act 2010 and the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.

Decision

The Integration Joint Board –

1. noted the content of the submitted report, including progress towards the 2021-2025 Equalities Outcomes, for publication by June to meet the legal requirement;

2. agreed the proposed new Equalities Outcomes for 2025-2029, for publication by June to meet the legal requirement;

3. noted the requirement for an HSCP process to assess the impact of service changes and decision on children's rights, as per the UNCRC legislation, noting that these are known as Child Rights and Wellbeing Impact Assessments (CRWIA); and

4. approved, in principle, the move to Argyll and Bute Council Integrated Impact Assessment (IIA) tool, in order for the HSCP to remain aligned to Argyll and Bute Council processes.

(Reference: Report by Associate Director of Public Health dated 28 May 2025, submitted)

9. JOINT STRATEGIC PLAN 2022 - 2025 YEAR THREE PROGRESS REPORT

The Board gave consideration to a report presenting the Joint Strategic Plan Progress Report for Year 3 setting out future priorities which would be taken forward for the current year of 2025-26 and the future Joint Strategic Plan.

Decision

The Integration Joint Board –

1. noted the Joint Strategic Plan Progress report for Year 3: 2024 – 2025; and

2. agreed what would be taken forward as priorities into 2025-2026 and for the future five-year JSP.

(Reference: Report by Interim Head of Strategic Planning, Performance and Technology dated 28 May 2025, submitted)

10. DIRECTION LOG

The Direction Log was before the Board for noting.

Decision

The Integration Joint Board noted the content of the Direction Log.

(Reference: Direction Log as at 28 May 2025, submitted)

11. DATE OF NEXT MEETING

It was noted that the date of the next meeting was Wednesday 17 September 2025; and that the meeting would be held in the Cowal area.

Agenda Item 4

NHS Highland

Meeting:	**NHS Highland Board Meeting**
Meeting date:	**29 July 2025**
Title:	**Finance Report – Month 2 2025/2026**
Responsible Executive/Non-Executive:	**Heledd Cooper, Director of Finance**
Report Author:	**Elaine Ward, Deputy Director of Finance**

Report Recommendation:

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

1 Purpose

This is presented to the 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 2 (May) 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 has been 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 May 2025 (Month 2) an overspend of £12.729m is reported with this forecast to increase to £40.005m by the end of the financial year. The forecast position is predicated on the assumption that further work will enable delivery of a breakeven position within ASC by 31 March 2026. This currently presents a risk of £19.930m to the Board.

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 delivery of the Value & Efficiency programme. The Board are developing further plans to generate cost reductions/ improvements. There is an emerging risk associated with allocations – this has been reflected in the forecast year end position.

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.

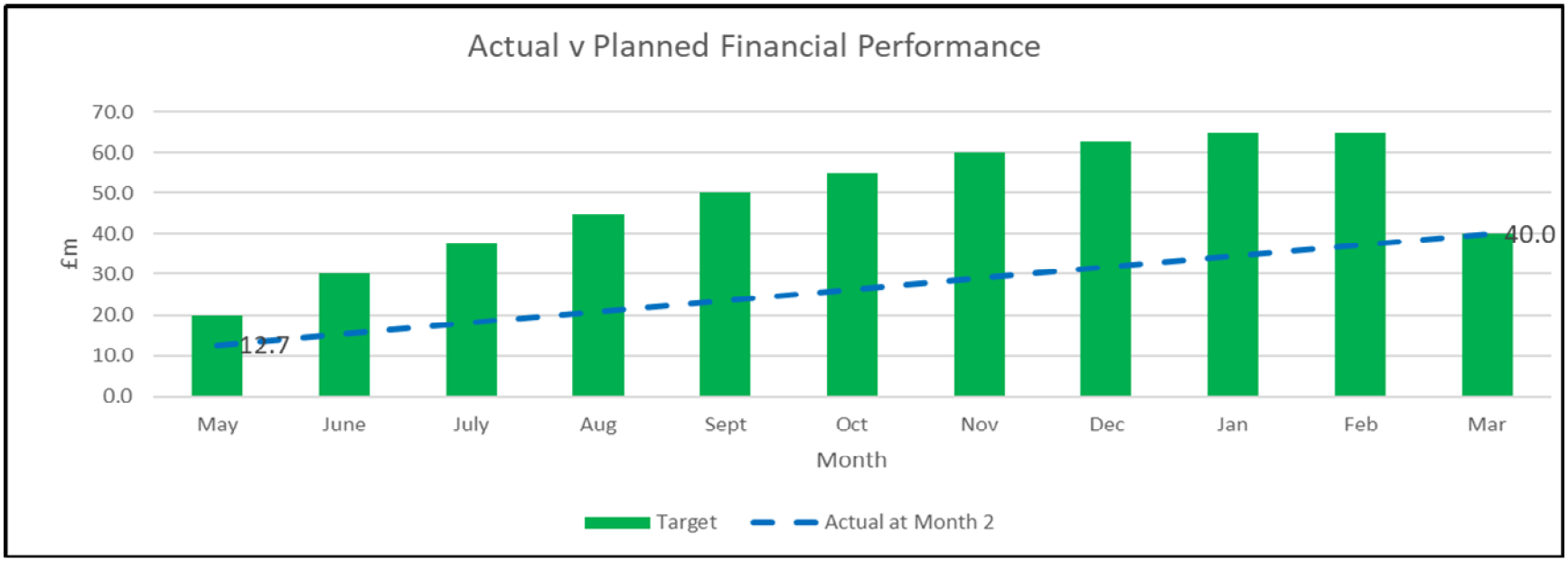
- EDG
- FRPC

4.1 List of appendices

Month 2 Presentation

Finance Report –Month 2 (May) 2025/2026

MONTH 2 2025/2026 –MAY 2025



Target	YTD £m	YE Position £m
Delivery against Revenue Resource Limit (RRL) DEFICIT/ SURPLUS	12.7	40.0
Deliver against plan DEFICIT/ SURPLUS	7.3	0.0

- No brokerage available in 2025/2026
- SG requested plan with a deficit no greater than £40m
- Current forecast is £40m worse than RRL but in line with SG request and revised plan submitted to SG in June 2025

MONTH 2 2025/2026 –MAY 2025

Current Plan £m	Summary Funding & Expenditure	Plan To Date £m	Actual To Date £m	Variance To Date £m	Forecast Outturn £m	Forecast Variance £m
1,322.410	**Total Funding**	216.155	216.155	-	1,322.410	-
	Expenditure					
487.385	HHSCP	79.961	86.371	(6.410)	512.726	(25.341)
	ASC Position to breakeven				(19.930)	19.930
	Revised HHSCP				492.796	(5.411)
328.869	Acute Services	54.505	58.542	(4.037)	345.974	(17.105)
206.589	Support Services	35.915	37.901	(1.987)	223.292	(16.703)
1,022.843	**Sub Total**	**170.380**	**182.814**	**(12.434)**	**1,062.062**	**(39.219)**
299.566	Argyll & Bute	45.775	46.070	(0.296)	300.352	(0.786)
1,322.410	**Total Expenditure**	**216.155**	**228.884**	**(12.729)**	**1,362.415**	**(40.005)**

MONTH 2 2025/2026 SUMMARY

- Overspend of £12.729m reported with this forecast to increase to £40.005m by the end of the financial year
- This is in line with the revised financial plan submitted to Scottish Government at the beginning of June 2025
- Assuming that ASC will deliver a breakeven position at the end of the financial year

MONTH 2 2025/2026 –MAY 2025

KEY RISKS

- ASC – At this stage there is no plan in place to deliver breakeven by the end of the financial year
- 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
- Health & Care staffing
- Financial impact of Agenda for Change pay award from 2023
- Price increases in excess of inflationary assumptions
- SLA Uplift
- Allocations less than anticipated

MITIGATIONS

- Ongoing robust governance structures around agency nursing utilisation
- Sustainability funding received from SG
- Additional funding for AfC non pay element of 2023/2024 pay award

Pressure of £0.534m relating to recurring sustainability funding has already materialised. At this time it is assumed that this will be managed and not deteriorate the planned £40.005m net deficit – this will continue to be monitored monthly

MONTH 2 2025/2026 –MAY 2025

Summary Funding & Expenditure	Current Plan £m
RRL Funding - SGHSCD	
Baseline Funding	954.315
Baseline Funding GMS	5.291
FHS GMS Allocation	79.118
Supplemental Allocations	0.000
Non Core Funding	-
Total Confirmed SGHSCD Funding	**1,038.724**
Anticipated funding	
Non Core allocations	76.204
Core allocations	76.942
Total Anticipated Allocations	153.146
Total SGHSCD RRL Funding	**1,191.870**
Integrated Care Funding	
Adult Services Quantum from THC	141.522
Childrens Services Quantum to THC	(10.983)
Total Integrated care	130.539
Total NHS Highland Funding	**1,322.410**

FUNDING

- £1,322.410m of funding confirmed at end of Month 2
- SG working to get 80% of allocations out by the end of Q1

MONTH 2 2025/2026 –MAY 2025

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	HHSCP					
270.475	NH Communities	44.661	48.421	(3.760)	292.358	(21.883)
59.413	Mental Health Services	9.977	10.407	(0.430)	61.016	(1.604)
168.358	Primary Care	28.479	28.463	0.016	171.101	(2.744)
(10.860)	ASC Other includes ASC Income	(3.156)	(0.920)	(2.236)	(11.750)	0.890
487.385	**Total HHSCP**	**79.961**	**86.371**	**(6.410)**	**512.726**	**(25.341)**
	HHSCP					
305.505	Health	50.663	52.033	(1.371)	311.008	(5.503)
181.880	Social Care	29.298	34.338	(5.039)	201.718	(19.838)
487.385	**Total HHSCP**	**79.961**	**86.371**	**(6.410)**	**512.726**	**(25.341)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	529	633
Agency (Nursing)	225	392
Bank	803	1,714
Agency (exclu Med & Nurs)	143	347
Total	**1,699**	**3,086**

HHSCP

- YTD overspend of £6.410m reported with this forecast to increase to £25.341m by the end of the financial year
- ASC overspend forecast at £19.838 – assuming delivery of 3% V&E cost reductions/ improvements
- Drugs/ prescribing pressure forecast at £1.429m
- Locum costs of £1.185m contributing to overspend within Primary Care
- Supplementary staffing costs of £3.086m incurred to date
- High cost out of area placements continue to impact on the Mental Health position

MONTH 2 2025/2026 – ADULT SOCIAL CARE

Services Category (HHSCP - less ASC Estates)	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	60.078	10.242	10.453	(0.211)	61.144	(1.066)
Total Older People - Care at Home	38.322	6.395	7.231	(0.836)	44.114	(5.792)
Total People with a Learning Disability	50.059	8.362	9.988	(1.626)	60.834	(10.775)
Total People with a Mental Illness	10.388	1.732	1.723	0.009	10.304	0.084
Total People with a Physical Disability	9.364	1.570	1.877	(0.307)	11.402	(2.039)
Total Other Community Care	13.184	2.197	1.998	0.199	13.317	(0.133)
Total Support Services	0.485	(1.200)	0.943	(2.143)	0.186	0.299
Care Home Support/Sustainability Payments	0.000	0.000	0.123	(0.123)	0.417	(0.417)
Total Adult Social Care Services	181.880	29.298	34.338	(5.039)	201.718	(19.838)

ADULT SOCIAL CARE

- YTD an overspend of £5.039m is reported with this forecast to increase to £19.838m by the end of the financial – this includes Estates costs reported outwith ASC
- The overall financial position for the Board assumes that ASC will deliver a breakeven position by the end of the financial year
- £4.052m of supplementary staffing costs within in-house care homes are included within the year to date position

MONTH 2 2025/2026 – ADULT SOCIAL CARE

NHSH Care Homes Supplementary Staffing

Care Home	Month 2 2025/2026 Agency £000's	Bank £000's	Cumulative Total YTD £000's
Ach an Eas	-	20.64	49.33
An Acarsaid	-	11.85	29.71
Bayview House	2.07	24.52	53.75
Caladh Sona	-	-	-
Dail Mhor House	-	-	-
Grant House	(23.59)	21.96	32.54
Home Farm	93.05	7.58	158.88
Invernevis	21.33	16.67	68.33
Lochbroom	-	18.16	33.68
Mackintosh Centre	-	2.12	2.48
Mains House	56.60	3.38	105.91
Moss Park	1.22	1.49	3.05
Melvich	-	4.47	11.13
Pulteney	-	26.78	61.09
Seaforth	-	18.97	46.05
Strathburn	-	-	-
Telford	-	10.70	25.19
Wade Centre	-	16.22	32.60
Total	**150.67**	**205.50**	**713.73**

- Ongoing reliance on agency/ bank staffing within Home Farm and Mains House
- Beginning to see low levels of spend in Moss Park

MONTH 2 2025/2026 –MAY 2025

Current Plan £000	Division	Plan to Date £000	Actual to Date £000	Variance to Date £000	Forecast Outturn £000	Forecast Variance £000
90.820	Medical Division	15.094	17.230	(2.136)	101.534	(10.714)
24.042	Cancer Services	4.342	4.587	(0.245)	25.366	(1.324)
77.132	Surgical Specialties	13.033	13.231	(0.198)	78.272	(1.140)
41.359	Woman and Child	6.930	6.724	0.205	41.115	0.244
49.232	Clinical Support Division	8.135	8.292	(0.157)	49.232	0.000
(12.815)	Raigmore Senior Mgt & Central Cost	(2.878)	(1.503)	(1.376)	(9.349)	(3.466)
28.029	NTC Highland	4.651	4.573	0.078	27.849	0.180
297.798	**Sub Total - Raigmore**	**49.306**	**53.133**	**(3.827)**	**314.018**	**(16.220)**
15.126	Belford	2.528	2.570	(0.042)	15.295	(0.169)
15.945	CGH	2.671	2.839	(0.168)	16.661	(0.716)
328.869	**Total for Acute**	**54.505**	**58.542**	**(4.037)**	**345.974**	**(17.105)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	1,118	2,192
Agency (Nursing)	171	180
Bank	770	1,639
Agency (exclu Med & Nurs)	110	224
Total	**2,169**	**4,235**

ACUTE

- £4.037m overspend reported year to date
- Forecast that this will increase to £17.105m by the end of the financial year
- Main drivers for overspend were supplementary staffing and drug costs
- £1.017m built into forecast in respect of non compliant junior doctor rotas
- £3.449m of costs incurred on unfunded services

MONTH 2 2025/2026 –MAY 2025

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	Support Services					
57.208	Central Services	12.523	14.254	(1.731)	72.311	(15.103)
49.316	Corporate Services	8.002	7.402	0.600	47.846	1.470
54.220	Estates Facilities & Capital Plannin	7.776	7.883	(0.107)	54.381	(0.161)
16.548	eHealth	2.731	3.010	(0.280)	17.769	(1.221)
29.297	Tertiary	4.883	5.351	(0.469)	30.985	(1.688)
206.589	**Total**	**35.915**	**37.901**	**(1.987)**	**223.292**	**(16.703)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	8	5
Agency (Nursing)	-	(55)
Bank	258	196
Agency (exclu Med & Nurs)	(34)	(16)
Total	**231**	**130**

SUPPORT SERVICES

- YTD overspend of £1.987m reported with this forecast to increase to £16.703m by the end of the financial year
- With Estates, Facilities and Capital Planning the cost of provisions continues to drive an overspend. This is being mitigated due to vacancies in a number for the estates and facilities teams
- Within eHealth further increases in the costs of service contracts is the main driver for the overspend
- Out of Area Forensic Psychiatry costs, TAVI procedures, rheumatology drugs continue to drive the overspend within Tertiary

MONTH 2 2025/2026 –MAY 2025

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					
154.946	Hospital & Community Services	25.867	26.630	(0.763)	157.725	(2.779)
20.258	Acute & Complex Care	3.363	3.516	(0.153)	20.417	(0.159)
11.047	Children & Families	1.847	2.032	(0.186)	11.247	(0.200)
42.177	Primary Care inc NCL	7.092	7.106	(0.015)	42.957	(0.780)
24.149	Prescribing	3.879	3.647	0.232	24.149	-
11.544	Estates	2.006	2.012	(0.005)	11.544	-
6.934	Management Services	1.169	1.259	(0.090)	7.061	(0.127)
32.702	Central/Public health	1.251	(0.131)	1.382	27.265	5.437
(4.190)	Central Held Savings	(0.698)	-	(0.698)	(2.012)	(2.178)
299.566	**Total Argyll & Bute**	**45.775**	**46.070**	**(0.296)**	**300.352**	**(0.786)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	791	1,068
Agency (Nursing)	164	164
Bank	250	566
Agency (exclu Med & Nurs)	100	147
Total	**1,305**	**1,945**

ARGYLL & BUTE

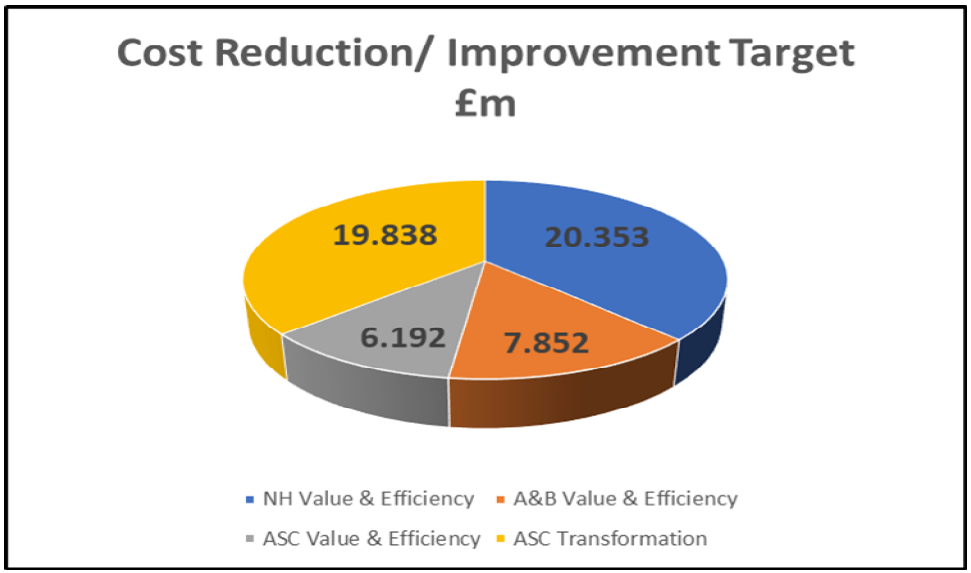
- Argyll & Bute have delivered a breakeven position through flexibly utilising reserves
- The use of supplementary staffing continued to adversely impact on the financial position but was mitigated by a significant number of ongoing vacancies
- Out of Board cost per case charges and out of area long stay patient treatments have also impacted on the position

2025/2026 FINANCIAL PLAN

	MARCH SUBMISSION		JUNE SUBMISSION	
	£m	£m	£m	£m
Financial Gap		**115.596**		**110.058**
Maximum Brokerage		-		-
Reduction required to deliver balance		**115.596**		**110.058**
Cost Improvement/ Reduction Programmes				
3% Cost Reduction/ Improvement	20.353		20.353	
A&B - 3% of baseline	7.852		7.852	
ASC - 3%	6.192		6.192	
Delivering ASC to breakeven	19.838		19.838	
Allocations Slippage	1.000		1.000	
Balance Sheet Adjustments	4.638		4.638	
Further non-recurrent actions				10.180
Opportunities		**59.873**		**70.053**
Gap to In Year Financial Balance		**55.723**		**40.005**

- The financial plan submitted to SG in March detailed an opening financial gap of £115.596m with opportunities identified to reduce this to £55.723m
- This submission was not acceptable to SG and they indicated that a resubmission was necessary with a requirement to 'not exceed a net financial deficit of £40 million'
- A revised plan has been submitted to and accepted by SG detailing a net financial deficit of £40.005m

MONTH 2 2025/2026 –MAY 2025



	Target £000s
NH Value & Efficiency	20.353
A&B Value & Efficiency	7.852
ASC Value & Efficiency	6.192
ASC Transformation	19.838
Total Cost Reduction/ Improvement Target	**54.235**

Other Action	5.638
Follow up actions post March Fin Plan Submission	10.180
Total to be delivered to align with financial plan	**70.053**

COST REDUCTON/ IMPROVEMENT

- NHS Highland submitted a financial plan to Scottish Government in March 2025 detailing a cost reduction/ improvement programme of £54.235m
- Whilst a further submission was made in Jue with a revised net financial gap of £40.005m the savings programme within the March submission remained unchanged

2025/2026 FINANCIAL PLAN - Targets

Summary	Target
Acute	7.750
HHSCP	6.760
Deputy Chief Exec (excluding eHealth)	0.037
People & Culture	0.476
Public Health	0.609
Finance	0.389
Medical	0.141
Nursing	0.130
Tertiary	1.094
Estates & Facilities	2.201
eHealth	0.639
Strategy & Transformation	0.127
TOTAL	**20.353**

- Targets based on combination of budget and type of V&E scheme
- Targets will be within devolved budgets from start of year rather than held centrally and reallocated when plans are in place/ cost reductions or improvements delivered
- Work with Finance and Strategy & Transformation to develop more detailed plans to support delivery of 3% recurring reductions

MONTH 2 2025/2026 – VALUE & EFFICIENCY

NHS Highland

2025-26 Value & Efficiency Plan (£'000)										
Reduction Programmes	100%			Risk Adjusted			Savings Achieved to Date			
	Allocated Target	Current Plan	Plan GAP	Allocated Target	Risk Adjusted Plan	Risk Adjusted Plan GAP	Allocated Target	Budget Savings Achieved	Cost Reductions Achieved	Current Savings GAP
Value & Efficiency - North Highland	**20,353**	13,131	-7,221	**20,353**	6,234	-14,118	**20,353**	295	1,189	-18,869
Value & Efficiency - Argyll & Bute	**7,852**	7,852	0	**7,852**	5,047	-2,805	**7,852**	370	0	-7,482
Total Value & Efficiency	**28,205**	20,983	-7,221	**28,205**	11,281	-16,923	**28,205**	**665**	**1,189**	**-26,351**
Value & Efficiency - ASC	**6,192**	1,510	-4,682	**6,192**	755	-5,437	**6,192**	0	0	-6,192
Total Value & Efficiency incl ASC	**34,397**	22,493	-11,903	**34,397**	12,036	-22,360	**34,397**	**665**	**1,189**	**-32,543**

The financial plan submitted to the Scottish Government includes a target of achieving 3% efficiency savings across both North Highland and Argyll.

This equates to a total Value & Efficiency savings goal of £34.397m for the FY 2025–26.

There is currently a shortfall of **£11.9m** between the 2025–26 savings target and the projected savings identified in the plan at 100% delivery.

MONTH 2 2025/2026 – VALUE & EFFICIENCY – CURRENT NUMBER OF SCHEMES (INC A&B)

Number of Schemes	Value at 100% (£'000)	Risk Adjusted Value (£'000)	Savings Delivered (£'000)
100	£22,493.145	£12,036.242	£1,853.732

The list of schemes is not exhaustive; several additional PIDs are currently under development and have therefore not been included in the above analysis

MONTH 2 2025/2026 – VALUE & EFFICIENCY – NUMBER OF SCHEMES PER AREA

Area	Number of Schemes	Schemes with Financial Plan	Schemes without Financial Plan	2025-26 Original Plan/Target (£'000)	Risk Adjusted Forecast (£'000)	Total Efficiencies Achieved/Delivered 25-26 £000s
HHSCP	22	20	2	£4,956.001	£2,328.566	£226.751
A&B	35	35	0	£7,852.000	£5,047.000	£370.000
ACUTE SERVICES	17	12	5	£5,550.858	£2,972.729	£962.164
ASC	3	3	0	£1,510.000	£755.000	£0.000
SUPPORT SERVICES	23	10	13	£2,624.286	£932.947	£294.817
Grand Total	**100**	**80**	**20**	**£22,493.145**	**£12,036.242**	**£1,853.732**

80% of all V&E schemes include a savings plan value, while 20% are still waiting for the values to be added.

MONTH 2 2025/2026 – VALUE & EFFICIENCY – RISK RATING

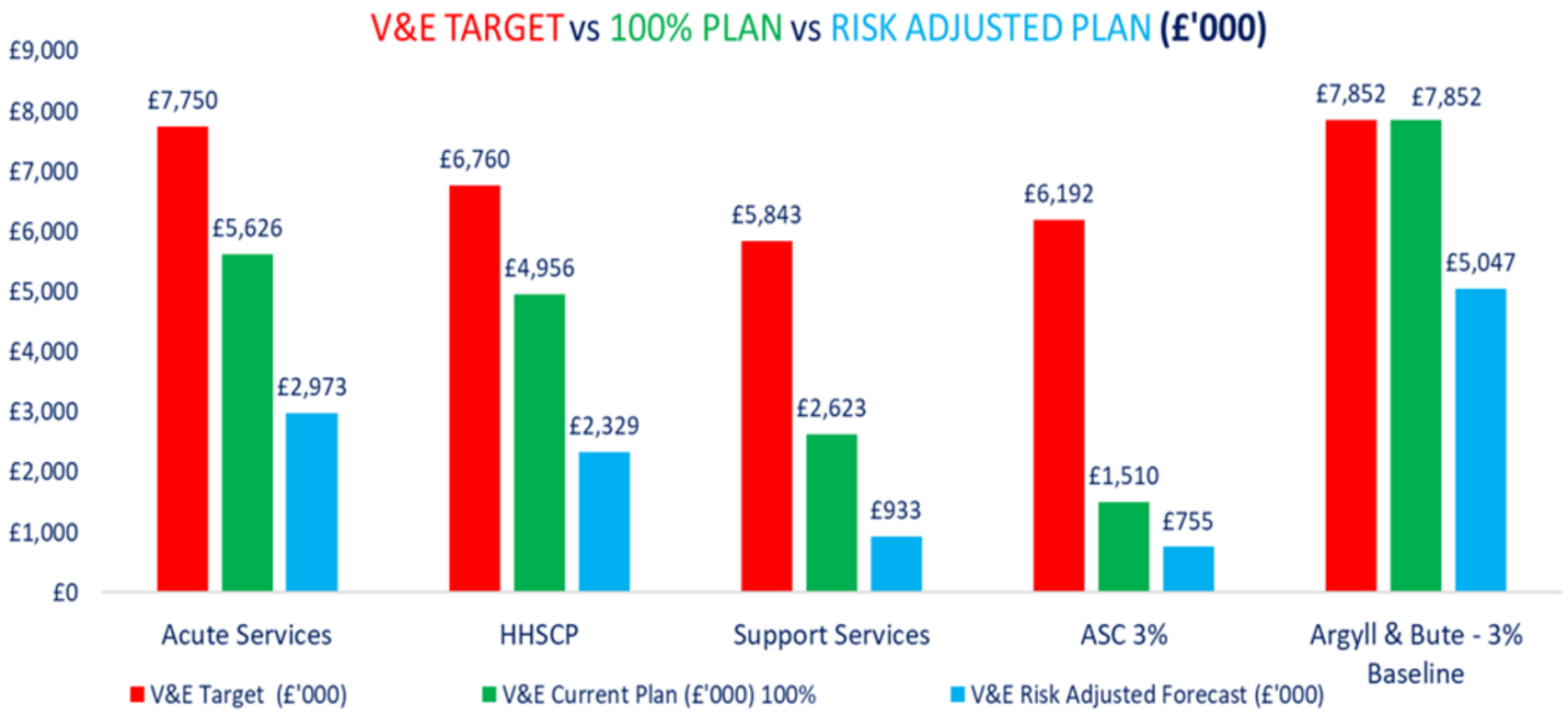
Risk Rating	HHSCP	ACUTE SERVICES	ASC	SUPPORT SERVICES	Grand Total
Fully Developed 75%	£750.000	£1,858.481		£312.130	£2,920.611
Idea 0%	£0.000	£0.000		£0.000	£0.000
Move to delivery 100%	£100.000	£53.000		£294.817	£447.817
Opportunity 10%	£140.048	£1,010.281		£126.000	£1,276.328
Plans in progress 50%	£1,338.519	£50.967	£755.000	£200.000	£2,344.486
	£2,328.566	**£2,972.729**	**£755.000**	**£932.947**	**£6,989.242**

In the 2025–26 financial year, a risk rating was introduced for each scheme and needs to be reviewed on monthly basis by the SRO.

Based on the risk rating indicated in the PID, a risk-adjusted savings forecast is arrived to.

Risk Description	Risk Adjusted Value	Description
Idea 0%	0%	An Identified area with potential for financial savings
Opportunity 10%	10%	An Identified area with estimated financial savings and resource allocated to progress
Plans in progress 50%	50%	A draft scheme outlining the project description and logic for estimated financial savings
Fully Developed 75%	75%	A scheme which has a completed PID that has been fully signed off.
Move to delivery 100%	100%	A scheme with cost centre information and QIA sign off (PMO Task)

MONTH 2 2025/2026 – VALUE & EFFICIENCY – TARGET, PLAN & RISK ADJUSTED PLAN BY AREA



MONTH 2 2025/2026 – VALUE & EFFICIENCY – HHSCP

Reduction Programmes	Value & Efficiency Plan as per Scheme			
	Allocated Target	Current Plan @ 100%	Risk Adjusted Forecast	Savings Achieved
Value & Efficiency - North Highland	**20,353**	**13,131**	**6,234**	**1,484**
HHSCP				
AHP Direct Engagement		50	25	0
Dental Redesign		1,000	750	0
HHSCP - Clinical Stores		5	3	0
HHSCP - Postages		10	1	0
HHSCP - Unfunded Posts		100	57	0
HHSCP Travel		59	6	0
LD/ASC - Transition Team Unfunded Posts		225	113	0
MHLD Discharge Pathway		50	5	0
MHLD Notes Retrieval		5	0	0
MHLD Reduction in Costs / Out of Area Placements		425	193	0
MHLD Reduction in Drug Costs		10	5	0
MHLD Reduction in Travel and Transport (inc taxis and pool cars)		50	25	0
New Craigs Hospital - Supplementary Nursing Staff		410	205	0
Oral Nutrional Supplements (ONS) Direct Supply		5	3	0
Police Custody/ SARC/ Forensic Medical Examiner (FME)		100	100	19
Prescribing - Highland - HHSCP		1,179	686	194
Prescribing - Sustainable - HHSCP		0	0	0
Supplementary Staffing - Medical - MH -SUPP REDUCTION IN LOCUM COSTS		50	30	14
Supplementary Staffing - Nursing - HHSCP (Community Hospitals)		579	58	0
Supplementary Staffing Primary Care 2C		0	0	0
TARA HHSCP		144	14	0
Time to Care		500	50	0
Total HHSCP		**4,956**	**2,329**	**227**

MONTH 2 2025/2026 – VALUE & EFFICIENCY – ACUTE SERVICES

Reduction Programmes	Value & Efficiency Plan as per Scheme			
	Allocated Target	Current Plan @ 100%	Risk Adjusted Forecast	Savings Achieved
Value & Efficiency - North Highland	**20,353**	**13,131**	**6,234**	**1,484**
ACUTE SERVICES				
ACUTE - Junior Doctors Compliance		435	44	0
ACUTE - W&C - MyoSure		0	0	0
ACUTE - Women & Children -Test of change - Mrg		10	8	0
Acute Management Structure Review		66	33	0
Acute Medical Directorate 3%		947	95	0
ACUTE Theatres Optimisation and PLCV		0	2	0
Child Health Record Storage		3	2	0
Diagnostics - (Primary and Secondary Care)		0	0	0
Ferinject & PrAMS project		11	5	0
IT Equipment		2	1	0
Outpatient (Women's & Childrens) inductions		0	0	0
Prescribing - Acute Services		704	166	0
RGHs Contracts		53	53	53
Supplementary Staffing - Nursing - Acute		2,300	1,759	136
Supplementary Staffing Medical Locum - Acute		1,000	796	773
TARA Acute		0	0	0
Travel and Accommodation		20	10	0
Total ACUTE SERVICES		**5,551**	**2,973**	**962**

MONTH 2 2025/2026 – VALUE & EFFICIENCY – SUPPORT SERVICES

Reduction Programmes	Value & Efficiency Plan as per Scheme			
	Allocated Target	Current Plan @ 100%	Risk Adjusted Forecast	Savings Achieved
Value & Efficiency - North Highland	**20,353**	**13,131**	**6,234**	**1,484**
SUPPORT SERVICES				
Building Lease Review		295	295	295
Corporate Teams		0	0	0
Direcotrate Savings Schemes - Corporate Services: Clinical Governance		0	0	0
Direcotrate Savings Schemes - Corporate Services: NMAHP		0	0	0
Direcotrate Savings Schemes - Corporate Services: People and Culture		0	0	0
Direcotrate Savings Schemes - Corporate Services: Pharmacy		0	0	0
Directorate Savings - Corporate Services - S&T		0	0	0
Directorate Savings - Corporate Services - sHealth		0	0	0
Directorate Savings - Estates, Facilities & Capital Planning		317	238	0
Directorate Savings: Finance		0	0	0
Energy Procurement		1,000	100	0
Fleet and Travel		179	0	0
NMAHP Corporate		99	74	0
Printing & Telephony		0	0	0
Printing, mail and communication services		0	0	0
Procurement Consolidation and Efficiency		2	0	0
Public Health Savings		250	25	0
SLA / Clinical Pathways expenditure review		0	0	0
SLA Income Review		0	0	0
TARA Corporate		0	0	0
Vaccination Service		150	75	0
Warehousing/Stores Optimisation		83	1	0
Waste Management		250	125	0
Total SUPPORT SERVICES		**2,624**	**933**	**295**

MONTH 2 2025/2026 –MAY 2025
SUPPLEMENTARY STAFFING

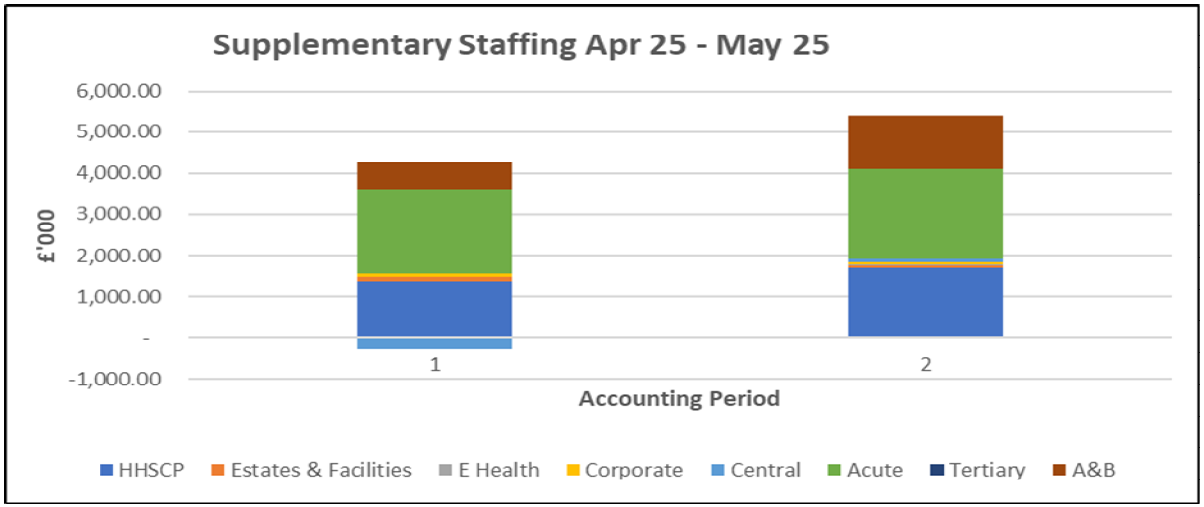
	2025/2026 YTD £'000	2024/2025 YTD £'000	Inc/ (Dec) YTD £'000
HHSCP	3,086	3,764	(678)
Estates & Facilities	178	295	(118)
E Health	1	4.21	(3)
Corporate	138	146	(8)
Central	(186)	(244)	58
Acute	4,235	4,089	146
Tertiary	-	-	-
Argyll & Bute	1,945	2,238	(293)
TOTAL	**9,396**	**10,292**	**(895)**

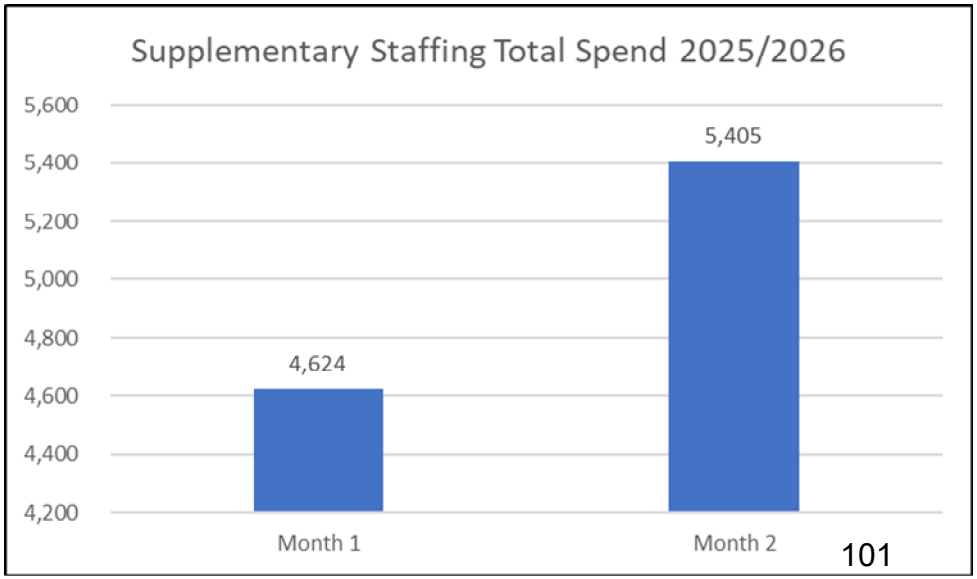
Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Pay			
133.378	Medical & Dental	22.391	22.951	(0.560)
7.788	Medical & Dental Support	1.206	1.503	(0.297)
229.231	Nursing & Midwifery	38.201	38.153	0.047
44.064	Allied Health Professionals	7.286	6.989	0.297
17.914	Healthcare Sciences	2.999	2.882	0.117
24.194	Other Therapeutic	4.002	4.029	(0.028)
48.941	Support Services	8.090	7.670	0.420
90.649	Admin & Clerical	15.050	14.375	0.675
3.375	Senior Managers	0.541	0.552	(0.011)
62.153	Social Care	10.540	9.354	1.186
16.000	Vacancy factor/pay savings	(1.544)	0.000	(1.544)
677.687	Total Pay	108.760	108.459	0.301

SUPPLEMENTARY STAFFING

- Recorded spend at end of Month 2 is £0.895m lower than at same point in 2024/2025
- Underspend of £0.301m at the end of month 2

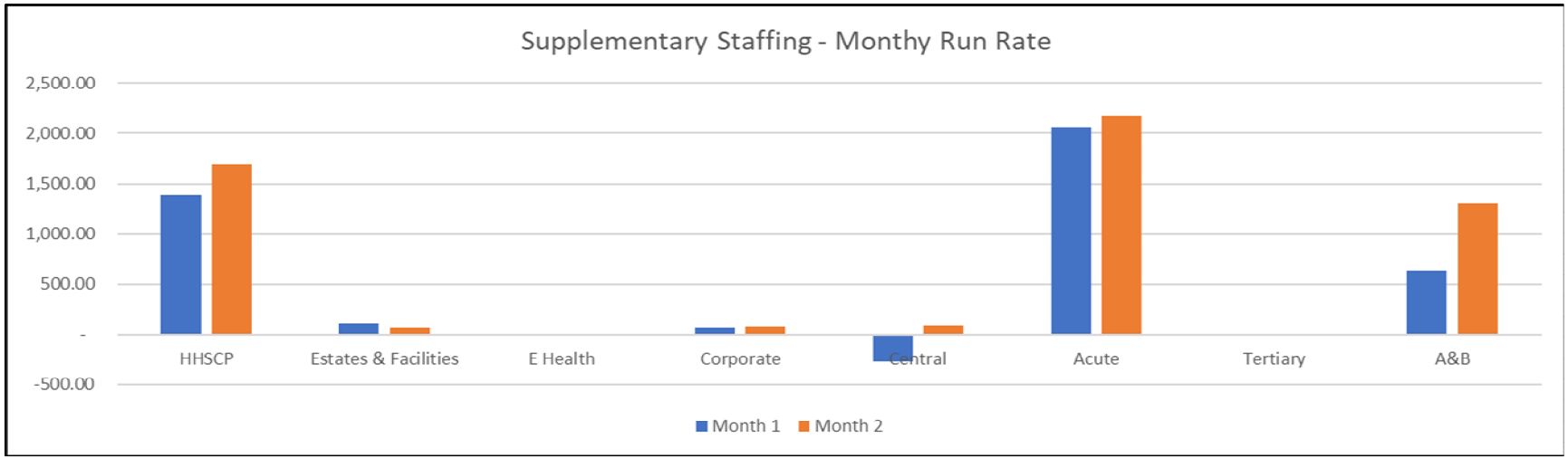
MONTH 2 2025/2026 –MAY 2025
SUPPLEMENTARY STAFFING

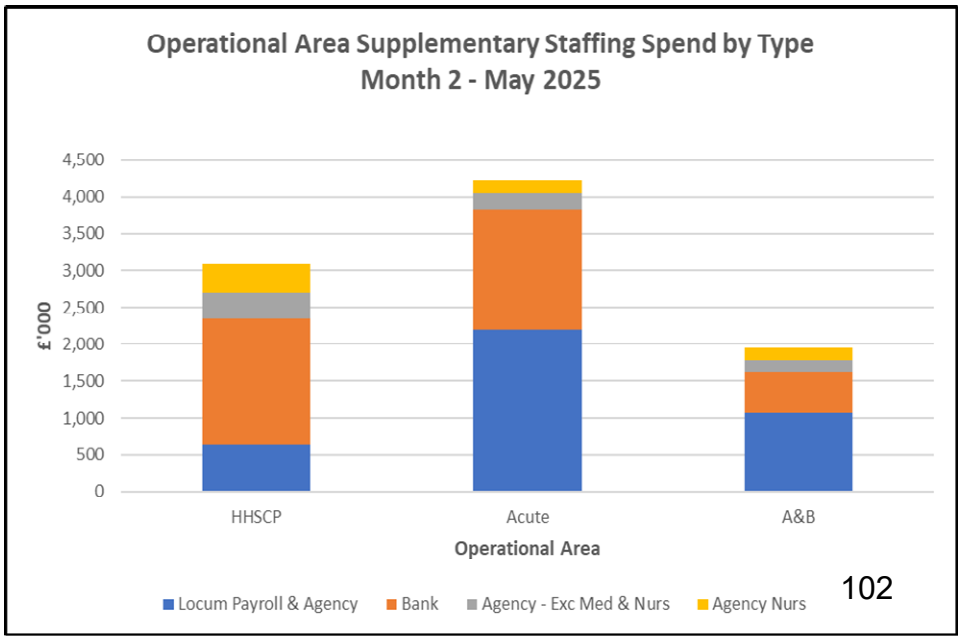




- Month 2 spend is £0.781m higher than Month 1
- Most significant increase is within A&B

MONTH 2 2025/2026 –MAY 2025
SUPPLEMENTARY STAFFING





- £0.781m increase from Month 1 to Month 2

MONTH 2 2025/2026 –MAY 2025

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Expenditure by Subjective spend			
677.687	Pay	108.760	108.459	0.301
137.195	Drugs and prescribing	23.136	23.147	(0.011)
60.244	Property Costs	9.074	9.195	(0.121)
40.926	General Non Pay	6.883	7.224	(0.341)
55.437	Clinical Non pay	9.809	11.007	(1.198)
162.604	Health care - SLA and out of area	39.246	40.594	(1.349)
132.567	Social Care ISC	22.142	25.340	(3.198)
119.012	FHS	20.051	19.831	0.220

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Drugs and prescribing			
52.115	**Hospital drugs**	**9.170**	**9.303**	**(0.132)**
85.081	**Prescribing**	**13.966**	**13.844**	**0.121**
137.195	**Total**	**23.136**	**23.147**	**(0.011)**

SUBJECTIVE ANALYSIS

- Pressures continue to be seen within all spend categories
- Vacancies across all staff groups continues to mitigate the high level of spend on supplementary staffing
- Drugs and prescribing expenditure slowing a slght pressure of £0.011m at the end of Month 2

MONTH 2 2025/2026 – CAPITAL

Budget (£000)	Scheme	Actuals	Variance
	FORMULA		
500	Contingency	9	491
1,036	eHealth	38	998
1,786	EPAG	326	1,461
1,972	Estates	115	1,857
1,000	Fire Compliance	-	1,000
500	PFI - Mid Argyll	68	432
500	PFI - Easter Ross	54	446
7,294	**Total**	**609**	**6,685**
	PROJECT SPECIFIC FUNDING		
2,000	Estates - Lochaber	57	1,943
1,291	EPAG - NIB	-	1,291
333	EV Chargers	-	333
400	Raigmore LV infrastructure	-	400
400	CGH Internal Drainage	-	400
80	CGH electrical Infrastructure	-	80
1,700	Raigmore Fire Compliance	-	1,700
400	LIDGH Fire Compliance	-	400
80	Islay Fire Compliance	-	80
-	CGH Cladding	-	-
6,684	**Total**	**57**	**6,627**
13,978	**Total**	**666**	**13,311**

CAPITAL

- Formula Capital of £7.294m confirmed
- Following submission of the BCP further funding has also been confirmed (but not yet received) by SG
- At this stage in the financial year expenditure is low but as expected

Agenda Item 5

NHS Highland

Meeting:	**NHS Highland Board Meeting**
Meeting date:	**29 July 2025**
Title:	**2025/26 Final Budget update**
Responsible Executive/Non-Executive:	**Heledd Cooper, Director of Finance**
Report Author:	**Heledd Cooper, Director of Finance**

Report Recommendation:

The Committee is asked to **Examine** and **Consider** the content of the report, to **Agree** the current budget and outline approach, and take **Moderate Assurance**.

1 Purpose

This is presented to the Board for:

- Agreement

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

NHS Highland is required to agree a budget for the financial year 2025/26 based on projected spend, estimated inflationary and growth impact and agreed funding. A finance plan was submitted to the Scottish Government (SG) on the 19th March 2025.

On the 31st March NHS Highland received its feedback letter stating that "The Board has the second highest level of outstanding brokerage across NHS Scotland at the end of 2024-25 and the forecast position for 2025-26 represents a further decline in the Board's financial sustainability. On this basis, I cannot approve the NHS Highland three year finance plan."

The letter set out the requirements for the Board:

• You must not exceed a net financial deficit of £40 million. I therefore expect you, with support from your Board, to develop a recovery plan to reduce expenditure and operate within this set limit and for this plan to be submitted for review by 7 June 2025.

• You must deliver a minimum 3% recurring savings target, progress against which will be monitored monthly.

This report is to provide the Board with an updated 3-year financial plan 2025/26 to 2027/28 for approval and sets out the actions proposed to reduce the financial gap to the SG requirements.

2.2 Background

On 4 December 2024 all Boards received a Scottish Government Budget 2025/26 letter providing details of the indicative funding settlement for NHS Boards.

The planning approach confirmed the needs for financial plans to present:

- a clear programme of work and supporting actions to achieve 3% recurring savings on baseline budgets over the three year period
- an improved forecast outturn position in 2025-26 compared to the forecast outturn position reported at the start of 2024-25, with improvements in the financial position being achieved in each of the years to 2027-28 for those Boards not in financial balance

- trajectories for improvement in the financial position supported by detailed plans as to how this would be achieved and the arrangements that will be implemented by the Board to oversee delivery
- No brokerage will be made available in 2025-26
- Should financial balance not be achieved this will be shown as an overspend in financial statements, leading to potential qualification of accounts and Section 22 report, as well as consideration of escalation status

At the Board meeting of the 27th May the draft budget submitted to the SG was presented but recognising that NHS Highland did not submit a plan that satisfied the requirement to demonstrate a trajectory of improvement. Therefore, a request was made by SG to resubmit the plan with a projected outturn of no more than £40 million and the submission would be re-presented to the Board.

2.3 Assessment

Work has been undertaken to assess the potential actions required to deliver the ask of Scottish Government and a plan to deliver £40m was provided to the government with the agreement of the Finance, Resource and Performance Committee on the 6th June.

The process for identifying the financial improvement actions is noted below.

Stage 1 – the plan was recalculated based on the 2024/25 actual outturn position which identified an improved opening position of £5.538m as highlighted below:

Table 1 – Revised three-year plan based on 24/25 outturn

Movement in plan post March Submission	Recurrent £000s	Non-recurrent £000s	Total £000s
March Plan	(139,519)	23,922	(115,596)
Changes post March Submission:			
Offsets to Acute Cost Pressres to match 2024-2025 Out-turn	2,145		2,145
Offsets to HHSCP Cost Pressres to match 2024-2025 Out-turn	3,393		3,393
Financial Gap before Savings	(133,981)	23,922	(110,058)

Stage 2 – review of VEAG and STAG workstreams
Work is ongoing in this area to provide assurance that the current 3% saving projection can be delivered and the financial contribution of the STAG programmes over the coming 3 years.

Stage 3 – assessment of further non-recurrent actions that could be delivered to support the position which are detailed in the table below:

Table 2 – assessment of further non-recurrent actions to be taken

Other NR actions:	2025-26 £000s
Allocation review	2,000
Annual leave accrual (reduce to 23/24 levels)	3,686
A4C non-pay slippage	2,394
Extended Provisions review	1300
New Craigs RAAC money	800
Total actions	**10,180**

The proposed actions can be taken to deliver a reduced outturn on a non-recurrent basis. This is also recognising and accepting the risks that were inherent within the original plan submitted but is not deemed to expose the Board to additional risks as these measures are considered to be deliverable.

The full response to SG has been included in Appendix 1 and the letter of response in Appendix 2 accepting the re-submitted plan.

2.4 Proposed level of Assurance

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

Moderate assurance that a plan has been identified to deliver a £40m deficit position for 2025/26 but recognising the risk that remains around the delivery of 3% cost reductions and a balanced ASC and IJB position.

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

The scale of the challenge to deliver the planned deficit position and the requirement to produce a plan to reduce the deficit to £40m as per SG requirements.

3.4 Risk Assessment/Management

There is a significant risk that NHS Highland cannot deliver the required financial position for 2025/26.

The scale of challenge to deliver 3% recurrent savings is significant and cannot be underestimated which is reflected across the full Board area including Argyll and Bute – where the risk of non-delivery is high.

The risk to delivering the Adult Social Care reductions is high with no clear plan in place to deliver change to reduce the financial outturn in year to a balanced position.

There continue to be ongoing operational risks that may not have been fully provided for in the plan and will need in year mitigation.

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
- Value & Efficiency Group
- Finance, Resource and Performance Committee
- Area Partnership Forum
- Staff Governance Committee
- 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
- SG

4.1 List of appendices

Appendix 1: NHS Highland 2025-28 Financial Plan letter of response

Appendix 2: NHS Highland 2025-28 Financial Plan Addendum letter

NHS Highland

Chief Executive's Office
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Beechwood Park
Inverness, IV2 3BW
Telephone: 01463 704000

www. nhshighland.scot.nhs.uk

Mr Alan Gray
Director of Health and Social Care Finance
Scottish Government

By email: Alan.Gray2@gov.scot

Date: 6 June 2025
Your Ref:
Our Ref: HC/FD/CL

Enquiries to: Fiona Davies
Email: fiona.davies5@nhs.scot

Dear Alan

NHS Highland – Three-Year Financial Plan

Thank you for your response to the NHS Highland three-year financial plan submission in March. We noted your expectation to review the submission and identify further actions required to reduce the planned deficit for 2025-26 to a maximum of £40m.

In response to this, our Director of Finance, Heledd Cooper and her team have been meeting with you and your team on a weekly basis to ensure that we are able to provide a comprehensive assessment and revised plan that the Board is comfortable that it can deliver, noting of course the significant risks that sit within our initial plan.

Background and context

I would like to take this opportunity to provide some context to the NHS Highland geography and demographics.

NHS Highland provides services across 40% of the total Scotland land mass and services a population of over 330,000. Our services are delivered across four acute sites, 17 community hospitals and numerous community settings. We have 66 care homes in the Highland Council area, of which 50 are independent. We have seen an increase in care homes permanently closing in the past years, and we are unique amongst territorial boards in having a lead agency model for health and social care in the Highland Council area, with NHS Highland having responsibility for delivering adult social care. In Argyll and Bute, we operate as part of an Integrated Joint Board.

The diverse geography includes Inverness, one of the fastest growing cities in Western Europe, and 36 populated islands (23 in Argyll & Bute and 13 in Highland). Our population lives with some challenges, including areas of deprivation and inequality and issues arising from fuel poverty and availability, complex transport difficulties and the rising cost of living. People living in the NHS Highland area are also older than the Scottish average and can have increasingly complex health and care needs. The economy is heavily reliant on tourism, with seasonal work being common, although an impact of COVID has seen tourism become much more of a year-round business, and that has added to our staffing challenges.

The following data has been extracted from the 2023 population estimates (NRS).

Table 1 – Age profile of the Highland population:

Area name	Area type	% 65 and over	% 75 and over
Dumfries and Galloway	Health board	28%	13%
Western Isles	Health board	27%	13%
Borders	Health board	27%	13%
Orkney	Health board	25%	12%
Highland	Health board	25%	12%
Ayrshire and Arran	Health board	24%	11%
Tayside	Health board	23%	11%
Shetland	Health board	22%	11%
Fife	Health board	22%	10%
Forth Valley	Health board	20%	9%
Grampian	Health board	20%	9%
Lanarkshire	Health board	19%	9%
Lothian	Health board	17%	8%
Greater Glasgow and Clyde	Health board	18%	8%

Area name	Area type	% 65 and over	% 75 and over
Scotland	Country	20%	9%
Argyll and Bute	Council area	27%	13%
Highland	Council area	24%	11%

Table 2 – Working age population and median age

Area name	Area type	Persons Median age	Total population	% working age population
Lothian	Health board	39.44	905,800.00	69%
Greater Glasgow and Clyde	Health board	39.73	1,179,200.00	68%
Lanarkshire	Health board	43.21	668,380.00	65%
Forth Valley	Health board	44.10	302,810.00	65%
Grampian	Health board	42.76	582,300.00	64%
Tayside	Health board	44.37	414,270.00	63%
Fife	Health board	44.52	371,390.00	63%
Shetland	Health board	44.99	23,020.00	62%
Ayrshire and Arran	Health board	47.93	365,450.00	61%
Highland	Health board	48.96	323,640.00	61%
Orkney	Health board	49.54	22,030.00	60%
Western Isles	Health board	51.29	26,120.00	59%
Borders	Health board	50.86	116,820.00	59%
Dumfries and Galloway	Health board	51.42	145,770.00	59%

Area name	Area type	Persons Median age	Total population	% working age population
Scotland	Country	42.88	5,490,100.00	65%
Argyll and Bute	Council area	51.36	87,810.00	60%
Highland	Council area	48.03	236,330.00	62%

Table 3 – Population density

Area name	Area type	Population density (persons per km^2)
Greater Glasgow and Clyde	Health board	1,081
Lothian	Health board	533
Lanarkshire	Health board	300
Fife	Health board	282
Forth Valley	Health board	115
Ayrshire and Arran	Health board	109
Grampian	Health board	67
Tayside	Health board	56
Borders	Health board	25
Dumfries and Galloway	Health board	23
Orkney	Health board	22
Shetland	Health board	16
Highland	Health board	10
Western Isles	Health board	9

Area name	Area type	Population density (persons per km^2)
Scotland	Country	70
Argyll and Bute	Council area	13
Highland	Council area	9

Note: shaded areas are Boards in financial escalation level 3 or above.

Financial history

As you will be aware, NHS Highland has been under financial escalation and intervention since at least 2013. The most recent escalation was in 2018, when the board was placed at Stage 4 of the NHS Scotland Performance Escalation Framework due to financial and governance concerns. In June 2021, NHS Highland was moved to Stage 3, indicating improved governance, leadership, and culture, though challenges remain with our financial position.

NHS Highland has also historically been funded below the NRAC target and, although we are now funded within 0.6% of parity (which equates to over £10m of funding), there is a cumulative impact of under-funding over the years, with less funding to invest in our rural services in particular.

Adding to this financial challenge is the previously mentioned Lead Agency model of integration. Since integration, the Adult Social Care provision has received no uplift funding other than any allocations directly funded by Scottish Government. In the recent years, Scottish Government has provided NHS Highland with additional funding to cover any Agenda for Change pay increases above baseline assumptions (leaving NHS Highland with the core gap to manage). This, alongside the NHS staffing model for Social Care staff, reducing independent providers and a disincentivised market landscape, has caused providers to exit the Highlands, resulting in reduced social care provision or increased cost due to directly provided NHS social care. The direct additional cost of Social Care has not only contributed to the overall financial deficit but has also resulted in less funding being available for Health.

Below is an illustration of the financial position of the Board over the past few years – which shows that the opening deficit of NHS Highland has stayed relatively stable around £100m underlying deficit, with a greater deterioration in 2024/25 to reflect the 0% uplift to baselines. This also shows the level of non-recurrent actions that have been utilised to reduce the opening position each year. These opportunities are reducing each year and has masked the true position over the past years.

Table 4 - NHS Highland Financial Plan history

Plan	2022-23 £000s	2023-24 £000s	2024-25 £000s	2025-26 £000s	Revised 25-26 £000s
Opening deficit	-84.52	-98.17	-112.50	-115.60	-110.06
Recurrent savings	19.00	20.00	26.73	29.76	29.76
NR actions	49.25	9.50	35.17	30.12	40.30
Planned deficit	**-16.27**	**-68.67**	**-50.60**	**-55.73**	**-40.01**
Actual deficit	**-15.81**	**-29.24**	**-49.5**		
Actual recurrent savings	9.90	8.113	21.309		
ASC deficit	5.60	9.87	16.7		

To note – ASC 2022-23 and 2023-24 was offset with reserves in year; 2024-25 was reduced by £5.6m of THC transformation fund.

Finance Plan Review

NHS Highland's Executive team has been fully involved in all discussions and agreements since receipt of your letter.

A decision was taken at the Executive Director's Group (EDG) meeting that the areas to scrutinise for an improved outlook would be:

- The March plan based on a revised 24/25 outlook
- Value and Efficiency (VEAG) workstreams
- Strategic (STAG) workstreams
- Any further non-recurrent benefits/ actions to be taken

It was also agreed that no actions that would reduce services or activity that sat outside of this process would be considered or suggested at this time.

The finance team undertook the initial action to re-work the plan and identified an improved opening position based on the 24/25 position of £5.538m as highlighted below:

Table 5 – Revised NHS Highland three-year plan based on 24/25 outturn

Movement in plan post March Submission	Recurrent £000s	Non-recurrent £000s	Total £000s
March Plan	(139,519)	23,922	(115,596)
Changes post March Submission:			
Offsets to Acute Cost Pressres to match 2024-2025 Out-turn	2,145		2,145
Offsets to HHSCP Cost Pressres to match 2024-2025 Out-turn	3,393		3,393
Financial Gap before Savings	(133,981)	23,922	(110,058)

There has also been a significant amount of work undertaken by managers in collaboration with both the Strategy & Transformation and Finance teams to refine the VEAG and STAG workstreams. Although these have not yet identified additional opportunities within the year, they have provided a greater level of assurance around the delivery of the 3% savings target for VEAG and work is ongoing to calculate financial benefit for the STAG programmes over years two and three.

Scrutiny of the balance sheet, allocations and other non-recurrent benefits not currently captured within the finance plan has also been undertaken, with further actions being identified to reduce the gap in year.

Table 6 – assessment of further non-recurrent actions to be taken

Other NR actions:	2025-26 £000s
Allocation review	2,000
Annual leave accrual (reduce to 23/24 levels)	3,686
A4C non-pay slippage	2,394
Extended Provisions review	1300
New Craigs RAAC money	800
Total actions	**10,180**

NHS Highland has introduced a new allocation review process to ensure that scrutiny is undertaken of all new allocations or those where full allocation has yet to be drawn down, which we have assessed will release c£2m through slippage in utilisation. The annual leave accrual is to be reduced to the 2023/24 closing position through greater visibility and oversight of annual leave usage and an assessment of the total use of the A4C pay reform funding in year has been undertaken.

The cumulative result of this work is a revised plan which is summarised below:

Table 7 – Revised NHS Highland three-year financial plan following further actions

	2025-26 £000s	2026-27 £000s	2027-28 £000s
Deficit Brought Forward	(109,817)	(104,224)	(93,593)
New Funding	92,420	51,530	52,575
Inflation/New Pressures	(92,661)	(63,393)	(65,202)
Less savings/ reductions	59,873	55,862	57,536
Additional NR actions	10,180		
Net Gap before Savings	**(40,005)**	**(60,225)**	**(48,684)**

I can therefore confirm that NHS Highland is submitting a revised plan with a trajectory to deliver a forecast deficit of £40m as requested by Scottish Government.

Risks

I will also take this opportunity to reiterate the level of financial risk being held in the original plan submitted in March, which remain as live risks as we navigate through the 2025/26 financial year.

The key risks are:

1. Adult Social Care position – There is currently a £26m gap in the ASC position for 2025/26, and in line with 2024/25 we are reporting that this gap will be closed during the year, in part through a 3% savings target, equating to £6.192m, the remaining £19.8m is being driven through an ASC STAG workstream, but is unlikely to deliver the full gap in year. Therefore, the risk of delivering this position is high.
2. Argyll & Bute IJB – has been allocated a 3% savings target to deliver a balanced position, circa £2m of this has identified plans, but the remaining is as yet unidentified. The IJB has been requested to produce a recovery plan for the remainder – but currently is a moderate risk.
3. North Highland & Acute 3% savings target – 3% is an ambitious target and is a moderate delivery risk.
4. SLA uplift – NHS Highland, and in particular Argyll & Bute is a high exporter of cross-Board activity. Whilst the SLA uplift takes into account all funding uplifts received by the Board to transfer to other NHS Boards, it does not equally transfer a savings target expectation. Therefore, reducing the ability to deliver savings against a significant portion of allocation and limited efficiency of scale opportunity whilst providing equality of services over a remote and rural geography.

These risks will be managed and monitored throughout the year and we look forward to working with your teams to discuss the risks and opportunities.

Forward look

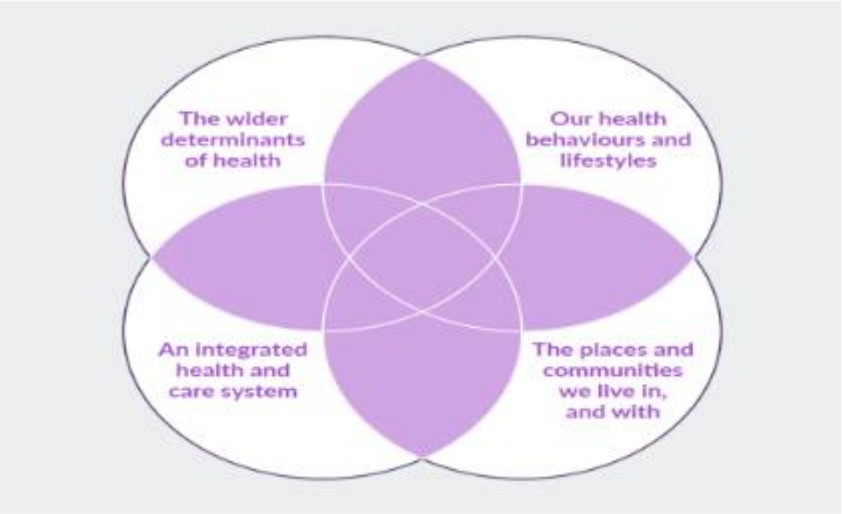
NHS Highland agreed a proposal to deliver a new strategy for 2026 to refresh the Together We Care strategy and ensure we are equipped to deal with the unprecedented challenges ahead for both health and social care into the future.

A new Population and Public Health Committee is being created to oversee the development and delivery of the new strategy. The diagram below sets out what is required from the Board to shift focus to a population health approach.

A refresh of NHS Highland's vision and strategic objectives is essential to set out how we will deliver on high value and sustainable care into the future.

In creating the new strategy we need to understand the Population Health of NHS Highland and plan for high value sustainable care by:

- Understanding the health and health needs of the population utilising our joint strategic needs assessment.
- Provide evidence to demonstrate needs and capture improvement in population health outcomes, as part of our governance framework.
- Community collaboration; learning from those with lived experience.
- Maximise use of health and wellbeing information intelligence.
- We need to work locally, regionally and nationally with our partners, including local councils, Health and Social Care Partnerships, voluntary organsiations and community groups to develop a local population health system and to explore the best approaches. System focus and collaboration is essential to tackle system-wide challenges that cannot be solved by one organisation, sector or profession alone to improve the health of the population and tackle inequalities.
- Decreasing health inequalities in conjunction with Community Planning Partners.
- Address social determinants of health.
- Ensure equality of access to health care.
- Reducing health harming activities and risks from smoking, drugs and alcohol, low levels of physical activity. (Implement and use the Public Health Annual report as a springboard for this work.)
- Improve the mental health of our population.
- Maximising the impact on our local economy through our role as an Anchor Institution utilising Marmot principles to target key communities or groups needing focus.



The diagram above is from the Kings Fund and it details a model for population health. It is proposed that this could be a potential framework on which to build the new board strategy.

We are keen to work with you over the coming months and years to stabilise the financial position of NHS Highland and to enable the Board to deliver sustainable services for our people.

Yours sincerely

Fiona Davies

Fiona Davies
Chief Executive

Health and Social Care Finance
Alan Gray, Director

Scottish Government
Riaghaltas na h-Alba
gov.scot

E: alan.gray2@gov.scot

Fiona Davies
Chief Executive
NHS Highland

Cc:
Chair, NHS Highland
Heledd Cooper, Director of Finance

Dear Fiona

NHS Highland – 2025-26 Financial Recovery Plan

Thank you for submission of your revised financial plan for 2025-26 and would acknowledge the commitment from you and the wider team to reducing the forecast deficit.

The revised plan identifies options to improve the forecast deficit from £55.7 million to £40.0 million, a 28% reduction. I am content to accept the plan as submitted on the basis any unexpected in year benefits are used to reduce the 2025-26 deficit and any in year pressures are managed within existing budget.

The revised plan assumes total financial savings of £65.8 million, with a recurring savings target of £29.8 million, which does meet the Scottish Government target of at least 3% recurring savings. We also note a number of the savings schemes set out are high risk and will work with you to understand delivery during the year.

As previously indicated, the Accountable Officer for NHS Highland has a statutory responsibility to achieve a breakeven position or where this cannot be met, to set out a plan and timescale for this to be achieved. Although the revised financial plans include a lower deficit for 2025-26, NHS Highland forecast an increase in deficit in future years. Further work will be required during the year on options to reducing the 2026-27 and 2027-28 deficit positions and finance and performance colleagues within the Scottish Government will continue to provide support to deliver an improved financial outturn, including mitigating the additional risk arising from adult social care.

I would wish you and colleagues in NHS Highland all the best for the future.

Yours sincerely

Ala Gray

Alan Gray
Director of Health and Social Care Finance

Agenda Item 6

NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**29th July 2025**
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 note limited assurance and 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 and Care 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.

The S&T team are working with Exec leads to agree the Board level deliverables that will be within the IPQR, and then the operational deliverables that will be part of performance review reporting. These deliverables will be taken from the ADP 25/26. Mapping of the deliverables through other governance committees is required like Clinical Governance and Staff Governance. The new updated IPQR will be presented to NHS Highland Board meeting in September.

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	
Limited	X	None	

Comment on the level of assurance

The level of assurance has been proposed as Limited due to the current pressures faced across the health and care services in NHS Highland. The system requires to redesign systematically to maximise efficiency opportunities and to enable service changes that bolster resilience and utilise resources that are cost effective for the Board and maximise value for our population.

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;

- Clinical Governance Committee – 3rd July 2025
- Finance Resource Performance Committee – 6th June 2025
- Staff Governance Committee – 1st July 2025

4.1 List of appendices

The following appendices are included with this report:

- Integrated Performance and Quality Report – July 2025 Board Meeting

Integrated Performance and Quality Report

Board Meeting for 29 July 2025

NHS Highland
na Gàidhealtachd

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

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Executive Summary of Performance Indicators: June 2025

		NATIONAL TARGETS			PERFORMANCE AGAINST TARGETS	
Well Theme (Slide #)	**Area**	**Average 23/24 Performance**	**Current Performance**	**National Target**	**Activity (ADP) Target Set**	**Performance Rating**
Thrive Well (4)	**CAMHS**	70.8%	79.5%	90%	No	
Thrive Well (5)	**NDAS**	n/a	1958 waiting list	n/a	No	
Stay Well (6)	**Screening**	Various	Various	90%	No	
Stay Well (7)	**Vaccinations (Children & COVID)**	n/a	n/a	n/a	No	
Stay Well (8)	**Smoking Cessation**		52			
Stay Well (9)	**Alcohol Brief Interventions**	n/a	77.4% vs. trajectory	n/a	Yes	
Stay Well (10)	**Drug & Alcohol Waiting Times**					
Respond Well (11)	**Emergency Access**	78.5%	82.6%	95%	No	
Care Well (12)	**Delayed Discharges**	195	233	30% reduction (interim)	Yes	
Treat Well (13-14)	**Outpatients**	39.2%	39.6%	95%	Yes	
Treat Well (15)	**Treatment Time Guarantee**	56.5%	66.3%	100%	Yes	
Treat Well (16)	**Diagnostics - Radiology**	70.3%	56.8%	100%	Yes	
Treat Well (17)	**Diagnostics – Endoscopy**		70.9%	100%		
Journey Well (18)	**31 Day Cancer Target**	93.6%	91.4%	95%	No	
Journey Well (19)	**62 Day Cancer Target**	68.8%	76.0%	95%	No	
Journey Well (20)	**SACT Access and Benchmarking**					
Live Well (21)	**Psychological Therapies**	83.1%	82.8%	90%	No	

Guide to Performance Rating

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

Additional Guidance

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

Within the narrative section areas where action was highlighted in the previous IPQR all Executive Leads have been asked for assurance of insights to current performance and plans and mitigation in progress.

Not all performance indicators are included within this summary table.

Integrated Performance & Quality Report Guidance

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 and Care Governance Committee and the Health and Social Care Partnership committees a bi-monthly update on performance and quality based on the latest information available. The Argyll & Bute Integrated Performance Management Framework metrics will be included in the NHS Highland Board IPQR as an appendix.

For this IPQR, the format and detail has been modified to bring together the measurable progress against ADP deliverables across the Together We Care "Well" themes and to start to embed the themes of the quality framework across Highland. This is an update to end of Quarter 4 (31st March 2025) for deliverables linked to these performance measures.

In addition, a narrative summary table has been provided against each "Well" theme to summarise the known issues and causes of current performance, how these issues and causes will be mitigated through improvements detailed in the ADP, and what the anticipated impact of these improvements will be.

ADP Due Date Colour	Interpretation
R	ADP Deliverable is not on track to deliver by planned due date. Issues being resolved locally to ensure progression towards implementation.
G	ADP Deliverable is on track to deliver by planned due date OR ADP Deliverable has been achieved.
No Colour	Update to be provided at subsequent committee/Board meetings within Q3 and/or Q4 as target date is in the future.
A	Due date in next quarter (Q3) or ADP Deliverable has been delayed due to factor outwith NHS Highland's control

NHS Highland
na Gàidhealtachd

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with you, for you

Exec Lead
Katherine Sutton
Chief Officer, Acute

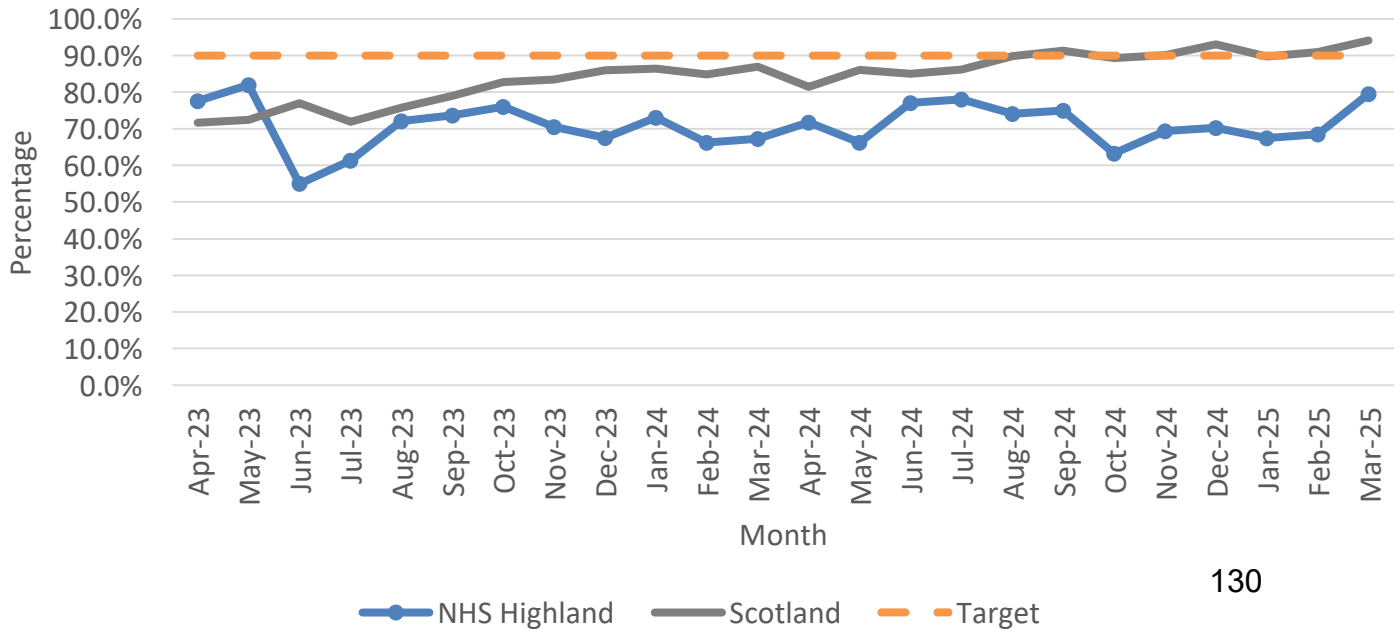
CAMHS (Child and Adolescent Mental Health Service)

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
Delivery of CAMHS Improvement Plan to reduce CAMHS waiting times and improved data quality for NHS Scotland Waiting Times Standards. Targets and trajectories will be developed and be part of our performance monitoring as part of NHS Board Delivery Framework expectations.	Mar 25	CAMHS remains one of, if not the lowest staffed service per population rate in Scotland with approx. 30-35% vacancies Service remodelling and performance management around activity rates in place. all of which have brought improvements both in waiting times and in clinical quality and outcomes. March 2025, performance has increased to its highest point since May 2023.	• Engagement appointments for all new referrals • Unused capacity directed to these cases most recently placed on wait list • New system for wait list management in place. • Unscheduled care team realignment in place • CAMHS Programme Board reestablished from Nov 2024, including A&B representation • Working closely with SG on the most effective service model to support delivery across A&B and the Highland HSCPs

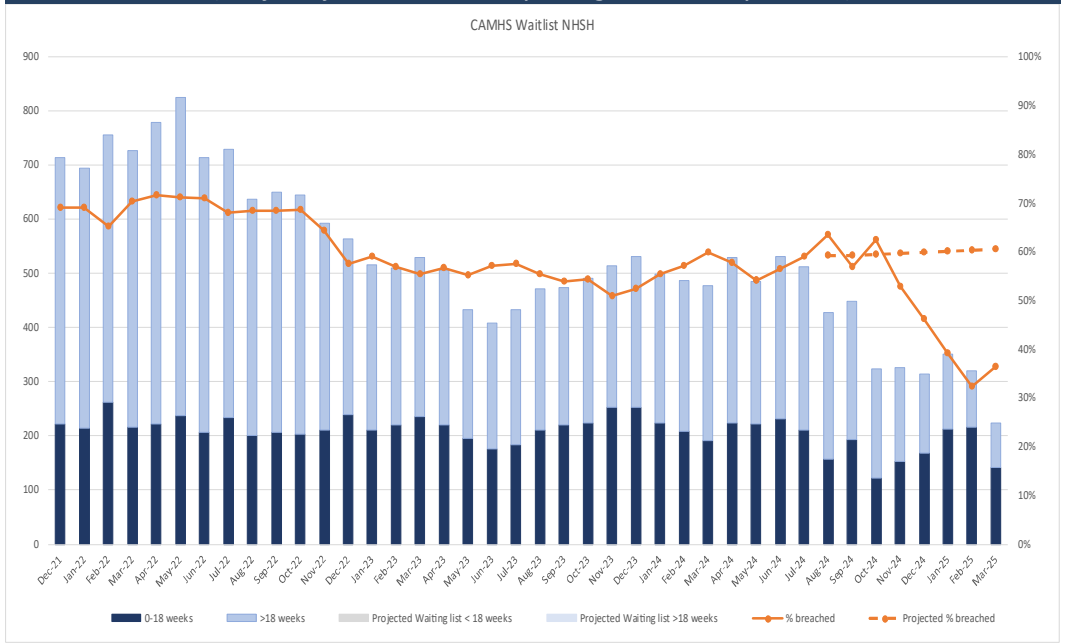
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	Increasing
Latest Performance	79.5%
National Average	94.1%
National Target	Full compliance to the Service Spec by end March 2026, RTT 90%
National Target Achievement	n/a
Position	13th out of 14 Boards

CAMHS Waiting Time < 18 Weeks (P)



CAMHS Waiting List in Weeks (P&Q)
(Draft trajectories currently being reviewed by service)



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Exec Lead
Katherine Sutton
Chief Officer, Acute

Neurodevelopmental Assessment Service (NDAS)

ADP Deliverables Progress as at End of Q4 2024/25	
Waiting list validation to offer 1st appointment <4 weeks	June 2024
All to receive a comprehensive NDAS, leading to shared and collaborative formulation and intervention plan	July 2024
Ensure systems and processes are in place to flex capacity	Dec 2024
Improve service user experience through communications	Dec 2024
Progress NDAS Service Development including reviewing structure, leadership and governance.	Mar 2025
Develop data recording SOP and reporting dashboard	Mar 2025

Insights to Current Performance

The NDAS North Highland / Highland Council position was presented to the Joint Monitoring Committee in November 2024.

- Interim Clinical Director in post
- Authority Framework is in place
- Targeted waiting list interventions using current resource / private assessment options investigated
- Comms delivered to all on waiting list. Comms strategy established to update colleagues / partners / public
- ICSP ND Programme Board is established and has been meeting monthly
- Waiting list cleansing exercise is completed
- ICSP GIRFEC and Child Planning training for MDTs rolled out

Plans and Mitigations

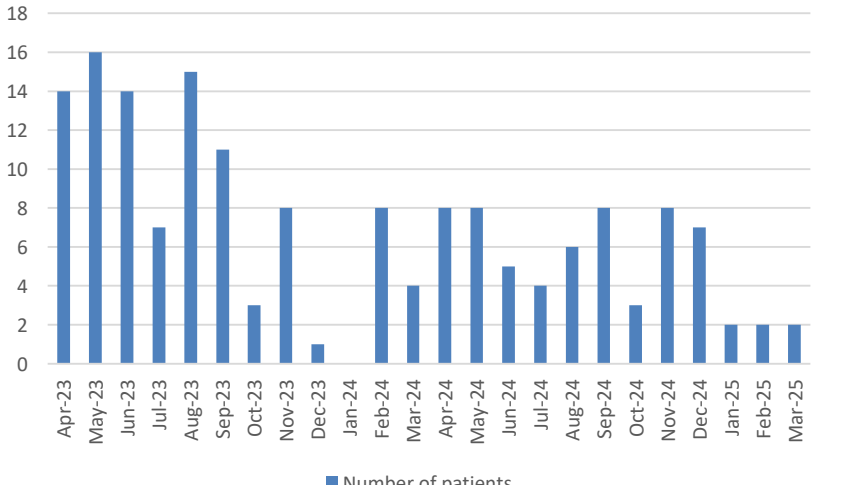
Actions agreed at NDAS programme board being progressed:

- Progression of joint leadership to improve NDAS position across NHSH North/ HC Co-chaired Programme Board
- 1 year interim workforce plan to be developed
- Alignment with Integrated childrens services
- Additionality planning 2025/26
- Communication with service users and professionals

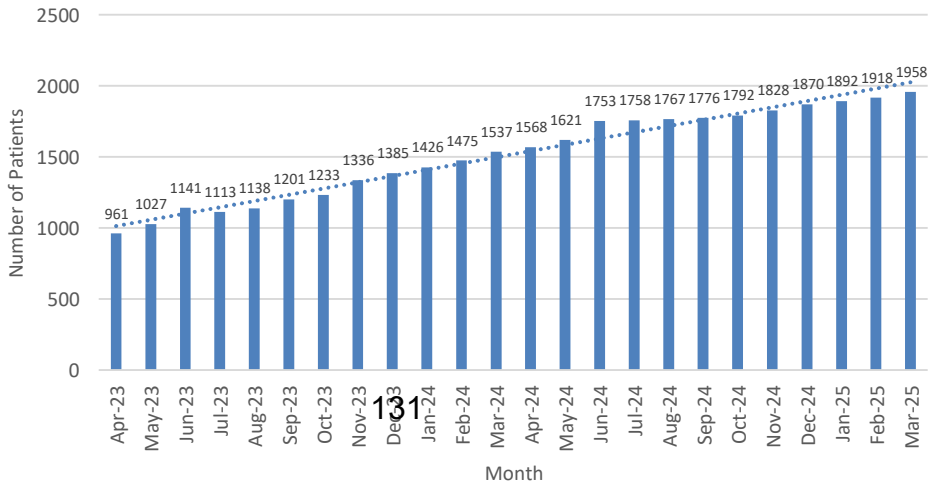
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	
Latest Performance	1958 on waiting list
National Benchmarking	n/a
National Target	Full compliance to the National NDAS Service Spec by end March 2026.
National Target Achievement	n/a
Position	n/a

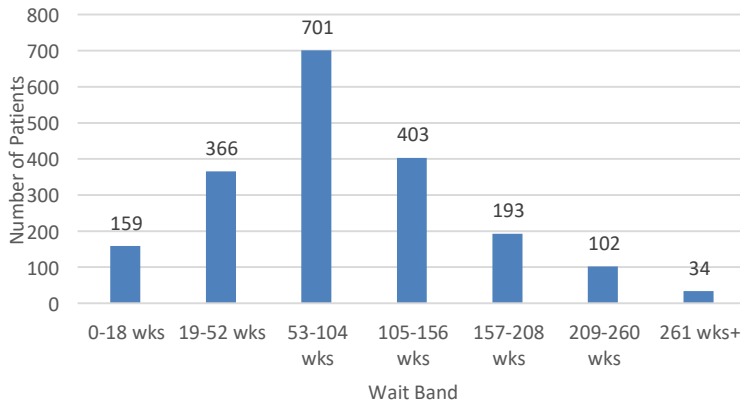
1st New Appointment Only



NDAS Total Awaiting 1st Appointment (inc unvetted)



New + Unvetted Patients Awaiting 1st Appointment by wait band



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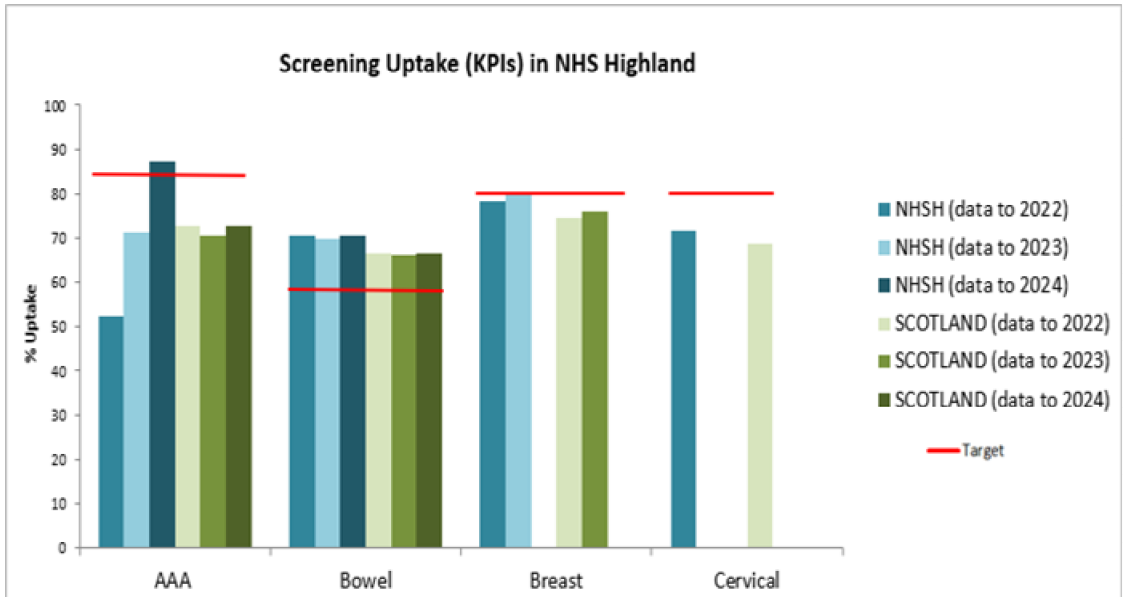
Exec Lead
Jennifer Davies,
Director of Public Health

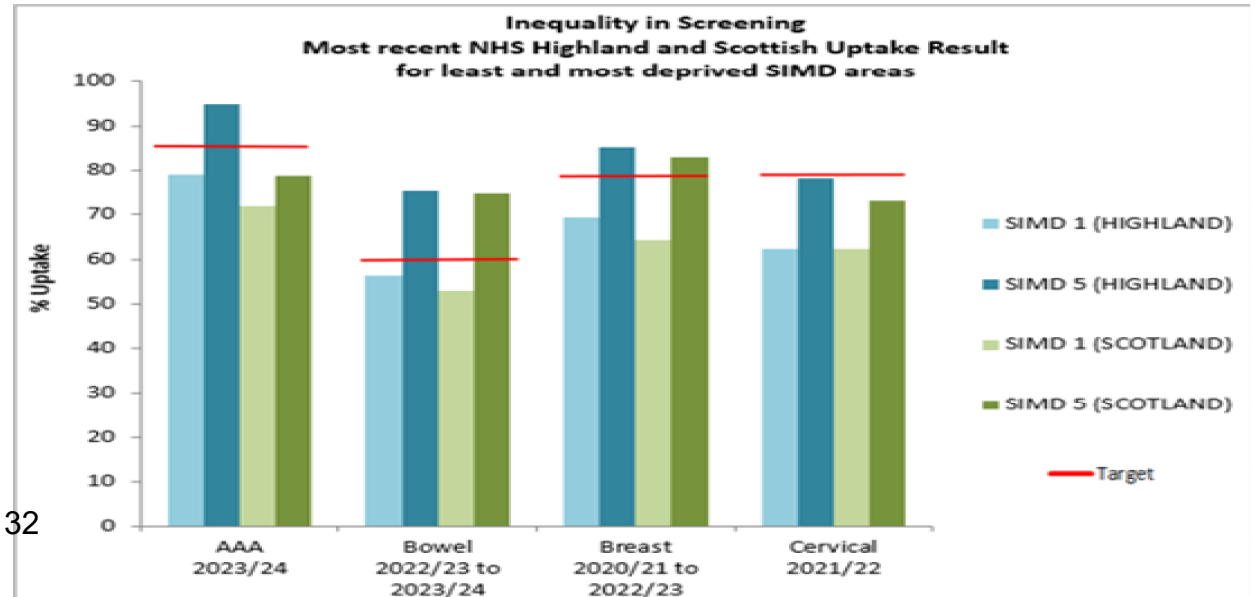
Screening

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance (Updated 4 March 2025)	Plans and Mitigations
Encourage and promote screening programmes and increase uptake across available screening programmes above national targets.	Ongoing	• A comparison of screening performance against Scottish benchmarks shows that the overall participation for NHSH continues to be higher than average uptake levels throughout Scotland for Bowel, Breast, Cervical cancers and AAA screening programmes (based on latest information arising from locally sourced management data). • For internal performance monitoring for Pregnancy & Newborn screening, actions to improve data quality and reporting from Badgernet was completed at end of 2024. • The backlog in reporting on the UNHS (Universal Newborn Hearing Screening) has been almost filled by the newly established team in Raigmore at the beginning of 2024. • It must be acknowledged that the latest official figures are used to monitor uptake trends, so that comparisons against benchmark figures can be made. Such official figures are published with 1 year delay at the beginning of each financial year. Only the data for two programmes has been published in March 2025 (for data up to 2024 reporting period). • Provision of Diabetic Eye Screening (DES) and Pregnancy & Newborn KPI monitoring from Public Health Scotland is pending, so it is not possible to officially report on the performance of these programmes. However non verified management data indicates comparable performance with Scottish levels.	Work continues to drive improvements withi n the screening programmes. The NHS Highland Screening Inequalities Plan 2023-26 outlines focused activities to specifically address equality gaps and widen access to screening.

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

Performance Rating	Increasing
Latest Performance	See chart
National Benchmarking	See narrative
National Target	2 of 4 cancer screening uptakes meeting target
National Target Achievement	See charts
Benchmarking	See charts





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Exec Lead
Jennifer Davies,
Director of Public Health

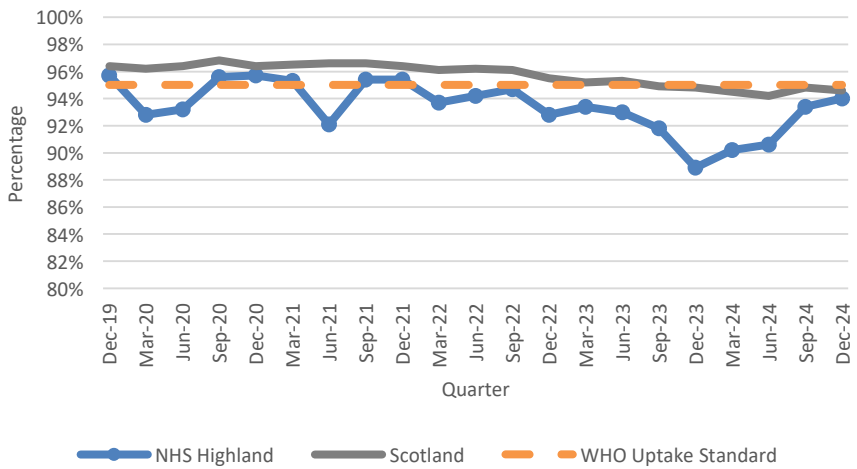
Vaccinations (Children's)

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance (updated Feb 2025)	Plans and Mitigations
Vaccination Programme: Options being developed for the delivery of the collaborative hybrid model in Highland HSCP. Planning underway for the delivery of the national childhood schedule change.	April 2025	There continues to be improvement required in relation to both the uptake and timeliness of pre-school vaccinations. For most of the vaccinations at each of the time-points measured, the WHO 95% vaccination uptake target is not being met. However, for over half of the pre-school vaccinations measured at 12 months, 24 months and five years, the vaccination uptake across A&B HSCP exceeded the Scottish average. Improvement continues to be required in relation to the timeliness of pre-school vaccinations. Improved performance across a range of metrics is a key aim of the delivery of the hybrid model.	Scottish Government is working with Highland HSCP in level 2 of its performance framework. The Vaccination Transformation Implementation Group has been convened to support the delivery of the collaborative hybrid model across the partnership. A tripartite advisory group has been convened (SG, PHS, NHSH) to offer external support to Highland HSCP as part of the implementation of the hybrid model of delivery.
Medium-Term Plan priority: Improved disease prevention and reduced inequalities in access through consolidated NHS Highland vaccination programme.	March 2027		

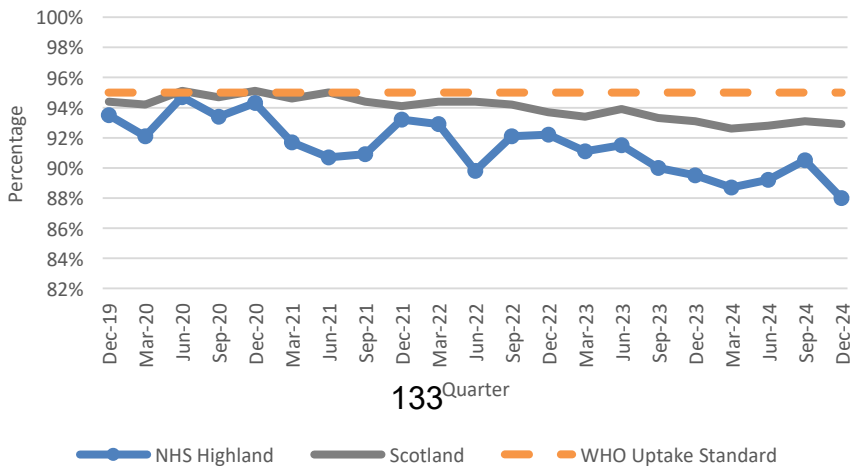
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Stay Well

Performance Rating	MMR Below national averages
Latest Performance	MMR 2 Range of 83 - 90% when measured at five years (Q4 – Oct 1st to Dec 31st 2024)
National Benchmarking	MMR 1 uptake below national average for both partnerships at 24 months. MMR 1 and MMR 2 for A&B HSCP exceeds national average when measured at five years.
National Target	MMR 95%
National Target Achievement	See charts
Position	See charts

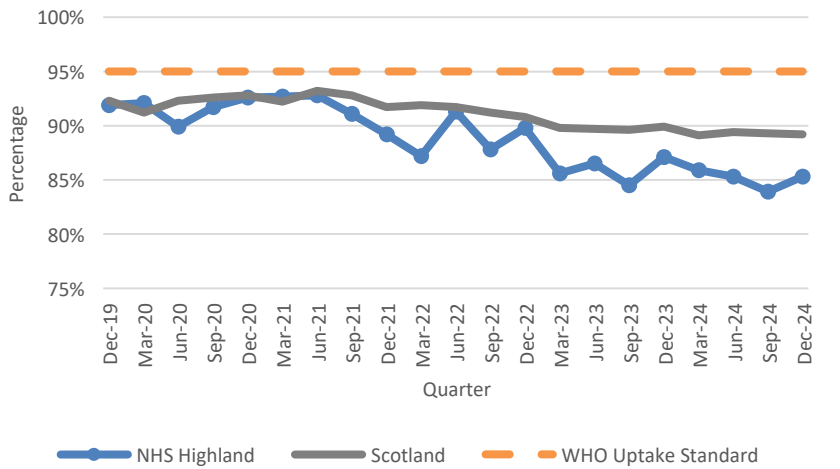
Six-in-One at 12 Months



MMR1 at 24 Months



MMR2 at 5 Years



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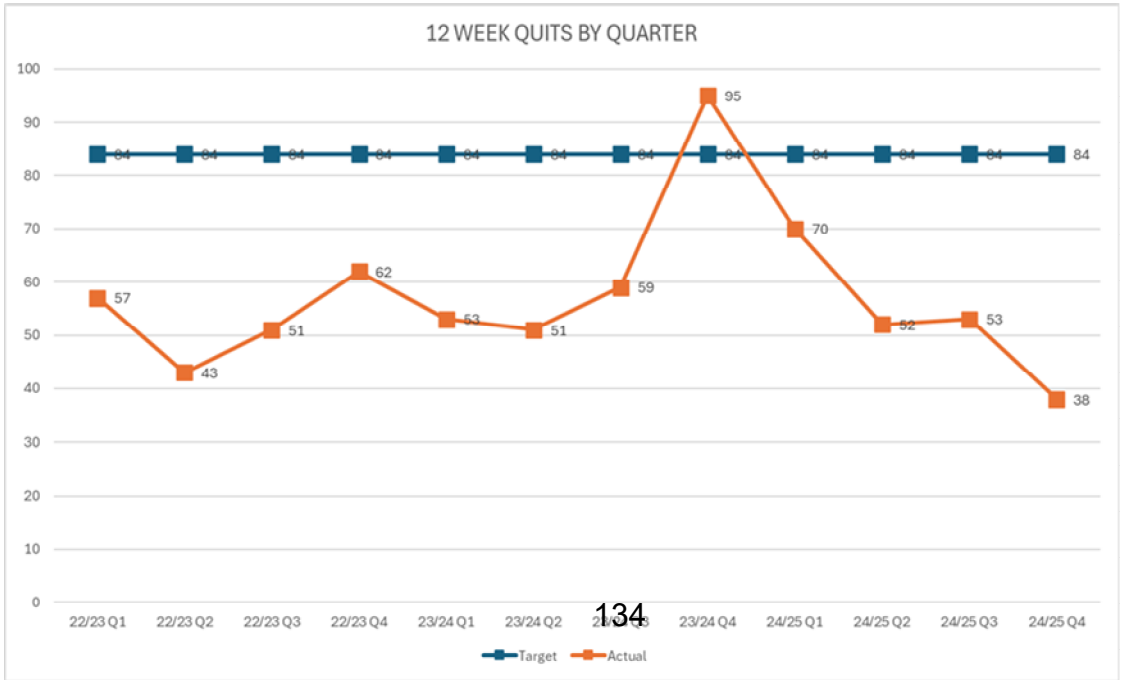
Exec Lead
Jennifer Davies,
Director of Public Health

Smoking Cessation

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
Respond to and deliver on national strategy and targets – including smoking cessation		• 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 within young pregnant women who are hard to reach. • Limited support for patients within our acute setting.	• Monthly review of missing follow up data at both 1 month and 3 months. Training on tool has now taken place and reports can now progress. • Pilot of a financial incentive stop smoking scheme for pregnant women who are eligible for NHS Highland Family Nurse Partnership (FNP) ready to go. Unable to progress due to issues with ordering vouchers via PECOS. • Flowchart and materials have gone out via senior management at Raigmore and discussed at daily huddles over the next few weeks. Additional adviser capacity commencing 8th May.



PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Stay Well	
Performance Rating	
Latest Performance	
National Benchmarking	
National Target	336 successful quits in 12 weeks in 40 most deprived SIMD areas
National Target Achievement	
Position	

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Exec Lead
Jennifer Davies,
Director of Public Health

Alcohol Brief Interventions (ABIs)

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance (Updated 3 March 25)	Plans and Mitigations
Health Improvement Delivery focused on: Alcohol Brief Interventions, Smoking Cessation, Breastfeeding, Suicide Prevention and Weight Management as target areas.	Ongoing	•Fig. 1: ABI delivery is above target trajectory in each month of Q4 for NHS Highland. Increases to ABI delivery in Q3 and Q4 have resulted in the annual target for delivery of ABIs in NHS Highland being exceeded by 17%. •Fig. 2: Total no of ABI delivered Apr 24 – March 2025 is 4311. The Scottish Government Local Delivery Plan (LDP) standard requires NHS Highland to achieve 4,688 ABIs per year. Significant majority of ABI deliver takes place in Primary care in Highland HSCP.	• ABI training continues to be in high demand across board area. However, despite high numbers signing up for courses, attendance at ABI courses is around 70%. Attempts are being made to mitigate this gap. • Next ABI trainers network meeting in June. This will include a review of participant feedback to review if current provision is meeting learning outcomes. • Online wider setting ABI recording form and data review continues to be adapted to meet needs of both HSCP areas.
Embed MAT Standards within practice in NHS Highland.	Mar 2025		

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

Performance Rating	Above trajectory
Latest Performance	4311
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	n/a
Position	n/a

Fig.1

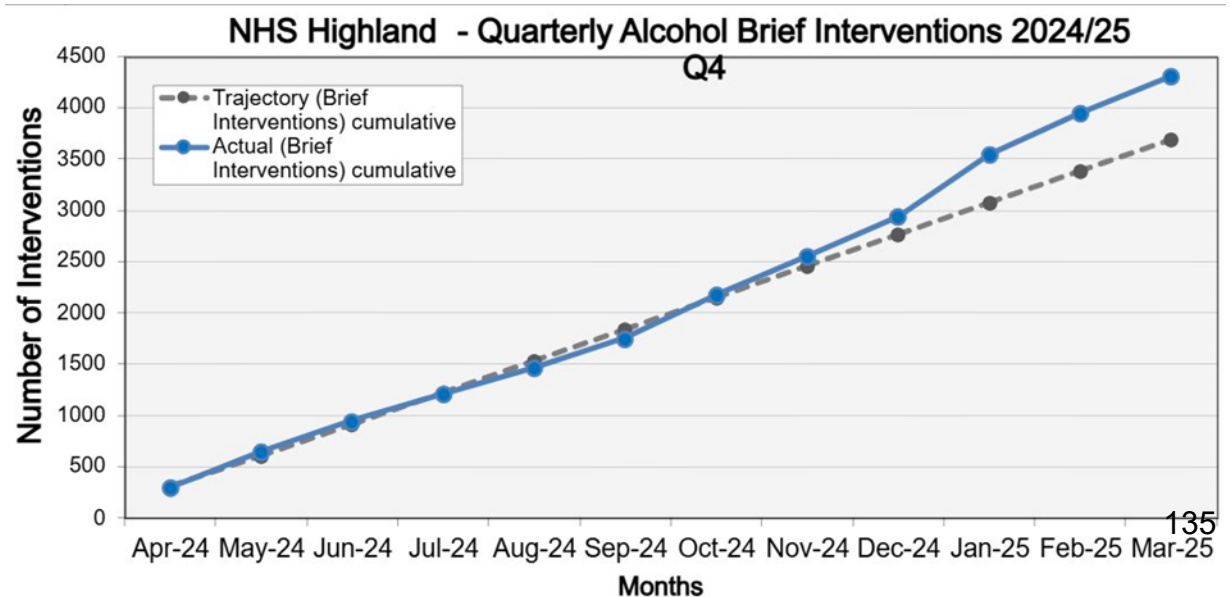

Fig.2

Setting Contribution in 2024/25

Primary Care	3989	92.5%
Antenatal	13	0.3%
Wider Settings	309	7.2%
TOTAL	**4311**	**100%**

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Exec Lead
Louise Bussell

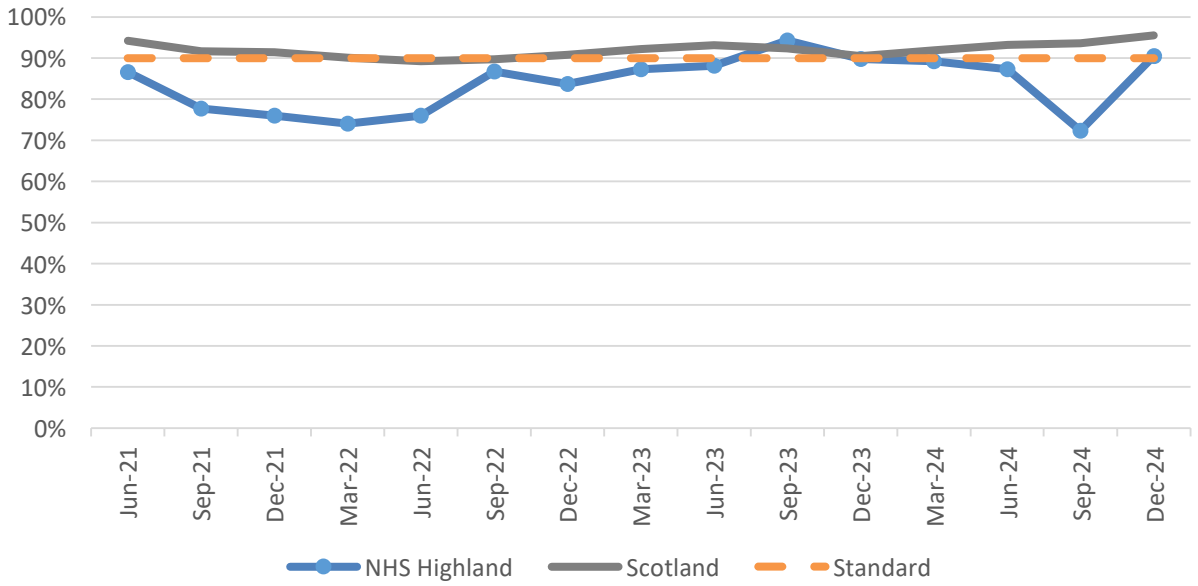
Drug & Alcohol Recovery

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance (Updated 3 March 25)	Plans and Mitigations
Drug and Alcohol Waiting Times from referral to treatment <21 days		Over the last 12 months, the proportion of patients waiting more than three weeks from referral to start of treatment has increased (62% HHSCP patients versus 14% Scottish average). 56% of HHSCP referrals to community-based services are being complete within 3 weeks, compared to a Scottish average of 94%. This is primarily due to staffing pressures and availability.	Ongoing work is being undertaken to maximise capacity and staffing stability in this area and improve treatment access through workforce planning.

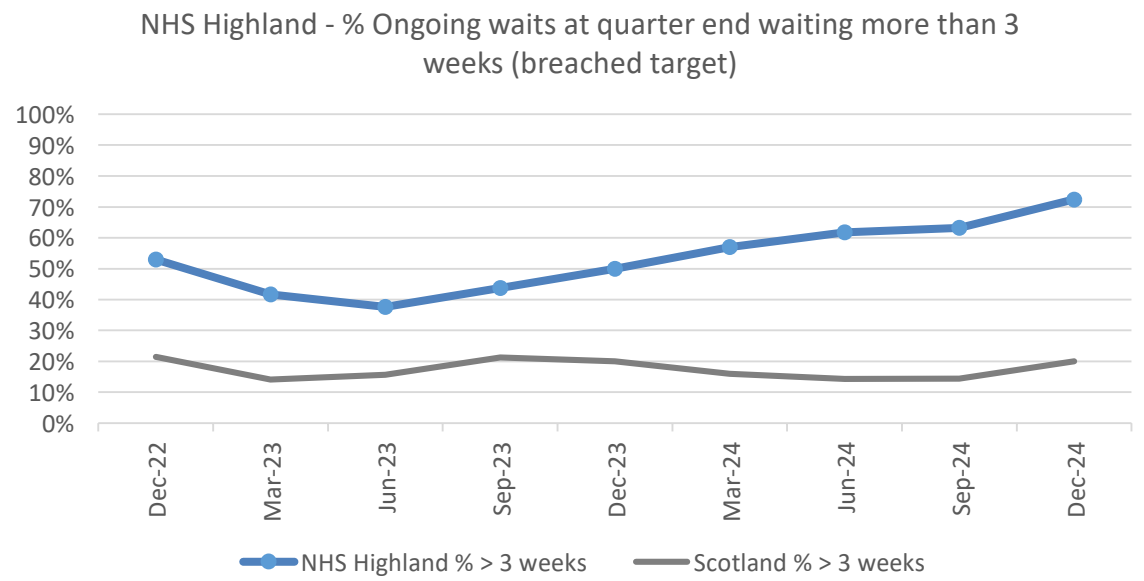
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Stay Well

Performance Rating	
Latest Performance	
National Benchmarking	n/a
National Target	90% DARS referrals seen within 3 weeks
National Target Achievement	n/a
Position	n/a

NHS Highland Performance Against Standard for Completed Waits



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



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Katherine Sutton
Chief Officer, Acute

Emergency Department Access

ADP Deliverables Progress as at End of Q4 2024/25	
ADP Deliverables superseded by Urgent & Unscheduled Care 90-day recovery mission, incorporating ADP actions in phased approach.	Oct 2024
Acute Front Door; Develop a range of pathways to reduce demand on in patient acute beds – in primary care and secondary care.	March 2025
Optimising Flow; Scope pathways and processes which support early diagnosis, promotion of realistic medicine and timely discharge from in-patient care for those requiring admission	March 2025
OPEL; Develop whole system OPEL collaboratively to respond when our services are experience pressures to manage and mitigate risk across all services	March 2025

Insights to Current Performance

From the most recent PHS figure, the NHS Highland 4-hour performance is 82.6%, against the Scotland figure of 70.6%.

Scottish Ambulance Service performance for patients conveyed within 60 mins is currently 75.8% (aim = 100%). The median turn-around time is just over 33 mins (33:12).

The percentage of patients waiting over 12 hours in ED has remained steady at around 3.0%, for all attendance types, since a high of 3.9% at the end of Dec-24. This equates to an average of 38 patients waiting over 12-hours.

Please note the data reported here is board-wide and significant pressures remain at Raigmore Hospital.

Plans and Mitigations

Second 90 Day Urgent & Unscheduled Care planning cycle has ended. The plan up to March 2026 has been developed through STAG and is reflected within our annual delivery plan. Our focuses will be:

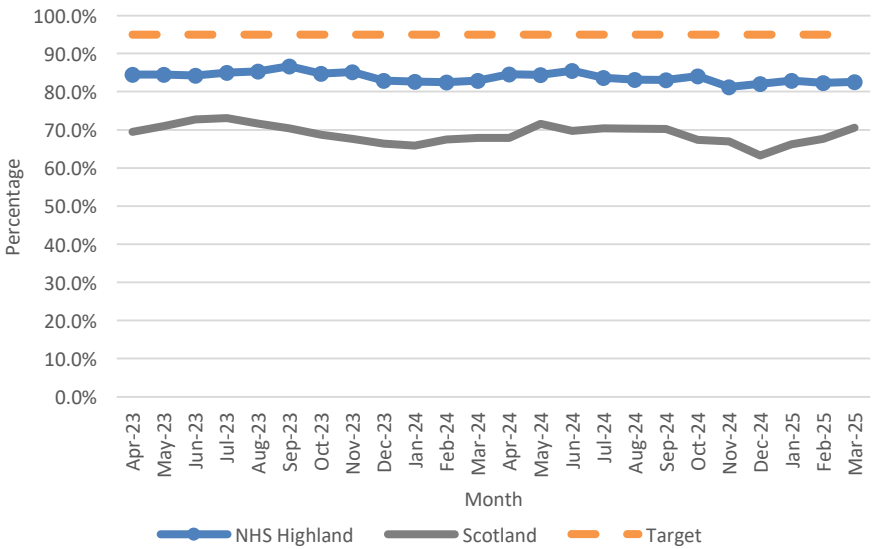
- Frailty
- Community Urgent Response
- ED Improvement plans
- Targeted pathway redesign
- Discharge without delay

Progress will continue to be reported regularly to EDG/STAG

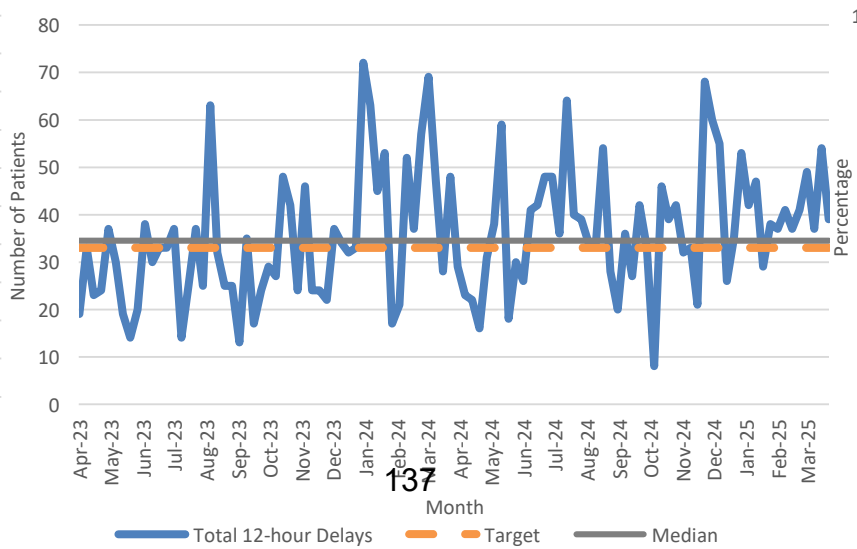
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Respond Well

Performance Rating	Decreasing performance
Latest Performance	82.6%
National Benchmarking	70.6% Scotland average
National Target	95%
National Target Achievement	NHS H as a whole remains above the Scotland average, but off target
Position	4th out of 14 Boards

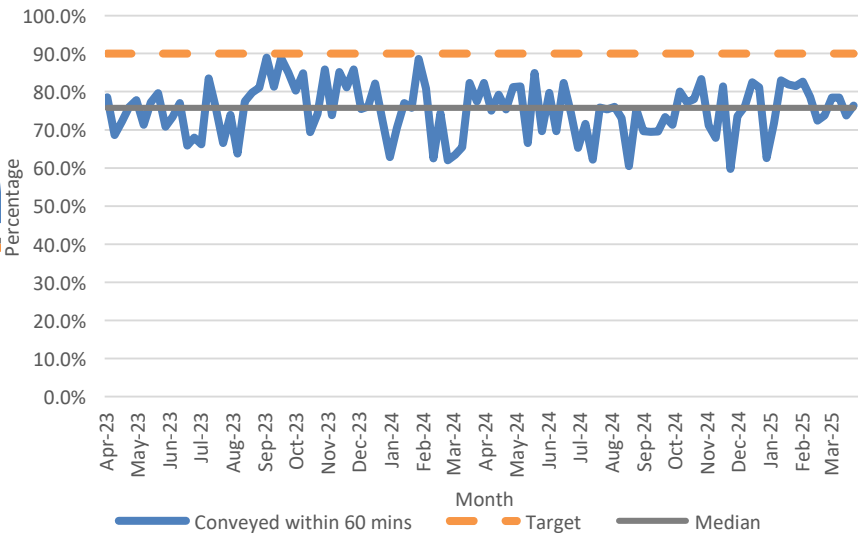
People seen in ED within < 4 hours (P)



Total Patients waiting > 12 hours in ED (Q)



Ambulance Handover < 60 mins (Q)



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Exec Lead
Katherine Sutton
Chief Officer, Acute

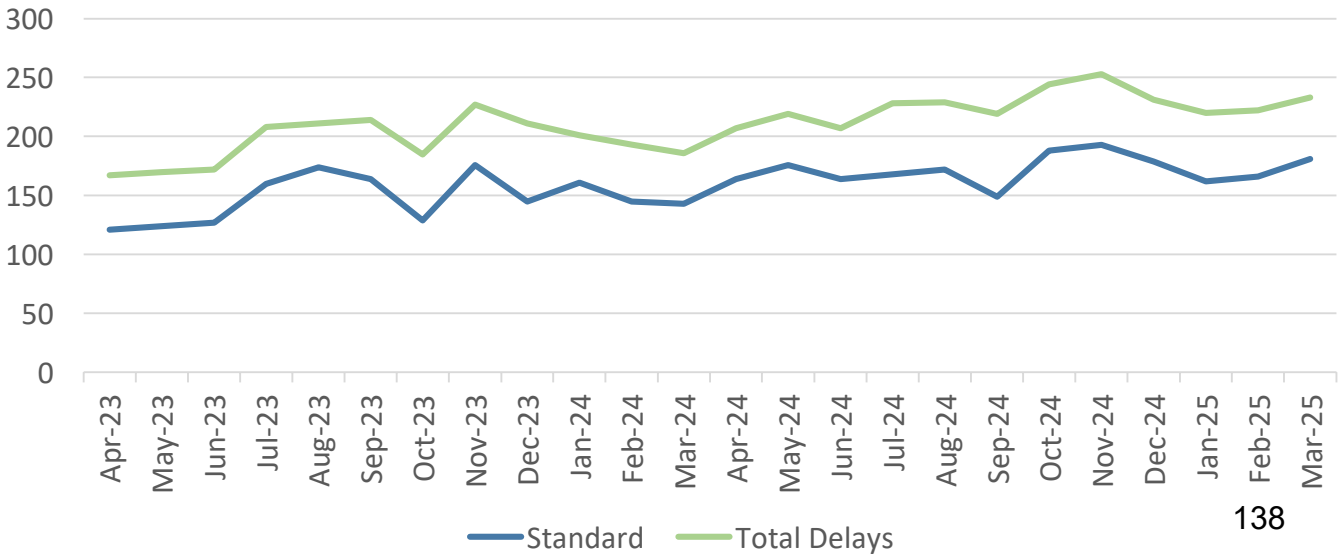
Delayed Discharges

ADP Deliverables: Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
ADP Deliverables underpinned by Urgent & Unscheduled Care 90-plan, incorporating ADP discovery work and delivery of ADP actions	Oct 2024	There has been an overall reduction in people affected by delayed discharge from a peak of 253 at the end of November 2024 to 233 by the end of March 2025 in Highland. There has been a reduction in "standard delays" and for "other" delay reasons. The main reasons for the reduction in the "other" reason category has been more assessments completed and a reduction in delays due to complex reasons - as this is a wide category, would require further analysis to identify any specific reason(s) Standard reasons have reduced across waits for nursing and residential homes and care at home services.	The Urgent and Unscheduled Care Programme, as agreed by STAG will focus on the following areas from now until March 2026: • Community Urgent Care Model • Emergency Department Improvement Plans • Discharge without Delay • Targeted pathway redesign A key metric for the programme is the reduction of delayed hospital discharges. In addition, a focused programme is being developed with managerial colleagues and professional leads focusing on improving decision making and allocation processes for adult social care which aim to reduce unmet need. This work has starting within the Inverness district with the care home allocation process and a targeted Care at Home plan..

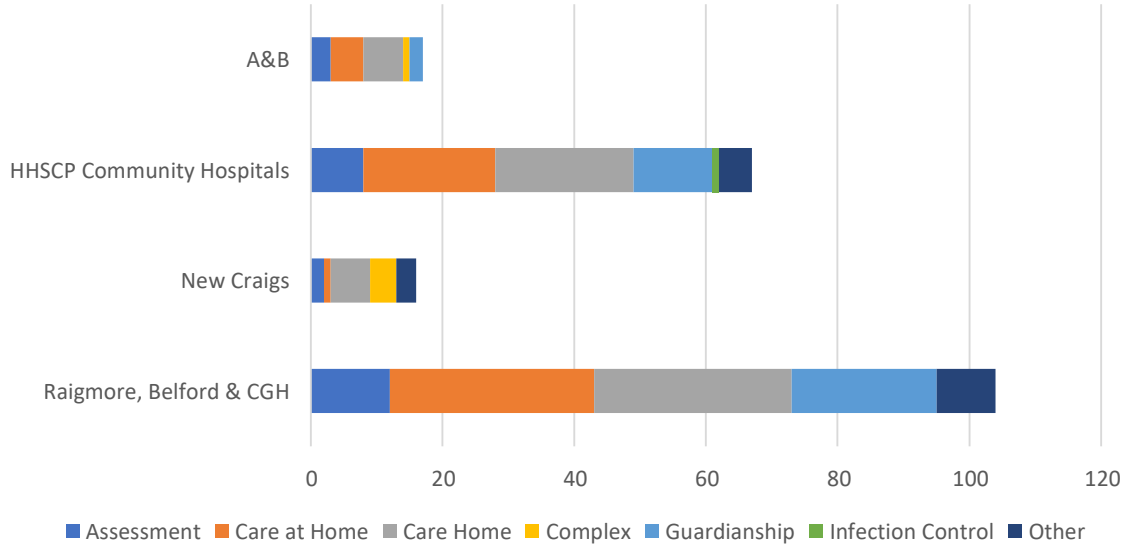
PERFORMANCE OVERVIEW
Strategic Objective: In Partnership
Outcome Area: Care Well

Performance Rating	Below trajectory
Latest Performance	233 at Census Point 6,969 bed days lost
National Benchmarking	Engagement through national CRAG group
National Target	30% reduction of standard delays from baseline
National Target Achievement	Not Met
Position	14th out of 14 Boards

Delayed Discharges at Monthly Census Point (P) - NHS Highland inc A&B



Delayed Discharge – Location and Code (P&Q)



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Outpatients (New Outpatients – NOP – seen within 12 week target) – Slide 1 of 2

ADP Deliverables Progress as at End of Q4 2024/25	
Increase in virtual appointments to improve efficiency and reduce travel associated.	Aug 24
Outpatient services immediate improvement plan including increasing the use of remote appointments, patient-initiated return, ACRT and rebase job plans	May 24
Utilise Patient Hub in acute settings to digitalise letters and reduction in use of consumables.	Mar 25
Implement the outcomes from work undertaken by the Centre for Sustainable Delivery / NECU in a planned and managed way across NHS Highland.	Mar 25

Insights to Current Performance

The number of NOP seen within 12 weeks is 61.1% which is above the Scottish average of 41.4%.

Reasons for level of performance include:

- Inconsistencies in the application of clinic booking processes and Patient Access Policy
- Approach to adherence to principles of WTG at service level.
- Approach to list management for long waits at service level
- Managing the efficient use of clinic rooms and spaces to correlate with clinic types, e.g. face to face clinics/NHS Near Me clinics/telephone clinics
- CfSD initiatives not fully embedded across all specialties. This will move further forward when eHealth systems can be updated to accept the required changes on TrakCare PMS
- Overall increasing numbers of NOP

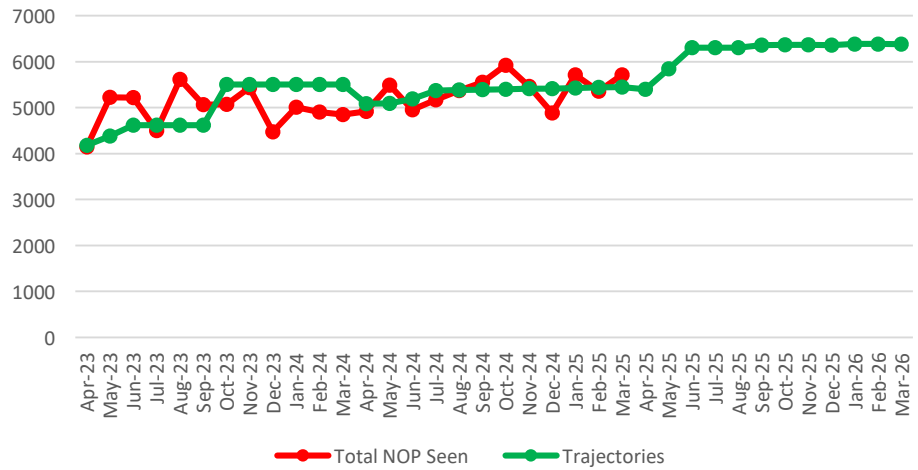
Plans and Mitigations

Further modification of referral pathways, working with Primary Care to manage demand more efficiently. Provide a better patient journey and supports the validation of waiting lists, ensuring that appropriate patients only are waiting to be seen. Use NECU admin. Validation with CfSD agreement.
Focus on the delivery of ISP continues, zoning in on core new outpatient activity and its close management. Shortfalls in core delivery are identified early and required delivery targets increased to address shortfalls quickly.
Continuous governance and management of allocated SG additional activity funds to target longest NOP waiter.
Robust patient access/WTG policy management with teams at all levels.
Additional clinic space identified and now in use for dermatology, progressing well.

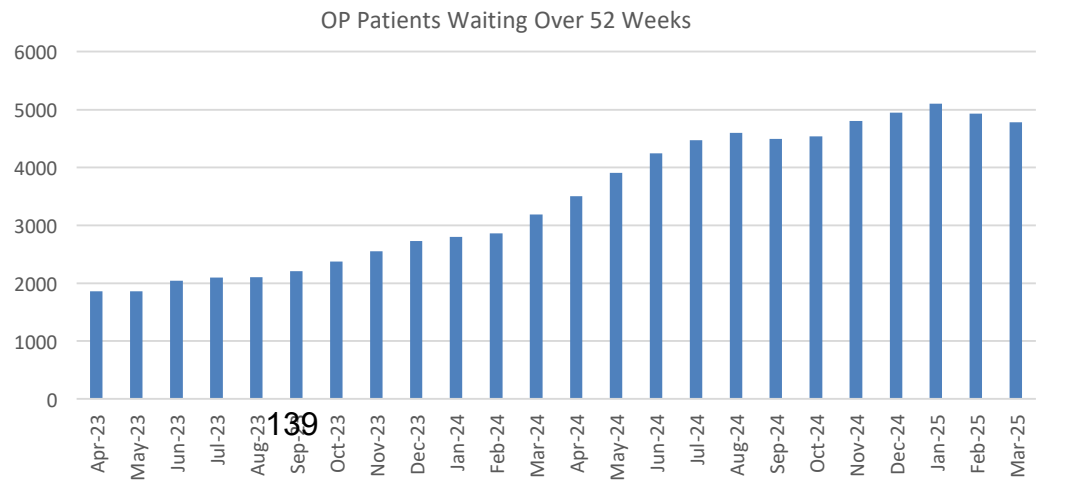
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	Decreasing performance but near Scotland average; activity levels above target
Latest Performance	61.1%
National Benchmarking	41.4% Scotland average
National Target	95%
National Target Achievement	Target not met Below lower control limit
Position	10th out of 15 Boards

Patients Seen & Trajectories (P)



Target 3 – Long Waits



Target 2 – ADP Target

Yearly Trajectory	64,045
YTD Performance	64,045 (100%)
Patients Seen – Mar 25	64,484 (100.69%)
Overall	0.69% above target

Outpatients (Delivery Plan and Long Waits) - Slide 2 of 2

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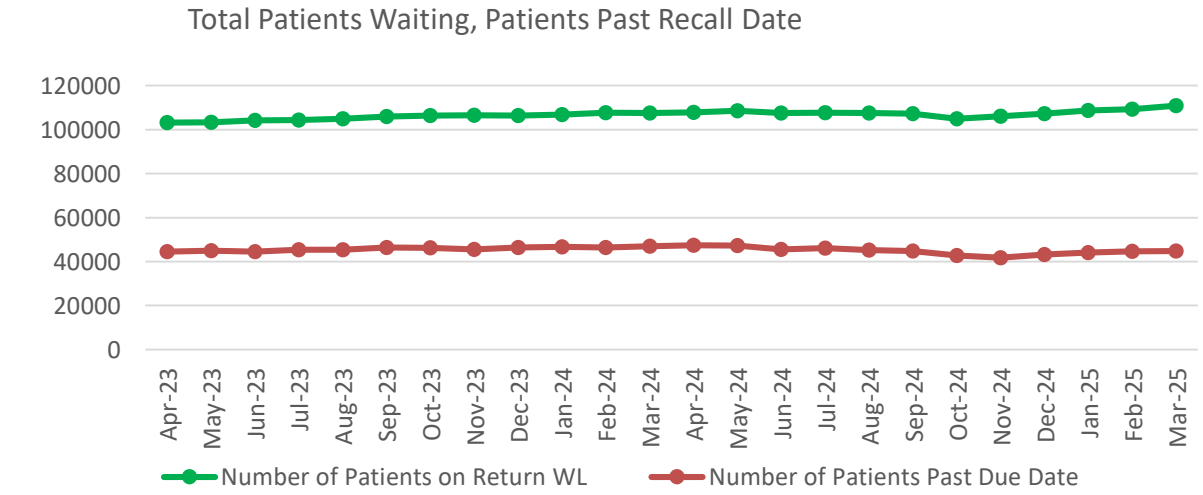
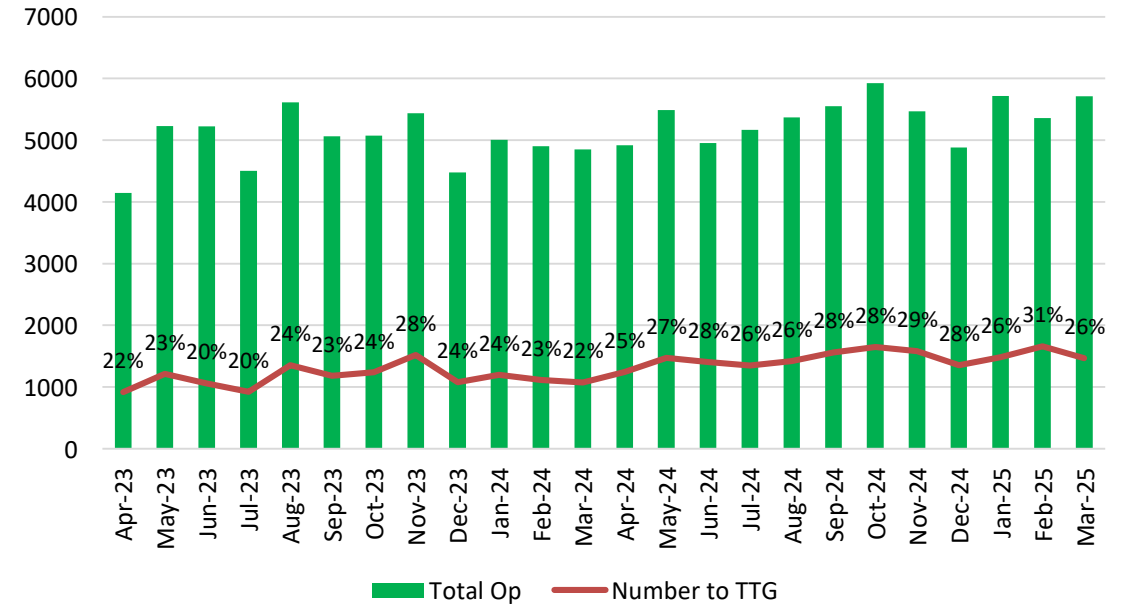
Chief Officer, Acute

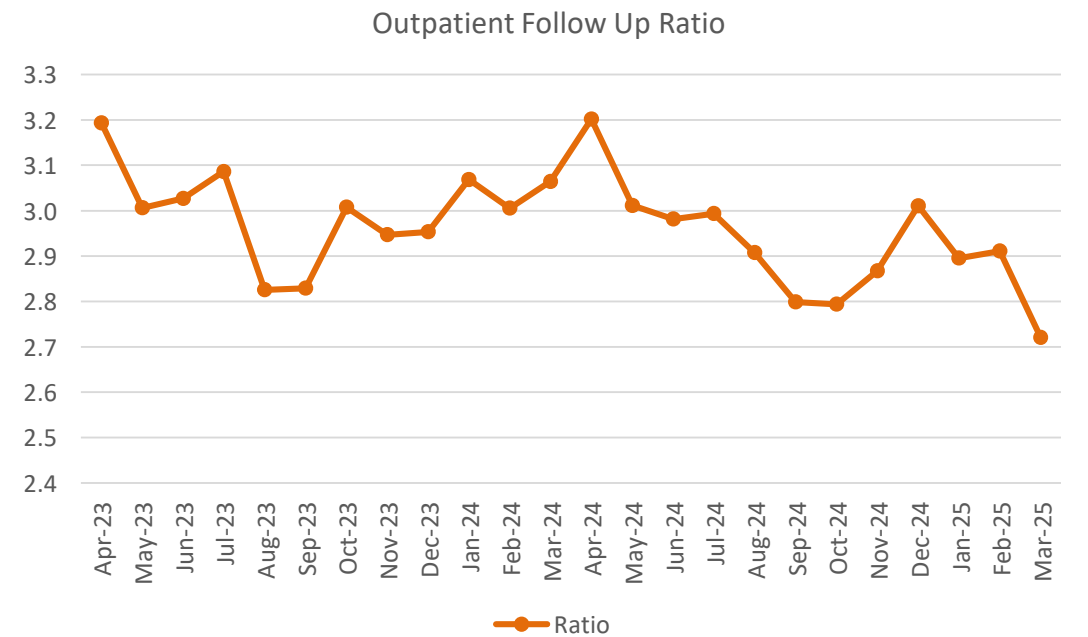
Return Outpatients Wait List (P)



OP Conversion Rates to TTG (Q)



Follow Up (Q)



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Chief Officer, Acute

Treatment Time Guarantee: TTG < 12 week target

ADP Deliverables Progress as at End of Q4 2024/25	
Reduction in number of procedures of low clinical value	Aug 24
Implement the outcomes from work undertaken by the Centre for Sustainable Delivery / NECU	Mar 25
Review of SLAs in Acute for patients who travel out with the board for treatment	Mar 25
Increased theatre productivity (national target 90%) by utilising new processes including optimising the use of digital tools that are available within NHS Highland and exploring further opportunities, utilising available resource.	Mar 25
Local improvement plans in place for all Acute fragile services working collaboratively with the national clinical sustainability reviews	July 24
Continue to maximise the opportunities of the NTC with partner boards	Mar 25

Insights to Current Performance

- Increasing demand and complexity.
- Lack in some specialties of workforce to deliver care pathways.
- Patients referred into services with long waits who may realise better outcomes if care managed in primary care.
- Currently behind on TTG however confident that we can turn this around with focus on long waiting patients along with the use of the RGH capacity.

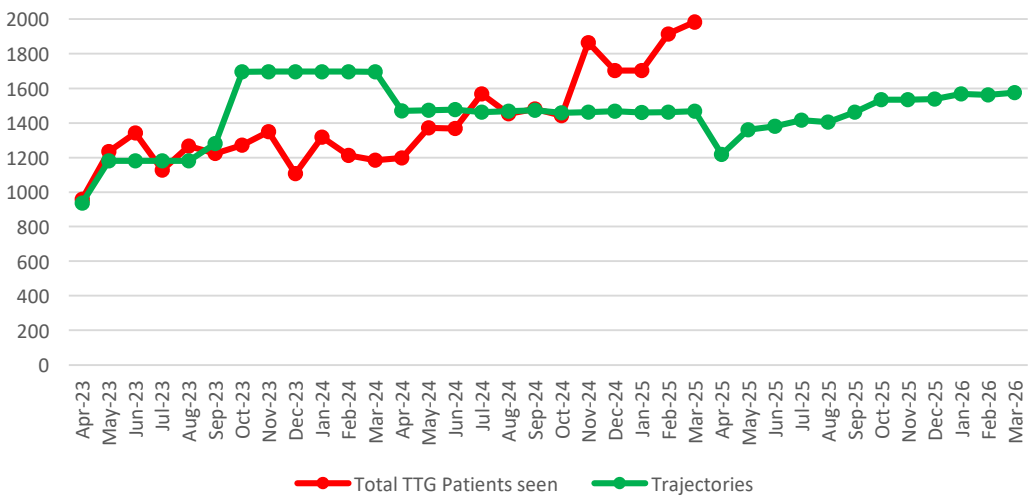
Plans and Mitigations

- Service planning implemented through ISP workstreams to realise efficiencies in process and alternative workforce models.
- Implementation of CfSD initiatives.
- Awareness and delivery of new WTG to ensure that only those who are fit, willing, and able are on a waiting list.
- Review of waiting list management processes
- Delivery of NHSH waiting times dashboard to support appropriate management of care pathways.

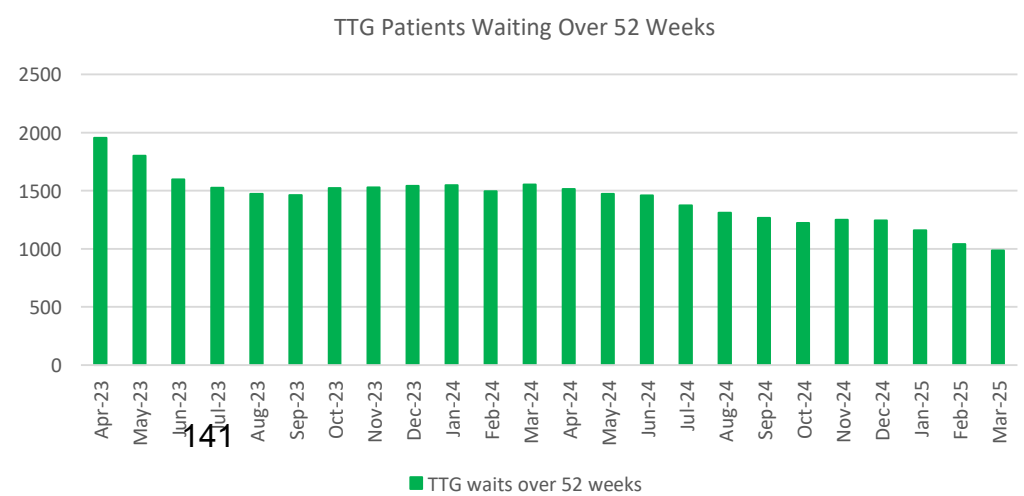
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	0.02% below ADP target
Latest Performance	65.4%
National Benchmarking	56.3% Scottish average
National Target	100%
National Target Achievement	Target Not Met; Above median for 1 month after 2 below
Benchmarking	5th out of 15 Boards

Patients Seen & Trajectories (P)



Long Waits (P&Q)



ADP Targets (P)

Yearly Trajectory	17,603
YTD Performance	17,603 (100%)
Patients Seen – Mar 25	19,048 (108.21%)
Overall	8.21% above target

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Katherine Sutton
Chief Officer, Acute

Diagnostics - Radiology

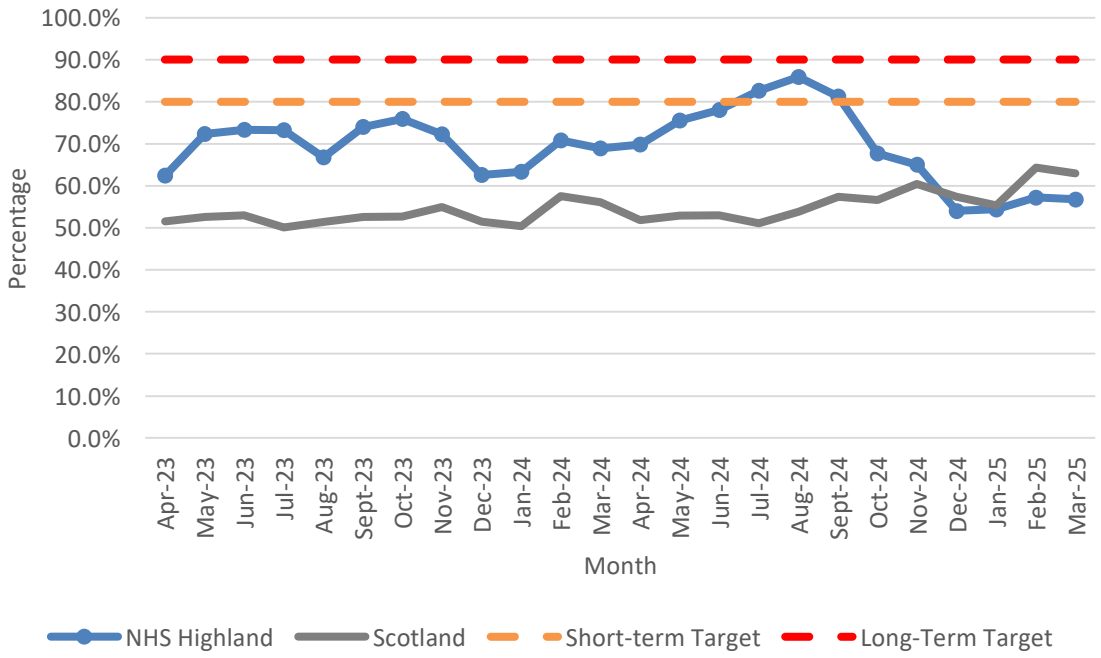
ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plan and Mitigation
Create a value-based diagnostic plan for NHS Highland through understanding delivery models and utilising a shared decision-making approach. Prioritised understanding and improvement plan for diagnostic capacity for USC and surveillance.	Mar 2025	Current performance is meeting planned trajectories. Unplanned demand remains fairly constant.	A workshop was held Dec 2024 to identify areas of improvement. Priorities for 2025/26s: • Review radiology admin team(s) incl booking • Review and streamline IR(ME)R admin processes • Replace Radiology Information System (RIS) • Upgrade PACS (national approach) • Implement TrakCare Order Comms for secondary care requests (Raigmore and L&I hospital)

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

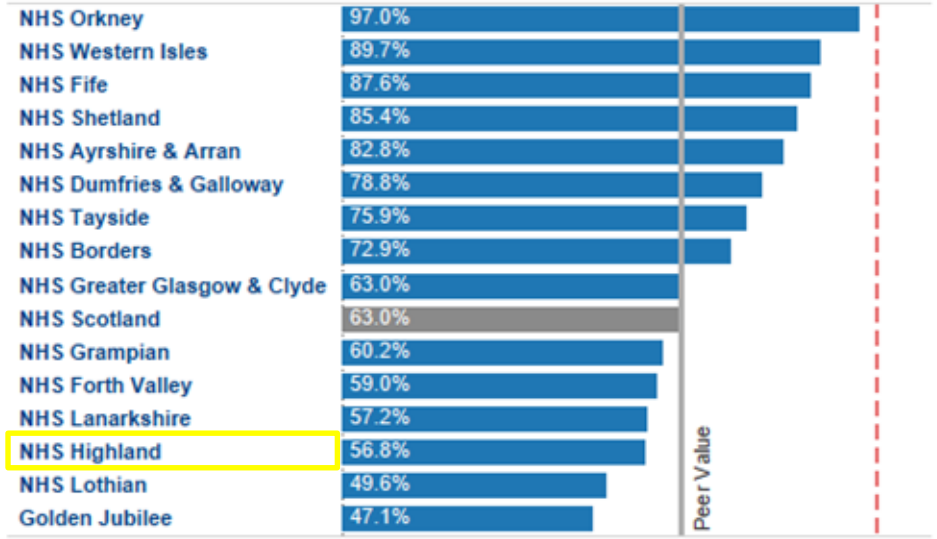
Performance Rating	1.19% below ADP
Latest Performance	56.8%
National Benchmark	63.0%
National Target	80% (Short-term) 90% (Long-term)
National Target Achievement	National target not met, performance in NHSH is below Scotland average
Benchmarking	13th out of 15 Boards

Imaging Tests: Maximum Wait Target 6 Weeks

Yearly Trajectory	YTD Target	Patients Seen- Mar 25	Overall
33,229	33,229 (100.00%)	32,752 (98.56%)	-1.44% Below target



Benchmarking with Other Boards



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Chief Officer, Acute

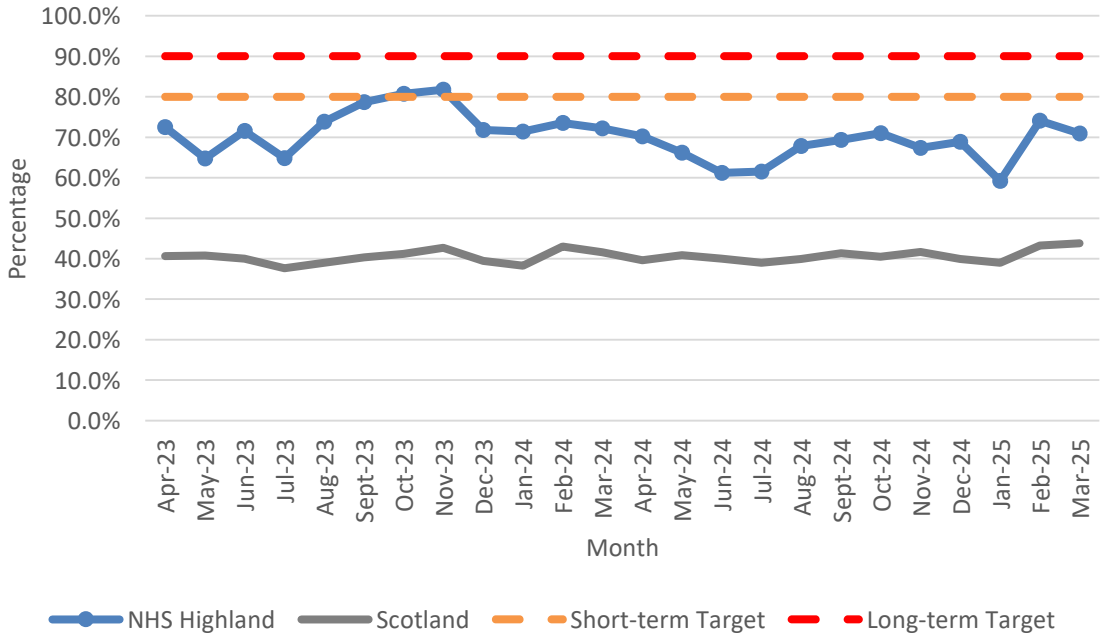
Diagnostics - Endoscopy

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plan and Mitigation
GI Endoscopy – on track Cystoscopy – recovery plan and strategic plan to be developed. Medilogik EMS to be used for all Cystoscopy procedures from 1st February 2025		TrakCare PMS to be reconfigured to measure waiting time rules against national 42-day target rather than local 28-day standard. This would provide a true reflection of current performance.	GI Endoscopy now in strong position, surveillance backlog reduced to just two months across Highland. Next step to reduce new urgent and routine wait. Cystoscopy – appointment type review to be completed

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

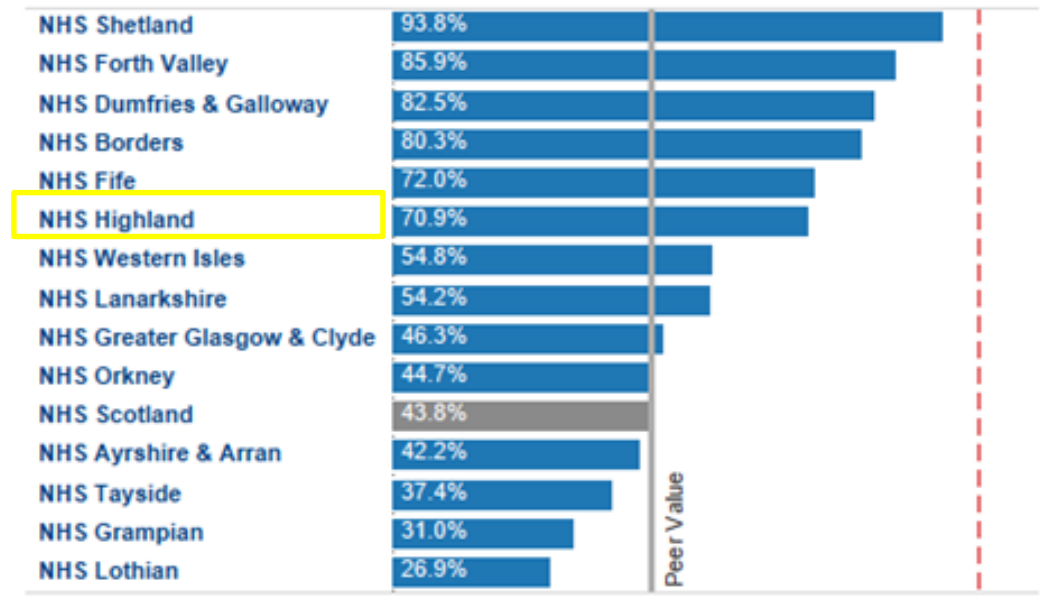
Performance Rating	Meeting ADP Target
Latest Performance	70.9%
National Benchmark	43.8%
National Target	80% (Short-term) 90% (Long-term)
National Target Achievement	While national target not met, performance in NHSH is ahead of Scotland average
Benchmarking	6th out of 14 Boards

Endoscopy Tests: Maximum Wait Target 6 Weeks



Yearly Trajectory	YTD Target	Patients Seen - Mar 25	Overall
6,576	6,576 (100.00%)	6,866 (104.41%)	4.41% over target

Benchmarking with Other Boards



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Katherine Sutton
Chief Officer, Acute

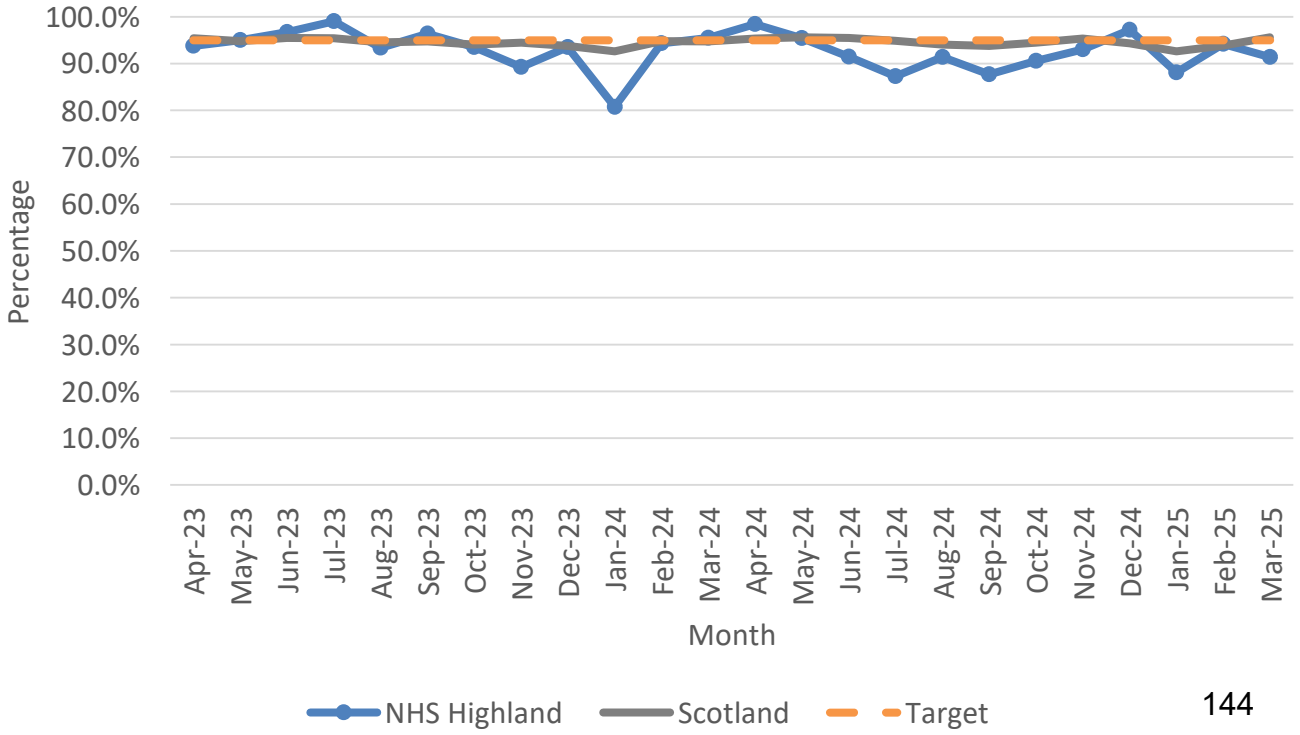
31 Day Cancer Waiting Times

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plan and Mitigations
Implement the local actions identified to meet the Framework for Effective Cancer management	Mar 25	Increasing demand and lack of workforce to manage / deliver **oncology** services. "Batching" of mutual aid for Breast assessment leading to peak in surgery Performance most recently improved to above the required 95% standard.	Breach analysis of every patient to learn lessons, on-going. 1. Additional Operating availability for Urology and 2. Mutual aid for Breast assessment & treatment w/c 28 Oct from FV 3. CRC Oncology Mutual Aid from 15/12
Implement review of Breach Analysis areas e.g. Breast, Renal, Bladder & Colorectal to understand issues re 31/62 day targets	Mar 25		

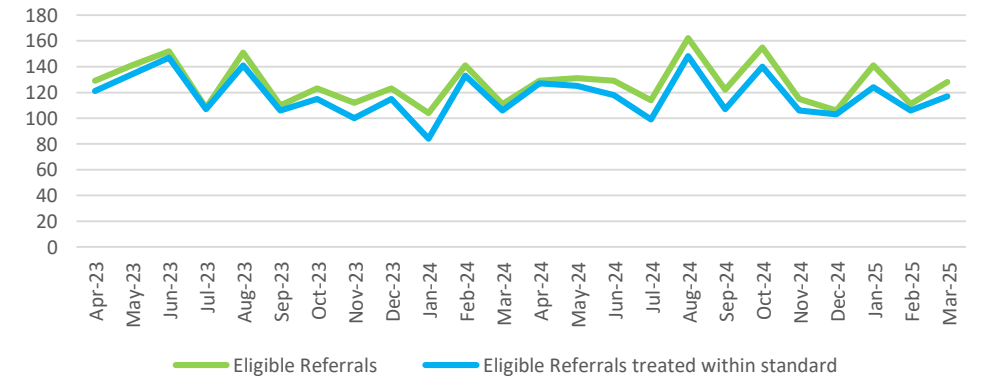
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	Below natonal average
Latest Performance	91.4%
National Benchmarking	95.6% Scotland average
National Target Achievement	Last met in December 2024
Position	14th out of 14 Boards

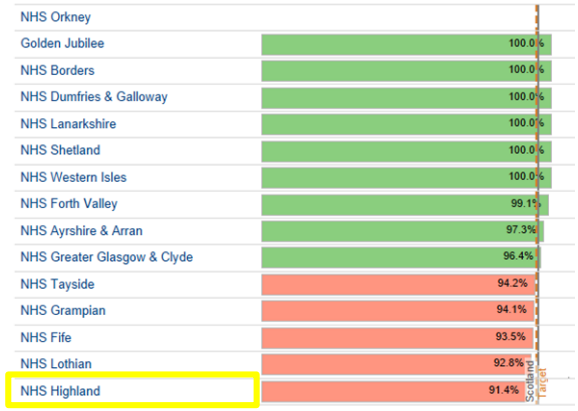
31 Day Cancer Waiting Times



Patients Seen on 31 Day Pathway



31 Day Benchmarking with Other Boards



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Chief Officer, Acute

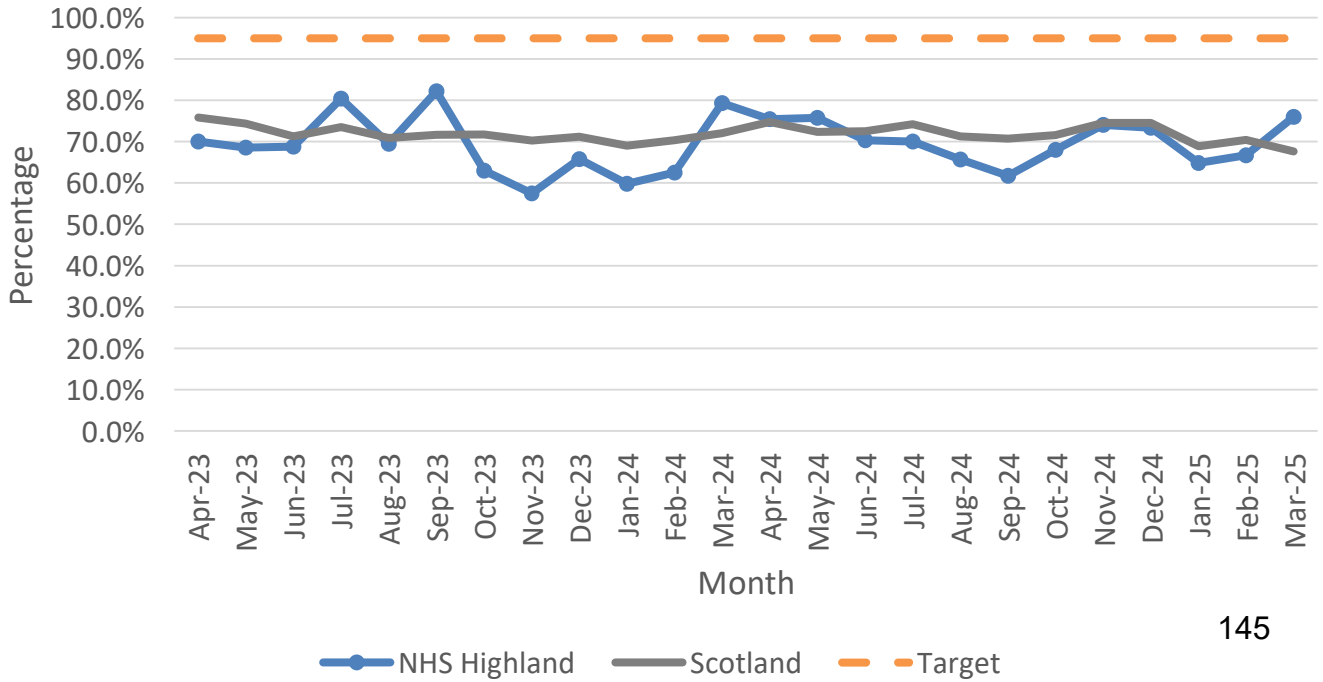
62 Day Cancer Waiting Times

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
Develop a collaborative plan aligned to the Diagnostics workstream of rapid cancer diagnostic pathways across our system. Consider capacity and demand for cancer surveillance	Sept 24	The total number of patients receiving treatment increased over the last 3 months. 50% of Problem - Breast One Stop Assessment capacity only meeting 50 per cent of demand due to lack of radiology support. Recurring aid requested from FV pending establishment of Con Radiographer model.	Improved implementation of national guidance (FECM) and learning lessons from Lanarkshire. Establishment of Cancer Performance & Delivery Group Recurring and frequent support from Forth Valley Breast Team
Engage with Maggie's Highland and other programmes of work focussing on the prehabilitation-rehabilitation continuum.	Mar 25		
Continue to deliver our Single Point of Contact programme of Community Link Workers and embed them within the Highland Health and Social Care Partnership.	Mar 25		

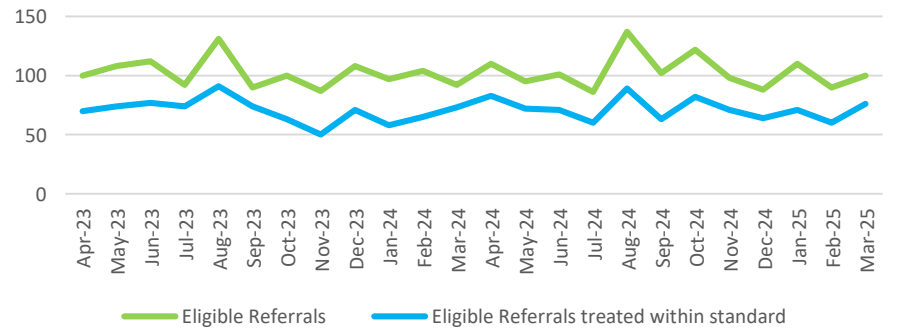
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	Above national average
Latest Performance	76.0%
National Benchmarking	67.6% Scotland average
National Target	95%
National Target Achievement	Nationally target not achieved in some time
Position	2nd out of 13 Boards

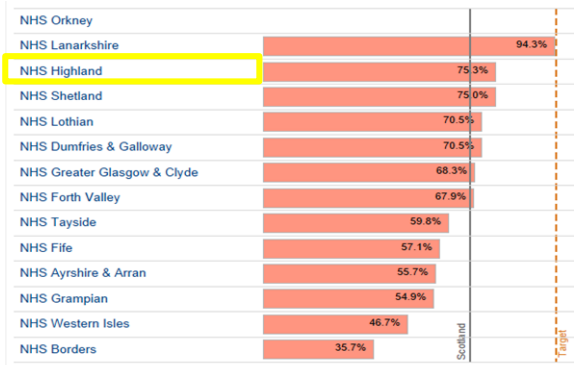
62 Day Cancer Waiting Times



Patients Seen on 62 Day Pathway



62 Day Benchmarking with Other Boards



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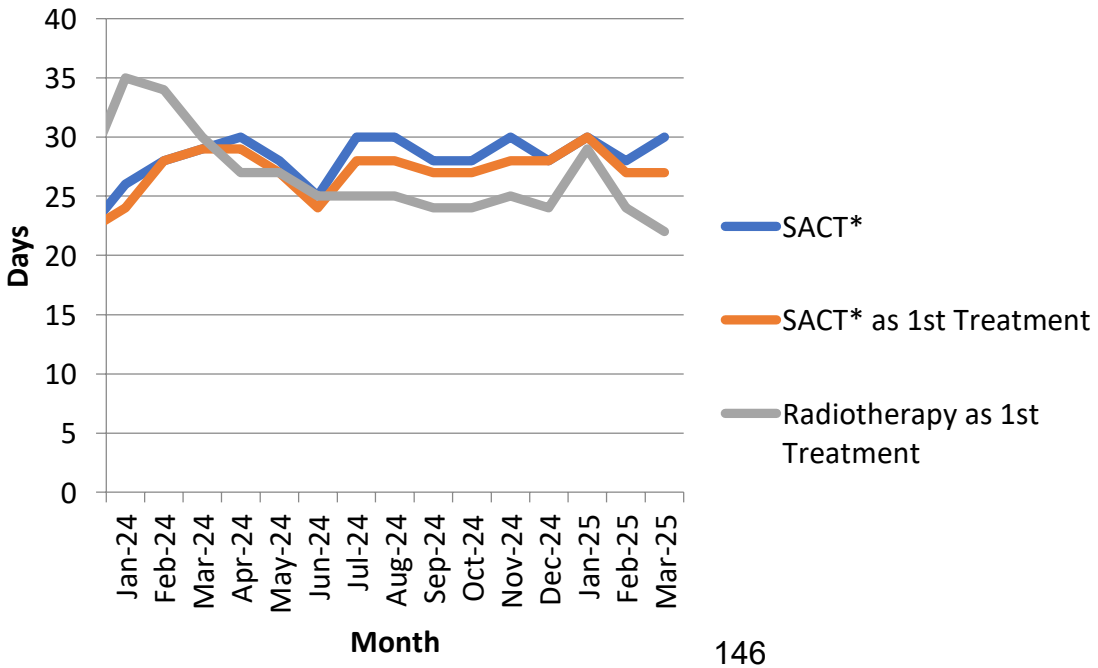
Chief Officer, Acute

SACT Access and Benchmarking

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
Moving towards networked delivery of Oncology & SACT services aligned to developing national strategy	Mar 25	Waiting times to start SACT and Radiotherapy treatment remain stable in 2024 following a sharp increase in recent years. The service is very much dependent upon senior clinicians to prescribe and trained nurses to administer. The latter position has improved with 2 additional nurses in post and 1 additional nurse being interviewed This is against a backdrop of increasing number of patients being treated in Highland, mirroring the national trend.	Development of national oncology target operating model to improve Oncologist capacity initially Appointment of 3rd additional SACT trained nurse. Review of the national cancer actions underway. Gap analysis report in creation to go to Cancer Strategy Board for review and prioritisation.
Moving, where clinically appropriate, from IV to oral medications through learning from other cancer networks.	Mar 25		
Localised immediate improvement plan to reduce reliance on locum / agency staffing for non-surgical cancer treatment	Mar 25		

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	Waiting times decreased
Latest Performance	24-29 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 – Waiting Times



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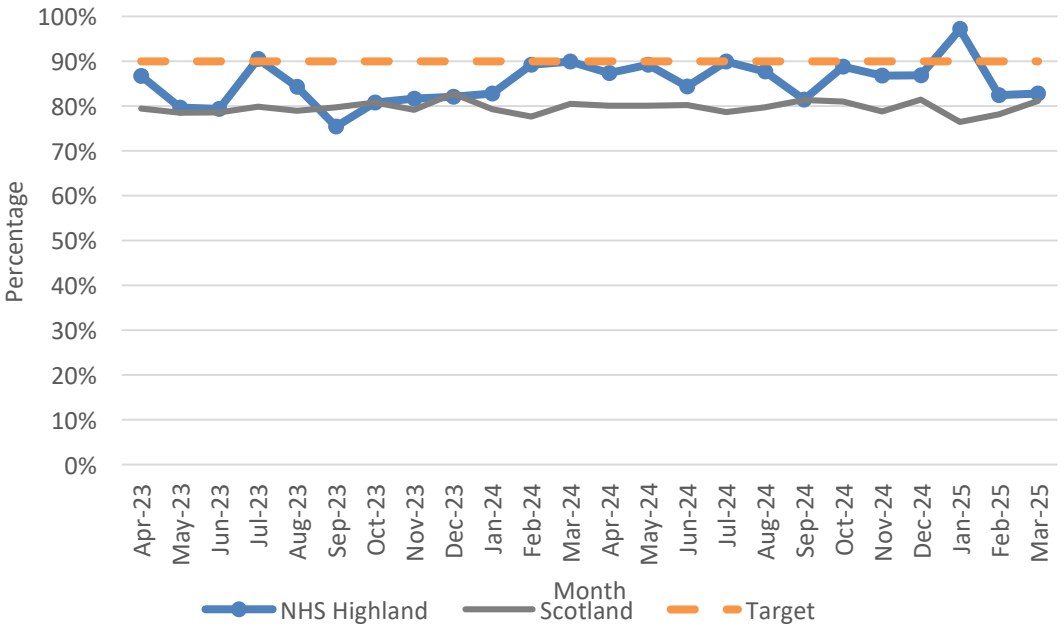
Psychological Therapies Waiting Times

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plan and Mitigations
Implementation of Psychological Therapies Local Improvement Plan with a focus on progressing towards achieving the 18-week referral to treatment standard. Targets and trajectories will be developed and be part of our performance monitoring as part of NHS Board Delivery Framework expectations	Mar 25	Scottish Government response to PT Improvement Plan submission confirmed that NHSH PT no longer require enhanced support from SG due to the recent performance improvement in 2024.	• The Psychological Therapies Steering Group is currently under review as we will be aligning it with the requirements of the PT National Specification • Our data dashboard has been developed to reflect the KPIs identified and those required for reporting to Scottish Government. • The development of our digital dashboard and data gathering activities has allowed us to utilise intelligence proactively to improve waiting times.

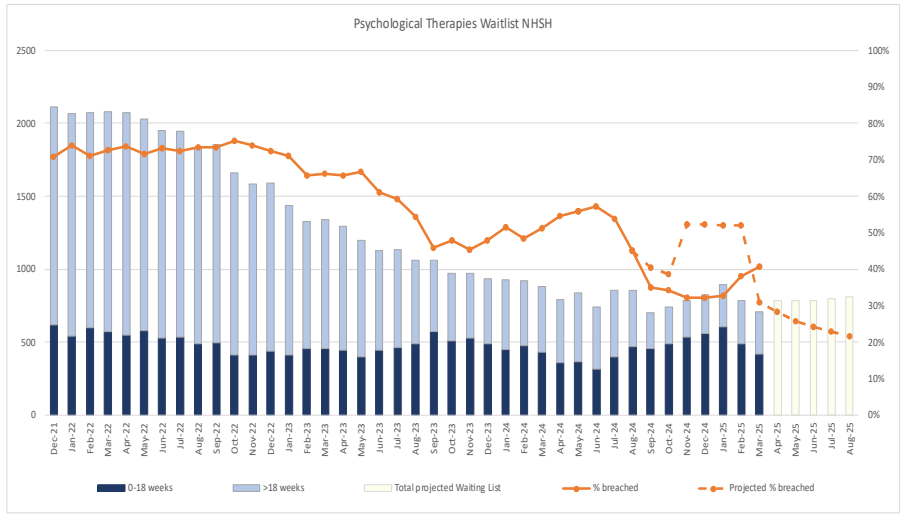
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	Below target but performance improved
Latest Performance	82.8%
National Benchmarking	81.2% Scotland average
National Target	90%
National Target Achievement	Consistent improvements in targets and downward trajectory
Position	4th out of 14 Boards

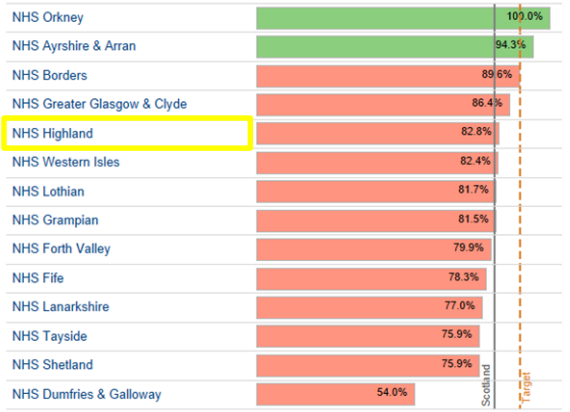
Patient seen < 18 weeks



Waiting List Size



Benchmarking with Other Boards



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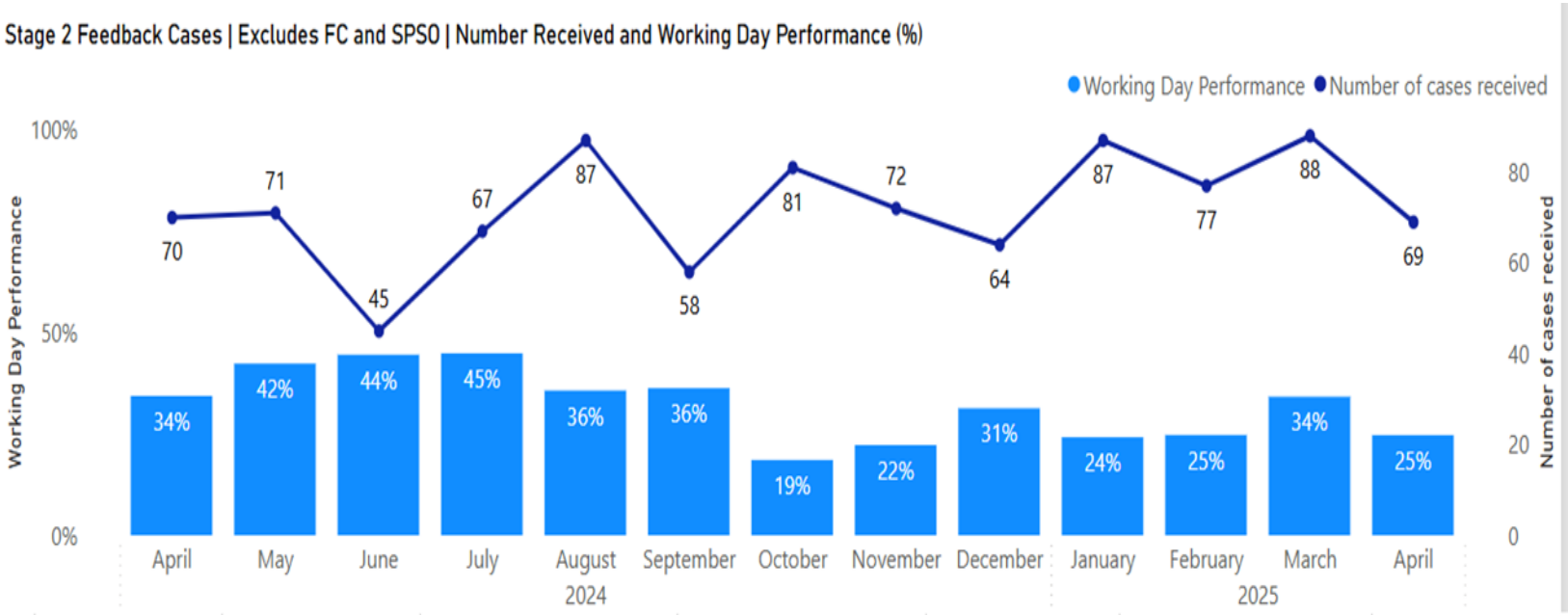
Stage 2 Complaint Activity (April 2024 – April 2025)

ADP Deliverables Progress as at End of Q4 2024/25	Insights to Current Performance	Plans and Mitigations
N/A	Continued poor performance against the 20 working day target. The Services to receive most complaints over the past 2 months are: GP Services (Non-salaried) Adult Psychiatry Orthopaedics	Reporting to EDG and escalation via the Board Medical and Nurse Director Introduced case management within Feedback from May 2025 team to improve oversight of each complaint. Review of other escalation routes including requesting specific timescales from OUs when hold letter is sent

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

Performance Rating	
Latest Performance	25%
National Benchmarking	None
National Target	60%
National Target Achievement	
Position	



Top Issue Categories/Last 3 months	Acute	HHSCP	A&B
Treatment	**35**	**21**	**9**
Poor Care	17	12	4
Poor Nursing Care	6	1	1
Delays with investigation/test results	4		
Poor Co-ordination/Aftercare	3	3	1
Delays in Diagnosis/Treatments	2	2	1
Problems with medication or prescribing	2	3	
Treatment/Investigations carried out poorly	1		
Problems with Test Results			1
Wrong Diagnosis/Treatment			1
Communication	**26**	**18**	**5**
Patient/carers not given full information	16	8	2
Insensitive Information	3		1
Patient/carers not fully involved in treatment decisions	3	6	1
Poor communication between professionals/staff	3	2	
Breach of Patient Confidentiality	1	2	1
Waiting Times / Delays	**12**	**2**	**2**
Outpatient	10	2	2
Day Case	1		
Inpatient	1		

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SPSO Activity (May 2024 – May 2025)

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
N/A		Slight decrease in the number of enquiries from the SPSO. Reassuring that most complainants are content with their response, Continuing trend that most cases are not taken forward.	SPSO cases are being closely monitored and reported through 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

SPSO cases received last 3 months:
8 received:

- 3 Acute
- 3 A&B
- 2 HHSCP

These relate to Mental Health Services - Community Mental Health, Clinical Psychology, Adult Psychiatry, Child and Adolescent Mental Health, Dental Services - Public Dental Services, Cancer Services - Oncology, Outpatients, Surgical - Orthopaedics

SPSO cases closed last 3 months:
10 SPSO enquiries closed.

- 6 not taken forward / 1 Investigation Report
- 1 Fully Upheld, 1 Partially Upheld, 1 Not Upheld

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Level 1 SAERs Declared and Status Overview (May 2024 – May 2025)

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
N/A		10 SAERs are over 26 week target. 76 SAER actions are overdue	A gap analysis has been undertaken against the New national framework and Board's current policy and procedures. This is being presented to the Professional Leads Oversight meeting in July. Open reviews and actions are monitored by the QPS groups in each Operational Area. Revised assurance report being developed based on the Vincent Framework and will be issued in the next two months. This will include SAER performance.

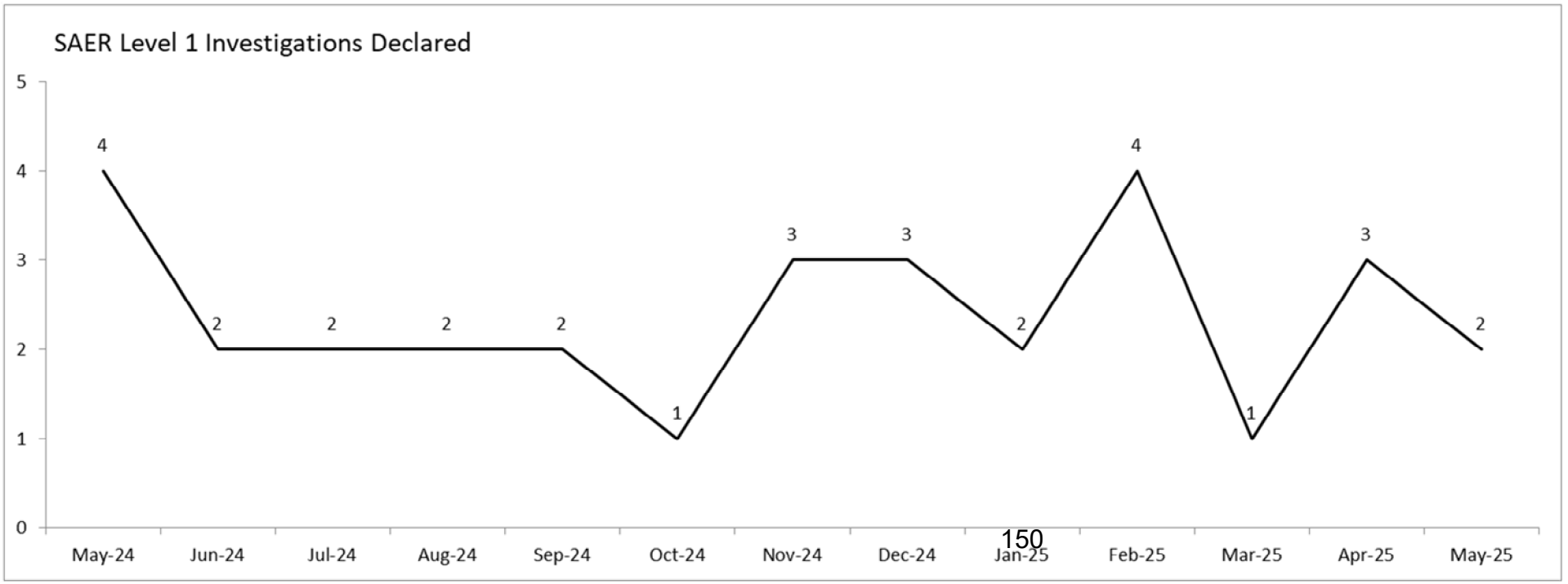
PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	
National Benchmarking	
National Target	
National Target Achievement	
Position	

25
Open Level 1 (L1) Incidents

10
L1: Active more than 26 weeks

31
L1: SAER Declared Last 13 Months

0.20%
Incident | SAER Conversion Last 13 Months



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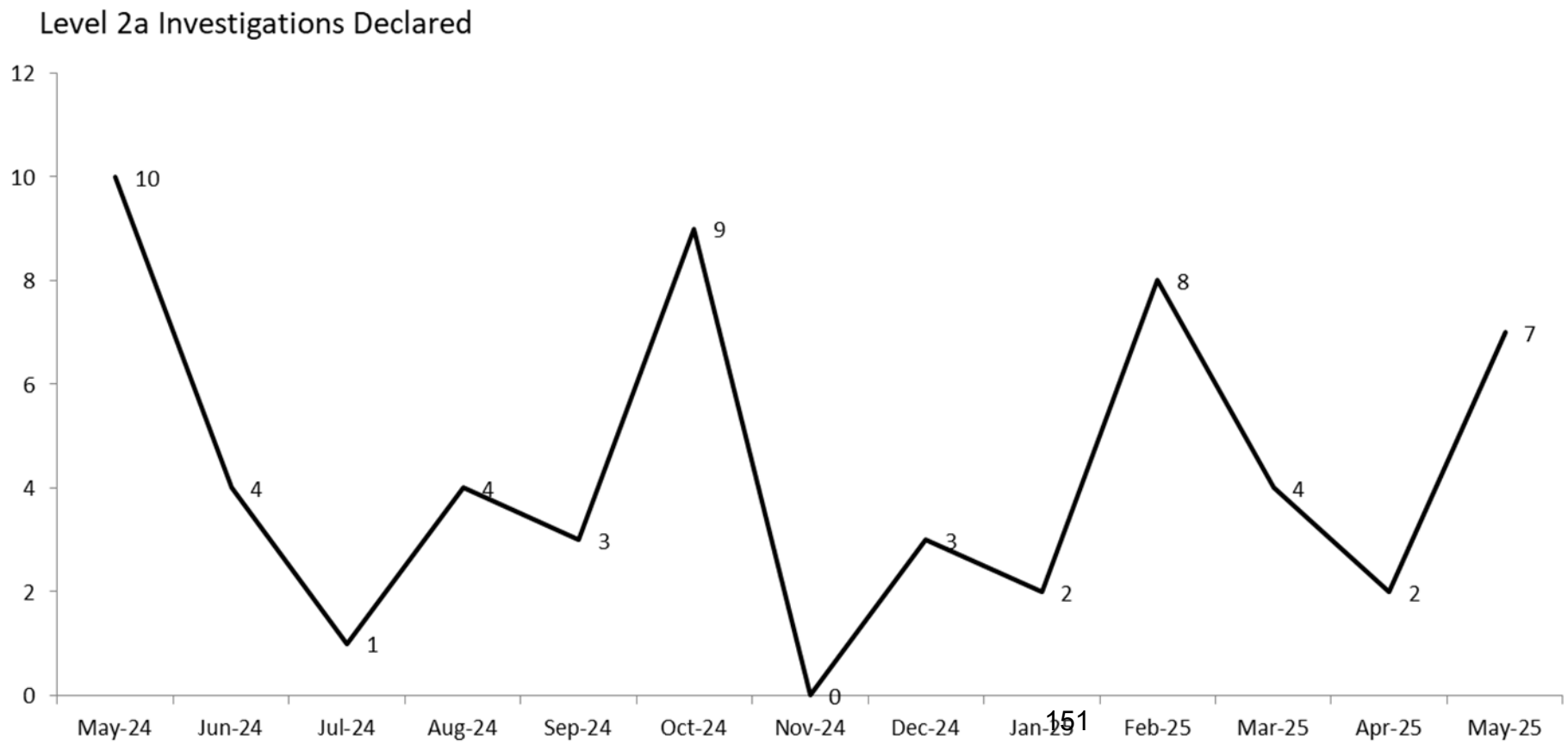
Level 2a Declared and Status Overview (May 2024 – May 2025)

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
N/A		24 Level 2a reviews are over 12 weeks. There are 34 actions open, with 26 being overdue.	Open reviews and actions are monitored by the QPS groups in each Operational Area. Revised assurance report being developed based on the Vincent Framework and will be issued in the next two months. This will include 2a reviews

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

Performance Rating	
Latest Performance	
National Benchmarking	
National Target	
National Target Achievement	
Position	



54

Open Level 2a (L2) Incidents

46

L2: Active more than 12 weeks

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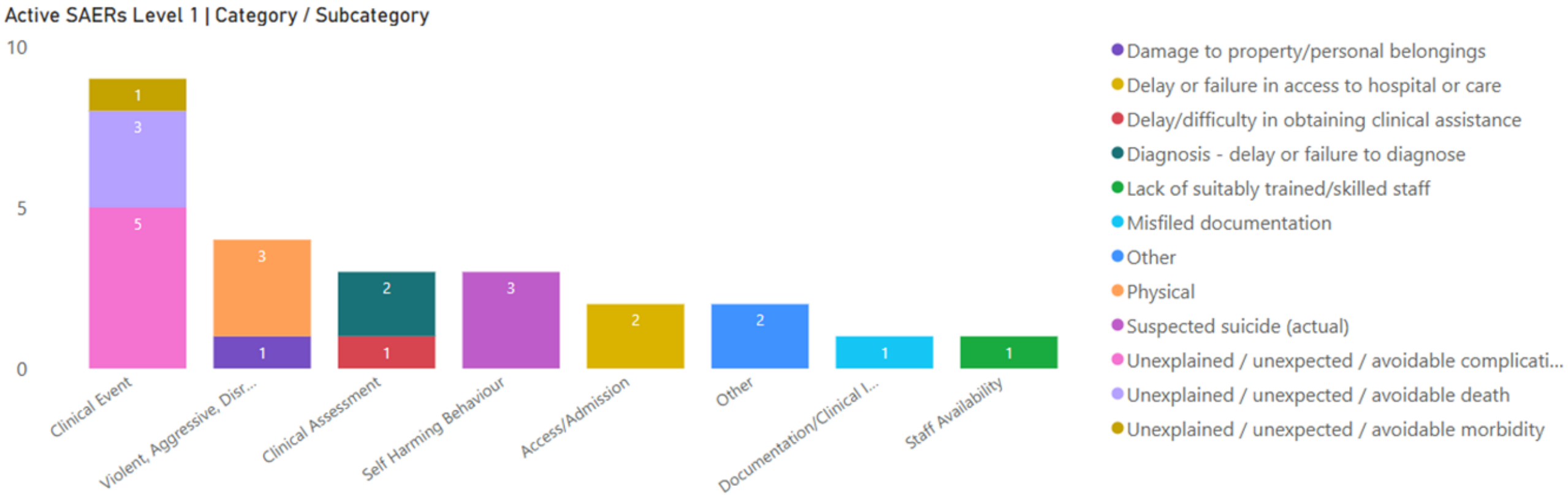
Active (open) Level 1 SAERs | Categorisation (May 2024 – May 2025)

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
N/A		The categories of SAER are varied. Most fall under clinical care followed by suicide.	A review of SAER categories is being undertaken as part of the review of Boad's adverse Event Policy and Procedures. Suggested SAER categorisation is going to be discussed at the professional leads meeting. .

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



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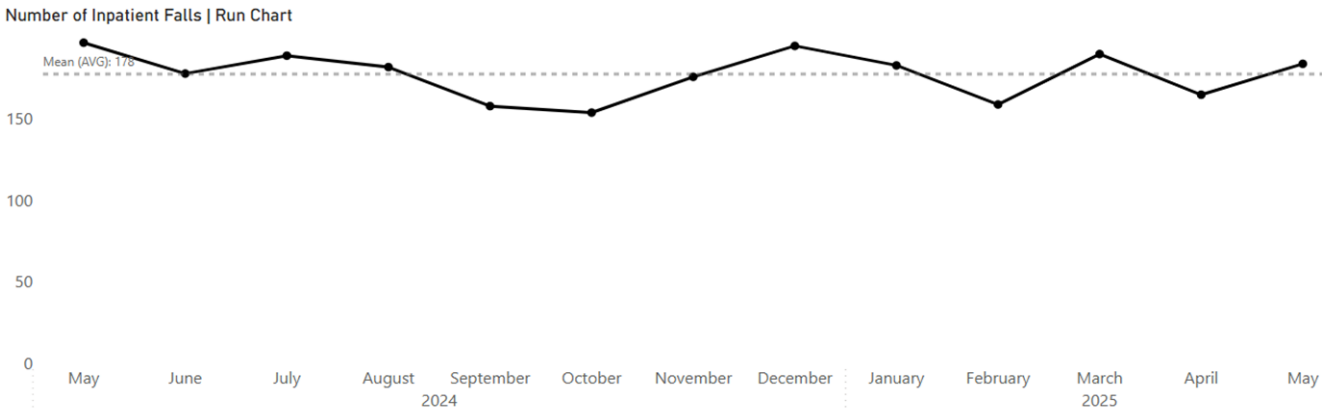
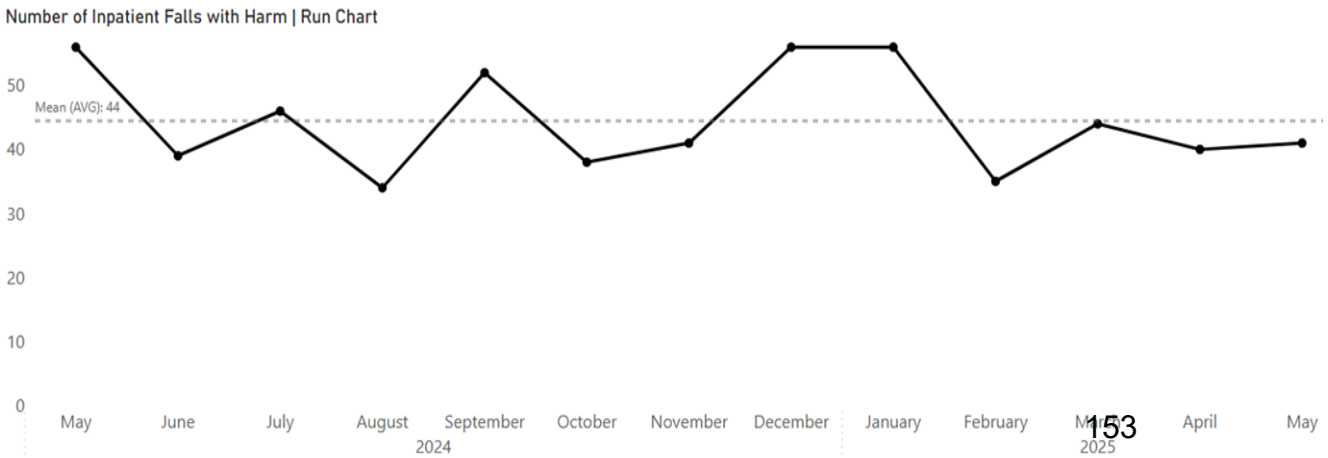
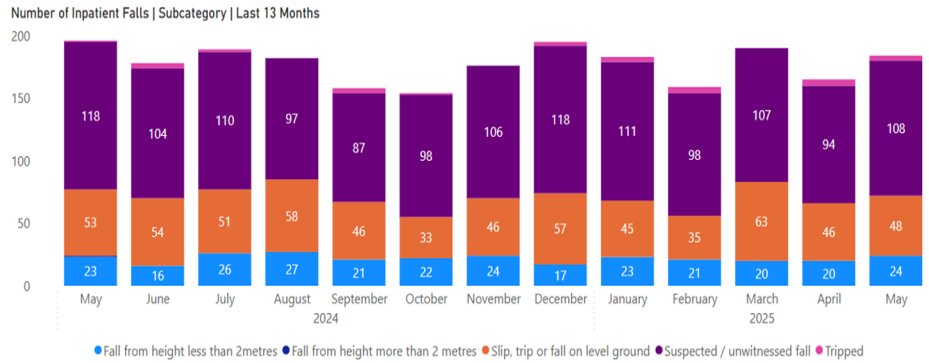
Hospital Inpatient Falls (May 2024 – May 2025)

ADP Deliverables		Insights to Current Performance	Plans and Mitigations
Reducing trend in falls		Overall falls rate has remained static. Decrease in falls with harm over April and May.	Continued use of falls audit to drive improvement across all areas. Reinforcing Daily Care Plan completion and documentation of Safe Care Pause Focus on falls.
Falls with harm reduced below the mean			

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	







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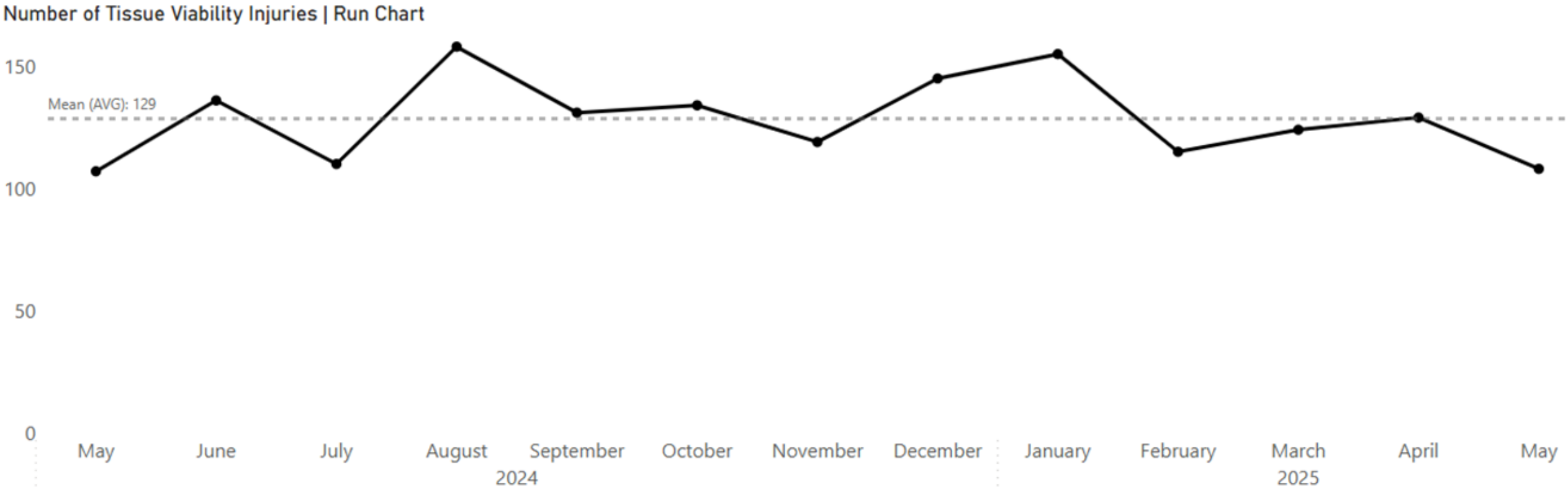
Tissue Viability Injuries (May 2024 – May 2025)

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
- Continue to work with high risk areas which is proving successful - Pressure Ulcer reduction documents for BSL and Easy Read in circulation. NATVNS new document with Medical Ills		- Awaiting new grading tool from EPUAP which influences training material - November and December seem to be high risk months for increased PU occurrence and pre planning seems to be a necessary consideration, but factors such as staff and patient admissions cannot be predicted - Should Datix meetings be held for Grade 1 /2 /3/4/DTI and ungradeables developed in care as avoidable harm?, not just from Grade 3- please consider	- Showcase targeted approaches to change and adapting to specific areas - Consider Gaelic translation of NATVNS pressure ulcer prevention leaflet when ready- due very soon - -Community Pressure Ulcer Prevention Pathway in progress - Consider lowering the median so that we have more strategic and reaisitc targets - Preventative Strategies as Grade 2 and Grade 1s are highest- Beds and hybrid Mattress and specialist equipment discussion due
- Leg Ulcer training in progress - Wound Care Policy complete and for TVLG in April - Leg Ulcer Policy for TVLG in April			

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	



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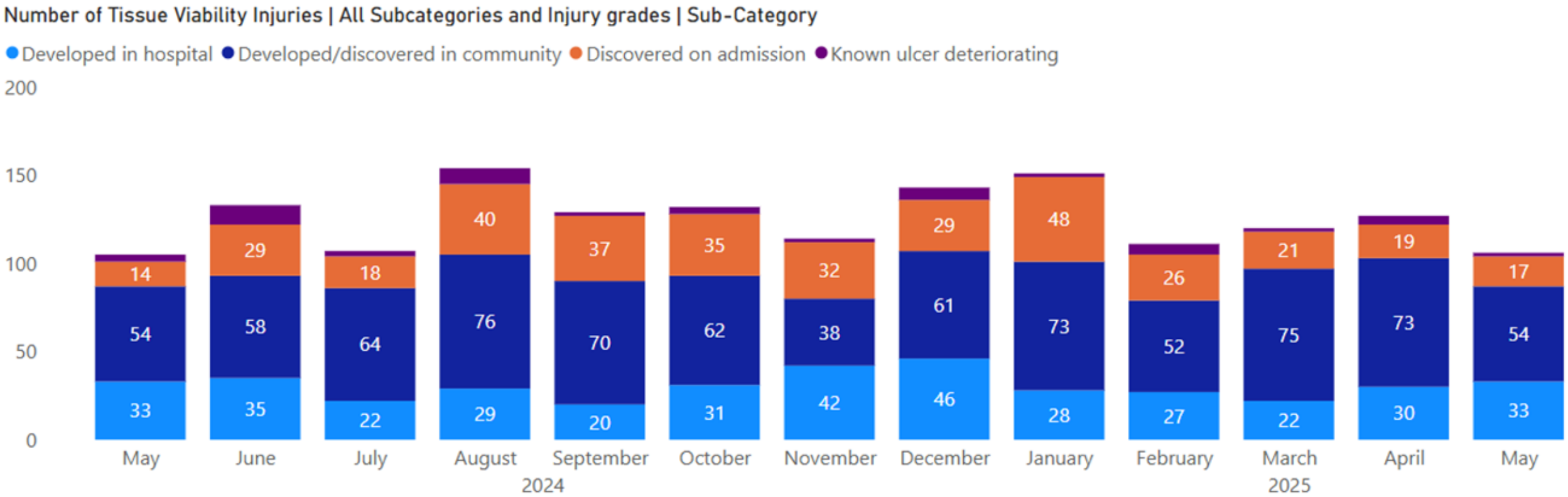
Tissue Viability Injuries by Subcategory (May 2024 – May 2025)

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
- Continue to work with high risk areas which is proving successful - Pressure Ulcer reduction documents for BSL and Easy Read in circulation. NATVNS new document with Medical Ills		- Awaiting new grading tool from EPUAP which influences training material - November and December seem to be high risk months for increased PU occurrence and pre planning seems to be a necessary consideration, but factors such as staff and patient admissions cannot be predicted - Should Datix meetings be held for Grade 1 /2 /3/4/DTI and ungradeables developed in care as avoidable harm?, not just from Grade 3- please consider	- Showcase targeted approaches to change and adapting to specific areas - Consider Gaelic translation of NATVNS pressure ulcer prevention leaflet when ready- due very soon - -Community Pressure Ulcer Prevention Pathway in progress - Consider lowering the median so that we have more strategic and reaisitc targets - Preventative Strategies as Grade 2 and Grade 1s are highest- Beds and hybrid Mattress and specialist equipment discussion due
- Leg Ulcer training in progress - Wound Care Policy complete and for TVLG in April - Leg Ulcer Policy for TVLG in April			

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	



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Tissue Viability Injuries | Subcategory by Injury Grade (May 2024 – May 2025)

ADP Deliverables Progress as at End of Q4 2024/25		Insights to Current Performance	Plans and Mitigations
- Work with NATVNS on a standard Scottish document for HCSWs to undertake wound care within limitations		- Awaiting new grading tool from EPUAP which influences training material however Policy started alongside review of a standardised NATVNS moisture associated damage information leaflet	1-Audit wound swab and infections via Infection and Biofilm Pathway _ Leg Ulcer audit to be presented to Caldicott Guardian for approval - -Community Pressure Ulcer Prevention Pathway in progress - Consider lowering the median so that we have more strategic and reaisitc targets - Preventative Strategies as Grade 2 and Grade 1s are highest- Beds and hybrid Mattress and specialist equipment discussion due
- Leg Ulcer training in progress - Wound Care Policy complete and training has started - Leg Ulcer Policy await SIGN update		- Should Datix meetings be held for Grade 1 /2 /3/4/DTI and unstageable developed in care as avoidable harm?, not just from Grade 3- please consider	

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	

Injury	Developed in hospital	Developed/discovered in community	Discovered on admission	Known ulcer deteriorating	**Total**
Mucosal Pressure Damage	24	1	11		**36**
Pressure Ulcer - combination lesions	5	9	0	0	**14**
Pressure Ulcer - deep tissue injury	19	77	12	6	**114**
Pressure Ulcer - ungradable	36	102	36	15	**189**
Pressure ulcer (grade not specified)	9	9	9	0	**27**
Pressure ulcer Grade 1	119	146	84	3	**352**
Pressure ulcer Grade 2	170	385	157	9	**721**
Pressure ulcer Grade 3	15	62	36	13	**126**
Pressure ulcer Grade 4	1	19	20	13	**53**
Ulcers	0	4	6	0	**10**
Total	**398**	**814**	**371**	**59**	**1642**

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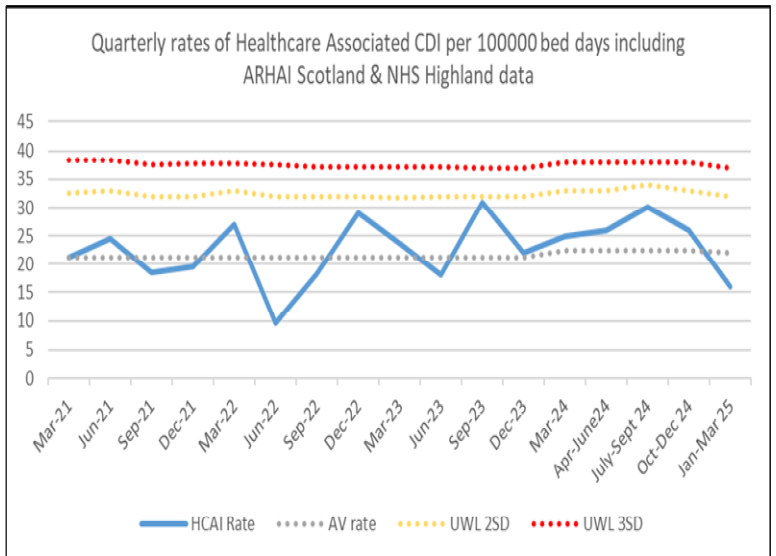
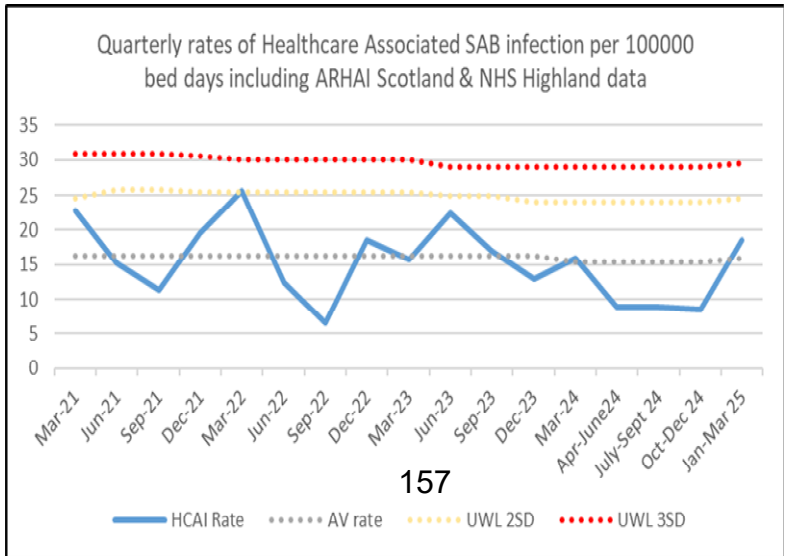
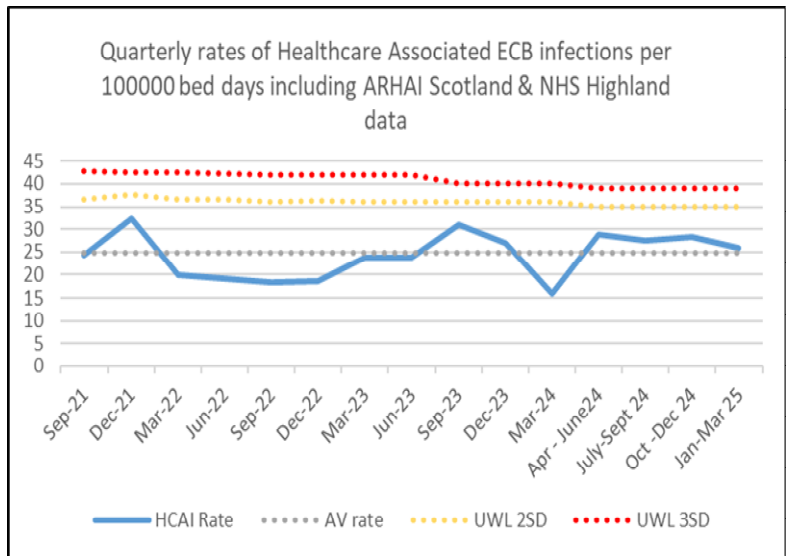
Infection Control - CDI, SAB and ECB Healthcare Associated Infection (HCAI) Reduction aims

ADP Deliverables: Progress for 2024/25 and current position for 2025/26	Insights to Current Performance	Plans and Mitigations
Clostridioides *difficile* (CDI) Predicted end of year Healthcare associated infection (HCAI) rate of 24.5 (79 cases) against target of 15.6 (Apri 24– March 25). This reduction aim has not been met. 2025/26 reduction aim is 75 HCAI cases, as of 01/06/25 4 HCAI cases reported	NHS England and NHS Scotland are reviewing the increased incidence of Clostridiodes difficile seen across the four nations in the previous quarters (Sept-Dec2024) NHS Highland saw a recent increase in the case numbers of SAB, following review no commonalities have been identified.. NHS Scotland updated NHS Boards on the local delivery plan aims for 2025/2026 via DL (2025) 05. For NHS Highland the aim is not to exceed the case number data based on 2023/24 by end of March 2026. Clostridioides diffiicle – 75 cases SAB – 53 cases EColi – 75 cases The rag rating is calculated on the predicted monthly number.	Continue to review individual cases for learning. Targeted work with antimicrobial prescribing continues. The introduction of faecal microbiota transplant therapy has commenced. Continue to ensure adherence to national guidance for the management of infections.
<u>*Staphylococcus aureus*</u> bacteraemia (SAB) Predicted end of year HCAI rate of 11.8 (38 cases) against target of 15.3 (April24 – March 25). This reduction aim has been met. 2025/26 reduction aim is 53 HCAI cases, as of 01/06/25 10 HCAI cases reported		
Escherichia Coli Bacteraemia (ECB) Predicted end of year HCAI rate of 27.6 (89) against target of 17.1 (April24-March25). This reduction aim has not been met. 2025/26 reduction aim is 75 cases, as of 01/06/25 10 HCAI cases reported.		

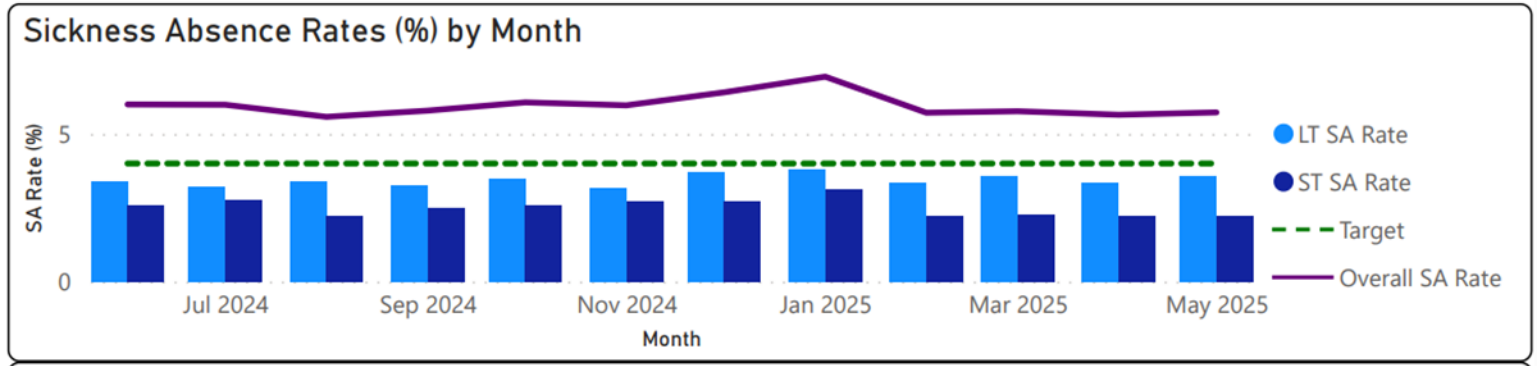


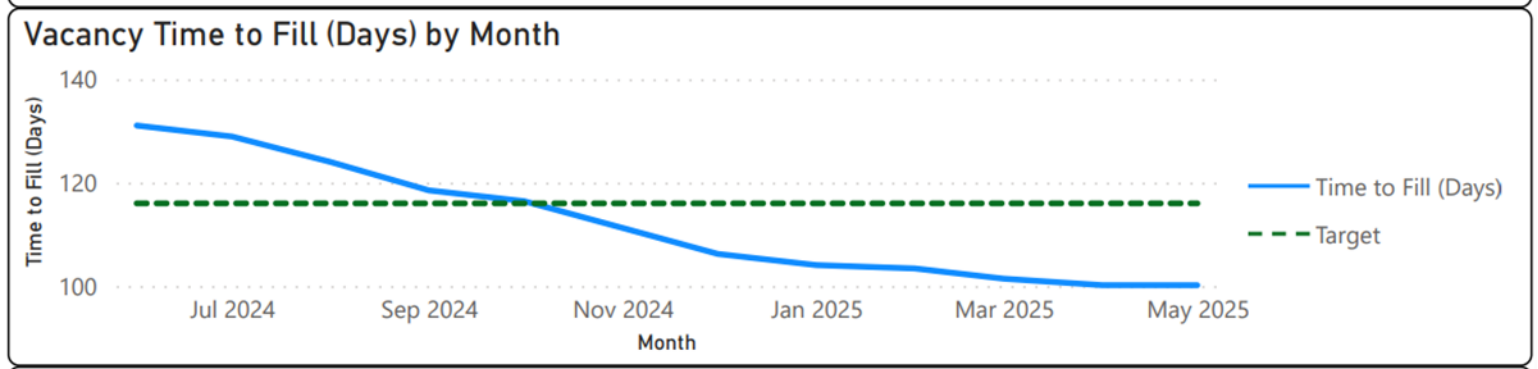


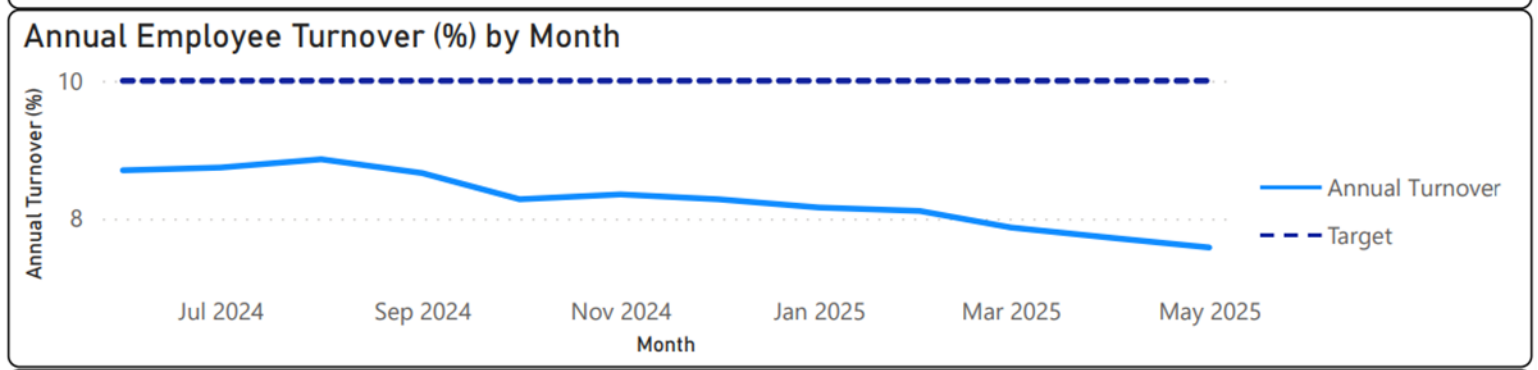


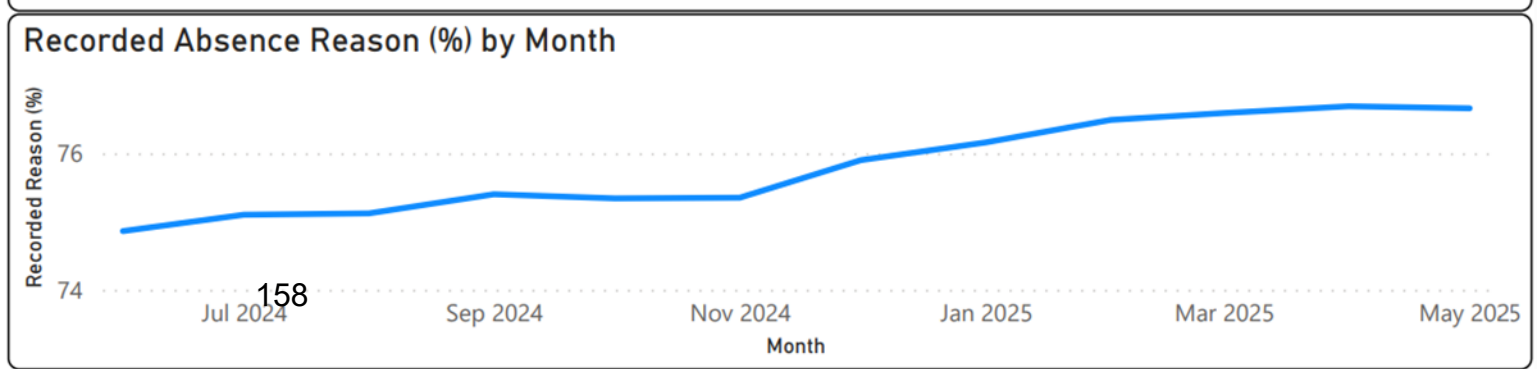
Organisational Metrics May 2025

Sickness Absence Rate (%)	5.73
Long Term SA Rate (%)	3.57
Short Term SA Rate (%)	2.21
Recorded Absence Reason (%)	76.66
Vacancy Time to Fill (Days)	100.16
Annual Employee Turnover (%)	7.58









Training Metrics May 2025

Bank eLearning Completion Rate (%)	Substantive eLearning Completion Rate (%)
47.7	78.3

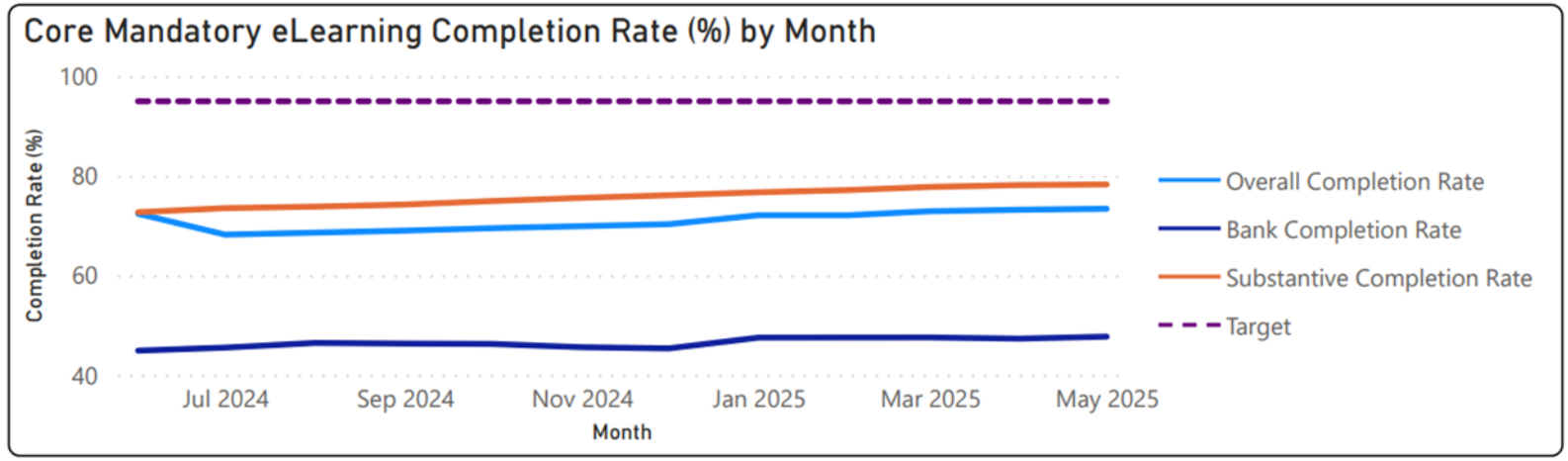
Overall eLearning Completion (%)
73.4

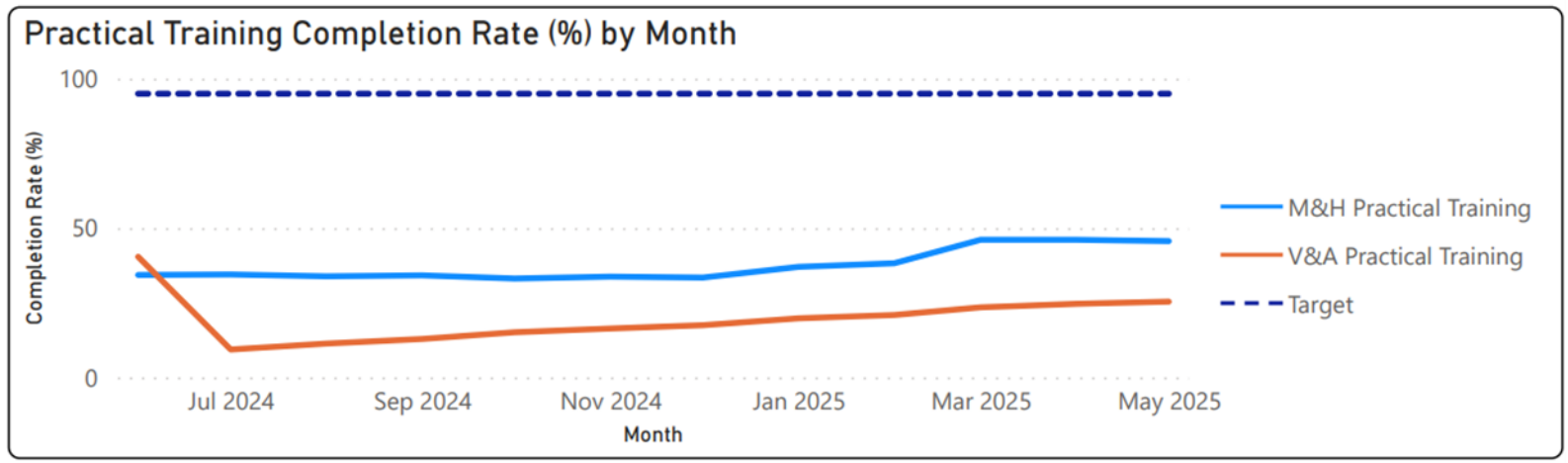
Note that from Jul 2024 V&A e-Learning module has been reintroduced to Mandatory Training compliance figures as a new course was launched in June for all Job Families. V&A Practical figures have dropped due to a new template report which is mirroring the new V&A training pathway requirements.

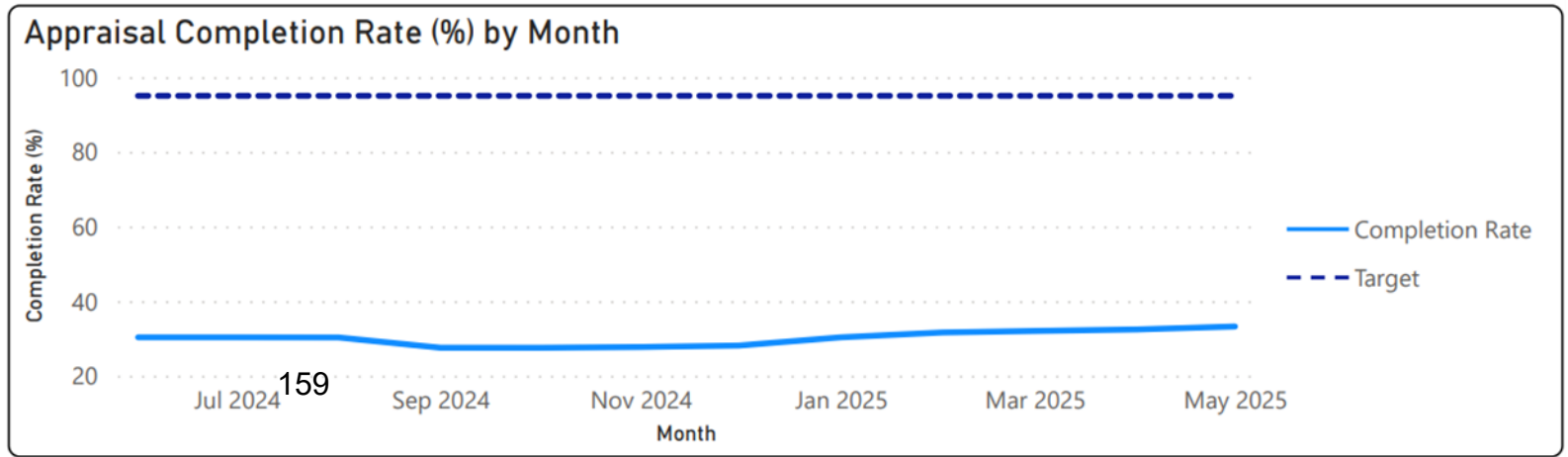
M&H Practical Training Completion Rate (%)	V&A Practical Training Completion Rate (%)
45.6	25.4

Appraisal Completion Rate (%)
33.2

Note that from Sep 2024, new starts are no longer excluded from Appraisal figures.







- NHS Highland absence remains above the national 4% target and has increased slightly to 5.73% for May2025 . The absence rate has decreased since a peak of 6.94% in January 2025.
- 24.2% of Long-term absences are related to anxiety/stress /depression/other psychiatric illnesses. Short term absences in Cold, Cough, Flu (22.1% of short-term absences) remain high as well as gastro-intestinal problems (15.8% of short-term absences).
- Absences with an unknown cause/not specified remaining are high, accounting for around 23.3% of all absence. Managers are asked to ensure that an appropriate reason is recorded and continuously updated. Manger attendance remains low on Once for Scotland courses, reports are now distributed to SLTs, via the People Partners to demonstrate attendance at the Once for Scotland courses, both online and eLearning.
- The NHS Highland Health and Wellbeing Strategy is in final draft and being presented to the appropriate Governance Committees prior to launch. The Strategy details our commitment to supporting health and wellbeing but also what resources and support is already available to our workforce. An action plan detailing the short, medium and long-term actions is being progressed by the Health & Wellbeing Group.
- The average time to fill vacancies has dropped below the NHS Scotland KPI of 116 days. Its has improved markedly since its peak of 134.8 days in April 2024 and is now 100.2 days. Work continues to improve on timescales.
- NHS Highland's annual turnover sits at 7.58% for May 2025.
- In May 2025 we continued to see high levels of leavers related to voluntary resignation (27.7%) and retirement (33.8%) and we see high levels of leavers with the reason recorded as 'other' which accounts for 18.5% of our leavers. Further encouragement is required to capture leaving reasons.
- An improvement plan for Appraisals is being progressed with refreshed awareness sessions for managers and staff. Compliance reports are distributed monthly to Senior Managers and Appraisal statistics are part of the Mandatory Training Compliance online dashboard. All direct reports of a Director level post and the tier below them must be completed by Oct 2024.
- Detailed Statutory and Mandatory training compliance reports continue to be shared with the senior managers across the organisation and a dashboard is available online to support planning and discussions with teams.

Appendix: IPQR Contents

Slide #	Report	Frequency of Update	Last Presented
4	18 Weeks CAMHS Services Treatment	Monthly	May 2025
4	CAMHS Waitlist NHSH	Monthly	May 2025
5	1st New Appointment Only	Monthly	NEW
5	NDAS Total Awaiting 1st App (incl unvetted)	Monthly	May 2025
5	New + Unvetted Patients Awaiting First Appointment by Wait Band	Monthly	May 2025
6	Screening Programme Uptake KPIs in NHS Highland	Annual	May 2025
6	Inequality in Screening Comparison of NHS Highland and Scotland	Annual	May 2025
7	Children's Vaccination Uptake	Quarterly	May 2025
8	Smoking Cessation	Quarterly	NEW
9	NHS Highland-Alcohol brief interventions 2023/24 Q2	Quarterly	May 2025
9	Setting Contribution 2024/25	Quarterly	May 2025
10	Drug and Alcohol Recovery Performance Against Standard for Completed Waits	Quarterly	September 2024
10	% Ongoing Waits at Quarter End Waiting More than 3 Weeks (Breached Target)	Quarterly	September 2024
11	A&E – 4 Hour Target	Monthly	May 2025
11	Weekly ED Patients Waiting 12-Hour Plus	Monthly	May 2025
11	Weekly Ambulance Handover Results: Under 60 Minutes	Monthly	May 2025
12	Delayed Discharges at Monthly Census Point	Monthly	May 2025
12	Delayed Discharge – Location and Code	Monthly	May 2025

Slide #	Report	Frequency of Update	Last Presented
13	New Outpatients Patients seen and Trajectories	Monthly	May 2025
13	OP Patients Waiting Over 52 Weeks	Monthly	May 2025
14	Return Outpatients Wait List	Monthly	May 2025
14	Outpatient Conversion Rates to TTG	Monthly	May 2025
14	Outpatient Follow Up Ratio	Monthly	May 2025
15	Planned Care Patients Seen and Trajectories	Monthly	May 2025
15	TTG Patients waiting over 52 weeks	Monthly	NEW
16	Imaging Tests: Maximum Wait Target 6 weeks	Monthly	May 2025
16	Board Comparison % met Waiting time standard	Monthly	May 2025
17	Endoscopy Tests: Maximum Wait Target 6 Weeks	Monthly	May 2025
17	Board Comparison % met Waiting time standard	Monthly	May 2025
18	Cancer 31 Day Waiting Times	Monthly	May 2025
18	Board Comparison % Met waiting time standard	Monthly	May 2025
18	Patients Seen on 31 Day Pathway	Monthly	May 2025
19	Cancer 62 Day Waiting Times	Monthly	May 2025
19	Board Comparison % Met waiting time standard	Monthly	May 2025
19	Patients Seen on 62 Day Pathway	Monthly	May 2025

Slide #	Report	Frequency of Update	Last Presented
20	Systemic Anti Cancer Therapy – Waiting Times	Monthly	May 2025
21	18 Weeks All Ages Psychological Therapy Treatment	Monthly	May 2025
21	Board Comparison % Met waiting time standard	Monthly	May 2025
21	Psychological Therapies Waitlist NHSH	Monthly	May 2025
22	Highland Wide Stage 2 Complaint Volumes Received and % Performance Achieved	Monthly	May 2025
23	SPSO Feedback Cases	Monthly	May 2025
24	SAER & Level 1 Volumes: Declared Last 13 Months	Monthly	May 2025
25	Level 2a Investigations Declared	Monthly	NEW
26	Active SAERs Level 1	Monthly	NEW
27	Number of Hospital Inpatient Falls 2024/25	Monthly	May 2025
28	Number of Hospital Inpatient Falls with Harm 2024/25	Monthly	May 2025
29	Number of Hospiital Inpatient Falls by Subcategory	Monthly	May 2025
30	Number of Tissue Viability Injuries | Run Chart	Monthly	May 2025
31	Number of Tissue Viability Injuries | All Subcategories and Injury Grades | Sub-Category	Monthly	May 2025
32	Number of Tissue Viability Injuries | Subcategory by Injury Grade	Monthly	May 2025

Slide #	Report	Frequency of Update	Last Presented
33	Quarterly Rate of Healthcare Associated CDI per 100,000 Bed Days	Quarterly	May 2025
33	Quarterly Rate of Healthcare Associated ECB per 100,000 Bed Days	Quarterly	May 2025
33	Quarterly Rate of Healthcare Associated SAB per 100,000 Bed Days	Quarterly	May 2025
34	Organisational Workforce Metrics	Bi-monthly	May 2025
35	Workforce Training Metrics	Bi-monthly	May 2025
36	Workforce IPQR Narrative	Bi-monthly	May 2025

Agenda Item

NHS Highland

NHS Highland na Gàidhealtachd

Meeting: **Board Meeting**

Meeting date: **27 July 2025**

Title: **DPH Annual Report 2024 Update**

Responsible Executive/Non-Executive: **Jennifer Davies, Director of Public Health**

Report Author: **Public Health Team,**
Paul Nairn, Strategy and Transformation

Report Recommendation:

- **Note** the content of the report and summary update on progress in relation to the recommendations of the 2024 Director of Public Health Annual Report.
- **Note** that the report recommendations will be key in developing the strategic framework
- **Note** that future updates will be assured via the Population Health and Planning Committee

1 Purpose

This is presented to the Board for:

- Awareness and noting

This report relates to a:

- 5 Year Strategy, Together We Care, with you, for you.
- Government policy / directive
- Local policy

This report will align to the following NHS Scotland 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 Annual Report of the Director of Public Health for 2024 was presented in January 2025 and the report recommendations were noted and accepted by the Board with an expectation that Executives would bring forward six-monthly and 12-monthly reports through an appropriate governance route to provide assurance on how the Board was implementing the recommendations. This report provides an initial 6-month update.

2.2 Background

Directors of Public Health are required to produce an annual report concerning the state of health of their local population. Its main purpose is to provide an independent, evidence-based assessment of the health and wellbeing of the local population and advocate for action. There is no set format for the report agenda and in recent years the reports have tended to focus on individual themes rather than acting as a repository for population health intelligence. The Director of Public Health Annual Report (DPHAR) for 2024 focussed on health inequalities and laid out a series of recommendations.

Following the Board's noting and acceptance of the recommendations from the report in January 2025, there was an expectation of there being six- and twelve-monthly reports by Executives, through an appropriate governance route as part of providing assurance on how the Board was implementing the recommendations. The current mechanism for reporting is through the Population Health Programme Board, chaired by the Director of Public Health.

In May 2025 the Board agreed to bring forward the refresh of the existing organisational strategy Together We Care, to embed tackling health inequalities as part of achieving equitable population health outcomes. There was also approval for establishing a new Population Health and Planning Committee with the purpose of:

- advising and assuring the Board on the development and implementation of strategic plans that enable population health improvement and strengthen our prevention approach.
- Providing assurance that population health measures are utilised to understand the impact and effectiveness of our board strategy and associated strategic plan for population health.

The first meeting is planned for autumn 2025.

2.3 Assessment

The DPHAR for 2024, outlined information about the health and wellbeing of people in Highland and Argyll and Bute with a focus on health inequalities. It included key measures such as people's life expectancy and how things have changed over several years. This was followed by chapters that explained health inequalities, what they are and how they affect local people and ways of tackling them. The report went on to look at different groups of people or different factors that relate to health inequalities including chapters on children; vaccination; the effects of alcohol; and on under-represented groups. The report's intent was to generate consideration of and indicative action which would tackle this important priority for NHS Highland and its partners. A total of 11 recommendations were outlined across 7 broad thematic areas. These were primarily designed to:

- Advocate for a population health approach to tackling health inequalities;
- Inform policy and decision-making;
- Engage a range of stakeholders to stimulate consideration of and purposeful action;
- Promote accountability and transparency; and
- Guide continuous improvement

Appendix 1 provides a short summary of some examples of action against these recommendations. The update has been taken from contributions made through the Population Health Programme Board. As such, it is not a comprehensive summary of all the work that is being undertaken by NHS Highland and our partners, as there is currently no systematic way of gathering evidence to demonstrate delivery. Indeed, there is likely to be action underway that contributes to these recommendations, beyond what is captured here.

Since publishing the DPHAR, other significant developments include:

- Agreement to refresh the NHSH organisational strategy with a focus on tackling health inequalities through a population health approach
- Establishment of a new Committee to take forward the development of the strategy and provide assurance on its implementation over time
- Publication of key national frameworks, including the Population Health Framework, the Health & Social Care Service Renewal Framework (June 2025) alongside the NHS Scotland Operational Improvement Plan. Taken together, they act as levers for adopting a population approach to prevention and tackling health inequalities.

These developments together act as the foundations upon which we can create the conditions that will increase the likelihood of achieving impact through systematic action across all aspects of the Health Board's functions. These include:

- As a healthcare provider – planning and delivering our core business through a prevention, equity and population health lens
- As an employer – adopting practices that consider equity and fair employment practices for all our current and future staff
- As an anchor organisation – as part of an anchor system, taking purposeful action around procurement, sustainability, climate, employability/skills
- As a productive partner – working collaboratively with a range of organisations, including other NHS organisations, to purposefully take action that addresses health inequalities

In moving towards becoming a population health focused organisation, there is recognition of the need to ensure the enablers of action are understood and where required, developed including capacity and capability, leadership, governance and infrastructure recognising the challenges of moving towards action that requires longer term, preventative approaches at a time of significant pressure on immediate challenges. In doing so, consideration is needed of:

- How to knit together / make sense of the different strategies and strategic intents into a coherent set of priorities over the short, medium and longer term – recognising our starting position
- Understanding of our differential roles and responsibilities in action to tackle health inequalities – balancing the need for sustained, longer term focus
- Our role as an NHS organisation and as part of a wider system – given that action needed to tackle health inequalities is beyond a single agency and requires bold, collective action over the longer term
- Ability to monitor and measure progress and success – as a Health Board and as part of a system.

2.4 Proposed level of Assurance

The report provides moderate assurance to the Board regarding the

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

There is moderate assurance in that there is progress in establishing the internal delivery mechanisms that can provide assurance to the Board of delivery / progress in tackling health inequalities. Given the developmental nature of this work, that is likely to take time to be established and mature and will require review as we progress the development of our new organisational strategy.

3 Impact Analysis

3.1 Quality/ Patient Care

Tackling health inequalities is an important part of both patient care and quality improvement. Health inequalities remain a major aspect of NHS Highland strategy and service delivery.

3.2 Workforce

It is important that the board's staff members are aware of the impact of health inequalities and the need to act to reduce their effects. We should also be cognisant of how the root causes of health inequalities impacts our own staff. We are also focusing on employability and inequalities, both to support the community and strengthen the workforce.

3.3 Financial

Taking a whole system approach to tackling health inequalities will entail costs which are as yet not able to be quantified. However, in doing so, there are also possibilities for savings via associated prevention activity. Addressing health inequalities is a fundamental part of the work of the board and its partners, for example through community planning.

3.4 Risk Assessment/Management

Strategic - By not focussing the NHS Highland's strategic approach to delivery of care at a population health level will put significant risk for sustainability into the future.

Operational - There will be limited success if the organisation does not fully engage in the new strategic approach and implement the recommendations and strategic vision within operational working. Risks are managed in line with NHS Highland's policy.

3.5 Data Protection

No personally identifiable information is involved.

3.6 Equality and Diversity, including health inequalities

The focus of the report is on health inequalities; these include inequalities relating to protected characteristics.

3.7 Other impacts

No other impacts to note.

3.8 Communication, involvement, engagement and consultation

The principles of public and user involvement and engagement are embedded in public health actions. This update has been presented via discussions with colleagues leading on health and system inequalities reviews.

3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development, through the period January to July 2025. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Population health Programme Board and working group considering the status of health inequalities
- EDI – EQIA workstream group

4 Recommendation

The Board is asked to note the content of the report and summary update on progress in relation to the recommendations of the 2024 Director of Public Health Annual Report.

This report should be embedded in the development of the organisation's strategic framework and 10-year strategy.

Future updates will be assured via the Population Health and Planning Committee, though noting that all Committees will have a role in demonstrating our population health strategic approach.

4.1 List of appendices

The following appendix is included with this report:

Appendix 1 - **Population Health Programme Board update on reducing health inequalities**

Area	Recommendation	Update at July 2025
Health Inequalities	*NHS Highland and its partners should regularly review and monitor progress in reducing health inequalities*	• NHS Scotland Population Health Framework published in June, reflecting the need for the NHS to be population health organisations incorporating greater prevention measures and reduced inequalities within the current resource climate. NHS England has also published its 10-year strategy based on population health philosophy. • NHS Highland responded to the Scottish Parliament's consultation on the proposed Community Wealth Building Bill in May 2025. Wealth and how it is distributed across society is a key enabler of health and wellbeing. Scotland will be the first country in the world to enact such legislation to invest in wealth creation in local communities. We welcome the CWB legislation as a starting point and recognise the need for ongoing brave and forward thinking legislation in Scotland to realise the aspirations of the 10-year Population Health Framework. Examples include stronger community empowerment, Scottish specific procurement laws and land reform. • NHS Highland continues to embed our Anchor Strategy work. This has significant potential to improve health and wellbeing outcomes for the population and reduce inequalities and to reduce child poverty. Local procurement, fair pay and employment practices and targeting recruitment, shared use of NHS owned land and assets and improving the environment all have a key role in reducing inequalities. There is more potential of doing Anchor work beyond the NHS with Community Planning. • Reviewing current state of published EQIAs and processes to determine options for best practice as we develop into a population health organisation. e.g. agreeing a revised EQIA process; raising awareness; developing training; monitoring of EQIA's etc • STAG programme "Prevention and Health Inequalities" established • Strategic Framework and 10-year Population Health Strategy under development • Population Health and Planning Committee terms of reference agreed
Approaches to Health Inequalities	*Highland and A&B Community Planning Partners should consider the best ways to tackle local health inequalities and how to learn from models such as Collaboration for Health Equity and place-based approaches*	• Will come under remit of upcoming NHSH Board Strategy – working with Kings Fund to define approaches, HEU and HIS. • Subgroup established to agree health inequalities indicators for the Highland CPP. • Initial work focused on mapping current CPP priorities and plans against the 8 Marmot principles identified in the Collaboration for Health Equity in Scotland program (CHES). This is to support decision making on where the CPP should focus its efforts by highlighting where partners are already undertaking joint work that

		aims to tackle health inequalities, identify areas where this could be strengthened and identifying any gaps. • Progress reported at Highland CPP June meeting. • Full report to Highland CPP in September
Child Health	*NHS Highland and partners should evidence compliance with the UNCRC and increase completion rates for Equality and Integrated Impact Assessments by Nov 2026*	• Putting Children's Rights into Practice training pilot delivered with further roll out planned. • EQIA project group established to progress Integrated Impact Assessment inclusive of Children's Rights and Wellbeing Impact Assessment (CRWIA)requirements. • Within Argyll and Bute, work continues within the UNCRC group to review compliance with UNCRC including piloting and development of Integrated Impact Assessment process to align with Argyll and Bute Council. The IIA will combine EQUA and CRWIA process and this approach was approved by Argyll and Bute IJB in March 2025.
	NHS Highland and partners should deliver the actions set out in local child poverty action reports by November2026	• Subgroups established to reflect life course approach progressing. • Work continues through the Highland CPP Poverty Reduction Group to review delivery against the current Child Poverty Action Plan including development of the 2024/25 annual update which will outline the progress made on priority actions over the last year. Work has also started on the next iteration of the plan which will run 2026-31.the group has undertaken self-assessment with the Improvement Service. • A&B child poverty action group progressing action plan report 24/25 with draft being prepared.
	NHS Highland should work with local authority partners to deliver on The Promise Plan 24-30 to improve outcomes for children with care experience by 2030.	• NHSH representative to take on vice chair of Highland Promise Board • Draft NHSH corporate parenting / Promise improvement plan to compliment HSCP plans to be consulted on. • A&B corporate parenting plan extended to enable consideration of integrated planning with Promise priorities
Immunisation	*NHS Highland should continue work to improve vaccination uptake especially among disadvantaged groups.*	• Vaccination Implementation Collaborative group convened in Highland HSCP to support the implementation of the hybrid model for vaccination. • Objectives developed including to support targeted delivery to increase uptake across our hard-to-reach groups and underserved populations to address existing health inequalities. • Ongoing development of a plan which serves to demonstrate how the SVIP Five Year Vaccination and Immunisation Framework and Delivery Plan will be implemented and which incorporates targeted actions and approaches which aim to reduce inequalities. • Involvement in the national SVIP Inequalities and Inclusion Group.
Minorities or Underrepresented Groups	*Public sector organisations in Highland and A&B should acknowledge the poor health experienced by underrepresented groups and address these health inequalities with help from the skills and resources of the groups. This includes building strong collaborative relationships with those in positions of trust within communities*	• Overseen by people and culture and population health programme boards. • PH has developed training on cultural awareness for Gypsy / Travellers and delivered this to the Professional Vaccination Forum and Inverness Vaccination Service Team in June. Working to develop a plan to support relationship building between the Vaccination Team and local Gypsy / Traveller communities through MECOPP's Community Health Worker. Impact will be monitored through ongoing feedback from the community and review of ethnicity data collected by the vaccination service. • Locally funded research to identify the themes that impact on the mental health of the Gypsy/Traveller community now completed. The project was led by PH and co-produced with MECOPP and the Gypsy/Traveller community. The project report 'Progress in Dialogue' 'Bingin Naggins Tobar' is now available and highlights 8 themes. The research supports the need to establish long-term community health service partnerships and a small working group is being set up to look at establishing a local 'Health Partnership' with Gypsy/Travellers. As part of this work, collaboration with the local third sector Mental Health Service ‘Mikeys Line’ has started to

		address impacts around stigma and discrimination and access to mental health support. • Work is underway to develop a Quality Improvement Framework to improve Gypsy/Traveller Access and Experience of Primary Care. PH is working with Dingwall Medical Group to measure impact using quality improvement methodologies. • NHS Highland staff collaborated with 3 LGBT pride events this year (so far), alongside the newly established LGBT+ Staff network. Two of the three were the first in the area, Lochaber and Caithness.
	Organisations and individuals should take action to address stigma and discrimination by adopting clear and inclusive language, supporting staff to be aware of unconscious bias, challenging discrimination wherever it is seen and supporting staff to undertake training on equality and diversity, anti-racism and cultural awareness.	• Equality and Diversity workforce strategy in place from May • Focus on EDI training at all levels • Promotion of the 'Raising Awareness of Gypsy / Traveller Communities' TURAS course support tackling stigma/discrimination and unconscious bias around Gypsy / Travellers. Total 162 learners in Q1, with 41 in Nursing, 10 in Social Care, 8 in Dentistry, 8 in Midwifery, 7 in Business and administration, 6 in Pharmacy, 5 in Clinical Healthcare Support, 3 Allied Health Professionals, 3 in Medicine 2 in Psychology - the rest had unknown professions recorded. • PH has developed a short awareness raising session on unconscious bias to increase understanding of what bias is, critically analyse information sources and reflect on how sources influence bias. This training will be piloted with the intention that it can be rolled out across the organisation. • Work to develop an Anti-Racism plan for NHS Highland is underway. Initially, engagement work will be undertaken with service leads across the organisation to establish priorities and actions to deliver equity-focused services. • NHS Highland Equality Outcomes 2025-29 approved and will tackle: 1. improve accessibility for disabled people, older adults, and those from underrepresented communities 2. enhance employment opportunities and career development for persons from underrepresented groups 3. progress towards becoming an anti-racist organisation 4. advance gender equality in our workforce and patient care 5. identify, understand, and address health needs of those at risk of poorer health outcomes 6. mainstream equalities in climate-related work • Within Argyll and Bute HSCP equality outcomes 2025-29 approved include: 1. Work Towards Fairer Health and Social Care for Everyone 2. Involve People and Communities in Shaping Services 3. Build Services That Feel Safe, Inclusive and Respectful 4. Work Together to Reduce Inequality
Alcohol	*Alcohol and Drug Partnership member organisations should consider and implement the most effective and efficient ways to reduce the harms and health inequalities caused by alcohol.*	• This recommendation included in Healthcare Needs Assessment which was considered at the HADP strategy group in May. • Agreed and included as an action in the HADP 2025-30 strategy, to be approved by the HADP strategy group in August
Cancer	*NHS Highland should ensure that health inequalities are actively monitored as part of cancer management and across all services.*	• We are currently addressing inequalities across the screening pathways, as part of the NHSH's Equity Strategy Plan for 2023-26
	NHS Highland should address health inequalities across the entire cancer pathway	• Developed accessible web content & resources to ensure those with learning disabilities, carers and support staff can access reliable screening information.

	from prevention to rehabilitation.	• Developed a suite of NHS Highland Screening TURAS CPD modules to improve access to reliable screening information & training designed to enable staff/volunteers and carers to support informed decision making about screening participation. • Delivering an ongoing programme of screening awareness and engagement activity targeted at a range of marginalised groups / communities where participation in screening is low. • Embedded screening conversations into smoking cessation intervention across NHS Highland. • Embedded an evidence based telephone reminder intervention into the breast screening service. Aimed at supporting attendance in people invited to breast screening for the first time.

Agenda Item 8

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**27 July 2025**
Title:	**Board Strategy – Planning Policy Frameworks and Performance Reporting**
Responsible Executive/Non-Executive:	**David Park, Deputy Chief Executive**
Report Author:	**Kristin Gillies, Interim Head of Strategy and Transformation**

Report Recommendation:

- **Note** the three Health and Social Care Reform Frameworks published in June 2025: Service Renewal Framework (SRF), Population Health Framework (PHF) and Operational Improvement Plan (OIP).
- **Note** that the NHSH Annual Delivery Plan has been approved as a robust foundation for 2025-26.
- **Note** that Annual Delivery Plans have been considered within this evolving context and remain a valuable tool for supporting local planning and aligning with a broad range of national priorities.
- **Note** that in 2025-26 Scottish Government focus will be on the delivery of the Operational Improvement Plan, which includes reduction of waiting times, improving patient flow and to expand access through innovation. This and the other Frameworks will be governed by the SG Reform Executive.
- **Note** that Chief Executives are required to provide a consolidated progress report on OIP delivery to SG Executive Group meetings
- **Note** the current position statement, as the OIP develops
- **Note** that as the strategic framework and 10-year strategy develop, delivery plans and performance reporting will continue to be assurance mechanisms to the relevant governance committees

1 Purpose

This is presented to the Board for:

- Decision
- Awareness

This report relates to a:

- 5 Year Strategy, Together We Care, with you, for you
- Policy change

This report will align to the following NHS Scotland 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

Policy focus is moving from accessing healthcare and shifting the balance of care but also towards improving the health of the population through prevention and addressing of health inequalities. This will include efforts to target the needs of disadvantaged communities focusing on factors like socio-economic status and lifestyle. While no simple solution exists, we are required to play a role in reshaping strategies aligned with these principles, as part of a reformation and renewal of public service. Three national frameworks, published in June 2025, describe this reformation and renewal approach to the NHS in Scotland:

Operational Improvement Plan

Health and Social Care Service Renewal Framework

Population Health Framework

The need for renewal and reformation comes from the significant population health challenges which Scotland faces both now and in the future. Life expectancy is stalling and health inequalities are widening; demand for and utilisation of our health and social care services continues to increase in an unsustainable way. Waiting lists are significant and we have a need to make best use of our limited workforce and financial resources to treat patients more quickly and to shift the balance of care from acute to community settings. These are the overriding principles of each of the three national frameworks (Appendix 1-3)

2.2 Background

The NHS Highland Together We Care Strategy 2022-2027 has focused on delivering on the strategic “well themes” to transform ways of working and begin to shift the balance of care closer to people’s homes. With the publication of the 3 national frameworks in June 2025, it is clear that NHS Highland must proactively build on this work to pursue fundamental change in how we improve health outcomes and approach the delivery of health and care, driving investment in prevention and early intervention.

2.3 Assessment

The current NHS Highland Annual Delivery Plan 2025-26 was approved by the Scottish Government in July, as a robust framework for delivery of our Together We Care strategy.

Monitoring of performance will continue to be reported quarterly and linked with the IPQR through the year.

Going forward, the Government advises that ADPs have been considered within the evolving context of the NHS and remain a valuable tool for supporting local planning and aligning with a broad range of national priorities.

In May 2025, the Board approved the requirement for a refresh to the TWC strategy (2022-2027) a year earlier than planned, from 2026.

The Board also approved the outline and approach to the development of a refreshed NHS Highland strategy using a population health focus.

The Board also approved the development of the Population and Public Health Committee.

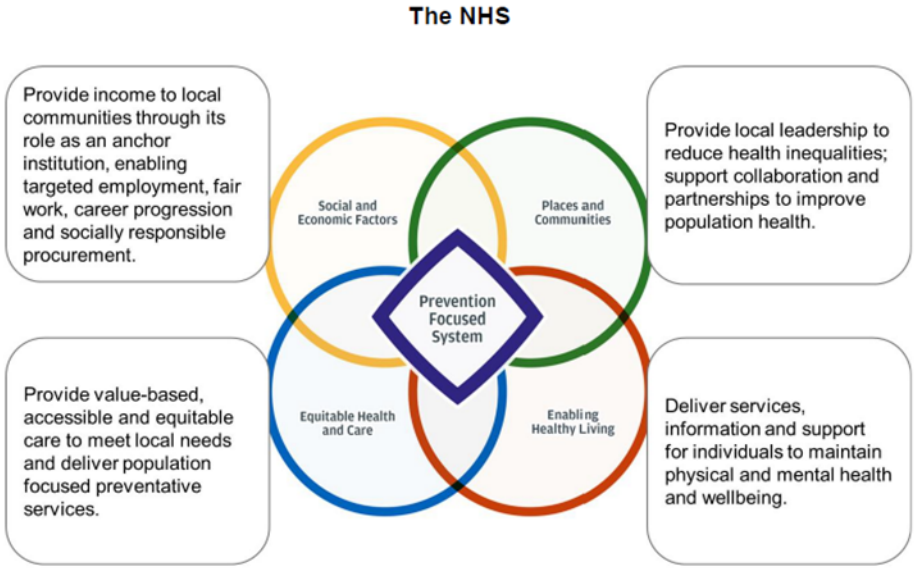
On 23 June 2025, the Government published three national frameworks, describing the reformation and renewal approach within NHS Scotland:

- Operational Improvement Plan
- Health and Social Care Service Renewal Framework
- Population Health Framework

The Operational Improvement Plan is described as the first component of 3 “products”, the second product will be the population health framework and the third the health and social care service renewal framework. Together these plans will focus on long-term sustainability, reducing health inequalities, the benefits of digital technology, and improving the population health outcomes in Scotland. They will set out how services for the whole population over the short, medium and longer term will be planned.

NHS Highland is developing a strategic framework to consider the delivery of the Health and Social Care Service Renewal and Population Health Frameworks, in order to deliver a new strategy for 2026 to refresh the Together We Care strategy and ensure we are equipped to deal with the challenges ahead for health and social care.

The diagram below is from the Population Health Framework and it details a model for population health, showing the role of the NHS. It is proposed that this will be part of the potential framework on which to build the new board strategy. It is recognised that to make this successful, this approach must be done in collaboration with local government, public sector, business sector and community and voluntary sector organisations.



To support the governance, development and delivery of the Board Strategy a Population Health and Planning Committee is being created with Terms of Reference Agreed at the May 2025 Board. The Committee will commence in autumn 2025.

Further discussions are in hand around the strategic framework development with a draft project plan in place that has been approved by EDG. How we develop a population health lens within other Committees and changing our approach from healthcare delivery to a system wide approach of population health are key considerations.

Performance monitoring of the developing strategic framework and 10-year strategy (i.e. the Population Health and Health and Social Care Renewal Frameworks) will be via the Annual Delivery plan (ADP) process used to performance manage the Together We Care Strategy. We will continue to annualise the reporting of each year's deliverables with Assurance being delivered via the quarterly ADP updates and bi-monthly IPQR.
These will report to Programme Groups and SLTs, the Committees, EDG and the Board.

The Operational Improvement Plan (OIP) for acute services has been under significant development since late May to:

- Review performance against waiting times (improving access to care);
- Improving patient flow (shifting the balance of care);
- Improving access via the use of technology;
- Improve prevention measures to prevent illness and more proactively meet patient needs.

For the waiting times work, weekly service meetings are in place, along with a systematic plan for training staff on the November 2023 waiting times guidance.
For all deliverables, various dashboards have been developed to monitor performance against trajectories. There is a weekly meeting with CfSD and also with Chief and Deputy Chief Executives to discuss the OIP performance and progress, via a consolidated progress report at Executive Group meetings.
Submissions will be made to the Government on a weekly and monthly basis.
OIP deliverables are included in the ADP 2024-26 and will be reported internally via quarterly updates to EDG and 6-monthly to FRPC. All OIP performance reporting for assurance will be through the IPQR received by FRPC. Reporting will vary accordingly across the different types of commitments in the OIP, but wherever possible will quantify progress against planned trajectories and milestones.

Sector Performance Reviews will monitor sector-level deliverables and performance relating to the OIP with Key Performance Indicators (KPIs) in development with sectors. A weekly CE assurance huddle is in place and is currently focussed on Planned Care and Cancer performance and improvement actions.

Metrics developed include:

- Scheduled Care – core and additional new outpatients and Treatment Time Guarantee activity and reducing waiting times to less than 52 weeks, will be reported monthly to SG
- Cancer performance – 31 and 62 day cancer performance as standard across tumour groups
- Unscheduled Care – reducing in standard delayed discharges, improving ED4, 8 and 13 hour performance, and Length of Stay performance linked to projects. (Quarterly reporting to SG)

Unscheduled care trajectories aligned to additional funding made available (frailty unit and Hospital at Home as examples) are currently being developed for submission to SG by 08/08. Reporting against these trajectories will be aligned to IPQR and all performance reporting.

Current performance at week 3 of July 2025:

- Planned Care - dashboards available weekly to track both NOP and TTG activity vs. plan and any areas requiring deviation. Long waits dashboard being developed for trajectories to 0 > 52 weeks. Largely on track across all specialties, actions in place where activity is above / below committed trajectories.
- Cancer - NHS Highland is challenged relating to 62-day performance from USC referral to treatment - recent performance of 67% for June 2025 was due to capacity challenges within Breast service pathways, particularly for surgery. Recent data monitoring has noted an improvement into July. Similarly, urology pathways, particularly Prostate, are subject to fluctuation due to Consultant availability. We are exploring locum opportunities to maintain the throughput required to achieve the performance required.
- Unscheduled Care - NHS Highland has redefined its Urgent & Unscheduled Care portfolio of programmes and is now progressing Performance and Delivery groups for both Highland HSCP and Acute to monitor the key governance metrics of Delayed Discharges, ED 4/8/12-hour access and Length of Stay. Programmes of work are being prioritised to focus on

performance improvement of these measures and agreeing trajectories, for submission to SG by 8 August. Recent ED performance (4 hours = 71.7%) has been impacted by the holiday period, in particular. DDs are currently high and have remained this way for a number of weeks.

2.4 Proposed level of Assurance

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

The report provides moderate assurance to the Board regarding the development of a refreshed strategic approach to NHS Highland's Strategy encompassing population health and proposing an early update to the current "Together We Care" strategy by 2026. It outlines a shift in focus from healthcare access to improving population health through prevention and addressing health inequalities, particularly among disadvantaged communities. To support this, the creation of a new Population and Health Planning Committee is recommended, which will oversee the strategy's development, ensure alignment with value-based care, and monitor progress against the outcomes in the Director of Public Health's annual report.

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

In order to increase the assurance level to substantial the proposed committee will require a period of transition so it can provide the Board assurance around strengthening governance structures, enhancing data and evidence use alongside deepening community engagement and aligning with national and local partners.

3 Impact Analysis

3.1 Quality/ Patient Care

As part of the development of the new strategy, quality and improvements to patient care and experience will be an essential component.

3.2 Workforce

Developing a Workforce Strategy will be an integral part of the Board wide strategy and staff-side will be part of the development process.

3.3 Financial

The scale of the financial challenge across health and social care is unprecedented. Inflation, rising energy costs and the ongoing impacts of Covid and Brexit, along with rising demand, mean that the finite funding available is worth less in real terms but required to deliver more. By setting out NHS Highlands new Strategy, we will aim to deliver a health and social care system fit for the future.

3.4 Risk Assessment/Management

Strategic - By not focussing the NHS Highland's strategic approach to delivery of Care at a population health angle will put significant risk for sustainability into the future.

Operational - There will be limited success if the organisation does not fully engage in the new strategic approach and implement the recommendations and strategic vision within operational working.

3.5 Data Protection

There will be no personal or identifiable information used in the creation of the strategy.

3.6 Equality and Diversity, including health inequalities

The Rights of the Child (UNCRC) - Priority areas for prevention are: Children and Young People, Child Poverty work and poverty across the life course will be reflected within the new strategy

The focus of the proposed Committee is on health inequalities; these include inequalities relating to protected characteristics, Socio-economic duties and UNCRC.

3.7 Other impacts

Describe other relevant impacts.

3.8 Communication, involvement, engagement and consultation

As part of the creation of a new strategy a full Communications and Engagement plan will be developed.

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 28 July 2025

4.1 List of appendices

The following appendices are included with this report:

1. NHS Scotland Operational Improvement Plan (March 2025)
2. Scotland's Population Health Framework 2025-2035 (June 2025)
3. The Health and Social Care Service Renewal Framework (June 2025)

Agenda Item 10

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**29 July 2025**
Title:	**Quarter 4 Whistleblowing Report**
Responsible Executive/Non-Executive:	**Gareth Adkins, Director of People & Culture**
Report Author:	**Gareth Adkins, Director of People & Culture**

Report Recommendation: The Board is asked to take moderate assurance on basis of robust process but noting the challenge of meeting the 20 working days within the standards.

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					

2 Report summary

2.1 Situation

This report is for Quarter 4 covering the period 1st January – 30th April 2025.

This is provided to give assurance to the Board 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 Staff Governance Committee 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 Guardian Service provide our Whistleblowing Standards confidential contacts service. The Guardian Service 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 4 covering the period 1st January – 30th April 2025:

- 1 concern has been received
- 1 case remains open
- INWO closed one case review and 1 case review remains open

One concern has been received via the non-executive whistleblowing executive lead is currently being considered in relation to the most appropriate way to undertake the investigation. The case involves allegations of not fulfilling contractual obligations in relation to working the hours contracted. This may be progressed under workforce policies as it is would most likely be managed under our policy conduct.

INWO asked asked for further information relating to case which was investigated and not upheld, which has been provided and they will not be pursuing any further.

INWO requested for information on a case that is closed and had upheld some aspects of the concerns and partially upheld other aspects of the concerns. This case and the associated report made recommendations which are now being progressed via an action plan. Information is being prepared for INWO to provide further clarification and detail that they had highlighted did not appear explicitly in the final report but they have acknowledged is in the information we have provided to them. INWO have now determined that further investigation by them is not required following further clarification and an update on the action plan provided but have not finalised the case review yet.

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.

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 Board 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

Staff Governance Committee

4 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.

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
WB02 2022-23	INWO review	• improve our concern handling • to apologise to complainant • carry out a review of specific patient feedback.	• Improvements progressed as part of speaking up action plan • Apology issued • Review of patient feedback being progressed	• Whistleblowing • Clinical Governance	• Complete • Complete • End of October 2024	This case is now closed
WB09 2023-24	Concerns raised in relation to contractor use and procurement practices in a service	• Review process for approving and engaging contractors to cover workforce shortages in specialist non-clinical roles • Review procurement processes in service area	• SLWG setup to review contractor processes including senior sign off • Review of procurement processes by procurement team	• Whistleblowing/ Staff Governance	• End of February 2025	All actions have been completed
WB11 2023-24	Concerns raised in relation to: • organisational change policy implementation • Clinical practice and supervision	• Undertake a review of service provision and produce recommendations on any changes required • Review training and competency framework • Adopt new organisational professional assurance framework • Undertake organisational development with teams to rebuild trust and promote psychologically safe workplace	• SLWG to be set up to progress all actions • Organisational development support commissioned	• Clinical Governance	• End of February 2025	Update currently being prepared Delays due to several vacancies within senior management team

WB13 2023-24	Concerns raised in relation to a community hospital: • Raising concerns through clinical governance • Effective management of concerns raised through clinical governance • Communication and engagement of staff in clinical governance	• Review and strengthen clinical governance arrangements within the hospital including raising concerns and involving staff in clinical governance activities locally • Improve communication to staff on clinical governance improvement plans • Strengthen multi-disciplinary working including MDT meetings, ward rounds and note keeping • Improve senior nursing staff visibility • Review opportunities to link with community dementia team and provide inreach to hospital	• SLWG set up to progress actions including senior nursing leadership	• Clinical Governance	• Initial review end of January 2025 • Next review end of March 2025	• Action plan developed and underway • Updates to be provided to whistleblower every 2 months

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**29 July 2025**
Title:	**Annual Whistleblowing Report 2024-2025**
Responsible Executive/Non-Executive:	**Gareth Adkins, Director of People and Culture**
Report Author:	**Gareth Adkins, Director of People and Culture**

Report Recommendation: The Board are asked to note substantial assurance based on the content and format of the annual whistleblowing report demonstrating compliance with our reporting requirements
under the standards.

1 Purpose

This is presented to Board for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Appendix 1 includes our 4th Annual Whistleblowing Report covering 2024-2025 for noting by Board. The report has been considered at APF, the Staff Governance and Clinical Governance Committees.

2.2 Background

The whistleblowing standards were introduced in April 2021 and include a requirement for every NHS board to produce quarterly reports and an annual report. The annual report summarises activity including nationally agreed Key Performance Indicators and also provides an overview of the learning outcomes from cases concluded during the year.

The annual report must be submitted to the Independent National Whistleblowing Officer (INWO) within 3 months of the end of the financial year. Where it is not possible to meet this timescale the report should be submitted as close to the deadline as possible and INWO informed of the reason for any delay.

2.3 Assessment

Appendix 1 includes our 4th Annual Whistleblowing Report which will be submitted to INWO following board approval at the end of July 2025. It has not been possible to submit this report within 3 month's of the end of the financial year due to governance cycle of the board. INWO will be kept informed of the expected submission date.

The key points from the report are summarised below.

- There have again been a small number of cases raised during 2024-2025
- We continue to manage around 180-200 contacts via our confidential contacts service (provided by the Guardian Service) and this may be one reason why the number of formal whistleblowing concerns remains low.
- There is learning from the small number of upheld cases outlined in this report but caution is required in interpreting the wider implications of the outcomes of these cases. (Further detail is provided within the report)

2.3.1 Quality/ Patient Care

The whistleblowing process primarily focuses on resolving individual issues including concerns related to the quality of care.

The annual report provides some insight into areas for improvement but given the limited number of cases caution is required when interpreting the findings of these cases. However, the findings do align with issues the board is aware of and the organisational priorities for the board for quality of care.

2.3.2 Workforce

The annual report demonstrates transparency in reporting our implementation of the whistleblowing standards and supports our commitment to encouraging staff to speak up and raise concerns.

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The main risk identified from the annual report is the timeliness of our investigations and challenges associated with meeting the 20 working days standard. However, we are committed to ensuring that thorough investigations are completed and actions progress to

address any risks identified this includes addressing any immediate risks to the organisation at the start of an investigation where this is required.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

The annual report will be considered and approved by the following groups prior to board approval:

- Executive Director's Group
- Area Partnership Forum
- Staff Governance Committee
- Clinical Governance Committee

2.4 Recommendation

This report proposes the following level of assurance:

Substantial	X	Moderate	
Limited		None	

APF is ask to note substantial assurance based on the content and format of the annual whistleblowing report demonstrating compliance with our reporting requirements under the standards

3 List of appendices

The following appendices are included with this report:

Appendix 1 – Annual Whistleblowing Report 2024-2025

Annual Whistleblowing Report 2024-2025

1 Introduction

This is our 4th annual report and builds on last year's report in relation to learning from feedback about the whistleblowing procedures and acting on specific concerns raised as well as wider themes that are emerging through the taking into account the feedback from 2023-2024 and 2024-2025.

This report provides an overview of NHS Highland's whistleblowing cases received and progressed during 2024-2025 including the key performance indicators used to benchmark the whistleblowing standards across NHS Scotland.

NHS Highland is committed to effective implementation of the standards, supporting staff to speak up and acting where required to improve how we work with our staff to deliver health and care services. This report includes a summary of the findings from the concerns investigated as well as Independent National Whistleblowing Officer (INWO) reviews of some of our cases. We also have also included details of changes and improvements resulting from these findings as well as some reflection from last year's report.

2 KPI 1: Learnings, Changes and Improvements as a result of considering Whistleblowing concerns

Our learning from whistleblowing concerns in 2024-2025 can be drawn from concerns upheld by NHS Highland. In this section we outline the findings and the changes and improvements we have planned and implemented or are in delivery.

2.1 Upheld Concerns

Of the 5 concerns closed in 2024-2025 two were upheld and two partially upheld. The key findings from the investigations of upheld concerns and resultant agreed actions are outlined below:

Case 1

Concerns previously raised in relation to patient safety and quality of care within a particular location had been acknowledged by senior management and were subject to ongoing work within through an action plan. However, this had not been communicated to staff and there was a disconnect in ongoing communication between 'front-line staff' and managers including professional leadership on the actions agreed and being progressed.

The recommendations from this report included strengthening involvement of staff delivering care in clinical governance activities so they can see the correlation between the concerns they may have raised through different routes including 'business as usual' such as through professional and operational management and their experience in delivering care. This would also enable staff to be kept informed of the actions agreed to address challenges and issues in delivering care, how these were being progressed and any issues in achieving sustainable changes

Case 2

One concern related to prolonged use of a contractor to provide services that could potentially have been delivered through appointing to substantive posts within the health board. This resulted in acknowledging that improved processes for reviewing circumstances where contractors are utilised to provide specialist services (non-clinical) to the board.

This would ensure an appropriate balance between investing in permanent or fixed term posts within the board where it is possible to attract people with the terms and conditions we offer including remuneration; and utilisation of contractors for time-limited periods where it is not feasible to appoint to employed positions due to wider market issues of workforce availability and remuneration offered by other industries and sectors.

This has similarities to the controls we have put in place to manage and reduce clinical agency staff usage whilst balancing the need to deliver safe, effective services with the impact of substantive workforce shortages

Case 3

Senior clinical staff within a service raised concerns of the impact of the current model of service delivery and the availability of certain key clinical staff groups on waiting lists. The concerns related to the impact on service users awaiting assessment and lack of progress in addressing these issues which had been reported over an extended period of time. This included reporting of these issues and impacts at our clinical governance committee.

In this context it was acknowledged and agreed that the concerns were 'upheld' and did not require extensive investigation to reach agreement on the nature of the problem and the concerns. The approach taken was to respond formally utilising the standards acknowledging the concerns and clearly outlining the actions that had been agreed previously with senior management and how these would be progressed.

Case 4

This was a complex case that identified many inter-related issues to be addressed.

Staff raised concerns in relation to the changes to the model of service provision within a rural community. This highlighted that changes brought in during the pandemic period were not properly communicated to staff and the organisational change process could have been conducted more robustly.

This resulted in staff working within a model that some staff did not agree with compared to the previous model of care delivery including the delegation of clinical tasks to non-registrant roles and employees in those roles. It was felt that clinical safety incidents had arisen and patients directly impacted by this model of care and inappropriate delegation of tasks.

It was acknowledged that improvements were required in the professional assurance that confirms with staff the tasks that can and will be delegated to non-registrants and assurance that appropriate training has been delivered.

It was also acknowledged that an incident related to inappropriate delegation that had happened and been addressed at the time but had not been reported through our adverse reporting system. It was not upheld that this incident caused harm as it was confirmed through investigation that the task inappropriately delegated was not completed by the delegate but escalated and dealt with appropriately. However, it was also noted that reporting of incidents through adverse events was notably low and further work was proposed to ensure staff report clinical incidents.

A wider observation of the investigation was that relationships between staff and between staff and managers had been damaged through unresolved differences of opinion of the changed care model. This was impacting on ongoing service delivery including staff (including managers) morale of those who supported the new model of care and those who did not. This break down appeared to be contributing to not reporting incidents and unwillingness to speak out in support of the new model or to voice concerns. This was evidenced through the confidential interviews of witnesses who did not necessarily agree with the views of others in relation to the concerns raised and feared the response they may receive if they voiced their opinions.

This case highlighted these key findings:

- Changes to service delivery can be challenging and the organisational change process if followed fully enables points of contention to be aired whilst recognising that not all staff will agree with proposed changes.

- Clinical governance processes including raising patient safety and care quality concerns are impacted if relationships have broken down in an area
- Professional assurance of care models and associated competency frameworks is critical to providing clarity on roles and responsibilities for staff. Where this is weak this can impact on individual staff and their ability to do their job safely and with confidence. It can also create conditions for disagreements between staff and between staff and managers in relation to day to day management of clinical activity and directions given to staff.
- Organisational development support was required to rebuild relationships and enable the disagreements in relation to the care model and staff roles and responsibilities within this to be resolved

The learning themes from these 4 cases are similar to themes highlighted in last year's annual report:

- Staff may not feel supported or be aware of how to raise clinical and safety concerns on a day to day basis through operational and professional management
- Staff may not feel supported or be aware of how to raise clinical and safety concerns through clinical governance processes
- Demand pressures can result in service users being cared for in a setting or location that was not designed for the needs of the service users and sometimes by staff without regular experience of the needs of service users
- Staff may not be aware of action plans that have been developed by management to address service pressures
- Staff may not be aware of action plans that have been developed by management to address quality of care concerns
- Whilst issues highlighted through concerns may be reported by management through governance mechanisms including clinical governance, staff are not necessarily kept informed of progress or routinely involved in meetings related to the action plans or issues
- Availability of permanently appointed workforce is an ongoing area of concern for staff in relation to the impact it has on staff morale and the potential for workforce shortages to impact on quality of care.
- Staff remain concerned about the use of supplementary staffing to address workforce shortages, with particular concern about the use of agency or contractors which may become 'routine' due to ongoing difficulty in recruiting staff permanently
- Staff are concerned about the persistence of challenges and issues relating to service pressure including the impact on quality of care and believe that either actions have not been identified or are not progressing quickly enough
- Where changes have not been managed well, differences of opinion remain and/or issues remain unresolved for various reasons over a period of time this can contribute in a breakdown in relations between staff and between staff and management.

It is important to note that whilst these themes have been written in a generalised way in relation to staff it is in relation to the service areas where these concerns were raised. Caution should be used in generalising these themes to the whole organisation.

2.2 Concerns not progressed as whistleblowing

Two concerns which are described in more detail in section 5 did not progress to investigation under the standards as it was agreed that the concerns were known to management and the outcomes sought were to seek assurance that actions could be progressed to address the issues raised.

These two cases along with a case that has progressed to a whistleblowing case following initial management through 'business as usual' processes (described further in section 5) highlight several learning themes:

- Some concerns are raised in the context of whistleblowing standards that on discussion with the individuals they have agreed have not required an investigation to agree with the concerns raised and 'uphold' them from a board perspective. The concerns relate more to progress by the board in addressing the issues raised through these concerns.
- Challenges faced within the health board of delivering sustainable services in the context of national workforce shortages in certain medical staff groups
- Challenges faced within the health board of delivering sustainable and effective services in the context of delayed discharges and associated impact on patient flow across our hospital sites
- The importance of engaging with individuals who raise concerns to discuss the best option for addressing their concerns including the whistleblowing route to understand what outcome they are seeking from raising their concerns.
- The importance of engaging with individuals who raise concerns to engage them in any ongoing efforts and actions to address the concerns raised where these are agreed or upheld through initial discussions
- The importance of ongoing engagement with individuals where the root causes of the concerns being raised is likely to require longer term improvement actions, redesign of services which may potentially include wider system transformation on a local, regional or national basis
- The need for the impact on quality of care and associated risks of concerns raised to be monitored through existing mechanisms such as clinical governance including progress against agreed action plans

Again caution should be used in generalising these themes to the whole organisation, nevertheless there are potential learning opportunities from these themes.

2.3 Organisational Changes and Improvements

Each individual case reported and upheld has resulted in specific actions to address the concerns within the associated service area. Some of this detail is outlined in section 2.1 and represents local change and improvement planned from the learning gained through the investigations.

The dataset from whistleblowing concerns is small so caution is required if attempting to interpret the data to inform wider organisational priorities for changes and improvements. However, the themes outlined in section 2.1 and 2.2 do align with issues and risks NHS Highland is aware of through its governance and management structures including:

- Workforce availability
- System and service pressures including the impact on staff morale and relationships
- Managing demand, performance, quality and safety within available resources within our clinical governance governance framework
- Risk management and escalation including clinical and care risks within our clinical governance governance framework
- Communication and involvement of staff in workforce management, risk management and clinical governance

These themes align well with NHS Highland's organisational priorities which include:

Health and Care Staffing Act Programme

We outlined last year this programme which is overseeing work across the organisation to strengthen:

- Workforce planning to ensure we have appropriate staffing in place to deliver our services
- Real time staffing processes to manage day to day workforce challenges, service demands and risk management

- Risk management and escalation to address short, medium and longer term challenges associated with workforce availability and safe, effective service delivery

This programme is making progress and particularly in relation to rolling out safecare as part of our rostering system to support real-time staffing processes.

Workforce availability

Whilst workforce remains a challenge there have been notable successes in focussed recruitment to some services that were experiencing challenges. The use of agency has reduced but supplementary staffing in the form of bank staff continues so there is further work to be done.

Our employability strategy has been developed during the course of the year which demonstrates our commitment to attracting people too health and social care and supporting 'earn why you learn' routes for staff to address our workforce challenges.

Developing Our Quality Framework

We outlined last year how we are engaging with our staff and working with our clinical and care leaders to agree a new approach to quality and our quality framework. This includes supporting our staff to:

- create and maintain a culture where it is safe to speak up and raise concerns about clinical and care safety and quality
- engage with our existing clinical and care governance framework to ensure concerns are captured and improvement plans are developed and delivered
- define what quality means to them and work together to deliver a high quality service within the resources available

This work is making progress but will take time to embed changes that will improve staff involvement in raising concerns and working with management locally to address any quality of care concerns.

Leadership development programme and organisational development support

We continue to deliver our leadership development programme which includes a focus on compassionate leadership and engaging staff in decision making. Ensuring we have strong leadership skills is vital to supporting staff through difficult times that the health and social care system has been and continues to experience due workforce shortages and high demand on services.

OD support is available and has been targeted to areas where particular issues related to effective team working and inter-personal relationships have been identified.

Strategic transformation

Our strategy includes a focus on sustainability and ensuring we can deliver safe, high quality services to our population with the resources we have available to us. We know that this will require ongoing work to redesign and transform our services and develop new workforce models to deliver new models of care.

Work has continued this year with priority areas of strategic change and transformation focussed on addressing system pressures, particularly availability of adult social care in the community and delayed discharges which impact on our hospitals.

It is evident from the learning themes in this report that the pace of change is an issue for staff experiencing the impact of system pressures including on quality of care. The challenge faced by NHS Highland, similar to other boards, is the complexity and difficulty of achieving change and improvement in the context of workforce availability that is a national issue and high demand for services.

It is also evident that better communication of the strategic change and improvement programmes to our staff is needed to provide assurance that their concerns are acknowledged by the board and there are plans to manage and address the issues they are raising.

We have improved our communication in relation to strategic change and transformation but will continue to look at ways of improving this.

2.4 Improving the Whistleblowing Procedures and processes.

The improvements planned and delivered last year were reported in last year's annual report and have resulted in improved processes for undertaking investigations. The timescales for completing investigations remains an issue and it is not clear what more is possible given the complexity of the cases as outlined in section 9.

A further improvement to our processes this year has been the addition to our quarterly report of a summary table of completed and upheld cases with associated actions, target dates and details of the governance mechanism overseeing the action plans, e.g. clinical governance.

This is enabling the progress of the action plans to be owned and managed by those involved in delivering the service where the concerns originated with assurance that regular monitoring is happening within the appropriate governance groups. However, it is also offers assurance through whistleblowing governance reporting that cases have been progressed and closed.

3 KPI 2 - Experiences of all those involved in the whistleblowing procedure

The number of whistleblowing cases raised and concluded each year remains small and the key information we have available to us to assess experience is feedback from:

- Individuals involved in the process
- INWO case reviews

Individual Feedback

Feedback from the 2 cases concluded this year is limited but in both cases the whistleblowers were satisfied with outcome of the process and the findings (both sets of concerns were upheld by NHS Highland).

INWO case reviews

The 3 INWO case reviews referred to above indicate that these individuals were dissatisfied where:

- they did not agree with the original consideration of eligibility or the outcomes of the investigation
- and/or they were dissatisfied with the process

It is understandable that some individuals will be dissatisfied with the outcomes of an investigation and where INWO uphold these concerns we will act. In 2023-2024 INWO did not uphold any outcome aspects of investigations but did highlight issues with our processes. We acknowledge the issues that have been raised and that these will impact on the experience of the individual whistleblowers. The action plan outlined above is a direct result of reflecting on the need for improvements and we aim to further improve our processes and the experience of whistleblowers.

4 KPI 3: Levels of staff perceptions, awareness and training

We continue to promote how staff can speak up through a range of different mechanisms including the formal whistleblowing policy and standards. Our confidential contacts service provided by the Guardian Service is also widely promoted throughout the organisation. This service was accessed by 184 staff last year for advice and support including support to access the whistleblowing procedure.

Whilst we know people actively seek out both the Guardian Service and access the whistleblowing procedures when they have concerns they wish to raise we are also aware that general awareness of the standards, and to some extent the Guardian Service, remains variable. Consequently, we continue to focus on raising awareness through a range of mechnanisms.

Speak Up Week
From the 30th September 2024 to 4th October 2024, NHS Highland actively participated in the National Speak Up Week, led by the INWO.

Our Guardians, who act as our Whistleblowing Confidential Contacts, travelled extensively across the Board area promoting Speaking Up and the Whistleblowing Standards. There were also a series of local and national resources, press releases and social media postings shared. Our executive team also participated in sessions across the organisation, engaging with staff to raise awareness and support speaking up.

Non-Executive Whistleblowing Champion visits
As in reported previously, in addition to the Speak Up week events, our Non-Executive Whistleblowing Champion carries out regular visits throughout the year to key locations and sites across the Board area and listening to colleagues and reporting back on his experiences and insights.

Executive Visits, Engagement and Visibility
The executive team also undertake regular visits throughout the year to locations and sites across the Board area and listening to colleagues. These visits cover a wide range of topics so are not exclusive to promoting speaking up but are related to the concept of senior management and board level visibility.

The geography does make it challenging to cover the area and be visible and this may be reflective of both the persistent challenge in shifting the feedback received through iMatter on relation to the question: I feel that board members who are responsible for my organisation are sufficiently visible. The average score has fallen within monitor to further improve over the last 3 years which indicates further improvement could be possible.

Staff Engagement

A new approach to staff engagement was tested during 2024-2025 and the results and action plan reported through our staff governance committee in the last quarter. The areas explore through surveys and focus groups were focussed on the four areas within imatter reported that consistently score lower:

- Visibility of Leaders
- Involved in Decisions
- Performance Management
- Celebrating Success

In the context of this annual report the main area of interest is the visibility of leaders. However, all the areas explored have some relevance to understanding issues that staff think there are opportunities to improve.

In relation to visibility we asked the following questions:

- Which leaders would you like to be more visible?
- How would you like them to be more visible?
- What would improve the visibility of leaders?
- What would you want to get from visibility of leaders?

- What would improve confidence and trust in leaders?

The results are outlined summarised below:

Be Present, in Person - make more face-to-face visits to where staff are located and spend time communicating and building relationships to decrease disconnection and really understand the experience and reality staff deal with. If leaders are visiting locations for meetings, spend time greeting the other staff located there. Relationships and the personal touch are important, and some felt like they've been lost.

Engagement and communication – not everyone sits at a computer, vlogs are not enough and are viewed as an easy way to say you're being visible. They're not received well by all and a more personal touch in person would be preferred. MS Teams is useful, but it can't be our default.

NHSH Structure & Communication - multi-layers of hierarchical structure don't help to facilitate effective communication and may in fact dilute the intended message. Both downward and upward feedback isn't working well. The structure feels very top heavy, perhaps too top heavy.

Organisational Charts – absence of these mean it's difficult to know who does what, and where. This was a commitment from previous engagement that has never been actioned and is frustrating. It would also improve accountability and remove ambiguity. Can EESS/SSTS/SLT's help with this?

Listening Leaders - issues raised are often not taken seriously and action is not taken. Leaders who genuinely listen and follow through or provide help to implement improvement actions is needed.

Leading by Example - create a welcoming environment and genuinely recognise contribution and hard work. Think about developing the leaders of the future and providing succession planning opportunities.

Public Engagement - difficult decisions feel skewed to pleasing the public rather than having an honest discussion about the challenges, issues and failures.

Training - face to face training for new managers would help them to understand their management responsibilities and help them to understand they don't have to have all the answers, and help is available. Leaders also need to balance time doing their own role and that of listening to and supporting team members.

The action plan developed in response to these points includes the following:

- Increase frequency and enhance effectiveness of executive team visits:
    - Increase visits to 1 per fortnight, with spread across localities and services.
    - Establish rota of visits from April 2025-July 2025
- Re-launch vlogs as reports back from visits to increase awareness of visits
- Utilise organisational chart functionality in MS365 to communicate structures and enable greater visibility of management structures.
- Continued focus on cascade brief and embedding this at every level
- Continued focus on leadership development including compassionate leadership which focusses on not shying away from difficult subjects and engaging staff effectively

This staff engagement exercise has been successful in identifying issues that we can focus on that contribute to speaking up and psychological safety.

Chief Executive Cascade Brief

NHS Highland appointed a new Chief Executive who commenced in post in April 2024. A new initiative introduced this year was the Chief Executive cascade brief which brings together the executive team and management from across the organization on a monthly basis to hear the Chief executive's brief on key issues and messages. There is an opportunity for questions and answers and managers are expected to 'cascade' these through the management structures so that key messages are communicated in person.

Induction and training

All new staff attend a 'Welcome to NHS Highland Induction' event, a half day online session where all new colleagues are updated on a range of information about NHS Highland, our services, our strategy, our values and our leadership. This includes how to raise concerns, Speaking up, the Guardian Service and the Whistleblowing Standards to ensure from the start of their career with us, colleagues know how to have their concerns heard and addressed.

We continue to signpost the online learning to colleagues, that is available on TURAS whenever we are talking about Speaking Up and Whistleblowing. We also signpost investigating managers to this, at the start of any new concern, to ensure they are up to date.

5 KPI 4: Total Number of Concerns Received

During the period 1st April 2024 to 31st March 2025, NHS Highland received 2 whistleblowing concerns, of these both were received in quarter two.

One of these cases was initially dealt with through a 'business as usual' approach. The concerns raised were related to sustainability of a clinical service provided by NHS Highland due to chronic staffing issues. This particularly related to the ability to fill medical consultant roles with either substantive staff or locum arrangements. There were concerns this was impacting on the board's ability to deliver care in a timely way and impacting on patient outcomes and quality of care. These issues had been reported through management and clinical governance mechanisms to board committee level and there were ongoing efforts to address them. Discussions between the executive lead for whistleblowing and the individual agreed that an investigation was not required to establish the facts and that the board and management were in agreement that these issues needed to be resolved. Confidentiality was also not required by the individual so it was agreed that ongoing contact would be between senior management and the individual in relation to the issues raised and actions underway to address them.

The individual subsequently contacted INWO in January 2025 as they were concerned that progress had not been made in relation to resolving the issues. It was agreed between the executive lead and the individual that the case would now be treated as a whistleblowing case under the standards and the original date of concerns would be retained for the purposes of continuity of record keeping. The case remains open at this stage. Work continues at a national level with other boards and Scottish Government involvement to address the challenges posed in relation to chronic medical staffing shortages that exist for the specialty related to this service which are not unique to NHS Highland and affects other boards. Actions to address the underlying cause of patient safety concerns, i.e. service sustainability and staffing shortages are being progressed at a national level including consideration of services being delivered by other boards on a regional and/or national basis.

One concern was received in Q2 which was not deemed eligible under the standards as it related to issues that were subject to processes under NHS Scotland workforce policies. There was an element of patient safety within the concern but on clarification it was confirmed that this had been responded to and addressed and was not the issue that the individual wished to be investigated.

Two further concerns were received in Q3 and Q4 related to issues that the individuals had openly discussed with senior management and neither were concerned with retaining their anonymity under the confidential protections of the standards. Discussions with the executive lead and the individuals took place to clarify the outcomes the individuals were seeking. In both cases the individuals did not think that an investigation under the standards was required to determine if the concerns should be upheld as the issues being raised were already subject to discussion with senior management. Both individuals were seeking resolution to the issues they felt were impacting on the ability of them and their teams to deliver their services effectively and impacting on the quality of care. These issues included:

- Adequate medical staffing levels (for one of the cases)
- Patient flow being impacted by high levels of delayed discharges within the hospital system
- 'Boarding' of patients – this is where a patient admitted under the care of one speciality is cared for on a ward primarily designated as caring for another speciality's patients
- Impact on staff of working in a system with high levels of boarding, sub-optimal patient flow and bed occupancy levels beyond the 'normal' operating levels due to delayed discharges

In one case it was agreed that a quality of care review would be undertaken to review the speciality with involvement of the individual. The aim of this review is to determine if there are actions that could be identified which have not already been suggested and are underway as well as any actions that may be required to 'unlock' barriers to progressing existing actions.

The second case has been resolved by further discussions with the individual and senior management to review actions underway and suggestions put forwards by the individual.

In summary, 5 concerns were received during 2024-2025 with 2 progressing to investigation under the standards. The category of the concerns were:

- Patient Safety & Quality (6)

1 case was investigated and closed during 2024-2025, 1 remains open at the end of 2024-2025 which was raised in the same year and is under investigation.

There are no other cases open from previous reporting years.

6 KPI 5: Concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed

All cases that were investigated and closed were stage 2 concerns (100% stage 2)

- 1 case was investigated and closed during 2024-2025
- 4 cases from 2023-2024 were closed during 2024-2025.

7 KPI 6: Concerns upheld, partially upheld, and not upheld at each stage of the whistleblowing procedure as a percentage of all concerns closed in full at each stage

Of the 5 concerns closed in 2024-2025 the outcomes were:

- 1 not upheld (20%)
- 2 upheld (40%)
- 2 partially upheld (40%)

8 KPI 7: The average time in working days for a full response to concerns at each stage of the whistleblowing procedure

The average time in working days for all cases closed in 2024-2025 was 123 working days. The minimum was 61 and the maximum was 182. The maximum was related to a case that was 'back-dated' to the original concern once initial attempts to resolve the issues through business as usual discussions were unsuccessful.

9 KPI 8: The number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working days

There were no stage 1 concerns raised in this period

None of the stage 2 concerns raised within this period were within the 20 working days standard.

We recognise that the average and maximum times of these cases exceed significantly the 20 working days for stage 2 concerns within the standards. As noted in our annual report for 2023-2024 we have worked on reducing avoidable delays in our whistleblowing processes. One particular aspect we have improved is the identification and assignment of investigating officers and ensuring they

have adequate time to undertake the task. This does not appear to be the main factor impacting on duration of investigations.

We would note the following ongoing challenges:

- **Coordinating and meeting with whistleblowers and witnesses** – Similar to our last annual report this remains a challenge in terms of both logistics and the need for separate interviews and arrangements to protect confidentiality. All cases closed this year have involved multiple witnesses and it takes time to coordinate and arrange meetings that are mutually agreeable to both the investigator and the witnesses. This is exacerbated by the large geographical spread of NHS Highland and the logistics of meeting individuals which often requires face to face meetings.
- **Analysing information and data including report writing –** The amount of information generated in each case is significant and takes time to synthesise and draw conclusions from as well as develop proposed actions to address any concerns that are upheld
- **Finalising reports** – good practice includes meeting with whistleblowers to finalise the report. This also takes time to complete with revisions and changes sometimes required and therefore more than one meeting with the whistleblower.
- **Potential delays due to early resolution efforts** – the standards allow for resolving issues through 'business as usual' processes but there is no clear definition from the standards of what constitutes business as usual. One interpretation is that raising concerns through alternative routes such as clinical governance and/or patient care or safety concern routes would be considered business as usual. As noted elsewhere in this report in 2 cases that progressed to whistleblowing investigations it has initially been agreed with the individual through the executive lead for whistleblowing to attempt resolution through raising concerns through clinical governance related routes, e.g. through professional leadership or with senior management. This has not proved satisfactory to the individual or has not resolved the issue and has resulted in a delay before a formal investigation has been started.

Whilst we are endeavouring to improve our processes it is also important to ensure that the desired outcomes for the whistleblower are important and we should continue to include a focus on the quality of the investigation and the final report.

10 KPI 9: The number of concerns at stage 1 where an extension was authorised as a percentage of all concerns at stage 1

There were no stage 1 concerns raised in this period

11 KPI 10: The number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at stage 2

There 5 concerns resolved at stage 2, 100% of these had extensions granted.

12 Reporting processes

Quarterly Reporting

NHS Highland Executive WB Lead presents the quarterly Whistleblowing reports to the following formal governance committees:

- NHS Highland Board
- NHS Highland Staff Governance Committee
- NHS Highland Area Partnership Forum

The reports are also discussed at the Executive Directors Group.

All efforts are made to ensure that reporting is timely and prompt, however, it has to be noted that meetings of governance committees are bi-monthly and so often there will be some lag. However, all committees are given time and space to scrutinise the reports and discuss.

In addition, there is dynamic discussion and reporting via the Executive Lead into the Executive Directors Group as well as to specific leaders, to ensure the any urgent matters are rapidly addressed.

2024 / 2025 reporting

Quarter	Period covered	Area Partnership Forum	Staff Governance Committee	NHS Highland Board
Q1 24-25	1 April – 30 June 2024			
Q2 24-25	1 July – 30 September 2024			
Q3 24-25	1 October – 31 December 2025			
Q4 24-25	1 January - 31 March 2025			
Annual Report 24-25	1 April 2024 - 31 March 2025			

13 Summary

There have again been a small number of whistleblowing concerns raised during 2024-2025 which we have managed through the whistleblowing standards. Our confidential contacts service has 184 contacts from staff during the year. This is in line with previous years activity which indicates no significant trends of increasing or decreasing numbers of concerns overall.

It is not possible to determine a correct level of concerns other than to highlight too few may be indicative of lack of awareness of how to raise concerns or a fear of speaking up. The data we have could be taken to indicate that we have some assurance that staff are able to raise concerns through these two routes. However, it is important to remain vigilant and continue to promote the importance of speaking and to commit to action when concerns are raised.

There is learning from the small number of cases outlined in this report but caution is required in interpreting the wider implications of the outcomes of these cases. As outlined in our report we have reviewed the outcomes in relation to wider improvement work underway across the organisation and this provides assurance that there is alignment between the two.

We have also outlined in this report the linkage between the challenges faced by the board in addressing chronic workforce shortages and growing demand for services and the experience of staff delivering care including their experience of the impact on quality of care these pressures are having.

We are committed to ongoing change and transformation to address these pressures and therefore improve the experience of our staff and care for our patients.

We do know that further work to improve the timeliness of our processes has been required and we have made efforts to do this. Yet, whistleblowing cases are often complex and completing within the 20 working days for stage 2 remains challenging. We remain committed to progressing investigations as quickly as possible but also on the quality of the investigation and working with individuals to attempt to meet their expectations in terms of outcomes from investigations.

NHS Highland is committed to the whistleblowing standards and we will continue to refine our approach and support staff to speak up with confidence.

Agenda Item 12

NHS Highland

Meeting: **Board Meeting**

Meeting date: **29 July 2025**

Title: **HCSA, Quarter 4 Report 2024–2025**

Responsible Executive/Non-Executive: **Gareth Adkins, Director of People & Culture**

Report Author: **Brydie J Thatcher, Workforce Lead, HCSA Programme Manager**

Report Recommendation

This Quarter 4 Addendum **is** presented to the Board ahead of formal submission to the NHS Highland Board on 29 July 2025 for approval.

NHS Highland proposes an overall moderate level of assurance in relation to its delivery of the statutory duties set out in the Health and Care (Staffing) (Scotland) Act 2019 for the period 2024/25. This position is consistent with the assurance rating applied across Quarters 1 to 3 and remains valid following assessment of Quarter 4 activity.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy
- 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	x
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

Quarter 4 Addendum: Health & Care (Staffing) (Scotland) Act 2019

This addendum supplements the main 2024/25 End of Year Report (covering Quarters 1 to 3), providing an overview of developments and assurance activity during Quarter 4 (1 January – 31 March 2025). Its purpose is to ensure a complete account of implementation progress across the Act's inaugural year.

Although the main report was finalised ahead of the March 2025 HIS Board engagement call to meet legislative and internal submission timelines, this addendum enables retrospective review by the NHS Highland Board of final quarter activity. It also consolidates learning and implementation highlights to inform forward planning and improvement work for 2025/26.

To support transparency and assurance going forward, a separate report summarising Quarter 1 and the early part of Quarter 2 (April – August 2025) will be prepared and submitted to the NHS Highland Board in September 2025, continuing the established rhythm of oversight and statutory compliance.

Methodology for Assessing Compliance and Assurance

A combination of board-wide quantitative and qualitative methods has been used to evaluate implementation and compliance with the Act. Key sources of assurance include:

- Engagement with local and Board-level HCSA Implementation Groups
- Professional input from managers, lead clinicians, and staff-side representatives
- Programme team analysis and direct feedback gathered through engagement sessions

This mixed-methods approach ensures a balanced view of statutory delivery, supports identification of variation, and informs the Board's self-assessed assurance level.

Governance Note:
This report has been presented to the Area Partnership Forum (APF) ahead of its formal submission to the NHS Highland Board on 29 July 2025 for approval.

2.2 Background

The Health and Care (Staffing) (Scotland) Act 2019 came into legal effect on 1 April 2024, placing statutory duties on Health Boards and care service providers to ensure appropriate staffing for the delivery of safe and high-quality care. The Act supports improvements in staff wellbeing, transparency in workforce planning, and responsiveness to staffing risks by embedding professional advice and evidence-based methodologies into routine practice.

Following submission and formal approval of the NHS Highland Year-End Report 2024/25 (covering Quarters 1 to 3) by the Board in March 2025, the report was:

- Submitted to Healthcare Improvement Scotland (HIS) and the Scottish Government within required legislative timelines
- Published on the NHS Highland website in line with the public transparency duties outlined in the Act

NHS Highland has since received confirmation that no direct feedback will be issued by Scottish Government or HIS on the 2024/25 annual reports. However, all Board-submitted reports will be reviewed collectively at national level in 2026 to inform a broader understanding of implementation progress and future guidance. HIS will continue to undertake engagement calls with Boards as part of their monitoring duties.

The duties outlined in the Act continue to frame NHS Highland's approach to workforce planning, real-time staffing assessment, risk escalation, and leadership enablement across acute, community, and integrated care services. The guiding principle remains ensuring the right people, with the right skills, in the right place, at the right time to improve outcomes for both patients and staff.

Throughout Quarter 4, NHS Highland has focused on operationalising SOPs, finalising SafeCare implementation plans, and completing post-tool run reviews to drive completion of the first legislative reporting cycle with a consolidated evidence base

While not all ambitions set out for Quarter 4 were fully achieved**,** this was not due to a lack of effort or commitment**,** but rather reflective of the ongoing operational pressures, competing priorities, and capacity challenges across teams.

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 NHS Highland's compliance with the duties set out in the Health and Care (Staffing) (Scotland) Act 2019 and the progress made against HCSA Programme deliverables across the organisation during Quarter 4. This level of assurance is consistent with the assessment applied across Quarters 1 to 3 and is reflected in the HCSA annual report RAG status (Appendix 1).

Whilst we acknowledge that certain areas of practice now demonstrate a higher level of maturity and operational consistency, variances in compliance persist across sectors and service types. In line with our cautious and transparent approach, NHS Highland will continue to adopt a conservative self-assessment rating, using it to guide ongoing system improvement.

Best practices and learning identified during Q4, particularly in relation to SafeCare implementation, SOP testing, CSM process development which will be shared organisation-wide to support standardisation, continuous improvement, and service resilience as we move into the second year of legislative delivery.

	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.						
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						

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	

Comment on the level of assurance

NHS Highland proposes an overall moderate level of assurance in relation to its delivery of the statutory duties outlined in the Health and Care (Staffing) (Scotland) Act 2019 during 2024/25. This assessment is consistent with the assurance position taken throughout Quarters 1 to 3 and remains applicable following the review of Quarter 4 activity.

This moderate level of assurance reflects that:

- A generally sound system of governance, risk management, and internal controls is now in place across most Board functions and care sectors.
- Standard Operating Procedures (SOPs) for real-time staffing, risk escalation, and clinical leadership have been developed and are now being tested and embedded.
- SafeCare implementation is progressing, with rollout extending across rostered inpatient services.
- Post-tool run reviews and improved visibility of staffing data have supported more consistent and informed workforce planning and operational decision-making.

However, we also recognise that:

- Variation in implementation and uptake remains, particularly in non-rostered settings and in relation to wider engagement across professional groups beyond NMAHPs.
- A number of statutory duties still require targeted improvement, strengthened digital infrastructure, and more robust data collection to support consistent compliance and assurance.

In acknowledging these strengths and limitations, it is also important to reflect the ongoing complexity and pressure within the system. The pace of implementation continues to be affected by:

- Workload intensity and limited capacity across operational teams and professional leadership roles
- The need for sustained focus on digital maturity, leadership time, and cross-sector alignment
- The reality that not all Q4 deliverables were fully achieved, and some actions will continue into the work plan for 2025/26

The Scottish Government has recognised that system development and maturity will take time and has confirmed that there are no punitive implications for Boards taking an incremental and proportionate approach.

As per national definitions, most duties would be broadly classified as having "reasonable assurance" (Yellow RAG), with a small number remaining at "limited assurance" (Amber RAG) due to partial implementation or structural limitations. In balance, it is appropriate and proportionate to describe NHS Highland's overall assurance as moderate.

While this terminology does not precisely mirror the national assurance language, it has been agreed locally that "moderate" provides a clear and pragmatic interpretation for the purposes of Board-level reporting and aligns with NHS Highland's internal governance framework.

This assurance level will be reviewed again ahead of the September 2025 Board reporting cycle, which will cover Quarter 1 and early Quarter 2 of 2025/26.

3 Impact Analysis

3.1 Quality/ Patient Care

The Health and Care (Staffing) (Scotland) Act 2019 is fundamentally designed to support the delivery of safe, effective, and person-centred care**.** By ensuring that staffing decisions are based on robust data, clinical advice, and real-time service pressures, the Act strengthens NHS Highland's ability to maintain high standards of care across all settings

3.2 Workforce

While the Act does not introduce new principles in relation to workforce investment, it reinforces the expectation that services must be planned, staffed, and resourced appropriately to deliver safe care.

NHS Highland recognises that identifying and responding to staffing risks, particularly through enhanced agency controls, e-rostering improvements, and

escalation protocols, will carry financial implications. However, the development of standardised establishment reviews, real-time data dashboards, and more efficient use of substantive staff are expected to support cost avoidance, reduction of unnecessary premium spend, and improved workforce deployment over time. The alignment of CSM tool outputs with budget-setting and service planning in 2025/26 will be key to ensuring financial sustainability while maintaining safe staffing standards.

3.3 Financial

There are 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 Staffing risk remains a strategic risk for NHS Highland and is routinely reflected in Board-level risk registers. The HCSA duties, particularly those relating to real-time assessment, escalation, and management of severe/recurrent risks, provide a structured mechanism to identify, respond to, and learn from workforce-related risks.

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

APF & Staff Governance

4.1 List of appendices

The following appendices are included with this report:

- **Appendix 1:** Strategic Priorities for 2025–26
- **Appendix 2:** Quarter 4 Progress, Challenges, and Quarter 1 (2025/26) Priorities – High-Level Summary
- **Appendix 3:** Revised HIS Board Engagement Arrangements: 2025/26
- **Appendix 4:** HCSA Quarter 3 External High-Cost Agency Report- attached

Appendix 1: Strategic Priorities for 2025–26

The work programme for 2025–26 is structured across six strategic domains:

1. Programme Governance and Oversight

    - Transition the HCSA Programme Board to a Transitional Oversight Board, with updated membership and clarified implementation group structures.
    - Define and agree programme success measures for 2025–26.
    - Support local governance embedding through groups such as the Acute Workforce Group and HSCP-level governance structures.
    - Maintain oversight of key national reporting requirements, including the September 2025 report summarising Quarter 1 and early Quarter 2 activity.

2. Safe Staffing Tools, Systems and SOP Implementation

    - Finalise SafeCare rollout and activation across all remaining rostered inpatient areas, including Raigmore Acute.
    - Align SafeCare with the national Maternity and Neonatal Tool, supported by completed roster rebuilds.
    - Expand use of real-time staffing escalation SOPs and refine data collection methods for assurance reporting.
    - Develop and test new SOPs in HSCP and social care settings.

3. Workforce Planning and Data-Driven Decision-Making

    - Complete the 2024/25 Common Staffing Methodology (CSM) cycle, ensuring that all outputs are finalised, reviewed, and shared. Focus will be placed on capturing shared learning and embedding findings into local workforce planning processes.
    - Commence the 2025/26 CSM cycle**,** including planning workshops, stakeholder engagement, output review, and aligned governance reporting Establish clear alignment between CSM outputs and establishment reviews, budget setting, and service redesign.
    - Advance medical staffing planning in Acute services through a structured, service-based approach.
    - Develop flexible workforce modelling tools for scenario planning (e.g. bed base, LOS).
    - Build on the operationalising a framework to strengthen integrated service and workforce planning, reducing duplication, improving data coherence, and enabling operational teams to plan against a single, aligned set of workforce assumptions.

4. Policy, Practice and Local Implementation Support

    - Finalise and disseminate key policies (Health Roster Policy, Locum and Bank Governance Framework, Maternity Escalation Policy).

- Launch a suite of “Policy into Practice” Fact Sheets and visual tools to support local implementation and compliance.
- Continue delivery of engagement and education sessions to managers and professional leads across all sectors.
- Initiate targeted support for social care and local authority partners, with a focus on third-party compliance obligations and reporting clarity.

5. Collaboration and National Alignment

- Participate actively in HCSA Leads Network and contribute to national working groups and shared learning forums.
- Maintain regular engagement through Healthcare Improvement Scotland Board Calls, sharing implementation updates and lessons learned.
- Engage in cross-Board improvement activities and peer learning—especially in partnership with NHS Grampian, NHS Ayrshire & Arran, and NHS Lothian.

6. Culture and Leadership Development

- Begin scoping work on how to define and embed the “Time to Lead” principle, supporting protected leadership time for SCNs, AHP leads, and clinicians.
- Continue delivery of leadership engagement sessions and alignment of job planning to reflect statutory responsibilities.
- Develop tools to support ongoing clinical leadership development, linked to service delivery, staff wellbeing, and safe staffing assurance.

Appendix 2: Quarter 4 Progress, Challenges, and Quarter 1 (2025/26)

Key Area	Progress in Quarter 4 (2024/25)	Key Challenges	Planned Work for Quarter 1 (2025/26)
Embedding Guiding Principles	Applied in post-tool run reviews; referenced in SafeCare and escalation SOPs; bulletin shared.	Inconsistent interpretation across services; limited use in third-party service planning.	Integrate principles explicitly into annual service planning and local establishment
Standardising Contracting Processes	Legal and commissionin g leads engaged; early draft guidance	Variation in third-party contracts; complex governance for HSCP-commissioned services.	Finalise contract templates; initiate phased implementation and training.
Strengthening Governance	RTS and leadership SOPs tested; reporting template refinements	Full revision of HCSA governance structure delayed; Implementation Groups not yet	Relaunch Programme Board and Implementation Groups with 'BAU' focus; embed in performance cycles.
Improving Data Management	SafeCare data introduced in pilot areas; early reporting examples gathered.	Data entry variation; system reliance on consistent roster rebuild progress.	Begin RTS reporting audits; create data validation framework with digital & clinical
Enhancing Risk Management	SOPs for RTS and severe/recurrent risks implemented; early local testing initiated.	Limited uptake in non-acute areas; mixed use of escalation documentation tools.	Embed SOPs into daily huddle structure and Datix prompts; monitor use via weekly reviews.
Leadership Development	"Time to Lead" SOP circulated and National Group engagement	Protected time not consistently reflected in job plans; uptake varied in medical teams.	Provide targeted support for SCNs, AHP leads, and medical leaders.
Training & Staff Engagement	SafeCare & CSM, training delivered to >150 staff; staff-side consulted on new	Training uptake low in smaller and mixed teams; training not always linked to policy use.	Develop Safe Staffing Essentials e-learning bundle; link SOP training to induction/mandatory systems.

Key Area	Progress in Quarter 4 (2024/25)	Key Challenges	Planned Work for Quarter 1 (2025/26)
Common Staffing Method (CSM) Implementation	2024/25 cycle completed; post-run workshops held; feedback [illegible]	Gaps in how output is translated into planning actions; variation in tool	Establish output review panels; produce CSM Output-to-Action toolkit and workforce planning links. Look to digitisation of output
Additional Key Milestones and Actions	Acute e-rostering rebuild commenced; MHLD/Maternity areas SafeCare test sites.	Incomplete SafeCare coverage; issues with alignment across hybrid (paper/digital)	Prioritise inpatient SafeCare rollout; develop switch-on checklist; finalise roster and locum policy reviews.

Appendix 3: Revised HIS Board Engagement Arrangements:

2025/26 Revised HIS Board Engagement Arrangements: 2025/26

Healthcare Improvement Scotland (HIS), under Duty 12IP of the Health and Care (Staffing) (Scotland) Act 2019, has a statutory responsibility to monitor NHS Boards' compliance with staffing duties. To support this function, HIS introduced a programme of Board Engagement Calls (BECs) as part of a broader, intelligence-led monitoring approach. These calls provide a structured opportunity for HIS to triangulate Board-submitted reports with wider data, evidence, and context.

Following a review of this process and stakeholder feedback, the Healthcare Staffing Programme (HSP) has confirmed a revised model for 2025/26, moving to a biannual (6-monthly) engagement structure, as outlined below:

Quarter	Engagement Activity	Key Notes
Q1 (Apr–	Board Engagement Call	To be scheduled at any point during Q1; not dependent on an internal quarterly report.
Q2 (Jul–Sep)	No Call	HIS/HSP will undertake a desk-based review of available data, including annual reports and internal submissions. Boards may be contacted to provide additional information if needed.
Q3 (Oct–	Board Engagement Call	To be scheduled during Q3; again, not dependent on a current internal report being available.
Q4 (Jan–	No Call	Further desk-based review by HIS/HSP. Boards may be contacted to clarify or supplement evidence.

This approach supports a flexible and proportionate model for HIS engagement, balancing assurance responsibilities with feedback received from Boards on capacity and reporting burden. HIS will continue to assess and refine this model annually, in alignment with its statutory obligations and Boards' Duty 12IT to assist HIS in discharging its functions.

NHS Highland will maintain internal readiness for engagement calls in Q1 and Q3, and ensure all submitted reports are prepared in line with expected content and timelines.

Agenda Item 13

NHS Highland

Meeting: **Board Meeting**

Meeting date: **29 July 2025**

Title: **Workforce Monitoring Report 2025**

Responsible Executive/Non-Executive: **Gareth Adkins, Director of People and Culture**

Report Author: **Gayle Macrae – EDI Lead Workforce**

Report Recommendation:
The Board are asked to take substantial assurance that the publication of the report demonstrates compliance with the Public Sector Equality Duty, Specific Duties Scotland requirement to gather, use and publish employee information.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal requirement
- 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	x	Listen Well	x	Nurture Well	x	Plan Well	x
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well		Progress well		**All** Well Themes			

2 Report summary

2.1 Situation

The Workforce Monitoring Report is an annual report that must be published to demonstrate that NHS Highland meets the requirement as set out in the Public Sector Equality Duty to gather, use and publish employee information. The information within the report considers the workforce position as of 31st December 2024 for the period January 1st - December 31st 2024.

The Board are being asked to take substantial assurance that the publication of the report demonstrates compliance with the Public Sector Equality Duty, Specific Duties Scotland requirement to gather, use and publish employee information.

2.2 Background

The Public Sector Equality Duty is a legal requirement for public authorities to consider how they can improve society and promote equality in every aspect of their day-to-day business.

The PSED has 2 parts – the general duty and specific

duties. The general duty has 3 needs –

- To put an end to unlawful behaviour that is banned by the Equality Act 2010, including discrimination, harassment, and victimisation.
- To advance equal opportunities between people who have a protected characteristic and those who do not.
- To foster good relations between people who have a protected characteristic and those who do not.

The purpose of the specific duties is to help public authorities improve their performance on the general duties. To comply with the specific duties, public authorities must publish accessible information that shows how they are complying with the general duty.

To meet the requirements of the specific duties, NHS Highland must –

1. Report on mainstreaming the equality duty.
2. Publish equality outcomes and report progress.
3. Assess and review the equality impact of policies and practices.
4. Gather, use, and publish employee information.
5. Use information on the characteristics of members or board members gathered by the Scottish Ministers.
6. Publish gender pay gap information.
7. Publish equal pay statements.
8. Consider award criteria and conditions in relation to public procurement.
9. Publish in a manner that is accessible.

The Workforce Monitoring Report relates to point 4 and must be published annually on the NHS Highland website in an accessible format, (which is set out in point 9).

The data contained within the report was provided by the Workforce Systems Team who proactively assess data quality based on agreed principles to ensure that our workforce data is of high value to NHS Highland, and its stakeholders.

2.3 Assessment

NHS Highland's Workforce Monitoring report details the position as of 31st December 2024, for the time period 1st January 2024 - 31st December 2024 unless otherwise highlighted. Some key points from the report are –

- The % of equalities data on e-ESS has increased, however this is mainly due to the interface between job train and e-ESS. We are proposing to run a campaign to raise awareness of the importance of colleagues sharing their equalities data. This campaign will target existing staff who joined prior to January 2023 which is when the interface came into operation.
- Nursing & Midwifery headcount is 2.3% higher than in 2023
- The % of males in the workforce has increased slightly year on year, females remain the dominant sex at 82%
- The only job families where the ratio of males is in close proximity to females is Medical & Dental and Medical Support. This is also the area where we see a significant gender pay gap occurring and further investigation into the causes of this will be carried out through the Equally Safe at Work Accreditation programme planned for 2025/26.
- The age bracket with the highest % of colleagues in Nursing & Midwifery and Medical & Dental is 50-54 years old. These job families could be impacted by retirements so may be useful to promote flexible retirement options targeted in these areas.
- Increase of 15,000 people applying to NHSH in 2024, almost 12000 of this came from persons of African ethnicity.
- Compared to 2023 there were 600 fewer vacancy forms submitted to recruitment
- The conversion rate for Allied Health Profession roles is 6.52% female and 0.95 % male although the number of applications received from both sexes are almost identical. The professional leadership team in this field will analyse the potential causes for this and build actions into their workforce plan.
- Large number of applications (3125) from males into Personal & Social Care however conversion rate of only 0.70% vs 4.69% of females. Potential causes of this will be analysed and actions developed in conjunction with our Employability Lead.

2.4 Proposed level of Assurance

This report proposes the following level of assurance

Substantial	x	Moderate	
Limited		None	

Comment on the level of assurance

The level of assurance is substantial as the report meets the needs as set out in the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 to gather, use and publish information annually about the recruitment, development and retention of staff with protected characteristics.

3 Impact Analysis

3.1 Quality/ Patient Care

By understanding the demographics of our workforce, we can strive to create an inclusive culture which impacts positively on patient care.

3.2 Workforce

Monitoring of workforce profiles will raise awareness of potential workforce implications such as barriers to recruitment for certain ethnic groups. We can review our internal processes to ensure they are inclusive and accessible to all, which in turn makes NHS Highland an attractive employer. We can use the information to identify areas for improvement and introduce new initiatives such as unconscious bias training and awareness campaigns.

3.3 Financial

No known financial implications

3.4 Risk Assessment/Management

If the information contained within the report is not used to further the 3 needs as set out in the General Equality Duty, then the organisation risks not meeting its legal obligations in respect of Section 149 of the Equality Act 2010 (the public sector equality duty).

3.5 Data Protection

This report does not include personally identifiable information. Where numbers in a category/table are small, some figures have been rounded to one decimal place or expressed as ‘less than five’, to reduce the risk of inadvertently identifying individuals

3.6 Equality and Diversity, including health inequalities

This report demonstrates that NHS Highland is complying with the requirements of the Equality Act 2010, (Specific Duties) (Scotland) Regulations 2012. The publication of this report on our website, enables external monitoring bodies such as the Equality and Human Rights Commission for Scotland and the Scottish Human Rights Commission to monitor our compliance with current equality and diversity legislation and good practice guidelines.
An EQIA is not required for purposes of publishing this report.

3.7 Other impacts

No relevant impacts.

3.8 Communication, involvement, engagement and consultation

This report has been published in collaboration with members of the workforce systems and workforce planning teams. The information contained within was also reviewed by the EDI Oversight group and Professional Leads who provided feedback and suggestions for amendments.

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.

- EDI Oversight Group 01/04/25 and 13/05/25
- People Portfolio Board 20/05/25
- Area Partnership Forum June 2025
- Staff Governance Committee July 2025

4.1 List of appendices

The following appendices are included with this report:

- Appendix 1 – Workforce Monitoring Report 2025

Workforce Monitoring Report
2024

NHS Highland
na Gàidhealtachd

1 Contents

1 Introduction

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 came into force on the 27th of May 2012. This requires public bodies such as NHS Highland to produce an Annual Workforce Monitoring Report covering all nine of the "protected characteristics", as defined in the Equality Act 2010.
The nine "protected characteristics" are:

- Race
- Disability
- Sex (male or female)
- Religion or belief
- Sexual orientation
- Gender reassignment
- Age
- Pregnancy and maternity
- Marriage and civil partnership

The Regulations require that the Workforce Report must include details of:

- The number of staff and their relevant protected characteristics.
- Information on the recruitment, development, and retention of employees, in terms of their protected characteristics.
- Details of the progress the public body has made to gather and use the above information to enable it to better perform the equality duty.

2 Gathering Workforce Information

2.1 Specific Duties Required In Relation To Personal Information

Public authorities in England, Scotland and Wales are legally required to publish equality information under the specific equality duties. Data about people and their protected characteristics (also called "equality monitoring") is shared and reported to build an evidence-based compliance with the public sector equality duties (PSED) and to meet the specific duties. Collecting and analysing equality information is an important way to develop an understanding how policies and practices affect those with protected characteristics. Public authorities should always use a proportionate approach to collecting personal information.
The national database is used to support workforce planning within NHS Scotland and ensures that NHS Highland meet or exceed our legal requirements in respect of equality and diversity monitoring. This information is held confidentially and used only for purposes of equality monitoring to ensure no group of staff are discriminated against or disadvantaged.

2.2 Data Collection

The workforce monitoring report for 2025 is based on NHS Highland employee data provided for the period of January 2024 to December 2024. The primary sources of data were from the national workforce systems, eESS (the Electronic Employee Support System, which is the HR information system), ePayroll, JobTrain (the recruitment system) and Turas Learn (the learning management system for health and social care staff).
Staff have the legal right not to disclose information about their protected characteristics, therefore any information supplied by staff is on a purely voluntary basis. As a result, the completeness of our information therefore varies by protected characteristic. The percentage of responses collated for each protected characteristic is shown below, this includes those who selected "prefer not to say". Anything less than 100% is caused by no information being provided by the colleague.

Protected Characteristic 2023	% of Data Recorded on eESS	% of Data Recorded on eESS 2024
Race	80.8%	82.2%
Disability	84.2%	85.4%
Sex (male or female)	100.0%	100.0%
Religion / Faith	78.4%	79.8%
Sexual Orientation	81.1%	82.5%
Gender Reassignment	84.3%	84.4%
Age	100.0%	100.0%
Pregnancy and Maternity	100.0%	100.0%
Marital Status	100.0%	100.0%

The average volume of data collected per protected characteristic is 90.4% which is an increase of 0.5% since last year's report.

The Jobtrain and eESS systems were interfaced in January 2023 which meant that any new colleagues joining NHS Highland automatically had their personal details transferred from their job application into the internal HR systems. This accounts for, in part, the increase in information captured from 2023 to 2024.

In this report, where numbers in a category/table are small, some figures have been rounded to one decimal place or expressed as 'less than five', to reduce the risk of inadvertently identifying individuals.

Unless stipulated, the figures provided in this report do not include Bank Staff or Doctors in Training.

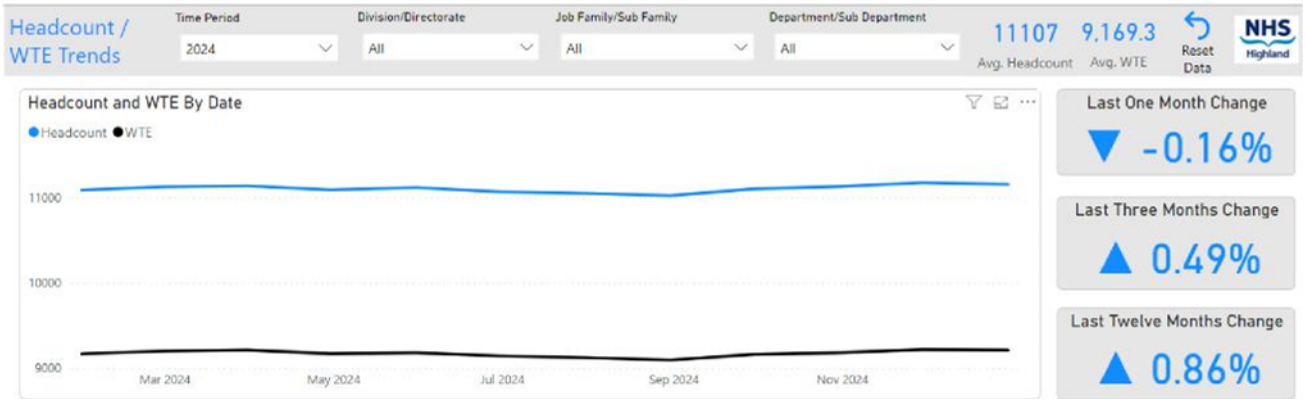
2.3 Using The Workforce Report

This report:

- Demonstrates NHS Highlands compliance with the requirements of the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, as amended.
- Will be formally submitted for approval to the NHS Highland Staff Governance Committee. Following approval, it will also be widely circulated within the organisation and posted on the NHS Highland website.
- Will help the NHS Highland Board and others, to gauge whether NHS Highland employees and prospective employees are being treated fairly and equitably. Any evidence to the contrary highlighted by the report will be reviewed and appropriate follow up action taken.
- Provides evidence which will support the work undertaken by NHS Highland to create a workplace free from prejudice or discrimination.
- Gives the population of Highland, Argyll and Bute and prospective employees, information regarding how NHS Highland strives to treat its staff fairly and equitably.
- Enables external monitoring bodies such as the Equality and Human Rights Commission for Scotland and the Scottish Human Rights Commission to monitor our compliance with current equality and diversity legislation and good practice guidelines.

3 Current Workforce

As at 31st December 2024, the substantive headcount for NHS Highland was 11,158 persons which equates to 9,210 whole time equivalent (WTE), with whole time being 37 hours per week for staff on Agenda for Change Terms and Conditions as of 1st April 2024.
The overall substantive headcount remained steady throughout 2024, growing by 68 between January and December but with small ups and downs across the months.



Headcount trend for 1st January 2024 – 31st December 2024

As well as substantive and fixed term members of staff, NHS Highland also uses "Bank" workers, which provides flexibility to increase staff over and above its core staff cohort at busier times, and to cover unexpected absences, such as sick leave. As at 31st December 2024 there were 2615 sole bank workers, this is an increase of 91 bank workers on the same date in 2023. There are also 2646 colleagues who hold both a substantive and a bank contract meaning they can work extra hours either within their own area or a different discipline within NHS Highland.

NHS Highland	31st December 2023	31st December 2024
Contract Type	**Persons in Post**	**Persons in Post**
Bank Only	2524	2615
Bank & Substantive	2517	2646
Substantive Only	8553	8519
Total	13594	13780

Number of persons in post by contract type

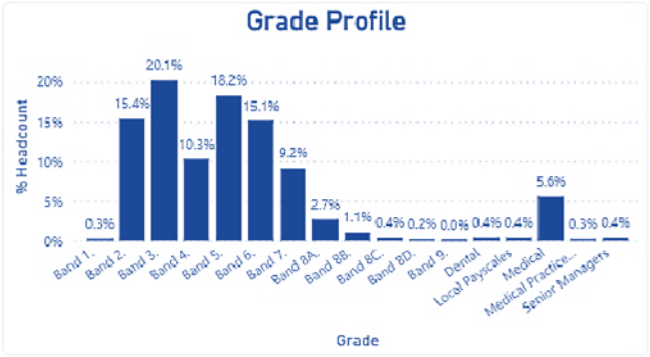
At the end of 2024, 37.7% of the workforce was in the Nursing and Midwifery job family (2.3% higher than the previous year). The next largest job family at 18.6% was Administrative Services (down 1.4% since 2023). The decrease in headcount within this job family can be partly attributed to transformation work that has been undertaken in Acute areas to redesign administrative job roles. There was a pause in recruitment into these areas whilst this work was in progress.

Job Family December 2023	Headcount 31st	Headcount 31st December 2024	Change in % of Workforce from 2023 - 2024
Administrative Services	2105	2076	-1.4%
Allied Health Profession	775	798	+3.0%
Dental Support	184	185	+0.5%
Healthcare Sciences	357	361	+1.1%
Medical and Dental	642	666	+3.7%
Medical Support	46	50	+8.7%
Nursing/Midwifery	4117	4211	+2.3%
Other Therapeutic	371	398	+7.3%
Personal and Social Care	1257	1262	+0.4%
Senior Managers	40	38	-5.0%
Support Services	1211	1160	-4.2%
Total	**11063**	**11158**	**+0.9%**

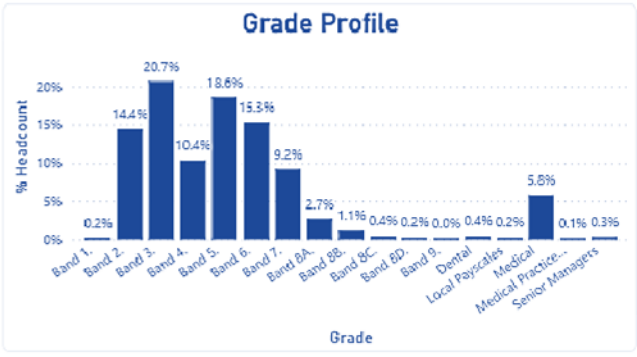
Number of persons in post by Job Family

The graphs below show the workforce split in terms of paybands for both 2023 and 2024. There has been an increase in the number of colleagues in Band 3 posts which may be attributed to a National job evaluation process over 2023/2024 which saw a large number of Band 2 Nursing staff be upgraded to Band 3.

31st December 2023



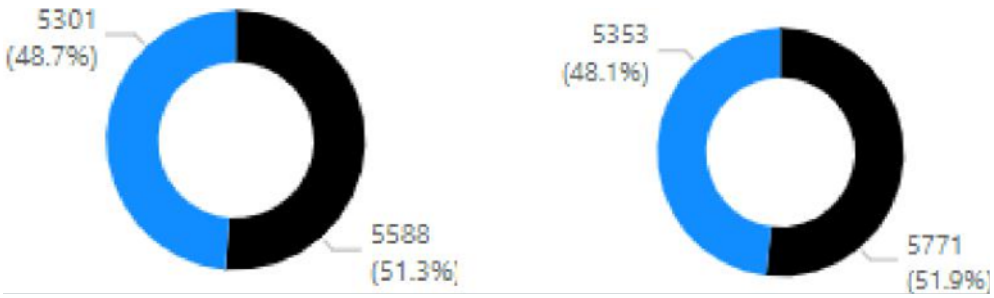
31st December 2024



Percentage of persons in post by salary banding

The workforce is split almost in half with regards to working hours and there has been a small shift in favour of part time working since 2023.

31st December 2023 **31st December 2024**



Percentage of persons in post by working hours

3.1 Ethnic Origin

NHS Highlands workforce is made up of 51.5% persons of White-Scottish origin which is less than the population of Highland (75.9% in the 2022 Census) and less than Argyll and Bute (74%). Since 2022, the headcount recorded of all ethnic groups has increased or remained the same, which correlates with a decrease in the number of persons not declaring any information or choosing "prefer not to say".

The following table shows the headcount and the percentage of the total workforce each ethnic group represents.

NHS Highland		2022	2023		2024	
Ethnicity	**Headcount**	**% Total**	**Headcount**	**% Total**	**Headcount**	**% Total**
African - African, African Scottish or African British	20	0.2%	34	0.3%	61	0.6%
African - Other	6	0.1%	12	0.1%	45	0.4%
Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	< 5	< 0.05%	< 5	< 0.05%	< 5	< 0.05%
Asian - Chinese, Chinese Scottish or Chinese British	9	0.1%	11	0.1%	13	0.1%
Asian - Indian, Indian Scottish or Indian British	36	0.3%	45	0.4%	61	0.6%
Asian - Other	71	0.7%	79	0.7%	89	0.8%
Asian - Pakistani, Pakistani Scottish or Pakistani British	13	0.1%	18	0.2%	20	0.2%
Caribbean or Black	N/A	N/A	N/A	N/A	< 5	< 0.05%
Caribbean or Black - Black, Black Scottish or Black British	< 5	< 0.05%	< 5	< 0.05%	6	0.1%
Caribbean or Black - Caribbean, Caribbean Scottish or Caribbean British	0	0.0%	< 5	< 0.05%	< 5	< 0.05%
Caribbean or Black - Other	< 5	< 0.05%	< 5	< 0.05%	< 5	< 0.05%
Mixed or Multiple Ethnic Group	37	0.4%	42	0.4%	48	0.4%
Other Ethnic Group - Arab, Arab Scottish or Arab British	10	0.1%	17	0.2%	20	0.2%
Other Ethnic Group - Other	21	0.2%	19	0.2%	18	0.2%
White - Gypsy Traveller	< 5	< 0.05%	< 5	< 0.05%	< 5	< 0.05%
White - Irish	78	0.7%	81	0.8%	83	0.8%
White - Other	340	3.2%	412	3.8%	448	4.0%
White - Other British	1236	11.7%	1323	12.2%	1365	12.3%
White - Polish	38	0.4%	57	0.5%	82	0.7%
White - Scottish	5283	50.0%	5498	50.6%	5719	51.5%
Not Declared	2161	20.5%	2083	19.2%	1972	17.8%
Prefer not to say	1197	11.3%	1129	10.4%	1052	9.5%

Number of persons in post by Ethnicity

In 2024, NHS Highland welcomed 21 Nurses through the North of Scotland international recruitment programme. NHS Highland, Grampian, Orkney, Shetland Western Isles and Tayside work together to provide employment opportunities for international applicants. Many of the colleagues who joined NHS Highland were from Nigeria although there were also applicants from Ghana and America.

Scotland Census 2022	Highland		Argyll and Bute		NHS Highland
Ethnicity	**Headcount**	**% Total**	**Headcount**	**% Total**	**% Total**
African - African, African Scottish or African British	51	0.02%	9	0.001%	0.6%
African - Other	364	0.15%	145	0.17%	0.4%
Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	256	0.11%	46	0.05%	<0.05%
Asian - Chinese, Chinese Scottish or Chinese British	513	0.22%	193	0.22%	0.1%
Asian - Indian, Indian Scottish or Indian British	704	0.30%	151	0.17%	0.6%
Asian - Other	872	0.37%	249	0.29%	0.8%
Asian - Pakistani, Pakistani Scottish or Pakistani British	391	0.17%	124	0.14%	0.2%
Caribbean or Black - Black, Black Scottish or Black British	13	0.001%	14	0.02%	0.1%
Caribbean or Black - Caribbean, Caribbean Scottish or Caribbean British	91	0.04%	37	0.04%	<0.05%
Caribbean or Black - Other	107	0.04%	31	0.04%	<0.05%
Mixed or Multiple Ethnic Group	1943	0.82%	663	0.77%	0.4%
Other Ethnic Group - Arab, Arab Scottish or Arab British	259	0.11%	100	0.12%	0.2%
Other Ethnic Group - Other	543	0.23%	199	0.23%	0.2%
White - Gypsy Traveller	263	0.11%	84	0.10%	<0.05%
White - Irish	1549	0.66%	853	0.99%	0.8%
White - Other	6185	2.63%	2102	2.45%	4.0%
White - Other British	38140	16.20%	16648	19.36%	12.3%
White - Polish	4506	1.91%	666	0.77%	0.7%
White - Scottish	178605	75.89%	63657	74.04%	51.5%

Population Data from 2022 Census vs NHSH workforce

In comparison to the population demographics displayed in the table above, NHS Highland employs a greater number of persons from the following ethnic backgrounds –

- African - African, African Scottish, or African British
- African - Other
- Asian - Indian, Indian Scottish, or Indian British
- Asian – Other
- Asian - Pakistani, Pakistani Scottish or Pakistani British
- Caribbean or Black - Black, Black Scottish or Black British
- Other Ethnic Group - Arab, Arab Scottish, or Arab British
- White – Other

In contrast, the organisation employs a disproportionate number of colleagues from the following ethnic groups –

- Asian – Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- Asian – Chinese, Chinese Scottish, or Chinese British
- Mixed or Multiple Ethnic Group
- Other Ethnic Group – Other
- White – Gypsy Traveller
- White – Other British
- White – Polish

It is important to note, however, that 9.5% of the workforce chose “prefer not to say” as an option to answer this question and 17.8% have not declared any information therefore the above analysis may be affected by these omissions.

The table on the next page shows how many persons are in each job family split down by Ethnicity. The Senior Manger job family is predominately White-Scottish although 12 persons have not declared or chosen “prefer not to say” when prompted to record their ethnicity on eESS. Medical Support is another job family that appears to lack diversity of ethnicities although nine persons have not declared their ethnicity.

Ethnicity	2024 Admin Services	2024 AHPs	2024 Dental Support	2024 Healthcare Sciences	2024 Medical & Dental	2024 Medical Support	2024 Nursing & Midwifery	2024 Other Therap - eutic	2024 Personal & Social Care	2024 Senior Manager	2024 Support Services
African - African, Scottish African or British African	< 5	6	0	< 5	12	0	24	0	12	0	< 5
African - Other	0	< 5	0	< 5	0	0	31	< 5	7	0	< 5
Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	< 5	0	0	0	< 5	0	0	0	< 5	0	< 5
Asian - Chinese, Chinese Scottish or Chinese British	< 5	0	0	0	8	0	0	< 5	0	0	0
Asian - Indian, Indian Scottish or Indian British	7	< 5	0	< 5	28	< 5	9	< 5	5	0	< 5
Asian - Other	11	< 5	< 5	5	12	0	36	< 5	< 5	0	15
Asian - Pakistani, Pakistani Scottish or Pakistani British	< 5	< 5	0	< 5	12	0	0	< 5	< 5	0	0
Caribbean or Black	0	0	0	0	0	0	< 5	0	0	0	0
Caribbean or Black - Black, Black Scottish or Black British	0	0	< 5	< 5	0	0	< 5	0	0	0	0
Caribbean or Black - Caribbean, Caribbean Scottish or Caribbean British	0	0	0	0	0	0	< 5	0	0	0	0
Caribbean or Black - Other	0	0	0	0	0	0	0	0	0	0	< 5
Mixed or Multiple Ethnic Groups	12	< 5	0	< 5	6	0	15	< 5	< 5	0	< 5
Other Ethnic Group - Arab, Arab Scottish or Arab British	< 5	< 5	0	< 5	13	0	< 5	< 5	0	0	0
Other Ethnic Group - Other	< 5	< 5	0	< 5	7	0	5	< 5	0	0	< 5
White - Gypsy Traveller/Roma	0	0	0	0	0	0	< 5	0	0	0	0
White - Irish	8	13	< 5	< 5	12	0	29	8	6	0	< 5
White - Other	67	22	5	22	61	< 5	163	20	28	< 5	60
White - Other British	264	128	12	57	141	7	492	56	96	8	109
White - Polish	20	< 5	0	< 5	0	< 5	18	< 5	7	0	28
White - Scottish	1174	434	141	187	211	25	2362	214	372	17	610
Prefer not to say	215	63	15	37	48	< 5	304	23	223	3	124
Not declared	308	101	10	26	82	9	660	47	498	9	228

Number of persons in post split down by Ethnicity and Job Family

3.2 Disability

The Equality Act 2010 defines disability as a person having:

- A physical or mental impairment
- An impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

A person is recognised as disabled whether their condition is either visible or hidden, and/or has a substantial and long-term (12 months or longer) impact on their ability to do normal daily activities. It should be noted that disability is also self-defined by the individual.

The number of staff who consider themselves to have a disability is 156, which is 1.4% of the workforce. The disability data is based on the answers given by staff when they joined NHS Highland. Currently, the disability status of staff is not changed during their employment unless the staff member voluntarily updates their information on eESS. Given that it is estimated that 27% of the Scottish population define themselves as disabled,[1] it is likely that the actual number of colleagues with a disability is higher. A campaign focusing on workforce equalities information is planned for 2025 to understand why over 28.9% of the workforce would "prefer not to say" whether they have a disability or fail to provide any information at all regarding this question.

It is worth noting however, that the percentage of people who choose "prefer not to say" as their answer, has fallen by 3.1% over the last 3 years.

Under the Equality Act 2010, employers have a legal responsibility to make reasonable adjustments for disabled staff. NHS Highland actively supports staff who require adjustments in their workplace. Staff are encouraged to have a discussion with their manager if they need reasonable adjustments to ensure positive impact on wellbeing and performance of the workforce.

A new Once For Scotland Reasonable Adjustments Guide is anticipated to be rolled out to all Scottish Health Boards in Spring 2025. This will provide managers with guidance on how to support colleagues who request adjustments in the workplace.

NHS Scotland also partners with the Business Disability Forum, an organisation who aims to improve the life experiences of disabled employees by removing barriers to inclusion. Being a partner brings benefits to NHS Highland such as access to their knowledge hub which contains lots of useful training resources and toolkits, as well as a dedicated business partner who can advise on how to improve inclusion and accessibility within the workplace.

NHS Highland		2022		2023		2024
Disability	**Headcount**	**% Total**	**Headcount**	**% Total**	**Headcount**	**% Total**
Yes	89	0.8%	110	1.0%	156	1.4%
No	6855	64.9%	7337	67.5%	7738	69.7%
Not Declared	1777	16.8%	1713	15.8%	1626	14.6%
Prefer not to say	1842	17.4%	1708	15.7%	1588	14.3%

[1] DWP Family Resources Survey: 2022 to 2023, disability tables 4.1 and 4.4

Number of persons in post by Disability statu

3.3 Sex (Male or Female)

In both the Highland and Argyll and Bute area, the 2022 Scottish Census figures report that the population is made up of 49% males and 51 % females. Traditionally, most members of the Nursing, Midwifery and Allied Health Professions have been female, which means that all Health Boards in Scotland have a much higher proportion of female staff to male staff. The most recent NHS Scotland data release (up to 30th September 2024) reports that 78.8% of the whole of NHS Scotland's workforce is female and 22.2% is male. The workforce of NHS Highland is predominantly female (9,151 headcount), representing 82.4% of staff in 2024. The trend data over the previous three years in the table below shows that the male headcount % has increased and female has decreased slightly.

NHS Highland	2022		2023		2024	
Sex (Male or Female)	**Headcount**	**% Total**	**Headcount**	**% Total**	**Headcount**	**% Total**
Female	8732	82.7%	8963	82.5%	9151	82.4%
Male	1831	17.3%	1906	17.5%	1956	17.6%

Number of persons in post by Sex

With a female dominated workforce, it is not surprising to note that all job families have a higher ratio of females to males. The only job families where the ratio of males falls within a 10% range of females are Medical & Dental and Medical Support. The breakdown of the job families by sex are outlined in the following table.

NHS Highland	Male		Female	
Job Family	**Headcount**	**% Total**	**Headcount**	**% Total**
Administrative Services	316	15.0%	1782	85.0%
Allied Health Profession	94	11.9%	692	88.1%
Dental Support	< 5	0.5%	186	99.5%
Healthcare Sciences	149	41.8%	207	58.2%
Medical and Dental	314	48.0%	340	52.0%
Medical Support	21	45.0%	26	55.0%
Nursing / Midwifery	371	8.9%	3787	91.1%
Other Therapeutic	66	17.1%	320	82.9%
Personal and Social Care	135	10.7%	1124	89.3%
Senior Managers	16	40.9%	23	59.1%
Support Services	477	40.2%	709	59.8%

Number of persons in post split down by Sex and Job Family

3.3.1 NHS Highland Board Members

As at 31st December 2024, the NHS Highland Board comprised 21 members made up of 5 Executive Members and 16 Non-Executive/Stakeholder Members. The reduction of 2 female members was due to their term of service ending and these vacant positions will be recruited to in 2025.

NHS Highland	2023		2024	
Role	**Male**	**Female**	**Male**	**Female**
Executive Director	2	3	2	3
Non-Executive Director and Employee Director	8	10	8	8

Number of Board Members in post by Sex

3.4 Religion or Belief

As with other protected characteristics, staff are asked to provide information regarding their religious and faith beliefs. Over the last few years the quality of information provided has improved, with more people providing information on religion and beliefs in 2024 than the previous years. Of those who provided information, the largest proportion of staff identify themselves as "No Religion" (33.1%: 2.2% higher than the previous year) or "Church of Scotland" (16.3%: 0.7% down on 2023).

NHS Highland	2022		2023		2024	
Religion or Belief	**Headcount**	**% Total**	**Headcount**	**% Total**	**Headcount**	**% Total**
Another Religion or Body*	N/A	N/A	N/A	N/A	< 5	< 0.05%
Buddhist	25	0.2%	27	0.3%	32	0.3%
Christian - Other	882	8.4%	943	8.7%	1018	9.2%
Church of Scotland	1872	17.7%	1850	17.0%	1810	16.3%
Hindu	33	0.3%	35	0.3%	39	0.4%
Jewish	< 5	< 0.05%	5	0.1%	5	< 0.05%
Muslim	49	0.5%	62	0.6%	71	0.6%
No Religion	3015	28.5%	3353	30.9%	3673	33.1%
Pagan*	N/A	N/A	N/A	N/A	< 5	< 0.05%
Roman Catholic	647	6.1%	688	6.3%	719	6.5%
Sikh	< 5	< 0.05%	5	0.1%	7	0.1%
Other	126	1.2%	143	1.3%	152	1.4%
Prefer not to say	1484	14.1%	1410	13.0%	1337	12.0%
Not declared	2422	22.9%	2348	21.6%	2241	20.2%

Number of persons in post by Religion or Belief

***Note these are new options for selection introduced in 2024**

Across Scotland, the 2022 census showed a similar picture with most people declaring they have no religion, 51.1% up from 36.7% in 2011.

	2022 Census Figures		
Religion or Belief	**% Highland Population**	**% Argyll and Bute Population**	**% NHSH Workforce**
Buddhist	0.28%	0.28%	0.3%
Christian - Other	7.62%	6.63%	9.2%
Church of Scotland	23.44%	26.97%	16.3%
Hindu	0.14%	0.10%	0.4%
Jewish	0.04%	0.08%	<0.05%
Muslim	0.48%	0.38%	0.6%
No Religion	54.33%	48.46%	33.1%
Roman Catholic	6.25%	9.17%	6.5%
Sikh	0.02%	0.06%	0.1%
Other	0.26%	0.22%	1.4%
Not declared	6.58%	7.04%	20.2%

Population Data from 2022 Census vs NHSH workforce split down by Religion or Belief

3.5 Sexual Orientation

There has been a decrease year on year in the number of staff who choose "prefer not to say" and those who do not complete their information. This is a positive indicator that staff feel more open to share their sexual orientation and that they trust that their data will be used appropriately.

NHS Highland	2022		2023		2024	
Sexual Orientation	**Headcount**	**% Total**	**Headcount**	**% Total**	**Headcount**	**% Total**
Bisexual	55	0.5%	76	0.7%	99	0.9%
Gay	29	0.3%	27	0.3%	25	0.2%
Gay/Lesbian	26	0.3%	46	0.4%	66	0.6%
Heterosexual	6462	61.2%	6890	63.4%	7276	65.5%
Lesbian	23	0.2%	22	0.2%	20	0.2%
Other	20	0.2%	24	0.2%	24	0.2%
Other sexual orientation*	N/A	N/A	N/A	N/A	< 5	< 0.05%
Prefer not to say	1808	17.1%	1724	15.9%	1648	14.8%
Not declared	2140	20.3%	2059	19.0%	1949	17.5%

Number of persons in post by Sexual Orientation

***Note this is a new option for selection introduced in 2024**

NHS Scotland introduced the NHS Scotland Pride Badge and Pride Pledge in June 2021 for staff to show their commitment to support equality for LGBTQ+ and other marginalised people. LGBTQ+

and minority ethnic people still face challenges in relation to employment and negative attitudes towards them.

In 2025, NHS Highland plans to relaunch its LGBTQ+ staff network. The network will be instrumental in supporting LGBTQ+ colleagues, participating in local events such as Highland and Oban Pride and consulting on organisational initiatives. Through working closely with the LGBTQ+ network, NHS Highland hopes to understand why 32.3% of colleagues choose "prefer not to say" or do not declare their sexual orientation when asked about equalities information.

3.6 Gender Reassignment

eESS allows members of staff to amend their personal details, including equalities information. Until April 2024, it contained the question -

"Have you, are you or do you plan to undergo gender reassignment (changing gender)?"

Members of staff had the option to respond "Yes", "No", "Don't know (not declared)" or "Prefer not to say".

The language of eESS, in the context of trans individuals, was out of date, and misrepresented the process of transition as a chiefly medical exercise. Because of this and to align with the Census and the advice of the Scottish Government and LGBTQ+ organisations, the question was amended in April 2024 to ask -

"Do you consider yourself to be trans or have a trans history?"

The answer options for this question are: "Yes", "No", "Prefer not to say" with an additional question – "If yes, please describe your trans status, for example, non-binary, trans man, trans woman".

There has been a reduction in the number of staff who choose "prefer not to say" or "don't know/not declared" over the last 3 years, in conjunction with an increase in the number of staff members identifying as transgender. (The figures have been rounded up/down due to low numbers so showing as 0.1% for each of the years)

NHS Highland	2022	2023	2024
Transgender	**% of Workforce**	**% of Workforce**	**% of Workforce**
Yes	0.1%	0.1%	0.1%
No	63.4%	64.9%	67.2%
Prefer not to say	19.5%	18.6%	17.1%
Not declared	17.0%	16.4%	15.6%

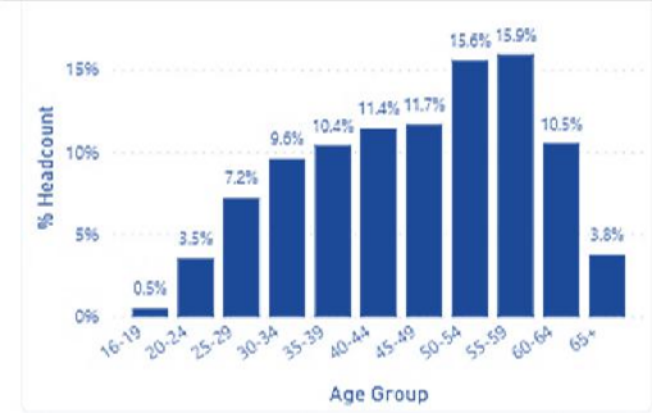
Percentage of persons in post by Transgender status

3.7 Age

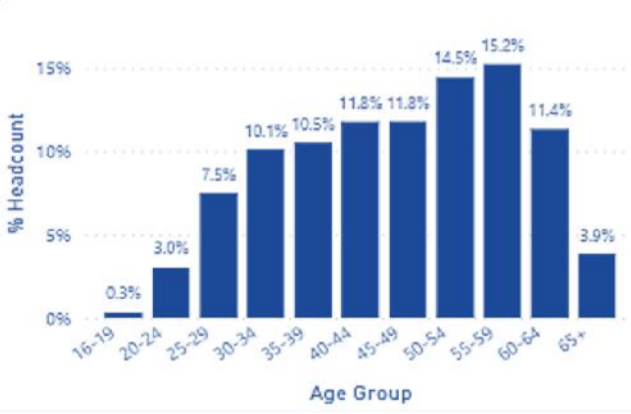
The profile of the workforce by age allows the organisation to look at the current workforce and assist in workforce planning at an organisation, departmental or team level.

The shape of the age profile of the workforce has remained relatively similar from 2023 to 2024.

31st December 2023



31st December 2024



Percentage of persons in post by Age group

Data from the Scotland Census 2022 is included in the following table to illustrate the age demographic of Highland, Argyll, and Bute. The NHS Highland workforce data is also included by means of comparison.

The data in the table would suggest that NHS Highland employ proportionately lower numbers of 16-19 year olds compared to the local populations. It is also demonstrated in the above graphs, that the numbers of under 25's in the workforce has declined from 2023 to 2024 by 0.7%.

To try and combat this decline, the NHSH Employability Strategy 2025 – 2028 sets out key aims in 2025 which are: to focus on school engagement, promote career pathways, develop an apprenticeship strategy and review delivery of work experience.

Age Range	% of Highland Population	% of Argyll & Bute Population	% of NHS Highland Workforce 2024
16-19	3.8%	3.5%	0.4%
20-24	4.5%	4.0%	3.2%
25-29	5.0%	4.3%	7.4%
30-34	5.6%	5.0%	9.9%
35-39	5.8%	5.1%	10.5%
40-44	6.0%	5.2%	11.6%
45-49	6.1%	5.9%	11.8%
50-54	7.6%	7.8%	15.0%
55-59	8.3%	8.9%	15.4%
60-64	7.6%	8.5%	11.0%
65+	7.6% (65-69 group)	7.5% (65-69 group)	3.8%

Population Data from 2022 Census vs NHSH workforce split down by Age

Age Group / Job Family	< 20	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65+
Administrative Services	0.2%	1.8%	6.1%	8.5%	9.5%	12.2%	11.5%	15.9%	16.7%	12.8%	4.9%
Allied Health Profession	0.2%	3.9%	10.1%	12.4%	11.4%	15.8%	12.1%	13.6%	12.2%	6.8%	1.5%
Dental Support	0.5%	3.0%	2.9%	13.7%	16.4%	14.4%	12.6%	15.9%	14.4%	5.9%	0.9%
Healthcare Sciences	0.3%	2.6%	9.3%	12.2%	13.7%	12.0%	11.7%	15.0%	13.1%	8.0%	2.4%
Medical and Dental	0.0%	0.2%	4.6%	5.0%	12.4%	13.6%	17.6%	18.5%	16.1%	7.7%	4.5%
Medical Support	0.0%	0.0%	13.1%	12.6%	17.0%	8.0%	16.3%	18.1%	11.5%	2.1%	2.1%
Nursing / Midwifery	0.4%	4.6%	9.2%	12.4%	10.9%	11.1%	11.4%	15.4%	13.8%	8.8%	2.2%
Other Therapeutic	0.5%	2.9%	8.4%	14.3%	14.1%	14.3%	12.2%	14.4%	10.2%	7.2%	1.6%
Personal and Social Care	0.5%	2.7%	5.4%	7.0%	8.6%	9.9%	11.8%	13.4%	18.4%	16.7%	5.6%
Senior Managers	0.0%	0.0%	0.0%	0.0%	6.2%	8.2%	15.1%	17.9%	30.8%	9.0%	12.9%
Support Services	1.4%	3.0%	4.6%	5.3%	8.3%	9.2%	10.1%	12.2%	19.9%	17.8%	8.3%

Percentage of persons in post split down by Age and Job Family

3.8 Pregnancy and Maternity

Maternity leave in NHS Highland can be taken for up to 52 weeks, made up of paid and unpaid elements. All colleagues must complete a maternity leave form to notify the organisation of their intention to take maternity leave. Included in the form are options that the colleague can choose regarding their return to work, namely –

- I intend to return to work
- I am undecided whether I will be returning to work
- I do not intend to return to work.

At present NHS Highland does not have an automated system for recording the above options and therefore the analysis of number of returners after maternity leave is not available for this report. An electronic solution is under ongoing development to enable this data to be recorded and analysed.

3.9 Marriage and Civil Partnership

The below table shows the marital status of NHS Highlands workforce as at 31st December 2024, 100% of staff provided their data in respect of this question. The workforce has a high percentage of married and single staff at 52.1% and 41.6%, respectively. It may be reasonable to deduce that "Single" should not be taken as the opposite of "Married" as more people choose not to marry due to social, economic, or health reasons, but are nevertheless in an enduring relationship.

NHS Highland	2022		2023		2024	
Marital Status	**Headcount**	**% Total**	**Headcount**	**% Total**	**Headcount**	**% Total**
Civil Partnership	82	0.8%	105	1.0%	137	1.2%
Divorced	476	4.5%	492	4.5%	501	4.5%
Married	5694	53.9%	5769	53.1%	5789	52.1%
Single	4256	40.3%	4449	40.9%	4625	41.6%
Widowed	55	0.5%	54	0.5%	55	0.5%

Number of persons in post by Martial status

4 Recruitment and Retention

A total of 1,999 persons joined the organisation in 2024, 812 less than in 2023. All jobs are advertised on the NHS Scotland careers website and applications made on Jobtrain, which is the National NHS Scotland recruitment portal. All applications are made online which can be a barrier for those whose first language is not English, people with learning disabilities or people with lower levels of digital skills.

A total of 59,172 applications were made to join NHS Highland, 3.38% of these applications were successfully appointed into a role.

There has been a decline in the number of ATR (Authority To Recruit) forms submitted to recruitment over the last three years, along with an increase in the number of applications received. This will contribute to a lower conversion rate for posts as more people are applying for less positions.

	Year	Number of ATRs submitted	Number of
2022	3852	24,116	
2023	3049	44,428	
2024	2470	59,172	

NHS Highland receives several applications from overseas workers who do not meet the visa eligibility or professional registration criteria, this results in a proportion of applications having to be refused at shortlisting stage. Applications are also generated by automated "bots" which provide false information such as NMC registration pins which are not genuine.

This issue affects jobs advertised from every job family within the organisation although it is most prevalent for Nursing/Midwifery posts. Some of these job adverts can attract over 100 applicants which all need to be reviewed and shortlisted individually.

At present, due to system constraints, it is not possible to determine the true numbers of applications declined due to false information and those not shortlisted for genuinely not meeting the minimum criteria.

Most of the applications for Nursing/Midwifery roles which are declined due to registration or visa ineligibility come from African countries which may account for the low conversion rate in the following table.

4.1 Ethnic Origin

Ethnicity	2023 No. Applicants	2023 Successful Applicants	2023 Conversion Rate	2024 No. Applicants	2024 Successful Applicants	2024 Conversion Rate
African - African, Scottish African or British African	9324	46	0.5%	26126	62	0.24%
African - Other	13494	39	0.3%	8664	10	0.12%
Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	295	2	0.7%	316	4	1.27%
Asian - Chinese, Chinese Scottish or Chinese British	113	6	5.3%	142	5	3.52%
Asian - Indian, Indian Scottish or Indian British	3558	26	0.7%	5511	35	0.64%
Asian - Other	1152	28	2.4%	544	5	0.92%
Asian - Pakistani, Pakistani Scottish or Pakistani British	2981	9	0.3%	3389	8	0.24%
Caribbean or Black	83	5	6.0%	472	6	1.27%
Caribbean or Black - Black, Black Scottish or Black British	132	6	4.6%	65	1	1.54%
Caribbean or Black - Caribbean, Caribbean Scottish or Caribbean British	23	1	4.4%	10	0	0.00%
Mixed or Multiple Ethnic Groups	193	22	11.4%	370	28	7.56%
Other Ethnic Group - Arab, Arab Scottish or Arab British	463	14	3.0%	433	8	1.85%
Other Ethnic Group - Other	457	8	1.8%	1703	13	0.76%
White - Gypsy Traveller	1	0	0.00%	5	0	0.00%
White - Irish	109	25	22.9%	176	29	16.4%
White - Other	1424	189	13.3%	1410	127	9.01%
White - Other British	2155	475	22.0%	1904	330	17.33%
White - Polish	434	72	16.6%	474	64	13.50%
White - Scottish	7586	1812	23.9%	7001	1244	17.77%
Not Declared	133	1	0.8%	0	0	0.00%
Prefer not to say	318	25	7.9%	446	20	4.48%

Number of applications received by Ethnicity

Ethnicity	2024 Admin Services	2024 AHPs	2024 Dental Support	2024 Healthcare Sciences	2024 Medical & Dental	2024 Medical Support	2024 Nursing & Midwifery	2024 Personal & Social Care	2024 Other Therap -eutic	2024 Senior Manager	2024 Support Services
African - African, Scottish African or British African	1995	1617	112	826	827	9	14719	4468	132	4	1417
African - Other	341	408	53	174	57	0	5794	1362	20	1	454
Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	34	3	1	12	168	1	50	26	0	0	21
Asian - Chinese, Chinese Scottish or Chinese British	16	22	0	14	40	0	22	6	5	1	16
Asian - Indian, Indian Scottish or Indian British	871	667	25	355	1008	7	1454	617	109	2	396
Asian - Other	57	63	1	30	169	0	136	46	0	0	42
Asian - Pakistani, Pakistani Scottish or Pakistani British	213	346	15	82	2048	5	354	143	34	1	148
Caribbean or Black	41	23	0	11	21	3	256	92	4	0	21
Caribbean or Black - Black, Black Scottish or Black British	5	6	0	3	4	0	3	5	0	0	4
Caribbean or Black - Caribbean, Caribbean Scottish or Caribbean British	1	0	0	0	1	0	4	2	0	0	2
Mixed or Multiple Ethnic Groups	42	21	1	32	97	1	108	28	15	1	24
Other Ethnic Group - Arab, Arab Scottish or Arab British	13	18	1	11	338	1	27	7	7	0	1
Other Ethnic Group - Other	147	88	4	80	437	2	679	155	10	1	101
White - Gypsy Traveller/Roma	1	1	0	0	5	0	1	1	0	0	7
White - Irish	24	27	0	14	10	0	56	13	12	0	17
White - Other	250	93	2	84	210	6	441	126	47	1	147
White - Other British	415	130	14	66	102	7	626	223	62	4	255
White - Polish	96	23	0	21	2	1	124	28	10	0	169
White - Scottish	1807	350	68	255	96	13	2437	684	202	6	1083
Prefer not to say	95	25	0	19	42	1	134	51	9	2	53

Number of applications received split down by Ethnicity and Job Family

4.2 Disability

All the Boards in NHS Scotland support the Disability Confident scheme. This scheme guarantees an interview to anyone with a recognised disability if their application meets the minimum job criteria. The applicant can also request reasonable adjustments to the recruitment process such as allowing extra time to a standard interview or viewing the interview questions in advance. In 2024, NHS Highland had a conversion rate of successful applicants with a disability which was more than three times that of applicants with no disability. Out of the 1456 applicants who answered "Yes", 105 requested an adjustment to their interview. The most common conditions to request adjustments for were Dyslexia, followed by Hearing Impairments and Autism.

Disability	2023 No. Applicants	2023 Successful Applicants	2023 Conversion Rate	2024 No. Applicants	2024 Successful Applicants	2024 Conversion Rate
No	42839	2597	6.1%	56993	1767	3.10%
Not known	133	1	0.8%	86	11	12.79%
Prefer not to say	0	0	0.00%	0	0	0.00%
Yes	1456	213	14.6%	2094	221	10.55%

Number of applications received by Disability status

4.3 Sex (Male or Female)

Job Family Applicants Applicants	Female	Successful Female	Female Conversion Rate	Male Applicants	Successful Male Applicants	Male Conversion Rate
Administrative Services	4093	264	6.45%	2325	38	1.63%
Allied Health Professions	1917	125	6.52%	2000	19	0.95%
Dental Support	211	16	7.58%	89	2	2.25%
Healthcare Sciences	1151	42	3.65%	926	30	3.24%
Medical and Dental	2327	59	2.54%	3332	58	1.74%
Medical Support	38	3	7.89%	19	2	10.53%
Nursing and Midwifery	19705	679	3.45%	7723	94	1.22%
Other Therapeutic	453	53	11.70%	218	9	4.13%
Personal and Social Care	4946	232	4.69%	3124	22	0.70%
Senior Managers	8	2	25.00%	15	0	0.00%
Support Services	1815	136	7.49%	2526	97	3.84%
Grand Total	**36664**	**1611**	**4.39%**	**22297**	**371**	**1.66%**

Number of applications received split down by Sex and Job Family

A larger number of females to males applied for roles in 2024. Further analysis is required to understand the low conversion rate for male applicants into Allied Health Profession roles which include professions such as Physiotherapist, Dietician and Occupational Therapist.

Medical and Dental roles receive a larger number of male applicants yet the number of appointments are almost exactly the same as the number of female appointments.

The conversion rates for males in Personal and Social care is almost 4% lower than female applicants, further analysis is needed to understand why.

4.4 Religion or Belief

The conversion rates of applicants from different religions vary between 0.0% for people of Jewish faith and 11.2% for Church of Scotland. As previously mentioned, a high number of applications come from oversees (predominantly Africa) which do not meet the visa requirements to work in the UK and therefore their applications are rejected. This may account for the high number of applications and lower conversion rates for Muslim and Christian candidates which are the 2 main religions in Africa. A new Religion or Belief, Pagan, was introduced in 2024 for candidates to select.

Religion or Belief Applicants 2023	Number of	Successful Applicants 2023	Conversion Rate 2023	Number of Applicants 2024	Successful Applicants 2024	Conversion Rate 2024
Another Religion or Body	408	68	16.7%	337	21	6.2%
Buddhist	388	12	3.1%	562	11	2.0%
Church of Scotland	1706	368	21.6%	2324	260	11.2%
Hindu	1842	5	0.3%	2908	16	0.6%
Jewish	19	2	10.5%	24	0	0.0%
Muslim	6478	38	0.6%	8186	28	0.3%
None	7456	1594	21.4%	7291	1171	16.1%
Other - Christian	20209	357	1.8%	28450	242	0.9%
Roman Catholic	4303	206	4.8%	7545	151	2.0%
Sikh	59	4	6.8%	77	2	2.6%
Pagan*	-	-	-	67	5	7.5%
Not Given	133	1	0.8%	0	0	0.0%
Prefer not to say	1427	156	10.9%	1402	92	6.7%

Number of applications by Religion or Belief

***Note these are new options for selection introduced in 2024**

4.5 Sexual Orientation

In 2024, candidates were successfully appointed from each of the sexual orientation categories monitored. The conversion rate for candidates who declared themselves as gay/lesbian was almost three times that of heterosexual/straight candidates. This suggests that the shortlisting and interview processes appear fair and free from discrimination based on sexual orientation.

Orientation Applicants	2023 No.	2023 Successful Applicants	2023 Conversion Rate	2024 No. Applicants	2024 Successful Applicants	2024 Conversion Rate
Bi-Sexual	1408	66	4.7%	1494	52	3.48%
Gay/Lesbian	472	62	13.1%	452	44	9.73%
Heterosexual/Straight	39692	2547	6.4%	54504	1796	3.30%
Not Known	133	1	0.8%	15	4	26.67%
Other	599	10	1.7%	458	7	1.53%
Prefer not to say	2124	125	5.9%	2250	96	4.27%

Number of applications received by Sexual Orientation

4.6 Gender Reassignment

As mentioned in Section 3.6, until April 2024 the question applicants had to answer relating to gender reassignment on Jobtrain was -

“Have you, are you or do you plan to undergo gender reassignment (changing gender)?”

As this question misrepresented gender transition as a medical exercise, this may have resulted in the applicants choosing “prefer not to say” or not declaring any information. It is not possible to determine which of the applicants choosing these options may have identified as trans or have a trans history and were successfully appointed.

Transgender	No. Applicants	Successful Applicants	Conversion Rate
Yes	233	8	3.4%
No	42256	2694	6.4%
Prefer not to say	331	18	5.4%
Not Declared	1608	91	5.7%

Number of applications received by Transgender status

4.7 Age

In 2024, people were employed from all the age ranges monitored in NHS Highland. The highest conversion rates were recorded in the 50-65+ age brackets.

Age Band No. Applicants	2023	2023 Successful Applicants	2023 Conversion Rate	2024 No. Applicants	2024 Successful Applicants	2024 Conversion Rate
<20	647	105	16.2%	624	65	10.42%
20-24	3673	275	7.5%	4010	173	4.31%
25-29	12714	367	2.9%	15888	290	1.83%
30-34	10005	403	4.0%	14176	265	1.87%
35-39	7098	355	5.0%	10523	270	2.57%
40-44	4666	338	7.2%	6965	243	3.49%
45-49	2099	276	13.2%	3153	209	6.63%
50-54	1648	321	19.5%	1876	215	11.46%
55-59	1023	237	23.2%	1103	153	13.87%
60-64	447	95	21.3%	510	92	18.04%
65+	86	21	24.4%	101	13	12.87%
DOB not given	322	18	5.6%	244	11	4.51%
Grand Total	**44428**	**2811**	**6.3%**	**59173**	**1999**	**3.38%**

Number of applications received by Age

Age Band Services Dental	Admin	AHPs	Dental Support	Healthcare Science	Medical &	Medical Support	Nursing & Midwifery	Other Thera-peutic	Personal Social Care	Senior Manager	Support Services
<20	122	12	2	19	0	0	208	29	52	0	180
20-24	530	299	18	339	88	4	1945	95	398	0	294
25-29	1265	1358	60	576	3347	26	6678	170	1709	2	697
30-34	1389	1093	76	455	1375	11	6837	135	1904	4	897
35-39	1121	475	71	324	472	5	5429	76	1783	4	763
40-44	739	379	48	189	184	3	3587	0	1234	3	529
45-49	457	149	12	98	98	3	1389	40	548	2	357
50-54	365	64	10	41	42	2	798	34	258	3	259
55-59	242	71	2	28	26	1	357	19	111	5	241
60-64	129	23	1	12	19	2	142	5	55	0	122
65+	32	2	0	1	8	0	3	0	8	0	20
DOB N/A	73	6	0	7	23	0	61	5	26	0	28
Grand Total	**6464**	**3933**	**300**	**2091**	**5682**	**57**	**27471**	**678**	**8087**	**23**	**4387**

Number of applications received split down by Age and Job Family

4.8 Pregnancy and Maternity

This information is not currently accessible from the National Jobtrain system.

4.9 Marriage and Civil Partnership

This information is not currently accessible from the National Jobtrain system.

5 Completion Of Training

The following mandatory training courses have been included in this analysis, based on completion rates as at 31st December 2024:

- Introduction to Equality, Diversity and Human Rights
- Fire Safety
- Hand Hygiene
- Why Infection Prevention Matters
- Moving and Handling Module A
- Public Protection
- Staying Safe Online
- Violence and Aggression

Of 13780 employees in eESS as of 31st December 2024, 13705 (99.5%) were successfully matched to training data available in TURAS. Of the matched employees, 2611 (19.1%) are Bank only.

NHS Grampian holds the training information for the Doctors in Training population.

As at 31st December 2024, the completion rates for the whole organisation for the nine mandatory training courses included in this analysis are –

Course Name	Completion Rate
Introduction to Equality, Diversity and Human Rights	68.2%
Fire Safety	66.4%
Hand Hygiene	88.5%
Safe Information Handling	70.4%
Moving and Handling Module A	71.7%
Public Protection	67.5%
Staying Safe Online	63.2%
Violence and Aggression*	49.2%
Why Infection Prevention Matters	87.3%

***New mandatory training course introduced in June 202**

The average overall completion rate for the organisation is 70.3%, up 1% since 2023.

5.1 Ethnic Origin

Based on the overall average completion rate given above (70.3%) it is reasonable to suggest the following ethnic groups are falling short of the organisations overall performance –

- Asian - Chinese, Chinese Scottish or Chinese British
- Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- Asian - Indian, Indian Scottish or Indian British
- Asian - Other
- Asian - Pakistani, Pakistani Scottish or Pakistani British
- Caribbean or Black – Other
- Mixed or Multiple Ethnic Group
- Other Ethnic Group - Arab, Arab Scottish or Arab British
- Other Ethnic Group – Other
- White – Irish
- White – Other
- White – Other British

Whilst completion rate is lower for some ethnic groups, it is not always clear if this is due to ethnicity or other factors, such as poor completion rate generally for the team/area in which people work. For example, “Asian - Pakistani, Pakistani Scottish or Pakistani British” and “Other Ethnic Group – Other” are the two groups with the lowest completion rates for all employees (where

there are 5 or more employees in the group). Within these groups, more than 60% of employees work within Raigmore Hospital, which has a lower completion rate, 65.0%, when compared to the organisation rate of 70.3%.

	All Employees		Substantive	Employee
Ethnicity	**Headcount**	**Completion Rate (%)**	**Headcount**	**Completion Rate (%)**
African - African, African Scottish or African British	111	72.3	72	74.2
African - Other	60	86.1	51	87.6
Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	< 5	29.6	< 5	29.6
Asian - Chinese, Chinese Scottish or Chinese British	21	52.9	15	68.1
Asian - Indian, Indian Scottish or Indian British	78	58.5	63	63.1
Asian - Other	110	69.9	91	72.3
Asian - Pakistani, Pakistani Scottish or Pakistani British	27	42.4	17	58.8
Caribbean or Black	< 5	0.0	N/A	N/A
Caribbean or Black - Black, Black Scottish or Black British	7	77.8	6	75.9
Caribbean or Black - Caribbean, Caribbean Scottish or Caribbean British	< 5	92.6	< 5	100.0
Caribbean or Black - Other	< 5	27.8	< 5	0.0
Mixed or Multiple Ethnic Group	62	64.2	45	70.1
Other Ethnic Group - Arab, Arab Scottish or Arab British	23	54.6	22	57.1
Other Ethnic Group - Other	20	48.3	17	54.9
White - Gypsy Traveller	< 5	77.8	< 5	77.8
White - Irish	109	58.3	82	69.4
White - Other	615	67.7	460	72.7
White - Other British	1820	67.0	1381	75.7
White - Polish	108	77.7	88	82.3
White - Scottish	7018	72.4	5746	77.3
Not Declared	2331	67.8	1915	74.4
Prefer not to say	1173	71.1	1016	75.8
Grand Total	**13705**	**70.3**	**11094**	**76.0**

Training completion rates by Ethnicity

5.2 Disability

The performance rate for colleagues with a disability is higher than those without.

		All Employees	Substantive	Employees
Disability	**Headcount**	**Completion Rate**	**Headcount**	**Completion Rate**
Yes	231	74.1	172	80.7
No	9834	70.4	7818	76.3
Prefer not to say	1713	72.3	1528	75.8
Not Declared	1927	67.1	1576	74.2
Grand Total	**13705**	**70.3**	**11094**	**76.0**

Training completion rates by Disability

5.3 Sex (Male or Female)

Both sexes are above the organisational average for completion of training in terms of substantive employees. There is no evidence to suggest discrimination on the grounds of sex when it comes to access to training opportunities.

		ALL EMPLOYEES	SUBSTANTIVE	EMPLOYEES
Sex (male or female)	**Headcount**	**Completion Rate %**	**Headcount**	**Completion Rate%**
Female	11207	71.9	9143	77.0
Male	2498	62.7	1951	71.5
Grand Total	**13705**	**70.3**	**11094**	**76.0**

Training completion rates by Sex

5.4 Religion or Belief

Pagan, Sikh and Hindu colleagues appear to have the lowest completion rates of the various religions or beliefs. Further analysis is needed to identify the areas where these colleagues work and understand whether the completion rates are related to their job type, geographical location or something else such as a language barrier.

	All Employees		Substantive Employees	
Religion or Belief	**Headcount**	**Completion Rate**	**Headcount**	**Completion Rate**
Another Religion or Body	8	73.6	5	80.0
Buddhist	37	73.6	34	74.2
Christian - Other	1238	68.0	954	75.0
Church of Scotland	2141	71.7	1790	76.1
Hindu	53	48.8	43	56.6
Jewish	7	57.1	5	62.2
Muslim	91	52.1	68	57.8
No Religion	4758	72.3	3780	78.2
Other	188	67.3	149	73.2
Other - Christian	113	68.1	75	71.0
Pagan	< 5	0.0	< 5	0.0
Roman Catholic	906	70.0	714	75.5
Sikh	7	42.9	7	42.9
Not Declared	2627	68.5	2172	75.3
Prefer not to say	1529	69.3	1297	74.4
Grand Total	**13705**	**70.3**	**11094**	**76.0**

Training completion rates by Religion or Belief

5.5 Sexual Orientation

Colleagues who have declared themselves to be gay or gay/lesbian appear to have a slightly lower than average training completion rate.

The LGBTQ+ staff network, planned for launch in 2025, may be able to provide some insight regarding any barriers to accessing training.

	All Employees		Substantive Employees	
Sexual Orientation	**Headcount**	**Completion Rate**	**Headcount**	**Completion Rate**
Bisexual	143	69.5	100	79.7
Gay	32	55.9	26	65.0
Gay/Lesbian	98	66.8	73	74.1
Heterosexual	9236	70.9	7355	76.7
Lesbian	22	67.2	19	73.1
Other	26	67.1	24	69.0
Other Sexual Orientation	< 5	100.0	< 5	100.0
Not Declared	2284	68.6	1890	75.1
Prefer not to say	1861	69.5	1604	73.9
Grand Total	**13705**	**70.3**	**11094**	**76.0**

Training completion rates by Sexual Orientation

5.6 Gender Reassignment

There is no evidence to suggest discrimination on the grounds of gender reassignment when it comes to access to training opportunities.

	All Employees		Substantive Employees	
Transgender	**Headcount**	**Completion Rate**	**Headcount**	**Completion Rate**
Yes	17	73.2	14	76.2
No	9395	71.0	7452	77.1
Prefer not to say	2043	71.7	1821	75.0
Not Declared	2250	65.7	1807	72.7
Grand Total	**13705**	**70.3**	**11094**	**76.0**

Training completion rates by Transgender status

5.7 Age

It is interesting to note that the lower completion rates in the age category are at opposite ends of the scale, the under 20s and over 65s. It could be assumed that those over 65 may have lower levels of digital competency than colleagues in the other age ranges however this cannot be substantiated.

All Employees			Substantive Employees	
Age Group	**Headcount**	**Completion Rate**	**Headcount**	**Completion Rate**
< 20	78	61.7	37	57.4
20 - 24	557	71.0	337	79.1
25 - 29	1073	69.9	830	76.3
30 - 34	1422	69.5	1123	76.5
35 - 39	1431	69.6	1170	76.0
40 - 44	1585	70.6	1309	76.5
45 - 49	1527	71.4	1299	76.8
50 - 54	1833	73.4	1608	77.4
55 - 59	1945	72.0	1694	75.7
60 - 64	1577	71.1	1261	76.1
65+	677	55.3	426	65.0
Grand Total	**13705**	**70.3**	**11094**	**76.0**

Training completion rates by Age

5.8 Pregnancy and Maternity

This information is not currently recorded. All training records are currently held in TURAS. The training and management system does not currently integrate across to eESS (the Human Resource system) directly to assist in collection of this data.

5.9 Marriage and Civil Partnership

All marital statuses with the exception of "widowed" are close to the organisational average for completion of training. As may be expected, a large proportion of those in the "widowed" category also fall within the older age ranges, with 31% being aged 65+ suggesting a link to age being a greater contributing factor than marital status. However, 51% of those widowed fall within the age ranges 55 – 59 and 60 – 64 which have slightly higher than average training completion rates.

		All Employees	Substantive	Employees
Marital Status	**Headcount**	**Completion Rate**	**Headcount**	**Completion Rate**
Civil Partnership	201	70.3	147	75.7
Divorced	620	74.1	503	79.8
Married	6969	70.4	5730	75.9
Single	5847	69.7	4661	75.8
Widowed	68	63.4	53	66.0
Grand Total	**13705**	**70.3**	**11094**	**76.0**

Training completion rates by Marital status

6 Promotion

The tables on the following pages contain information relating to colleagues who have received an increase to their grade in 2024. Although this information can be indicative of promotion opportunities, it can also be attributed to an increase in grade due to other processes such as a job evaluation outcome or organisational change. Therefore, the information cannot be wholly associated with promotion opportunities and should be read in that context. The figures are for staff on Agenda for Change terms and conditions only and do not include Bank colleagues. Figures only include those staff who were employed as of 31st December 2023 and remained employed as of 31st December 2024 to allow a direct comparison.

6.1 Ethnic Origin

The data does not suggest any barriers to promotion based on Ethnic Origin for the majority of groups, though in some groups the numbers are too small, making it more difficult to identify any barriers.

Ethnicity	% of AfC Substantive Workforce	% of Staff with Increased Grade
African - African, African Scottish or African British	0.3%	0.8%
African - Other	0.3%	1.7%
Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	< 0.1%	0.0%
Asian - Chinese, Chinese Scottish or Chinese British	< 0.1%	0.0%
Asian - Indian, Indian Scottish or Indian British	0.2%	0.2%
Asian - Other	0.7%	1.3%
Asian - Pakistani, Pakistani Scottish or Pakistani British	< 0.1%	0.0%
Caribbean or Black - Black, Black Scottish or Black British	< 0.1%	0.0%
Caribbean or Black - Caribbean, Caribbean Scottish or Caribbean British	< 0.1%	0.0%
Mixed or Multiple Ethnic Group	0.4%	0.8%
Other Ethnic Group - Arab, Arab Scottish or Arab British	< 0.1%	0.2%
Other Ethnic Group - Other	0.1%	0.0%
White - Gypsy Traveller	< 0.1%	0.0%
White - Irish	0.6%	0.4%
White - Other	3.6%	4.0%
White - Other British	11.4%	12.6%
White - Polish	0.7%	1.1%
White - Scottish	53.1%	54.7%
Prefer not to say	10.0%	6.9%
Not Declared	18.3%	15.2%

Percentage of staff with increased grade by Ethnicity

6.2 Disability

The data does not suggest any barriers to promotion based on Disability status.

Disability	% of AfC Substantive Workforce	% of Staff with Increased Grade
Yes	1.2%	2.3%
No	68.5%	74.1%
Prefer not to say	15.3%	10.1%
Not Declared	15.0%	13.5%

Percentage of staff with increased grade by Disability status

6.3 Sex (Male or Female)

Sex	% of Substantive Workforce	% of Staff with Increased Grade
Female	84.8%	86.3%
Male	15.2%	13.7%

Percentage of staff with increased grade by Sex

6.4 Religion or Belief

The data does not suggest any barriers to promotion based on Religion or Belief.

Religion	% of AfC Substantive Workforce	% of Staff with Increased Grade
Buddhist	0.3%	0.4%
Christian - Other	8.3%	8.6%
Church of Scotland	17.2%	13.3%
Hindu	0.2%	0.0%
Jewish	0.1%	0.0%
Muslim	0.2%	0.6%
No Religion	32.5%	40.8%
Other	1.4%	2.3%
Roman Catholic	6.6%	7.4%
Sikh	< 0.1%	0.2%
Prefer not to say	12.3%	8.4%
Not Declared	21.0%	17.9%

Percentage of staff with increased grade by Religion or Belief

6.5 Sexual Orientation

The data does not suggest any barriers to promotion based on Sexual Orientation.

Sexual Orientation	% of AfC Substantive Workforce	% of Staff with Increased Grade
Bisexual	0.9%	1.5%
Gay	0.2%	0.4%
Gay/Lesbian	0.6%	1.1%
Heterosexual	66.2%	70.7%
Lesbian	0.2%	0.6%
Other	0.2%	0.2%
Other Sexual Orientation	< 0.1%	0.0%
Prefer not to say	14.4%	10.3%
Not Declared	17.3%	15.2%

Percentage of staff with increased grade by Sexual Orientation

6.6 Gender Reassignment

The number of staff declaring themselves as Transgender is too small to identify if there are any barriers to promotion in this group.

Transgender	% of AfC Substantive Workforce	% of Staff with Increased Grade
Yes	0.1%	0.0%
No	66.3%	74.7%
Prefer not to say	18.0%	14.3%
Not Declared	15.5%	14.3%

Percentage of staff with increased grade by Transgender status

6.7 Age

Whilst it appears that those aged 45 and over are not increasing their grade at a proportional rate, this could be down to a number of factors such as responsibilities outside of the workplace or coming towards the end of a career leading to people not wishing to take on more responsibilities at work. There is no evidence to suggest that opportunities for promotion are limited in older age groups.

Age Group	% of AfC Substantive Workforce	% of Staff with Increased Grade
Under 20	0.2%	0.4%
20 - 24	2.4%	4.8%
25 - 29	6.7%	10.3%
30 - 34	10.1%	13.7%
35 - 39	10.4%	17.1%
40 - 44	11.6%	13.5%
45 - 49	11.6%	10.3%
50 - 54	14.9%	11.6%
55 - 59	15.9%	12.4%
60 - 64	12.3%	5.3%
65+	3.9%	0.6%

Percentage of staff with increased grade by Age

6.8 Pregnancy and Maternity

This information is not currently recorded. The payroll information system does not currently integrate across to eESS (the Human Resource system) directly to assist in collection of this data.

6.9 Marriage and Civil Partnership

Marital Status	% of AfC Substantive Workforce	% of Staff with Increased Grade
Civil Partnership	1.3%	0.8%
Divorced	4.7%	3.4%
Married	50.9%	47.8%
Single	42.6%	47.6%
Widowed	0.5%	0.4%

Percentage of staff with increased grade by Marital status

7 Leavers

The tables containing leavers data on the following pages include those who were substantive employees and left the organisation in 2024.

7.1 Ethnic Origin

Ethnicity	% of Substantive Workforce	% of Leavers
African - African, African Scottish or African British	0.6%	0.8%
African - Other	0.4%	0.4%
Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	< 0.05%	0.4%
Asian - Chinese, Chinese Scottish or Chinese British	0.1%	0.1%
Asian - Indian, Indian Scottish or Indian British	0.6%	1.0%
Asian - Other	0.8%	0.6%
Asian - Pakistani, Pakistani Scottish or Pakistani British	0.2%	0.8%
Caribbean or Black	< 0.05%	0.1%
Caribbean or Black - Black, Black Scottish or Black British	0.1%	0.1%
Caribbean or Black - Caribbean, Caribbean Scottish or Caribbean British	< 0.05%	0.0%
Caribbean or Black - Other	< 0.05%	0.0%
Mixed or Multiple Ethnic Group	0.4%	0.8%
Other Ethnic Group - Arab, Arab Scottish or Arab British	0.2%	0.2%
Other Ethnic Group - Other	0.2%	0.5%
White - Gypsy Traveller	< 0.05%	0.0%
White - Irish	0.8%	0.8%
White - Other	4.0%	4.5%
White - Other British	12.3%	15.6%
White - Polish	0.7%	1.2%
White - Scottish	51.5%	45.7%
Not Declared	17.8%	16.4%
Prefer not to say	9.5%	10.1%

Percentage of leavers by Ethnicity

7.2 Disability

Disability	% of Substantive Workforce	% of Leavers
Yes	1.4%	2.5%
No	69.7%	69.1%
Not Declared	14.6%	13.6%
Prefer not to say	14.3%	14.8%

Percentage of leavers by Disability status

7.3 Sex (Male or Female)

Sex	% of Substantive Workforce	% of Leavers
Female	82.4%	75.4%
Male	17.6%	24.6%

Percentage of leavers by Sex

7.4 Religion or Belief

Religion or Belief	% of Substantive Workforce	% of Leavers
Another Religion or Body	< 0.05%	0.1%
Buddhist	0.3%	0.5%
Christian - Other	9.2%	10.9%
Church of Scotland	16.3%	16.1%
Hindu	0.4%	0.4%
Jewish	< 0.05%	0.1%
Muslim	0.6%	1.7%
No Religion	33.1%	29.3%
Pagan*	< 0.05%	0.0%
Roman Catholic	6.5%	5.9%
Sikh	0.1%	0.2%
Other	1.4%	1.5%
Prefer not to say	12.0%	13.6%
Not declared	20.2%	19.8%

Percentage of leavers by Religion or Belief

7.5 Sexual Orientation

Sexual Orientation	% of Substantive Workforce	% of Leavers
Bisexual	0.9%	2.0%
Gay	0.2%	0.1%
Gay/Lesbian	0.6%	1.0%
Heterosexual	65.5%	63.9%
Lesbian	0.2%	0.1%
Other	0.2%	0.6%
Other Sexual Orientation	< 0.05%	0.0%
Prefer not to say	14.8%	15.0%
Not Declared	17.5%	17.3%

Percentage of leavers by Sexual Orientation

7.6 Gender Reassignment

Transgender	% of Substantive Workforce	% of Leavers
Yes	0.1%	0.4%
No	67.2%	68.0%
Prefer not to say	17.1%	16.7%
Not Declared	15.6%	14.9%

Percentage of leavers by Transgender status

7.7 Age

Age Group	% of Substantive Workforce	% of Leavers
Under 20	0.4%	1.3%
20 - 24	3.2%	4.2%
25 - 29	7.4%	8.9%
30 - 34	9.9%	8.8%
35 - 39	10.5%	6.5%
40 - 44	11.6%	5.7%
45 - 49	11.8%	6.2%
50 - 54	15.0%	7.9%
55 - 59	15.4%	15.0%
60 - 64	11.0%	19.5%
65+	3.8%	16.2%

Percentage of leavers by Age

7.8 Marriage and Civil Partnership

Marital Status	% of Substantive Workforce	% of Leavers
Civil Partnership	1.2%	0.9%
Divorced	4.5%	4.0%
Married	52.1%	54.3%
Single	41.6%	40.0%
Widowed	0.5%	0.8%

Percentage of leavers by Marital status

8 Conclusion

It is important to acknowledge that collecting workforce data provides evidence to support Equality Outcomes and targeted actions to have "due regard" to the Public Equality Duty defined in the Equality Act 2010, Part 11, Chapter 1, Section 149:

(a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Act;

(b) Advance equality of opportunity between persons who share a relevant protected characteristics and persons who do not share it;

(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The NHS Highland Workforce Monitoring Report 2025, shows that:

- NHS Highland is a fair and equitable employer in terms of the nine protected characteristics with areas for further improvement identified.
- The data gathered fulfils our duty to report the requirements set out in the Equality Act 2010 General Duty and the Specific Duties Scotland Regulations 2012.
- The diversity data showed proportionate promotion and completion of training in all protected characteristics. This indicates an equal opportunities employer and promoting a non-discriminatory workplace.
- The diversity data provided is a tool to monitor impact and outcome for different groups of employees. It helps identify current and future needs and possible inequalities.
- Any gaps identified may be investigated to understand causes and solutions.

Some significant difficulties remain with having to work with different employee systems to extract data relating to the protected characteristics profile of the NHS Highland workforce. In an acknowledgement of the limitations on the currently available data for this report, gaps have been identified and remedial actions will be developed in line with the NHS Highland Equality, Diversity and Inclusion Workforce Strategy 2023-2028

NHS Highland will continue to work on improving the quality of data collected which will -

- Enable a more complete evidence-based approach to demonstrating progress against our Equality Outcomes for 2025-2029.
- Help us evaluate the effectiveness of the Equality, Diversity and Inclusion Strategy 20252028 and the Employability Strategy 2025-2028.
- Enable more areas to be reported on in future Workforce Monitoring Reports including employee relations cases linked to protected characteristics.
- Provide supporting evidence as to how EDI practices are mainstreamed within NHS Highland
- Be reviewed by the Staff Networks who, through sharing lived experience, will assist us in identifying improvements.

This is not an exhaustive list, NHS Highland will continue to review workforce data and identify how the organisation can improve the experience of staff with protected characteristics.

9 Equal Pay Statement

In compliance with the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, NHS Highland produced an Equal Pay Statement in 2025.

10 Recommendations

The NHS Highland Workforce Monitoring Report is a publication that can encourage better evidence-informed decision making with increased transparency and accountability that will lead to a real change. The NHS Highland Staff Governance Committee will be asked to endorse the content of the report.

11 Publicising the Report

The Workforce Monitoring Report 2025 will be submitted to the NHS Highland Area Partnership Forum and the NHS Highland Staff Governance Committee for approval. The report will be available on the NHS Highland website once approved.

12 Comments and Feedback

All comments on the report will be warmly welcomed.

By email to: nhsh.EDIteam@nhs.scot

By post to:
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Assynt House
Beechwood Business Park
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13 Acknowledgements

Grateful thanks are expressed to the many staff who assisted in the compilation of this report –

- **Chloe Cuthbertson, Workforce Systems Analyst**
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- **Paul Maber, Workforce Systems Manager**
- **Fiona Helbert, Recruitment Manager**
- **Iain McDiarmid, Workforce Planning Manager**

Report written by:

Gayle Macrae
Equality, Diversity and Inclusion Lead - Workforce
NHS Highland
June 2025

Agenda Item 14

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**29 July 2025**
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 Supporte Officer A&B Council/HSCP**

Report Recommendation:

The Board is asked to take **substantial assurance** and:

1. **Agree** the revisions detailed within the updated Integration Scheme (appendix 1) and summary revisions document (appendix 2);
2. **Agree**, subject to approval of point 1, that arrangements for the joint consultation exercise proceed as set out within point 2 of the assessment section of this report, and the Consultation and Engagement Strategy, detailed in appendix 3.
3. **Agree** that, if the consultation feedback suggests no further changes to the Scheme and voices no opposition to the proposed changes, that the two Chief Executive Officers are authorised to approve the draft revised Integration Scheme on behalf of the Council and the NHS Highland Board prior to submitting to the Scottish Government for approval.

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

In line with the provisions of section 44 of the Public Bodies (Joint Working) (Scotland) Act 2014 a review of the current Integration requires to be completed and ready for submission to Scottish Ministers no later than 23rd March 2026. This report advises Members of the proposed steps to fulfil this requirement, including the creation of a Working Group.

2.2 Background

A report was tabled at the NHS Board Meeting on 25th March 2025 and Argyll & Bute Council on 24th April 2025, which advised Members of the requirement to review the Health and Social Care Integration Scheme (the Scheme) and the proposed actions to take this forward.

A joint review of the Scheme has now been undertaken via the Working Group put in place for this purpose, with Senior Officer representation from across the Council, Argyll and Bute HSCP, and NHS Highland. This report sets out the proposed revisions to the Scheme and, if agreeable, details the next steps, including the requirement for the Council and the Health Board to undertake a joint consultation with prescribed stakeholders.

2.3 Assessment

1. Review of the Integration Scheme

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, in this case 23rd March 2021.

On this basis a review of the Scheme is required by law to be completed by 23rd March 2026. The statutory responsibility to review the Scheme sits with the Board of NHS Highland and Argyll and Bute Council.

Drawing on the approach adopted for the previous review of the Scheme, which was undertaken in 2019/20, a Working Group was established to determine and agree any revisions required to the Scheme. The Working Group, made up of Senior Officers from across the Council, Argyll and Bute HSCP, and NHS Highland met on numerous occasions between March and May 2025 and have now concluded their review. The proposed revisions to the Scheme are detailed within appendix 1 for Members' consideration.

If both parent bodies are agreeable to the proposed revisions to the Scheme, as detailed in appendices 1 and 2, there are a number of subsequent steps which require to be taken and these are detailed below.

2. Next Steps

In accordance with Section 46(4) of the Public Bodies (Joint Working) (Scotland) Act 2014, the Council and the Health Board must jointly consult with groups and individuals, to include the prescribed stakeholders and any others deemed appropriate.

The Consultation and Engagement Strategy, attached at appendix 2, sets out the background and purpose of the exercise, and provides an overview of the proposed approach, including:-

- An 8-week consultation period from 25th August to 19th October 2025. Specific timescales or methodology for consultation are not prescribed in the Public Bodies (Joint Working) (Scotland) Act 2014, however the suggested 8-week consultation period is in line with national/local guidance on consultations.
- Details of the statutory / non statutory stakeholders. In line with the 2014 Act, the prescribed stakeholders are:-

    - Health professionals (GPs, management teams, clinical groups inlcuding 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 the Health Board and local authority 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
    - NHS Greater Glasgow and Cyde

- Details of the survey question set and how consultees can respond to the consultation / get in touch with any questions or queries.
- An operational plan, setting out the proposed engagement method(s) for each stakeholder group.

Following the consultation period, Argyll and Bute Council and NHS Highland will take into account any views expressed during the consultation prior to finalising the draft revised Integration Scheme. A report on the agreed revisions to the Integration Scheme following consultation will be submitted to meetings of Argyll and Bute Council and the NHS Highland Board at the earliest opportunity thereafter.

In the event that the consultation feedback suggests no further changes to the Scheme and voices no opposition to the proposed changes, it is recommended that the two Chief Executive Officers are authorised to approve the draft revised Integration Scheme on

behalf of the Council and the NHS Highland Board prior to submitting to the Scottish Government for approval.

Thereafter, both parent bodies must jointly submit the revised Scheme to the Scottish Ministers for approval by the 23rd March 2026 deadline.

The Council and NHS Highland must publish the revised Integration Scheme as soon as practicable after it takes effect.

This report is tabled at the NHS Highland Board on 29th July 2025 for approval.

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** – Updated Integration Scheme 2025
- **Appendix 2** – Summary of Proposed Revisions
- **Appendix 3** – Consultation and Engagement Strategy

INTEGRATION SCHEME

BETWEEN

ARGYLL AND BUTE COUNCIL

AND

NHS HIGHLAND

May 2025

Contents

1. Introduction

1.1 Vision and Values:

The vision of Argyll and Bute Health and Social Care Partnership ~~Council and NHS Highland~~ is that ~~the~~ 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
- Community co-production

~~The core values of Argyll and Bute Council and NHS Highland are: caring; creative; committed; collaborative; teamwork; excellence; and integrity.~~

~~The core values of the Health and Social Care Partnership are: compassion; integrity; respect; continuous learning; leadership; and excellence.~~

1.2 Aims and Outcomes:

The main purpose of integration is to improve the wellbeing of people who use health 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.

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 how it will effectively use allocated resources to deliver 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, 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.
- Any other National Health and Well Being outcome prescribed in the future will also be adopted.

Argyll and Bute Council and NHS Highland have agreed that Social Care services for Children & Families and Justice Services should be included within the functions and services to be delegated to the IJB, therefore the specific national outcomes as detailed below for Children & Families and Justice are also included:

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; and
- We have improved the life chances of children, young people and families at risk.
- Any national outcomes prescribed in the future will also be adopted.

National outcomes and standards for Social Care 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

1.3 Scope of Integration:

Argyll and Bute Council and NHS Highland have agreed to delegate to the IJB the following functions:

- All NHS services that the legislation permits for delegation.
- All Adult social care services.
- All Children & Families social care services.
- All Justice social care services.

1.4 Finance arrangements:

The general principles are agreed as:

- The Council and NHS Highland 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.
- The Council and NHS Highland will work together in the spirit of partnership, openness and transparency.
- ~~The Council and NHS Highland payments to the IJB derive from a process that recognises that both organisations have expenditure commitments that cannot be avoided in the short to medium term. The Council and NHS Highland will prepare and maintain a record of what those commitments are and provide this to the IJB.~~
- 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 the Council and NHS Highland. The IJB, the Council and NHS Highland will share financial information to ensure all parties have a full understanding of their current financial position, ~~information and~~ future financial outlook and key planning assumptions~~challenges and funding streams~~.
- The existing financial regulations of the Council and NHS Highland 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 "Argyll and Bute Integration Joint Board" means the Integration Joint Board established by Order under section 9 of the Act.

2.3 "IJB" means Argyll and Bute Integration Joint Board.

2.4 "Outcomes" means the Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act.

2.5 "The Integration Scheme Regulations" means The Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014.

2.6 "Integration Joint Board Order" means The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

2.7 "Scheme" means this Integration Scheme.

2.8 “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.

2.9 ‘’Acute Services’’ means medical and surgical treatment provided mainly in hospitals and minor injury units.

2.10 “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.

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: 4 members of the NHS Highland Health Board.

3.1.2 Council: 4 Elected Members of the Council nominated by the Council.

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 National Health and Wellbeing 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.
- Any further~~other~~ National Health and Wellb ~~B~~eing outcomes that may be subsequently prescribed by the Scottish Ministers via Regulations.

3.3 The Parties have agreed that Social Care services for Children & Families social care and Justice social care should be included within the functions and services to be delegated to the IJB. Therefore, the specific national outcomes as detailed below for Children & Families and Justice are also included:

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; and
- We have improved the life chances of children, young people and families at risk.
- Any national outcomes prescribed in the future will also be adopted.

National outcomes and standards for Social Care 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 and social care functions for adults and children 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 is responsible for the operational oversight of Integrated Services and, through the Chief Officer, will be responsible for the operational management of Integrated Services.

5.1.4 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.

5.1.5 As the majority of Acute services are contracted from a neighbouring Health Board (NHS Greater Glasgow and Clyde), the IJB will be responsible for the operational oversight of Acute Services. A lead Director for Acute Services in NHS Greater Glasgow and Clyde (GG&C) has been identified as the contract liaison officer who is responsible for the operational management of Acute Services in NHS GG&C.

5.1.6 NHS Greater Glasgow and Clyde 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 national health and wellbeing 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 National Health and Wellbeing Outcomes. The Integration Authorities that are most likely to be affected by the Strategic Plan are:

- West Dunbartonshire Integration Joint Board, Inverclyde and Renfrew and East Renfrew Integration Joint Boards share a common acute provider of services (NHS Greater Glasgow and Clyde).

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 ~~continue to~~ provide ~~the~~ corporate support services to ~~required to fulfil the duties of~~ the IJB. The Parties will:

- ~~Identify and agree on an ongoing basis, the corporate support services required to fully discharge the IJB's duties under the Act.~~ Agree the scope and level of services to be provided to support the IJB in discharging its duties under the Act
- ~~The Parties will continue to provide the IJB with the corporate support services it requires to fully discharge 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 national and local 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 national and local 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.

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 independent sectors, and by informal carers.

6.4 In relation to existing health and social care services, NHS Highland is accountable for health functions and services, whilst Argyll and Bute Council is responsible for social care services. Professional governance responsibilities are carried out by the professional leads through to the health and social care professional regulatory bodies.

6.5 The Chief Social Work Officer holds professional accountability for social care services. The Chief Social Work Officer reports directly to the Chief Executive and Elected Members of the Council in respect of professional social care matters. He/she is 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.
- Safety of integrated service delivery and personal outcomes and quality of registered services

6.9 Each of the four elements, listed at 5.8, 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.
- Planned and strategic approaches to learning, improvement, innovation and development, supporting an effective organisational learning culture.

6.12 The Medical Director, or his/her 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 his/her 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 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 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 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.
- 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.
- planned and strategic approaches to learning, improvement, innovation and development, supporting an effective organisational learning culture.

6.17 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.

6.18 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.

6.19 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.

6.20 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.

6.21 Annex 3 provides a schematic to show the systems governance arrangements.

6.22 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 his/her 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 development of the plan will be remitted to the Human Resources and Workforce Development and Organisational Development work streams already in place, for completion. These workstreams are led by Human Resources and Organisational Development Leads from both Parties and include NHS staff side (Trade Unions representing NHS Highland staff) and Trades Unions representatives (representing Council staff), as well as other key stakeholders.

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 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 Argyll and Bute Council and NHS Highland are responsible for the operational delivery of services commissioned ~~resources that are allocated~~ by the IJB ~~to~~from their respective

organisations ~~for operational delivery~~.

9.1.8 The Chief Financial Officer will work with the Council 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~~strategy~~ 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~~strategy~~ 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. ~~There is an expectation that it will deliver t~~The objectives of the Strategic Plan require to be delivered within agreed resources. The IJB ~~cannot~~must approve a balanced budget ~~which exceeds resources available~~.

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 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 Section 95 Officer for the Council 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 uses the previous year 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.
- 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 Section 95 Officer of the Council 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 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.
- 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 Section 95 Officer of the Council 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. The NHS and 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.

- 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 8.2.3 to 8.2.23 above, they should only be varied as a result of the circumstances set out in paragraphs 8.2.16, 8.2.22 and 8.2.23. 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 Section 95 Officer of the Council 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.
- 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 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.
- ~~Considering the proposals~~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 Section 95 Officer of the Council 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.
- 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 Section 95 Officer of the Council 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 Section 95 Officer of the Council 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 Argyll and Bute Integration Joint Board.
- Have access to sources of funding for capital expenditure.
- 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 ~~A joint consultation took place on the revised Integration Scheme during December/January 2019/20. The stakeholders who were consulted in this joint consultation were:~~ In line with the provisions of section 44 of the Public Bodies (Joint Working) (Scotland) Act 2014, the Integration 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 the Health Board and local authority 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
- NHS Greater Glasgow and Clyde

Other, local specific stakeholders include:-

- Argyll and Bute Council employees / elected members
- Staff side/TUs
- 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
- 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~~range of~~ methodologies to be adopted when engaging with ~~used to contact these~~ stakeholders, ~~included both Parties' websites and intranets, e-mail and postal correspondence.~~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.

~~11.1 The Communication and Engagement Strategy, along with the supporting Engagement Framework and Quality standards provides a platform for stakeholders to have their voices heard, their views considered and acknowledged, as well as strengthening relationships and building capacity. The IJB has adopted the "You Said, We Did" philosophy. A wide range of engagement methods have been adopted.~~

10.3 The Parties will carry out Equality and Socio-Economic Impact Assessments (EQSEIAs), 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.

~~12~~11 Information Sharing and Data Handling

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~~12.1~~11.1 The Parties agree to be bound by the Information Sharing Agreement~~Protocol~~ 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.

~~12.2~~11.2 The Parties have developed an Information Sharing Agreement~~Protocol~~ which covers guidance and procedures for staff for sharing of information.

~~12.3~~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~~Protocol~~.

~~12.4~~11.4 The Data Protection Officers of NHS Highland and Argyll and Bute Council, acting on behalf of the Parties, will meet every two years~~annually~~, or more frequently, if required, to review the Information Sharing Agreement~~Protocol~~ and will provide a report detailing recommendations for amendments, for the consideration of the IJB.

~~12.5~~11.5With 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.

~~12.6~~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.

~~12.7~~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').

~~12.8~~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.

~~13~~12 Complaints

The Parties agree the following arrangements in respect of complaints on behalf of, or by, service users.

~~13.1~~12.1 Both Parties will retain separate complaints policies reflecting the distinct statutory requirements.

~~13.1.1~~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.

~~13.1.2~~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.

~~13.2~~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.

~~13.3~~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.

~~13.4~~12.4 All complaints procedures will be clearly explained, well publicised, accessible, will allow for timely recourse and will sign-post independent advocacy services.

~~13.5~~12.5 The person making the complaint will always be informed which policies are being applied to their complaint.

~~13.6~~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.

~~14~~13 Claims Handling, Liability & Indemnity

The Parties agree the following arrangements in respect of claims handling, liability and indemnity:

~~14.1~~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.

~~14.2~~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.

~~14.3~~13.3 Liabilities arising from decisions taken by the IJB will be shared between the Parties.

~~15~~14 Risk Management/Internal Audit

~~15.1~~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.

~~15.2~~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
- Training

~~15.3~~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.

~~15.4~~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.

~~15.5~~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.

~~15.6~~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.

~~15.7~~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 Argyll & Bute IJB is responsible for commissioning an independent internal audit function, as part of an effective system of internal control.

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.

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.

~~16~~15 Dispute Resolution Mechanism

~~16.1~~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:

~~16.1.1~~15.1.1 A representative of NHS Highland and the Council will meet to resolve the issue, supported by appropriate Officers.

~~16.1.2~~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.

~~16.1.3~~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.

~~16.1.4~~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.

~~16.2~~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.

~~16.3~~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[1] (local consultative committees); section 17A[2] (NHS contracts); section 17C[3] (personal medical or dental services); section 17J[4] (Health Boards' power to enter into general medical services contracts); section 28A[5] (remuneration for Part II services); section 48[6] (residential and practice accommodation); section 57[7] (accommodation and services for private patients); section 64[8] (permission for use of facilities in private practice); section 79[9] (purchase of land and moveable property); section 86[10] (accounts of Health Boards and the Agency); section 88[11] (payment of allowances and remuneration to members of certain bodies connected with the health services);

[1] As relevantly amended by the National Health Service and Community Care Act 1990 (c.19), section 29(5) and the Health Act 1999 (c.8), Schedule 4.
[2] Section 17A was inserted by the National Health Service and Community Care Act 1990 (c.19) and was relevantly amended by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2; the Health Act 1999 (c.8), Schedules 4 and 5; the Health and Social Care (Community Health and Standards) Act 2003 (c.43), Schedule 14; the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 17; and the Health and Social Care Act 2012 (c.7), Schedule 21.
[3] Section 17C was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 21 and relevantly amended by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 2.
[4] Section 17J was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4.
[5] Section 28A was inserted by the Health Act 1999 (c.8), section 57.
[6] The functions of the Secretary of State under section 48 are conferred on Health Boards by virtue of S.I. 1991/570.
[7] Section 57 was substituted by the Health and Medicines Act 1988 (c.49), section 7(11), and relevantly amended by the National Health Service and Community Care Act 1990 (c.19), Schedules 9 and 10. The functions of the Secretary of State under section 57 are conferred on Health Boards by virtue of S.I. 1991/570.
[8] The functions of the Secretary of State under section 64 are conferred on Health Boards by virtue of S.I. 1991/570.
[9] As relevantly amended by the Health and Social Services and Social Security Adjudications Act 1983 (c.41), Schedule 7. National Health Service and Community Care Act 1990 (c.19), Schedule 9, the Requirements of Writing (Scotland) Act 1995 (c.7), Schedule 5 and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1. The functions of the Secretary of State under section 79 are conferred on Health Boards by virtue of S.I. 1991/570.
[10] As relevantly amended by the National Health Service and Community Care Act 1990 (c.19), section 36(6) and the Public Finance and Accountability (Scotland) Act 2000 (asp 1), schedule 4.
[11] The functions of the Secretary of State under section 88(1) (e) and (2) (d) are conferred on Health Boards by virtue of S.I. 1991/570. There are no amendments to section 88 relevant to the exercise of these functions by a Health Board.

	paragraphs 4, 5, 11A and 13 of Schedule 1[12] (Health Boards); and functions conferred by— The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000[13]; The Health Boards (Membership and Procedure) (Scotland) Regulations 2001[14], The National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004[15]; The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018[16] The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006[17]; The National Health Service (Discipline Committees) (Scotland) Regulations 2006[18]; The National Health Service (Appointment of Consultants) (Scotland) Regulations 2009[19]; The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009[20]; and The National Health Service (General Dental Services) (Scotland) Regulations 2010[21].
Disabled Persons (Services, Consultation and Representation) Act 1986[22] 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).

[12] Paragraph 4 of Schedule 4 was substituted by the Health Boards (Membership and Elections) (Scotland) Act 2009 (asp 5), schedule 1. Paragraph 5 of Schedule 1 was amended, and paragraph 11A of Schedule 1 inserted, by the Health Services Act 1980 (c.53), Schedule 6.

[13] To which there are amendments not relevant to the exercise of a Health Board's functions.

[14] To which there are amendments not relevant to the exercise of a Health Board's functions.

[15] As relevantly amended by S.S.I. 2004/216; S.S.I. 2006/136; S.S.I. 2007/207 and S.S.I. 2011/392.

[16] As relevantly amended by S.S.I. 2004/217; S.S.I. 2010/395; and S.S.I. 2011/55.

[17] As relevantly amended by S.S.I. 2007/193; S.S.I. 2010/86; S.S.I. 2010/378 and S.S.I. 2013/355.

[18] Amended by S.S.I 2009/183; S.S.I. 2009/308; S.S.I. 2010/226; S.I. 2010/231 and S.S.I. 2012/36.

[19] To which there are amendments not relevant to the exercise of a Health Board's functions.

[20] As relevantly amended by S.S.I. 2009/209; S.S.I. 2011/32; and S.S.I. 2014/148.

[21] As relevantly amended by S.S.I. 2004/292 and S.S.I 2010/378.

[22] Section 7 is relevantly amended by S.I. 2013/2341.

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.	
~~**Children and Young People (Scotland) Act 2014**~~	
~~All functions of Health Boards conferred by, or by virtue of, Part 4 (provision of named persons) and Part 5 (child's plan) of the Children and Young People (Scotland) Act 2014.~~	
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	*Column B*
The National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of— section 2(7) (Health Boards); section 2CB[23] (functions of Health Boards outside Scotland); section 9 (local consultative committees); section 17A (NHS contracts); section 17C (personal medical or dental services); section 17I[24] (use of accommodation); section 17J (Health Boards' power to enter into general medical services contracts); section 28A (remuneration for Part II services); section 38[25] (care of mothers and young children); section 38A[26] (breastfeeding);

[23] Section 2CB was inserted by S.S.I. 2010/283, regulation 3(2) (as section 2CA) and re-numbered as section 2CB by S.S.I. 2013/292, regulation 8(2).

[24] Section 17I was inserted by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2 and amended by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4. The functions of the Scottish Ministers under section 17I are conferred on Health Boards by virtue of S.I. 1991/570, as amended by S.S.I. 2006/132.

[25] The functions of the Secretary of State under section 38 are conferred on Health Boards by virtue of S.I. 1991/570.

[26] Section 38A was inserted by the Breastfeeding etc. (Scotland) Act 2005 (asp 1), section 4. The functions of the Scottish Ministers under

	section 39[27] (medical and dental inspection, supervision and treatment of pupils and young persons); section 48 (residential and practice accommodation); section 55[28] (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[29] (remission and repayment of charges and payment of travelling expenses); section 75B[30] (reimbursement of the cost of services provided in another EEA state); section 75BA[31] (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[32] use and administration of certain endowments and other property held by Health Boards); section 83[33] (power of Health Boards and local health councils to hold property on trust); section 84A[34] (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[35] (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[36]; The Health Boards (Membership and Procedure) (Scotland) Regulations 2001/302; 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;

section 38A are conferred on Health Boards by virtue of S.I. 1991/570 as amended by S.S.I. 2006/132.

[27] Section 39 was relevantly amended by the Self Governing Schools etc. (Scotland) Act 1989 (c.39) Schedule 11; the Health and Medicines Act 1988 (c.49) section 10 and Schedule 3, and the Standards in Scotland's Schools etc. Act 2000 (asp 6), schedule 3.

[28] Section 55 was amended by the Health and Medicines Act 1988 (c.49), section 7(9) and Schedule 3 and the National Health Service and Community Care Act 1990 (c.19), Schedule 9. The functions of the Secretary of State under section 55 are conferred on Health Boards by virtue of S.I. 1991/570.

[29] Section 75A was inserted by the Social Security Act 1988 (c.7), section 14, and relevantly amended by S.S.I. 2010/283. The functions of the Scottish Ministers in respect of the payment of expenses under section 75A are conferred on Health Boards by S.I. 1991/570.

[30] Section 75B was inserted by S.S.I. 2010/283, regulation 3(3) and amended by S.S.I. 2013/177.

[31] Section 75BA was inserted by S.S.I. 2013/292, regulation 8(4).

[32] Section 82 was amended by the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 4), section 10(2) and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 2.

[33] There are amendments to section 83 not relevant to the exercise of a Health Board's functions under that section.

[34] Section 84A was inserted by the Health Services Act 1980 (c.53), section 5(2). There are no amendments to section 84A which are relevant to the exercise of a Health Board's functions.

[35] Section 98 was amended by the Health and Medicines Act 1988 (c.49), section 7. The functions of the Secretary of State under section 98 in respect of the making, recovering, determination and calculation of charges in accordance with regulations made under that section is conferred on Health Boards by virtue of S.I. 1991/570.

[36] As amended by S.I. 1992/411; S.I. 1994/1770; S.S.I. 2004/369; S.S.I. 2005/445; S.S.I. 2005/572; S.S.I. 2006/141; S.S.I. 2008/290; S.S.I. 2011/25 and S.S.I. 2013/177.

	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[37].
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)[38]; section 38 (duties on hospital managers: examination, notification etc.)[39]; section 46 (hospital managers' duties: notification)[40]; 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[41] (correspondence of certain persons detained in hospital); and functions conferred by— The Mental Health (Safety and Security) (Scotland)

[37] To which there are amendments not relevant to the exercise of a Health Board's functions.

[38] There are amendments to section 34 not relevant to the exercise of a Health Board's functions under that section.

[39] Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") provides a definition of "managers" relevant to the functions of Health Boards under that Act.

[40] Section 46 is amended by S.S.I. 2005/465.

[41] Section 281 is amended by S.S.I. 2011/211.

	Regulations 2005[42]; The Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005[43]; 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)	
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[44].

[42] To which there are amendments not relevant to the exercise of the functions of a Health Board. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

[43] Section 329(1) of the 2003 Act provides a definition of "managers" relevant to the functions of Health Boards.

[44] Section 5(2) of the Patient Rights (Scotland) Act 2011 (asp 5) provides a definition of "relevant NHS body" relevant to the exercise of a Health Board's functions.

Part 2

Services ~~currently~~ 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 Psychiatric Nursing, Re-ablement, Geriatricians Community/Acute, 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([11])	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958([12])	
Section 3 (Provision of sheltered employment by local authorities)	

(10) 1948 c.29; section 48 was amended by the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 39, paragraph 31(4) and the Adult Support and Protection (Scotland) Act 2007 (asp 10) schedule 2 paragraph 1.

(11) 1958 c.33; section 3 was amended by the Local Government Act 1972 (c.70), section 195(6); the Local Government (Scotland) Act 1973 (c.65), Schedule 27; the National Health Service (Scotland) Act 1978 (c.70), schedule 23; the Local Government Act 1985 (c.51), Schedule 17; the Local Government (Wales) Act 1994 (c.19), Schedules 10 and 18; the Local Government etc. (Scotland) Act 1994 (c.49), Schedule 13; and the National Health Service (Consequential Provisions) Act 2006 (c.43), Schedule 1

Column A *Enactment conferring function*	*Column B* *Limitation*
The Social Work (Scotland) Act 1968[13]	
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.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.

(12) 1968 c.49; section 1 was relevantly amended by the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Children Act 1989 (c.41), Schedule 15; the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), schedule 10; S.S.I. 2005/486 and S.S.I. 2013/211. Section 4 was amended by the 1990 Act, Schedule 9, the Children (Scotland) Act 1995 (c.36) ("the 1995 Act"), schedule 4; the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) ("the 2003 Act"), schedule 4; and S.S.I. 2013/211. Section 10 was relevantly amended by the Children Act 1975 (c.72), Schedule 2; the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 13; the Regulation of Care (Scotland) Act 2001 (asp 8) ("the 2001 Act") schedule 3; S.S.I. 2010/21 and S.S.I. 2011/211. Section 12 was relevantly amended by the 1990 Act, section 66 and Schedule 9; the 1995 Act, Schedule 4; and the Immigration and Asylum Act 1999 (c.33), section 120(2). Section 12A was inserted by the 1990 Act, section 55, and amended by the Carers (Recognition and Services) Act 1995 (c.12), section 2(3) and the Community Care and Health (Scotland) Act 2002 (asp 5) ("the 2002 Act"), sections 8 and 9(1). Section 12AZA was inserted by the Social Care (Self Directed Support) (Scotland) Act 2013 (asp 1), section 17. Section 12AA and 12AB were inserted by the 2002 Act, section 9(2). Section 13 was amended by the Community Care (Direct Payments) Act 1996 (c.30), section 5. Section 13ZA was inserted by the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 64. Section 13A was inserted by the 1990 Act, section 56 and amended by the Immigration and Asylum Act 1999 (c.33), section 102(2); the 2001 Act, section 72 and schedule 3; the 2002 Act, schedule 2 and by S.S.I. 2011/211. Section 13B was inserted by the 1990 Act sections 56 and 67(2) and amended by the Immigration and Asylum Act 1999 (c.33), section 120(3). Section 14 was amended by the Health Services and Public Health Act 1968 (c.46), sections 13, 44 and 45; the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Guardianship Act 1973 (c.29), section 11(5); the Health and Social Service and Social Security Adjudications Act 1983 (c.41), schedule 10 and the 1990 Act, schedule 9. Section 28 was amended by the Social Security Act 1986 (c.50), Schedule 11 and the 1995 Act, schedule 4. Section 29 was amended by the 1995 Act, schedule 4. Section 59 was amended by the 1990 Act, schedule 9; the 2001 Act, section 72(c); the 2003 Act, section 25(4) and schedule 4 and by S.S.I. 2013/211.

Column A *Enactment conferring function*	*Column B* *Limitation*
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 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
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.
The Local Government and Planning (Scotland) Act 1982([14])	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Disabled Persons (Services, Consultation and Representation) Act 1986([15])	

(13) 1982 c.43; section 24(1) was amended by the Local Government etc. (Scotland) Act 1994 (c.39), schedule 13.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 2 (Rights of authorised representatives of disabled persons.)	
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([16])	
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
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

(14) 1986 c.33. There are amendments to sections 2 and 7 which are not relevant to the exercise of a local authority's functions under those sections.
(15) 2000 asp 4; section 12 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 5(1). Section 37 was amended by S.S.I. 2005/465. Section 39 was amended by the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and by S.S.I. 2013/137. Section 41 was amended by S.S.I. 2005/465; the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and S.S.I. 2013/137. Section 45 was amended by the Regulation of Care (Scotland) Act 2001 (asp 8), Schedule 3.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions
The Housing (Scotland) Act 2001([17])	
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([18])	
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([19])	
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.)	
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	

(16) 2001 asp 10; section 92 was amended by the Housing (Scotland) Act 2006 (asp 1), schedule 7.
([18]) 2002 asp 5.
(19) 2003 asp 13; section 17 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), section 111(4), and schedules 14 and 17, and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 25 was amended by S.S.I. 2011/211. Section 34 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 259 (Advocacy.)	
The Housing (Scotland) Act 2006([20])	
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([21])	
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.)	
Social Care (Self-directed Support) (Scotland) Act 2013 ([22])	

(20) 2006 asp 1; section 71 was amended by the Housing (Scotland) Act 2010 (asp 17) section 151.
(21) 2007 asp 10; section 5 and section 42 were amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17 and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 43 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 14.
([22]) 2013 asp 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
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 [2324]	
Section 6 (Duty to prepare adult carer support plan)	
Section 21 (Duty to set local eligibility criteria)	
Section 24 (Duty to provide support)	

(23) section 21 was inserted into the Schedule of the Public Bodies (Joint Working) (Scotland) Act 2014 by paragraph 6 of the schedule of the Carers (Scotland) Act 2016 (asp 9)

(24)inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017/190

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 25 (Provision of support to carers: breaks from caring) Section 31 (Duty to prepare local carer strategy) Section 34 (Information and advice service for carers) Section 35 (Short breaks services statements)	

Functions, conferred by virtue of enactments, 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*
The Community Care and Health (Scotland) Act 2002 Section 4([25]) **The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002([26])**	

([25]) Section 4 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp13) schedule 4 and the Adult Support and Protection (Scotland) Act 2007 (asp 10) section 62(3)

([26]) S.S.I. 2002/265, as amended by S.S.I. 2005/445.

Additional Functions delegated by the Council to Argyll and Bute Integration Joint Board

Column A Enactment conferring function	Column B
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.)	
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.)

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.)

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)

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)

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)

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

Section12
(Duty to prepare a Young Carer Statement)

Column A Functions conferred by virtue of enactments	Column B
Children's Hearings (Scotland) Act 2011 Section 153 (Secure accommodation: regulations.)	

Part 2

Services ~~currently~~ 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.

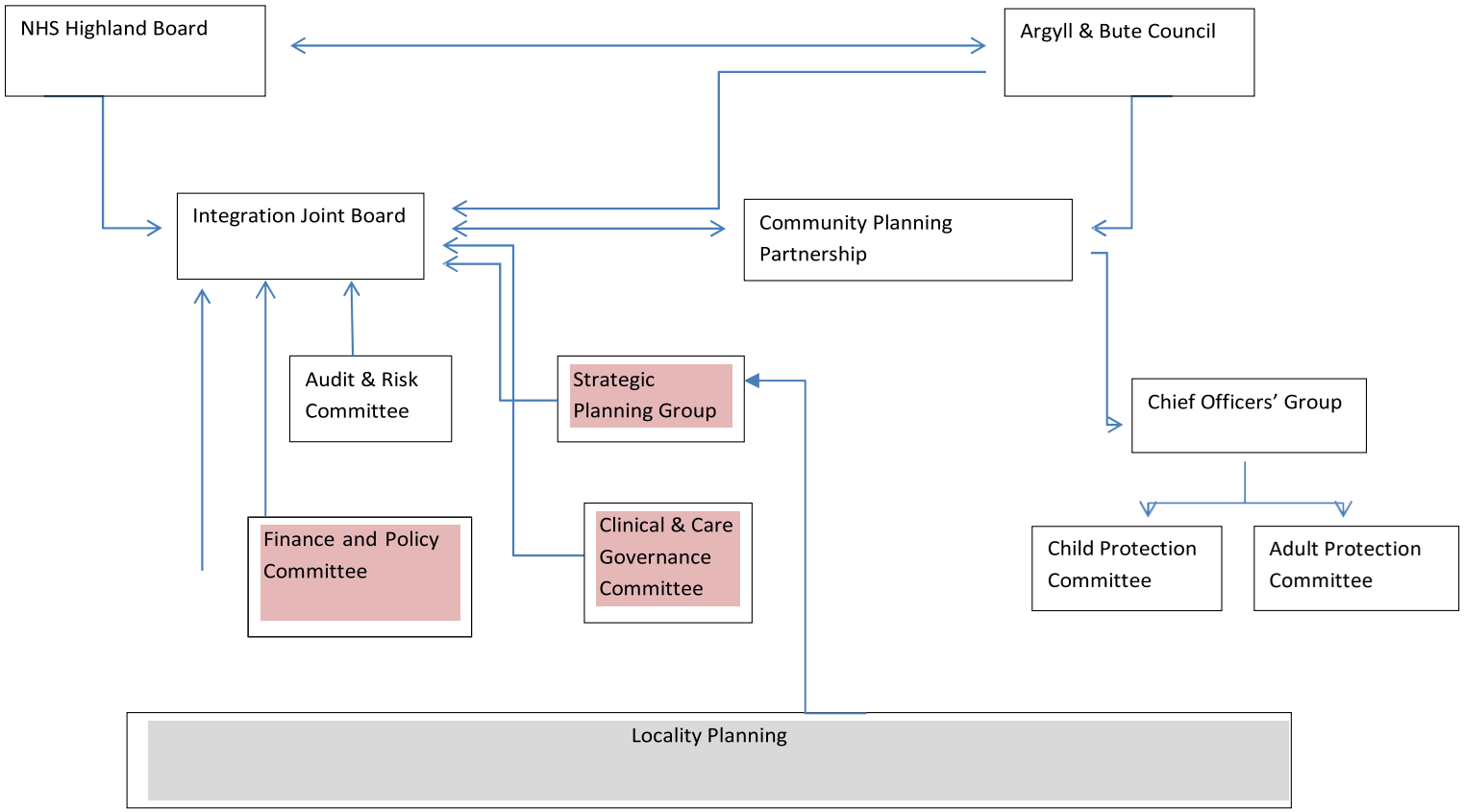
- Social care Services for Adults and Older People
    - Services and Support for Adults with Physical Disabilities and Learning Disabilities
    - Mental Health Services
    - Drug and Alcohol Services
    - Adult Protection and Domestic Abuse
    - Carers Support Services
    - Community Care Assessment 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

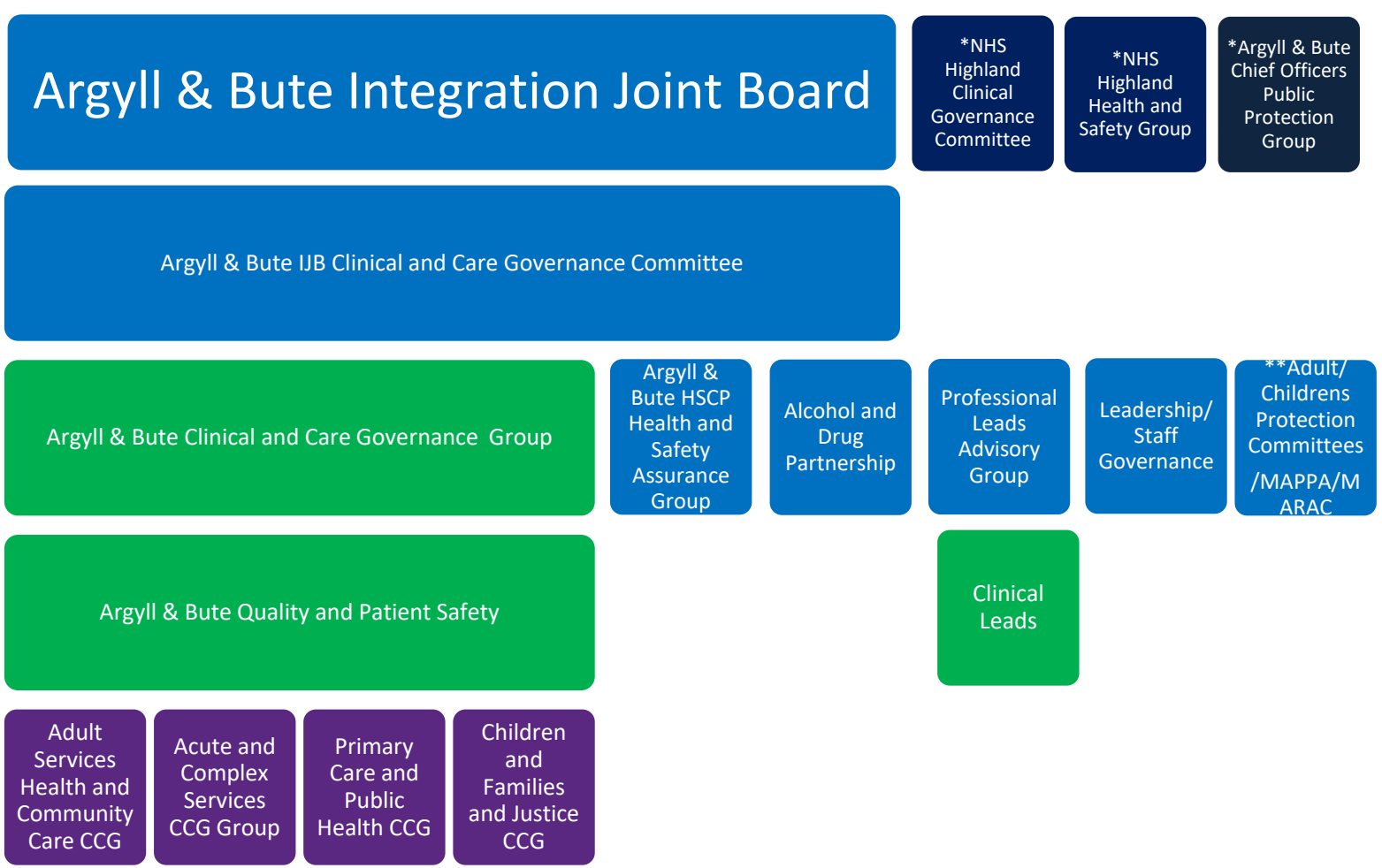
- Social care Justice Services
  - Services to Courts and Parole Board
  - Assessment of offenders
  - Diversions from Prosecution and Fiscal Work Orders
  - Supervision of offenders subject to a community based order
  - Through care and supervision of released prisoners
  - Multi Agency Public Protection Arrangements

Annex 3: Systems Governance.

System Governance Schematic



Annex 4: Clinical and Care Governance structure.



Strategic:
Executive and non-exec scrutiny
Senior HSCP accountable officer
Assurance, dissemination of action and learning

Tactical oversight:
Internal/ Partnership operational oversight

Operational:
Chaired by relevant head of service.
Professional leadership at depute level
Relevant corporate and planning

*Independent to the IJB but provides part of the structure for assurance
** Independent Committee/ Multi-agency group

APPENDIX 2

Review of the Argyll and Bute Integration Scheme

Summary of Revisions

Provision paragraph	Revision / Explanation
1.1 Vision and Values (p3)	Vision and values updated to reflect the wording within the Joint Strategic Plan 2022-25
1.4 (p5)	Propose that the 3rd bullet point (detailed below) is removed, on the basis that, within the context of the other detail in this section it is no longer relevant//meaningful. *The Council and NHS Highland payments to the IJB derive from a process that recognises that both organisations have expenditure commitments that cannot be avoided in the short to medium term. The Council and NHS Highland will prepare and maintain a record of what those commitments are and provide this to the IJB.*
1.4 (p5)	Propose that the last sentence of the 4th bullet point be reworded to provide clarity of process:- Original – The IJB, the Council and NHS Highland will share financial information to ensure all parties have a full understanding of their current financial information and future financial challenges and funding streams. Revision - *The IJB, the Council and NHS Highland will share financial information to ensure all parties have a full understanding of their current financial position, future financial outlook and key planning assumptions.*
3.2 (p8)	Propose that the last bullet point is reworded to provide further clarity. Original – Any other National Health and Well Being outcomes prescribed by the Scottish Ministers. Revision - *Any other National Health and Wellbeing outcomes that may be subsequently prescribed by the Scottish Ministers via Regulations.*
5.3.1 (p11)	Proposed changes as follows to clearly define the arrangement for Corporate Services:- • Original - Identify and agree on an ongoing basis, the corporate support services required to fully discharge the IJB's duties under the Act. Revision – *Agree the level and scope of services to be provided to support the IJB in discharging its duties under the Act.*

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	• Proposed deletion of 2nd bullet point - The Parties will continue to provide the IJB with the corporate support services it requires to fully discharge its duties under the Act. Not required in light of proposed change to first bullet point.
Section 9 Finance (p20 onwards)	The following changes are proposed to the financial section in order to strengthen the terminology and clarify the anticipated arrangements/actions:- • 9.1.6 Original – The Chief Financial Officer of the IJB will work with the Council 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. Revision - *The Chief Financial Officer of the IJB will work with the Council 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 Original - The Chief Executive Officers of Argyll and Bute Council and NHS Highland are responsible for the resources that are allocated by the IJB to their respective organisations for operational delivery. Revision - *The Chief Executive Officers of Argyll and Bute Council and NHS Highland are responsible for the operational delivery of services commissioned by the IJB from their respective organisations.* • 9.2.1 - “strategy” changed to “plan”. • 9.2.2 Original – The IJB is able to hold reserves. There is an expectation that it will deliver the objectives of the Strategic Plan within agreed resources. The IJB cannot approve a budget which exceeds resources available. Revision - *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.*

APPENDIX 2

	• 9.2.18 Original - Where it is forecast that an overspend will arise, 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 Section 95 Officer of the Council 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. Revision - *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 Section 95 Officer of the Council 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 Original – A recovery plan should aim to bring the forecast expenditure of the IJB back in line with the budget within the current financial year. 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. Revision - *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.*

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	9.4.1 Original - ➢ Developing a medium and longer term financial strategy to support delivery of the Strategic Plan. ➢ Preparation and review of the annual budget. ➢ Collating and reviewing budget savings proposals. ➢ Identifying and analysing financial risks. ➢ Considering the proposals in relation to reserves. Revision – ➢ *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.* ➢ *Policy relation to reserves, with regular updates on the use of reserves and the impact of the current financial monitoring position on available reserve balances.*
9.7 (p28)	Propose the addition of the following at 9.7.2 to further clarify arrangements in respect of assets and capital investment:- *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.*
Section 10 (p30 onwards)	The following changes are proposed to the Participation and Engagement section to provide clarity that the arrangements are in line with the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014, the associated Regulations, and local/national guidance. • 10.1 Original - A joint consultation took place on the revised Integration Scheme during December/January 2019/20. The stakeholders who were consulted in this joint consultation were:

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	Revision – *In line with the provisions of section 44 of the Public Bodies (Joint Working) (Scotland) Act 2014, the Integration 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:-* • 10.2 / 10.3 Original - The range of methodologies used to contact these stakeholders included both Parties' websites and intranets, e-mail and postal correspondence. The Communication and Engagement Strategy, along with the supporting Engagement Framework and Quality standards provides a platform for stakeholders to have their voices heard, their views considered and acknowledged, as well as strengthening relationships and building capacity. The IJB has adopted the "You Said, We Did" philosophy. A wide range of engagement methods have been adopted. Revision - *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.*
Section 11 (p32)	"Protocol" changed to "Agreement" to reflect the changes within the revised Information Sharing Agreement, which was reviewed in 2024.
Section 14 (p35)	*Proposed addition of the following section to cover responsibilities in terms of internal audit:-* *New 14.9 - The Argyll & Bute IJB is responsible for commissioning an independent internal audit function, as part of an effective system of internal control.* *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.*

APPENDIX 2

	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.
Annex 1 (p39)	The following has been deleted as the entry has been revoked by Children (Care and Justice) (Scotland) Act 2024 asp 5 (Scottish Act) Sch.1(9) para.30(2) - (May 5, 2025). **Children and Young People (Scotland) Act 2014** All functions of Health Boards conferred by, or by virtue of, Part 4 (provision of named persons) and Part 5 (child's plan) of the Children and Young People (Scotland) Act 2014. The following has been added as relevant regulations:- **Public Health etc. (Scotland) Act 2008** Section 2 (duty of Health Boards to protect public health) Section 7 (joint public health protection plans)
Annex 4 (p60)	Updated graphic added to reflect current Clinical and Care Governance structure.

APPENDIX 3

REVIEW OF ARGYLL AND BUTE INTEGRATION SCHEME

Consultation and Engagement Strategy

1. Introduction

The purpose of this document is to set out the strategy for engagement and consultation with key/prescribed stakeholders in respect of reviewing the current Health and Social Care Integration Scheme (the Scheme) between Argyll and Bute Council and NHS Highland.

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 has been undertaken and a number of proposed amendments have been recommended. These changes have been 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 parent bodies are agreeable to the proposed amendments, there is now a requirement to undertake a joint formal consultation exercise in accordance with Section 46(4) of the Act. Further detail on the consultation is provided in the section 3 below.

2. Background and Contextual Information

The Public Bodies (Joint Working) (Scotland) Act was passed by the Scottish Parliament in February 2014 and came into force on 1st April 2016, which changed the law to bring together health and social care into a single, integrated system. The legislation created 31 integration authorities, of which Argyll and Bute Health and Social Care Partnership (HSCP) are one, who are now responsible for local services. These services were previously managed separately by NHS Boards and local authorities.

The HSCP is governed by the Integrated Joint Board (IJB) – a separate legal entity in its own right - which is responsible for the planning, resourcing and overseeing of the operational delivery of integrated services. The IJB is responsible for allocating the integrated revenue budget for health and social care in accordance with the objectives set out in its Strategic Plan. The IJB includes members from NHS Highland, Argyll & Bute Council, representatives of the Third Sector, Independent Sector, staff representatives and others representing the interests of patients, service users and carers.

In line with the provisions of the Public Bodies (Joint Working) (Scotland) Act, the local authority and the Health Board must jointly prepare an Integration scheme, which sets out the model of integration and the functions that are to be delegated in accordance with that model. Argyll and Bute Council and NHS Highland have agreed to delegate the following functions to the IJB:-

- NHS Services
  - Community hospitals
  - Acute Care
  - Primary Care (including GPs)

  - Allied Health Professionals
  - Community Health Services
  - Maternity Services
- Public Health Services including the Prevention agenda
- Adult social care services including:-
  - Services for older adults
  - People with learning disabilities
  - People with mental health problems
- Children and Families social care services
- Alcohol and Drug Services
- Child and Adult Protection
- Criminal and Community Justice Services

3. Consultation Approach

As previously mentioned at section 1 above, in accordance with Section 46(4) of the Act, the Council and NHS Highland Health Board must jointly consult with the prescribed stakeholders (set out below) and any other deemed appropriate to obtain views on the proposed amendments to the current Integration Scheme. A copy of the Scheme, with the proposed changes highlighted, together with a summary document detailign the revisions can be accessed here – [insert link].

As well as adhering to the relevant legislative requirements, the consultation will be carried out in line with the approved Argyll and Bute HSCP Engagement Framework, which draws on national guidance and best practice including the National Standards for Community Engagement, and the relevant frameworks/toolkits adhered to by the partner bodies.

Consultation Period

An 8 week consultation will be undertaken between 25th August to 19th October 2025.

As part of the consultation process the partner bodies will:

- Provide accurate information in respect of the scope of the consultation subject
- Attempt to answer all relevant questions and requests for additonal information, as far as is reasonably practicable, before the end of the consultaton period;
- Take account of any views expressed as part of the consultation exercise when finalising the revised Integration Scheme.

Stakeholders/Audiences

For the purposes of this consultation the prescribed stakeholders, as set out in the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014, are:-

- Health professionals (GPs, management teams, clinical groups inlcuding 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 the Health Board and local authority 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
- NHS Greater Glasgow and Clyde

Other relevant stakeholders include:-

- Argyll and Bute Council elected members
- Community Councils
- Staff side/Trade Unions
- Argyll and Bute Commuity Planning Partnership
- Community Planning Groups
- Locality Planning Groups
- NHS 24
- Scottish Health Council
- MPs/MSPs
- Dentists
- Pharmacists
- Citizens Advice Bureau / Patient Advice and Support Service

Further detail on how each stakeholder group will be engaged as part of the process is included within the Operational Plan starting on page 6 below.

Question Set

The purpose/scope of the consutlation is to obtain views on the proposed amendments detailed within the Integration Scheme. On this basis, the survey questions for this engagement and consultation exercise are:-

1. Do you have any comments/views on the proposed amendments contained within the relevant sections of the Integration Scheme [insert link] as detailed below?

   [list relevant sections where changes are proposed]

2. About you – please note that personal details will not be shared or used as part of any reporting on the consultation.

   a) What is your primary interest in the Integration Scheme?
      - I am a health professional
      - I am a social care professional
      - I am a user of health services
      - I am a user of social care services
      - I am a carer
      - I am a commerical provider of health care

- I am a non commercial provider of health care
- I am an employee of the local authority and/or NHS
- Other – please specify

b) Please provide a contact email address if you would like us to communicate with you post consultation.

c) Please provide the first part of your postcode to enable us to establish the area you reside in.

Responding to the Consultation

- An online survey (using Google Forms) will be issued to all stakeholders – available here [insert link]
- Details of the consultation, with links to the relevant background information and the survey, will be available on the relevant pages of Argyll and Bute Council and NHS Highland websites.
- A dedicated email inbox has been set up to allow stakeholders to contact us about the consultation (integrationschemereview@argyll-bute.gov.uk).
- Hard copies/different formats of the consultation can be provided upon request.

Operational Plan

The table below sets out the proposed engagement activity / timescales in respect of each stakeholder group:-

Utilising the dedicated inbox (integrationschemereview@argyll-bute.gov.uk) to allow stakeholders to contact us, ongoing engagement will be undertaken to answer any questions / provide further information as requested.

Stakeholders	Engagement Method(s)	Dates
Prescribed		
Argyll and Bute Council / IJB / NHS Highland Board	• Endorsement of (a) proposed changes to the Scheme and (b) the consultation and engagement strategy / timeline • Details of the consultation will be promoted via respective websites, social media and relevant internal channels	June./July 2025
Health Professionals (GPs/Health centres, management teams, clinical groups including nursing staff and allied health professionals)	• Email / post copies of engagement materials	w/c 18th August
Social Care Professionals	• Email engagement materials to all Social Work/Social Care employees	w/c 18th August
Users of health care / social care	• Promotion of consultation via press release/social media/partner body websites	w/c 18th August
Carers of users of health care / social care	• Email engagement materials to all known carers groups / wider promotion to carers in general as part of engagement method to users of health/social care (above).	w/c 18th August
Commercial / non commercial providers of health care / social care	• Email engagement materials to all known social/healthcare providers	w/c 18th August

Non commercial providers of social housing	• Email engagement materials to all housing providers	w/c 18th August
Staff of the Health Board and local authority who are not health professionals or social care professionals	• Email engagement materials to wider staff groups / promote via respective websites, social media and relevant internal channels	w/c 18th August
Third sector bodies carrying out activities related to helath or social care	• Email engagement materials	w/c 18th August
Highland Council	• Email engagement materials	w/c 18th August
NHS Greater Glasgow	• Email engagement materials	w/c 18th August
Other relevant stakeholders		
Elected members	• Email engagement materials	w/c 18th August
Community Councils	• Email engagement materials	w/c 18th August
Constituency/List MSPs and MPs	• Email engagement materials	w/c 18th August
Staff side / Trade Unions	• Email engagement materials	w/c 18th August
Argyll and Bute Community Planning Partnership	• Email engagement materials	w/c 18th August
Community Planning Groups	• Email engagement materials	w/c 18th August
Locality Planning Groups	• Email engagement materials	w/c 18th August
Scottish Health Council	• Email engagement materials	w/c 18th August
NHS 24	• Email engagement materials	w/c 18th August

Dentists	• Email/post engagement materials	w/c 18th August
Pharmacists/GPs	• Email/post engagement materials	w/c 18th August
Citizens Advice Bureau / Patient Advice and Support Service	• Email engagement materials	w/c 18th August

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Agenda Item 15

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**29 July 2025**
Title:	**Single Authority Model Update**
Responsible Executive/Non-Executive:	**Gareth Adkins, Director of People & Culture**
Report Author:	**Gareth Adkins, Director of People & Culture**

Report Recommendation:

The Board is asked to:

Approve the establishment of a joint short-life working group between Argyll and Bute Council and NHS Highland to progress an options appraisal for a single authority model and associated work and take **Substantial Assurance**.

1 Purpose

This is presented to the Board for:

- Assurance
- Decision

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

This aligns 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	
Care Well		Live Well		Respond Well	X	Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well	X	Progress well	X				

2 Report summary

2.1 Situation

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The concept of a Single Authority Model (SAM) within the context of public sector reform has been discussed at a previous board development session in August 2023.

Since then, there have been ongoing discussions amongst various stakeholders in relation to progressing development of the SAM concept in Argyll and Bute, including the possibility of this including health, thereby impacting the existing health and social care integration arrangements.

The situation in relation to the SAM concept has been evolving over the last 6 months and has reached a point where more formal governance is required between Argyll and Bute Council and NHS Highland to oversee joint working on this concept.

This paper sets out the background and context for establishing a joint short life working group between Argyll and Bute Council and NHS Highland.

The board is asked to:

- Approve the establishment of a joint short-life working group between Argyll and Bute Council and NHS Highland to progress an options appraisal for single authority model and associated work.

2.2 Background

Since the board was last updated on the SAM concept in 2023 there have been a series of engagements including:

- Argyll and Bute Council Chief Executive led workshop with HSCP/NHS Highland senior colleagues to explore principles, potential key benefits and improved outcomes of a SAM for Argyll and Bute
- Official start up meeting between Argyll and Bute Council, Scottish Government and COSLA to discuss local drivers for reform and current options being considered for Argyll and Bute
- Minister for Public Finance visit to Lochgilphead – discussion on SAM proposals and showcase of current integration/ partnership working

This has included discussions with Scottish Government in the context of public sector reform led by Ivan McKee, Minister for Public Finance, MSP. The SAM concept is considered a key part of a wider package of local governance reform to enhance democratic decision making at a place basedlevel.

The 2024-25 Programme for Government included a commitment to '*continue to make progress towards concluding the joint review of local governance by the end of this parliamentary session'* and this included developing single authority models (SAMs) with local government and other partners including health to strengthen and streamline local decision making, and support a shift towards more preventative public services.

Consequently, progress in the SAM concept has been continuing and since late 2024 NHS Orkney and NHS Western Isles have been engaged with their council partners, along with NHS Highland and Argyll and Bute council, in discussions with Scottish government colleagues who are leading on this work.

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Gareth Adkins, Director of People and Culture, has been working with Douglas Hendry, Executive Director (Monitoring Officer / IJB Standards Officer) for Argyll and Bute council to provide input to a briefing paper developed by Argyll and Bute setting out possible models for a SAM within the Argyll and Bute context.

This input consisted of advice on key aspects of NHS governance that would need to be taken into account when considering any potential changes that a SAM would bring about.

Appendix 2 includes Argyll and Bute's briefing paper that sets out the proposals they developed for a SAM to inform early discussions with councillors and Scottish Government.

There was a ministerial meeting with Ivan McKee on 6th December 2024 which included NHS board chairs and chief executives (or deputies) as well as councillors and council officers.

Subsequent meetings took place in the first half of 2025 to explore the issues arising from the initial discussions with Ivan McKee including:

- NHS Board Chairs and Chief Executives
- NHS Board Chairs and Chief Executives and Cabinet Secretary for Health and Social Care
- Joint Ministerial Meeting with Cabinet Secretary for Health and Social Care and Cabinet Secretary for Public Finance and the NHS Board Chairs and Chief Executives

In addition Scottish Government colleagues have established more regular meetings during the first quarter of 2025 with key stakeholders. The draft SG programme timeline included in appendix 1 was shared with the partners exploring the SAM concept.

This highlighted that there were some key areas requiring clarity for NHS Boards:

- timelines and risks of achieving the milestones outlined
- need to engage with staffside, particularly in NHS context
- need for jointly developed and agreed proposals
- governance arrangements for any SAM in the context of continued requirement for NHS Board governance of NHS services within any SAM
- The need for any new arrangement to be able to demonstrate compliance with the current 1978 NHS legislation

It has been agreed that work should continue to jointly develop proposals in each council and health board partnership area. To support the key areas of clarification requested by NHS Boards it was agreed that Scottish Government officials would develop 'parameters' from an NHS perspective that any SAM proposal should be compatible with. These were received on 18th July 2025 and are still to be considered fully.

In the mean time correspondence and meetings have continued between NHS Highland and Argyll and Bute council in relation to the suite of options developed so far by the council.

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More recently the 2025-2026 programme for government was announced includes the commitment to publish:

> Preferred models for Single Authority Models in Argyll and Bute, Orkney and Western Isles that have been developed jointly by local government and health and enable a shift towards prevention. This will include a plan and timeline for implementation, with at least one area transitioning to shadow arrangements

Argyll and Bute Council established a short-life working group with councillor representation to progress discussions within the council on SAM options the council have developed which met on 16th May 2025. Key points of discussion at the meeting in relation the SAM were an expectation that no Single Authority Model option would be dismissed prior to engagement with relevant partners. Furthermore there was discussion and a sharing of views of the options that may be of more interest to the members of the SLWG.

To date there has been no formal joint governance group in place between the two organisations but key stakeholders from both have been engaged in the discussions as outlined above.

Recently it has been agreed to establish a formal working group at senior officer level that includes council senior officers and NHS executive directors to progress development of a jointly agreed suite of options for a SAM.

In addition it has been proposed that a joint short life working group is established and this would be presented to both organisations to agree.

2.3 Assessment

The concept of a SAM in relation to the principles of enabling greater levels of integration in the public sector has been in formation for some time and has gradually gained momentum and pace.

There has been engagement over the last 2 years between Argyll and Bute council and NHS Highland over this period with activity gradually increasing.

Given this context a joint short life working group is proposed to formalise the governance arrangements between Argyll and Bute council and NHS Highland in relation to a joint approach to considering preferred models for a SAM.

This would enable both organisations to consider the options already developed by Argyll and Bute Council as well as consider developing additional options.

A senior officer group has been established that will progress the work required to develop and evaluate a jointly agreed suite of options for a SAM.

The joint short life working group will include councillors and non-executive directors as well as members of the senior leadership teams from each

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organisation. This group will provide the forum and governance for jointly agreeing recommendations on preferred options to both organisations.

The proposed Terms of Reference based on the council's SLWG are included in Appendix 3 for consideration by the board and for the board to agree:

- NHS Highland board membership
- Reporting arrangements into NHS Highland Board

The joint short life working group will oversee the work of the development and appraisal of a preferred option(s) for a SAM for Argyll and Bute. The current purpose of the SLWG has been set out by the council as:

- Act as a sounding board / provide advice to the Council's representatives engaged at a national level, to enable them to effectively engage with and take forward work arising from the national workplan and timescales
- Examine and assess the current options identified
- Development of an engagement and consultation strategy/programme for key stakeholders
- Commentary and recommendations on all reports going to Policy and Resources Committee and Council

This will need further discussion on extension of this group to become a joint short life working group. This could include inclusion of more detail similar to the purpose of the joint steering group between NHS Highland and the Highland Council reviewing the lead agency model of integration:

- Development of options for a future model of integration aligned with the principles of the single authority model
- Development and completion of an options appraisal and recommendations to both organisations including the strengths, weaknesses, opportunities and threats that might be involved in such options in relation to the delivery of both adult and children's service and to clearly define the financial, legal and workforce implications to be addressed
- recommendations on the resources required to support both organisations in the event of a transition from the current model to a future model of integration
- recommendations on any support Argyll and Bute Council and NHS Highland may require from Scottish Government in terms of taking forward any change to the model currently in place.
- any legislative implications arising from recommendations and potential need for additional provisions

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	X	Moderate	
Limited		None	

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3 Impact Analysis

3.1 Quality/ Patient Care

The SAM concept is intended to progress the health and social care integration agenda and contribute to outcomes for people.

3.2 Workforce

Workforce elements of the model of integration for different SAMs will be considered as part of this work. Staffside engagement will be important as more clarity emerges on the potential direction of travel for a SAM.

3.3 Financial

Unknown at present but will be considered within this work.

3.4 Risk Assessment/Management

Risk assessment will be picked up as the work progresses and the clarity emerges on the potential direction of travel for a SAM.

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

A range of stakeholders have been involved to date as outlined above.

3.9 Route to the Meeting

Via EDG

4 List of appendices

The following appendices are included with this report:

Appendix 1 – Scottish Government Draft Timelines

Appendix 2 – Briefing Paper on Single Authority Models

Appendix 3 – Working Group Terms of Reference (Single Authority Model)

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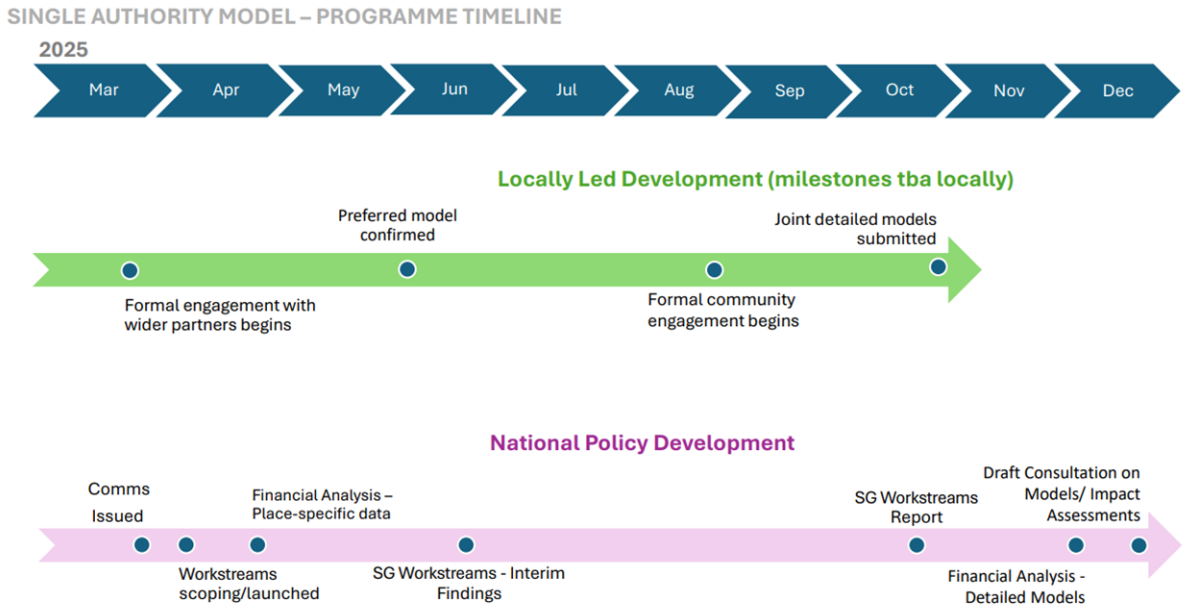
Appendix 1 – Scottish Government Programme Timelines



A SINGLE AUTHORITY MODEL FOR ARGYLL AND BUTE

Overview of Key Principles and Models

Introduction

This Paper outlines the work undertaken thus far by Argyll and Bute Council to explore the possibility of a Single Authority Model (SAM) for the area. It outlines they key principles that have guided the work to date, the potential benefits of a SAM for the area, and an overview of the possible models that have been identified.

Background

Understanding Argyll and Bute

Argyll and Bute is made up of a rich mix of remote, rural and island communities, which presents a number of challenges in terms of service delivery. For planning and service delivery purposes Argyll and Bute is divided into four areas: Bute and Cowal; Helensburgh and Lomond; Mid Argyll, Kintyre and the Islands; and Oban, Lorn and the Isles. The area has a population of 87,810 (NRS 2023 Mid-Year Estimates), spread across the second largest local authority area in Scotland.

There are 28 inhabited islands in Argyll and Bute (Census 2022) - more than any other local authority in Scotland. Approximately 17.5% of Argyll and Bute's population live on islands. Moreover, many of Argyll and Bute's mainland peninsulas could be considered to share the same characteristics and challenges to the island communities – given their remote/remote rural nature. 47.6% of Argyll and Bute's population live in areas classified by the Scottish Government as 'rural' and 43.2% live in areas classified as 'remote rural'.

The changing demographic profile of Argyll and Bute presents one of the greatest challenges. By 2028, the population is projected to decrease to 83,796. This is a decrease of 5.9% which compares to a projected population increase of 1.8% for Scotland as a whole. Argyll and Bute's population is predicted to continue ageing, with the proportion of 0-15 year olds projected to fall by 17.6%, working age population to decrease by 4.7%, and the proportion of those of pensionable age to decrease by 1.7%. However, it is anticipated that there will be an increase of 23.3% in the population aged 75 and over. (National Records of Scotland 2018-based Population Projections).

Other key challenges include:

- increased demand for health and social care services due to a projected increase in the number of older people in the area;
- increased need for end of life care;
- recruitment and retention of the local workforce as the working-age population decreases;
- the physical geography of Argyll and Bute provides limitations in terms of developing the road network, and a reliance on ferry travel in parts. This also creates issues in terms of the accessibility of services for all across a significant remote and rural geography;
- there is fragility in the economy in Argyll and Bute due to reliance on part time and seasonal employment;
- the Council recently declared a housing emergency in Argyll and Bute, with a consistent reduction in available housing, coupled with a rise in demand and increasing property prices;
- thirteen data zones in Argyll and Bute are included in the 20% most overall deprived data zones in Scotland; and
- although Argyll and Bute falls within the NHS Highland health board area, almost all patient pathways for Argyll and Bute residents are to NHS Greater Glasgow and Clyde. This factor, coupled with the unique geography of Argyll and Bute, poses a further challenge to the delivery of health services and outcomes for patients.

Addressing the Challenges

In recognition of the challenging demographics and geography outlined above, and the subsequent impacts of COVID-19 on the social determinants of health, we understand that a shift in public sector structures is required and that increased collaborative working is needed to

implement positive action. These issues cannot be addressed successfully by one single organisation/partner and requires a whole system approach, as advocated by Public Health Scotland. This whole system approach is about more than the delivery of clinical and care services for Argyll and Bute and is reflected in the relative success of the delegation of fully integrated services. The basis for the approach is rooted in an evidence based strategy that supports the implementation of the Christie Commission recommendations and supports Community Empowerment and Islands legislation.

National policy is increasingly prescriptive in its human rights approach, and the ability to apply this is becoming increasingly difficult in a remote mainland, island, rural and urban geography without some substantial change in how we can affect the design and delivery of safe care supported by sustainable services.

Public sector service sustainability in Argyll and Bute requires a multi-agency integrated model, robust infrastructure and the coordination of planning and commissioning for the longer term that supports public sector organisations in the area to meet their legislative and public duties.

Public Sector Reform

The Scottish Government has committed to a number of strands of reform that affect local government and HSCPs, which have the potential to result in significant change. These include the Local Governance Review, Fiscal Framework and the National Care Service.

The Local Governance Review was launched jointly by COSLA and the Scottish Government in December 2017 (Democracy Matters) to explore how power, responsibilities and resources might be shared across 'spheres' of government and with local communities, with a particular objective to devolve powers as far as reasonably possible in a manner that improves outcomes for communities.

COSLA's Plan (2022-2027) confirms that the Local Governance Review remains a key priority, and supports the following three inter-related empowerments as set out by the Scottish Government:

a) **Community Empowerment** through a new relationship with public services where communities have greater control over decisions.
b) **Functional Empowerment** of public sector partners to better share resources and work together.
c) **Fiscal Empowerment** of democratic decision-makers to deliver locally identified priorities.

In August 2023, Phase 2 of Democracy Matters was launched, which included a period of engagement with communities and organisations across Scotland. The report analysing the responses to this engagement exercise was launched on 19th September 2024 and can be read here.

In terms of the Fiscal Framework, in May 2022 the Scottish Government published its Resources Spending Review (RSR) - Investing in Scotland's Future. The RSR set out the Scottish Government's plans for public service reform and efficiency, and invited Local Government to take a complementary approach.

The RSR also proposed a 'New Deal' between the Scottish and Local Government, in the form of a Partnership Agreement.

A Fiscal Framework has also been proposed that will support:

(i) working together to achieve better outcomes for people and communities – especially on national priorities including addressing poverty, inequality, and supporting the economy;
(ii) balancing greater flexibility over financial arrangements with improved accountability;

(iii) providing certainty over inputs, outcomes and assurance, alongside scope to innovate and improve services; and
(iv) recognising the critical role played by local authorities in tackling the climate emergency, for example through delivering our heat and buildings, waste, active travel and nature restoration goals.

The Verity House Agreement, signed on 30th June 2023 as part of a New Deal between the Scottish Government and Local Government, committed to concluding a Fisal Framework which establishes early and meaningful budget engagement, the simplification and consolidation of the Local Government Settlement, and establishes a clear process for exploring local revenue raising powers and sources of funding. The Framework should also, wherever possible, provide multi-year funding certainty to support strategic planning and investment.

In December 2023, a Progress Report was published in order to provide an update on those sections of the Framework which were nearing completion, as well as those where work was still required.

Any proposals in relation to the possibility of a SAM in Argyll and Bute would have to take into account the above-mentioned Verity House Agreement, which reiterates the importance of working collaboratively to deliver sustainable public services at a local/place level.

The Agreement sets out 3 key priorities and forms a statement of intent in how Local Government and the Scottish Government will work together more effectively to improve the lives of the people of Scotland. The 3 priorities are to:

1. tackle poverty, particularly child poverty, in recognition of the joint national mission to tackle child poverty;
2. transform our economy through a just transition to deliver net zero, recognising climate change as one of the biggest threats to communities across Scotland; and
3. deliver sustainable person-centred public services recognising the fiscal challenges, ageing demography and opportunities to innovate.

The Scottish Government and Local Government have jointly accepted that changes are required in how they work together, how each are held to account, how progress is monitored, and how they will engage with each other in a positive and proactive manner. The Agreement is a statement of intent and provides a high-level framework for working together more effectively to improve the lives of the people of Scotland. Full detail on the Agreement can be found here.

National Care Service (Scotland) Bill

The *National Care Service (Scotland) Bill* was introduced to the Scottish Parliament on 20th June 2022. It proposed to establish a National Care Service (NCS) as well as powers to enable the Scottish Ministers to transfer social care responsibilities from local authorities to a NCS, and also for the transfer of healthcare functions from the NHS to the NCS.

The Council submitted a formal response to the Stage 1 Call for Views on the Bill, highlighting a number of key points including that any solution proposed must meet the rural and remote rural needs of Argyll and Bute.

Following the introduction of the Bill, in July 2023, COSLA and the Scottish Government announced a shared accountability partnership for delivering the NCS in an alternative way, with enhanced national strategic direction through the creation of a national NCS Board, but with a continued role for local decision-making and Local Government.

During the Stage 2 proceedings, the Bill was amended to the extent that it no longer proposes the structural reforms through the creation of a NCS. The further amended Bill is now at Stage 3, and has been renamed the *Care Reform (Scotland) Bill*.

Examples of Successful Strategic Joint Working in Argyll and Bute

In terms of the Argyll and Bute Health and Social Care Partnership (HSCP), it is one of only two Partnerships in Scotland to have delegated all health and social care functions permissible under the *Public Bodies (Joint Working) (Scotland) Act* 2014. This, coupled with other factors, has prompted the partner organisations to work innovatively and strategically in a joined-up fashion, and has produced numerous benefits to the people of Argyll and Bute – some of which are set out within this section.

Partnership in Innovative Adult and Older Adult Social Care Design and Delivery

The HSCP is currently developing an Older Adults Strategy alongside a Housing for Older People Strategy. The aim behind both is to design a future model of care for older people to ensure that residents of Argyll and Bute can live longer, healthier and independent lives.

In order to deliver that aim, co-location of multi-agency services in both health and social care premises was an early partnership decision and is the norm in all four localities. It provides an effective model in the daily review of care needs and supports discharges of patients from hospital back to their homes. Innovative models of care, such as this, support the attraction and retention of the workforce which is a key priority for Argyll and Bute.

In relation to care at home services, the HSCP continues to work collaboratively to commission flexible models of care which address different needs in different localities, and ones which connect with hospital pathways in order to secure the best outcomes for individuals, families and unpaid carers.

The delivery of effective palliative and end of life care is another ongoing joint process between social care, district nursing and community hospitals within Argyll and Bute to secure consistent approaches across the area, build capacity, and support those receiving those services.

The purchase of Kintyre Care Centre in Campbeltown by the Council, on behalf of the HSCP, is a recent example of positive joint decision making, strategic joint working, and an exercise which is generating positive wellbeing outcomes and securing longer term care for people in Kintyre.

The continued development of Technology Enabled Care, through a Joint Digital Modernisation Strategy, is a key strategic aim of the HSCP and a service which has been developed in cognisance of Argyll and Bute's unique and diverse geography.

Partnership in Planning with People

The Coll Health and Social Care Needs Assessment replicated the Argyll and Bute wide Joint Strategic Needs Assessment at a hyper-local scale. This community-based partnership approach aimed to deliver four overall priorities for the residents on Coll:

- Choice, control and innovation.
- Prevention, early intervention and enablement.
- Living well and active citizenship.
- Community co-production.

The approach taken in relation to this piece of work has contributed to the basis for the HSCP's Island Strategy development, and co-production approaches being implemented to the current Jura Out of Hours Care development.

In 2023, the Improvement Service supported place-based assessments for the HSCP, the Council and Community Planning – initially with a focus on Dunoon. The outputs of these assessments will support the collaborative approach to the delivery of the Joint Strategic Plan, and will consolidate approaches to Islands Community Empowerment, Wellbeing, Prevention and Early Intervention. It will further support delivering a human rights-based approach to

service design and delivery within the HSCP. Such a place-based approach has also supported the development and delivery of services through the Alcohol and Drugs Partnership, identifying gaps in wider services, and working together to deliver the national standards.

Argyll and Bute have a long-term local strategy of prevention and early intervention which supports the public sector approach to alleviating inequalities in the social determinants of health. These are acutely visible post-pandemic, and the HSCP are working in partnership with Live Argyll to promote public health messaging and tackle frailty.

Partnership in #KEEPINGTHEPROMISE

Children's health and social care services in Argyll and Bute offer a fully integrated approach to care delivery from pre-conception to transition – working closely with the Council's Education Service and jointly delivering on Child Poverty Action Planning, the Children's Service Plan, and the implementation of the *UN Convention on the Rights of the Child*.

Building on Successes

The preceding Section outlines several examples of successes achieved by the HSPC working across a breadth of regulated services, and the positive outcomes it has generated for people in Argyll and Bute. This is partly down to the fact that Argyll and Bute have fully integrated services in terms of the *Public Bodies (Joint Working) (Scotland) Act* 2014. However, an opportunity to extend this to a whole system approach, going further than clinical and care services, could present a further opportunity to build on these successes.

Expansion or development of the current arrangements could support a wider place-based approach – based on common planning and needs. It could also strengthen the resource and capacity to influence and deliver national policy with a consolidated rural approach.

All public sector organisations in Argyll and Bute wish to work together to attract and retain the skills and workforce in the area – ensuring that whole families have access to opportunities to grow, be educated, live, work and play in Argyll and Bute.

As mentioned above, the partner organisations in the Argyll and Bute HSCP have integrated all functions permissible under the *Public Bodies (Joint Working) (Scotland) Act* 2014. Many of the benefits described above have been delivered, in part, due to this fully integrated model. In order to build upon the successes and go further, this Paper explores options for a SAM in Argyll and Bute, which could allow us to progress our ambitions and improvements to the next stage.

Benefits of Exploring a SAM for Argyll and Bute

The concept of a SAM for Argyll and Bute is being explored as a tool to deliver lasting reform, which can be adapted to fit the specific and unique needs of this area (place-based – not one size fits all), concentrating on optimum governance arrangements to deliver the reform vision.

For the residents of Argyll and Bute, there would be an expectation that **a SAM would improve the services they receive**, or at least mitigate financial constraints.

Services currently available under existing frameworks can be, and mostly are, undertaken locally – in many instances by several public bodies. However, the strategic decision-making on their direction and resourcing is often determined elsewhere and at other times not practically accountable to the local public. The concept of a SAM could have the added value of recognising the importance of local operational decision-making and delivery, whilst re-aligning the organisational priorities of those bodies forming part of the SAM in order to deliver more effective joined-up services – with the parameters for that local delivery, in many cases, still being set by national policy.

Local whole-system decision-making by accountable decision-makers should result in improved decisions, as there would be better local knowledge of what is required and the existing strengths and weaknesses of the local system. In addition, the decision-makers would be accountable to the local communities whom they serve and which they live within.

Citizens need to know that, and how, they can influence decision making or they may not fully take part or even opt out of local democracy. Local democracy offers the best form of accountability with detailed scrutiny, analysis and consideration in a public forum the standard way of working. Of course, the electoral opportunity to remove the decision makers is the ultimate sanction. **A SAM would expand the democracy and accountability which is inherent in Local Government to include all services provided through the SAM or by other agencies with accountability to the SAM.** One of the most significant criticisms of unelected organisations and agencies which discharge important public functions is that they are *de facto* unaccountable.

The ultimate test of the vibrancy of local democracy is the willingness of the members of the community to participate in the democratic process. If people can interact with, communicate and believe they can influence the decision-makers, indeed even be the decision-makers, they are more likely to take part in the process that gives the decision-makers democratic legitimacy. **Local planning and delivery of services under an SAM would provide a vehicle of opportunity for significantly expanded democratic participation in the key decisions affecting communities.**

When considering the possibility of **better and more efficient use of declining revenue and capital budgets,** the fact of the Council, NHS Highland and other potential partners all having Chief Executives and associated Corporate Management Teams promotes an obvious question: is it really necessary, for a population of 87,810, that each of these public sector organisations has a Chief Executive and associated management structures, with all the costs that this entails?

Below that executive level are multiple Finance, HR, IT and other important internal structures supporting the public sector within Argyll and Bute. There are crossovers in those functions that could produce efficiencies and provide better value for money at a time of continuing financial challenge. However, a SAM is not about losing vital jobs in the public sector, which are essential to population retention and growth. The employment opportunities within the area which arose from previous Local Government reorganisations would be repeated following the formation of a ground-breaking SAM, with jobs and opportunities being better distributed across Argyll and Bute than at present.

Looking at functions wider than Health and Social Care, it can likewise be argued that in the context of Housing, the purpose of stock transfer and the formation of the Registered Social Landlords (RSLs) in Argyll and Bute has successfully been fulfilled. It is therefore now appropriate to consider the best structure for providing social housing and the essential role that can play in meeting the critical objectives of combatting depopulation and providing economic sustainability and prosperity for Argyll and Bute's communities – particularly in light of the ongoing Housing Emergency in the area, declared by the Council in June 2023. It could also be appropriate to consider bringing together the strategic housing role exercised by the Council and the operational functions of the RSLs. A SAM would provide the circumstances and possible vehicle for doing so.

Argyll and Bute Council was the first local authority in Scotland to declare a Housing Emergency. This declaration was intended as a call to action – envisioned as the catalyst to bring partners, stakeholders, investors and communities together to prioritise and commit to the collective action needed to tackle the housing shortage in Argyll and Bute. Several causes for the Housing Emergency have been identified, and they concern a range of agencies with responsibility for both social and private housing. The possibility of bringing those agencies

together, under the organisational banner of a SAM, could have potential to be an effective measure in promoting joint-working and more effectively tackling the Housing Emergency in Argyll and Bute.

In relation to the possibility of including the Further and Higher Education sector within the scope of a SAM, in an Argyll and Bute context, it is noted that University of Highlands and Islands (UHI) are currently undergoing a process of transformational activity - examining steps that they can take to become more integrated as an organisation – with the possibility of increased delegation to their areas/campuses. It is noted that there are currently effective links in place between a number of the secondary schools in Argyll and Bute (operated by the Council as the Education Authority) and UHI Argyll, with co-location in some instances. It is acknowledged that there could be scope to develop this relationship further under a SAM which could include the Further and Higher Education Sector – in order to produce further advantages for learners, and to promote the coordination of resources.

The challenges facing public funding, both revenue and capital, coupled with the reducing workforce, will demand significant changes to the delivery of public services throughout Scotland, and intervention at all levels of government is needed to bring this about before communities and services are detrimentally impacted even further. It is always of particular concern in rural and island communities that models will be developed with an urban/mainland focus and then imposed on rural/island areas without **consideration of their particular needs and opportunities. The development of bespoke, place-based models, tailored to the unique needs and circumstances of each area would help in avoiding that unintended, but detrimental, outcome.**

This is a critical time for Argyll and Bute, the public sector and the delivery of services on which communities have come to rely for many years. Current models are anticipated to face further strain in the forthcoming years. It is therefore time to consider alternative models, to free up resource currently tied into servicing organisational structures and to proceed with real, visible, accessible and accountable empowered government for areas such as Argyll and Bute. The advantages could be hugely significant and could offer enhanced opportunities for safeguarding public services, enhancing democratic oversight, making Argyll and Bute even more attractive as a place to live and work, whilst stimulating economic sustainability and reversing depopulation.

Key Principles

As part of the Council's ongoing exploration of the possibility of a SAM for the area, one aspect of this work has been the development of a set of key/guiding principles to ensure that all parties are clear from the outset, whilst engaging with stakeholders, regarding what is on or off the table in relation to the development of possible SAM models for Argyll and Bute. These are as follows:

Brand Identity – The NHS brand is nationally recognised and would have to, in our view, continue to be prevalent within the context of a SAM. The SAM would need to consider how the brand identity is protected whilst articulating the SAM 'brand' in much the same way as HSCPs have had to accommodate this. With multiple partners, it could become a 'house of brands' which, whilst possible, would need some consideration to ensure clarity of purpose of the SAM.

Protection of Professional status – Similar to the brand identity, the professional roles within each partner hold a significance in terms of both identity and professional status. The ambitions of the SAM would likely include opportunities to redesign or define new roles that fulfil the tasks undertaken within existing roles, potentially including professional roles. The SAM proposals would need to be clear on the ambitions for the workforce models and how professional bodies would be engaged at both a local and national level.

Professional Governance (including clinical and care governance) as outlined above, an IJB model could enable the SAM to expand the range of partners and retain professional accountability. It would also enable governance to be enacted through the IJB and the partner bodies' governance structures. Any move to a single corporate governance structure within one partner would need to consider the legal and practical implications of creating organisational level professional roles and governance committees to fulfil legislative and regulatory requirements.

Staff Terms and Conditions – Any SAM model which includes moving to a single employer/corporate structure would require fundamental changes to the relevant legislation, as well as the complication of managing national terms and conditions for NHS staff and other partners being integrated where national terms and conditions exist. TUPE would also have to be considered and whilst this is technically possible, the practical reality is that staff would most likely remain on their existing terms and conditions, unless the alternatives were more favourable.

Single Authority Models – Options

Against the above-mentioned reforms, Officers have begun considering potential models for a SAM in Argyll and Bute. A Working Group has been established to explore the identified options in further detail. In preparing the high-level options thus far, Officers have had regard to a number of guiding principles, including:

- Recognition that there is a spectrum of options available.
- A focus on models with the potential to achieve the most effective outcomes and benefits for communities.
- Focus on those areas where developed synergies already exist (such as Health and Social Care), building on the current level of integration.

The options for a SAM in Argyll and Bute considered thus far have been:

Option 1 – Status Quo

This option would be a continuation of current structures with the retention of the Health and Social Care Partnership with governance through the Integrated Joint Board.

In terms of positives, there would be continuity given that nothing would need to change, no transfer of staff would be required, and there would be no change to the current governance structures.

However, this option does not offer any change, offers only limited options for shared services (Health and Social Care only) and efficiency savings, and there would continue to be the existing issues around the burden of governance and delivery of integrated services.

Option 2 – Community Planning Plus

This model would be based on the current Community Planning Model and would maintain separate organisations. It would give the opportunity to pool budgets and share resources, but employees and structures would remain separate. It would build upon the provisions of the *Community Empowerment (Scotland) Act* 2015.

However, given that the partner organisations would maintain their independence and separate governance structures, it is likely that any integration would be very specific and limited. Given the number of organisations that could be involved in this model, it is likely that there would be a high probability of procedural disputes arising, meaning that developments could be delayed if one or more partners were not on board with a proposal.

Option 3 – Integrated Authority

This model would establish a new elected single legal entity which would have fully integrated service budgets (with opportunity for resource efficiencies and more shared services) and would be empowered by locally elected status to give clear and accountable leadership. The Authority would create specific Boards or Committees

which would provide the governance and decision-making structures required to ensure that resources and services are managed effectively.

Under this model, the Council would no longer exist and Council staff (as well as others falling under the umbrella) would need to be moved over to the employment of the new Integrated Authority. This type of model would require a significant change to structures across most, if not all, public bodies. It would also require a new scheme of public sector primary legislation to implement the model. Nonetheless, there is greater potential as to the range of public sector functions that could fall within the scope of such a model.

If this model were to be explored further, the role of local democratically elected members would be a vital component to the decision-making structure of such an Authority.

Option 4 – Further Empowered Local Boards

The starting point for this model would be through strengthening the Integration Joint Board (IJB) and the functions delegated to by the partners (i.e. the Council and NHS Highland) it under the *Public Bodies (Joint Working) (Scotland) Act* 2014. It could initially build on the existing synergies and effective partnership working that has been demonstrated thus far between the Council and NHS Highland.

However, in an Argyll and Bute context, it should be noted that the maximum functions permissible under the 2014 Act have already been delegated to the IJB. As such, in order to build upon the existing successes of integration in the area, and to go any further, the 2014 Act would have to be amended to expand the functions that could be delegated to the IJB to build upon the current level of partnership working.

In order to go to the next stage in an Argyll and Bute context, it might be possible either through amendment to the 2014 Act, or the enactment of new primary legislation, to open up the public bodies and public functions that can be integrated wider than just health and social care (but with similar governance structures to the HSCP/IJB) – for example, a statutory Housing Partnership, Further Education Partnership, Enterprise Partnership, etc. However, if new statutory partnerships and boards are created for all of those service areas, it is appreciated that this might result in a complex landscape of statutory partnerships/boards which could be difficult for those working within the public sector, and the wider public, to navigate. Confusion could be generated as to where certain roles, responsibilities and powers lie. It may also appear that additional layers of bureaucracy have been created.

This model is built upon existing legislation as a logical starting point, as well as numerous examples of effective local partnership working as a starting point.

More strategic alignment amongst the partnership organisations' priorities may have potential to generate a more user-focused approach to services delivered under this model. It can retain local accountability, decision-making structures, and knowledge to allow the circumstances and issues particular to Argyll and Bute to be addressed at a local level – according to the priorities and needs expressed by our local communities.

Under the current framework, the IJB has its own set of statutory responsibilities to engage the public. The IJB is also required by law to preside over locality planning arrangements, which prescribe further devolution of power to local professional and community groups, to ensure that services develop in line with local need and circumstances. These functions could be mirrored in any other statutory boards that would be established under this model, to ensure consistency of approach.

However, it should also be noted that under the current integration arrangements, the Council and NHS Highland are the partner bodies, but many of the patient pathways for Argyll and Bute residents is to the Greater Glasgow and Clyde Health Board. This arrangement, with its

perceived barriers, would remain in place initially under this model.

Option 5 – Single Authority Partnership

A change of the delivery model under the 2014 Act from the current IJB structure to a Lead Agency arrangement in Argyll and Bute, with NHS Highland as the Lead Agency, would have the same benefit (as discussed in the context of other models) of whole system planning. However, it would not satisfy the aspiration of local elected members to hardwire local accountability into the system of governance. This was also a key aspect of the Council's objection to the National Care Service (Scotland) Bill. Alternatively, the Council could become the Lead Agency. However, in these circumstances there is arguably a greater risk of fragmentation with secondary care, loss of NHS identity as an agency, employer and clinical network. To that end, a traditional Lead Agency arrangement (as currently envisaged within the 2014 Act) is potentially highly problematic.

An alternative option could be to consider a variant of the Lead Agency arrangement under the banner of a Single Authority Partnership. This could take effect by conducting a review of the current Integration Scheme (Under Section 45 of the 2014 Act), preparing a new Integration Scheme (under Section 47 of the 2014 Act), and subsequently through the use of Directions (issued under the 2014 Act).

Under such a Strategic Lead Agency arrangement, there would be no transfer of staff – only functions and resources. Under these terms, the Health Board would delegate all functions and resources to the Council (as Lead Agency) which could then:

- redesign back office and business functions to secure maximum efficiency through a process of aggregation (e.g. the two asset management services coming together);
- provide direction back to the Health Board to deliver its functions in accordance with a Strategic Plan conceived to deliver maximum functional integration alongside Council services; and
- Provide direction to the Health Board to devise operational arrangements that promote a single delivery agency.

In practice, under such a Single Authority Partnership (SAP) arrangement, the existing process for local government elections and political representation is acknowledged as being tried and tested, and would offer a suitable foundation for development to fit the particular requirements of Argyll and Bute. A Health and Social Care Board, or Committee – forming part of the SAP could act as the engine room of health and social care delivery. This could be populated in a way which is sympathetic to the principle of shared accountability – with local Elected Members, NHS Non-Executive Directors, professional leads, carers, third sector, etc. – a similar group to the membership of the IJB at present. In effect, the Board would become responsible for the strategic development of services.

The Health Board would accordingly play a different role under this governance arrangement. It would still be accountable to central Government for use of public funds, and it would retain its obligations as an employer and for clinical governance, but strategic matters would pass to the Health and Social Care Committee and the SAP.

The Chief Executive of NHS Highland would maintain oversight of all health services. They would continue to have a line of sight to the Chief Executive of NHS Scotland, but would also be accountable to the SAP for the delivery of services undertaken by Council employees and the strategic development of all health and social care services. Their relationship with the Health Board would be unchanged.

The Chief Executive of the Council would in effect function as the principal advisor to the SAP. They would not have a hierarchical or line management relationship with the Chief Executive of the NHS Board. They would ultimately be responsible, however, for ensuring discharge of functions and

deployment of resources delegated through the Integration Scheme.

A key driver of the Verity House Agreement is the focus on the achievement of better outcomes locally for individuals and communities by recognising local differences. A move to a SAP for Argyll and Bute has potential to build on the recognised success of joint working which is already in place via the fully integrated Argyll and Bute Health and Social Care Partnership, which operates in an environment where there are significant challenges - not least around the geography of the area.

Moreover, the Verity House Agreement's maxim of "local by default, national by agreement" can be embraced to provide an approach to service delivery through a SAP, delivering innovative services for our citizens locally taking account of need, efficiency and economy. The move towards greater flexibility in terms of budget and the removal of "ring fencing" will also allow for services to be developed and/or procured which meet the specific local needs of Argyll and Bute's residents.

The Verity House Agreement also makes clear that any exploration in terms of national delivery models should work on the presumption in favour of local flexibility. Evidence provided herein in supporting further exploring this model in particular strengthens the position for a more local approach to be taken in respect of Argyll and Bute. Such a model could allow for the design and delivery of services for and around people - which is pertinent in terms of the proposals.

If the scope and functions of the Partnership is to be increased beyond health and social care, amendments to the 2014 Act, or new legislation may be required.

This model protects the concept of strong local accountability. Retaining local accountability, decision-making structures, and knowledge allow the circumstances and issues particular to Argyll and Bute to be addressed at a local level – according to the priorities and needs expressed by our local communities.

Under the current framework, the IJB has its own set of statutory responsibilities to engage the public. The IJB is also required by law to preside over locality planning arrangements, which prescribe further devolution of power to local professional and community groups, to ensure that services develop in line with local need and circumstances. These functions would be transferred to the new decision-making Board under this model.

Continuing with the current IJB arrangement retains an additional third public body to sit between the NHS Board and Council, and as such, an additional bureaucratic layer. Moving to the strategic lead agency model as described above moves the decision-making functions to a Board within the Council (as the lead agency).

Next Steps

It is important to highlight that the outline of the potential models within this Paper is a very high-level articulation of what a deeper partnership between the Council and NHS Highland might look like. To progress any further, it would need both organisational and technical analysis.

In terms of a more detailed examination of a SAM for Argyll and Bute, and what that may encompass, a natural starting point is the high degree of synergies between the Council and the NHS. If or when a second phase of consideration and/or implementation is carried out, the Council may also wish to lobby the Scottish Government in relation to amending the 2014 Act, or considering the introduction of new legislation, which would allow other partner bodies to fall within the scope of this model (e.g. RSLs, HIE, etc.) and/or the inclusion of other public sector functions beyond health and social care. The inclusion of Community Planning Partners in this regard could be significant in promoting and improving outcomes for our communities, as Community Planning Partnerships are also to play a key role in delivering the shared priorities of the Verity House Agreement.

In terms of the further exploration of the feasibility of the potential models as outlined within this Paper, and/or identification of any other possibilities, the Council's Working Group are clear that we are approaching the stage where external expertise may be required in order to fully assess the models. This has already been highlighted to Scottish Government colleagues at previous meetings. The Council are continuing to explore the possibility and options for a SAM generally on a joint basis with Comhairle nan Eilean Siar, and will require both NHS Highland and the Argyll and Bute HSCP to continue to participate meaningfully with the ongoing work.

25th March 2025

Single Authority Model Short Life Working Group

Argyll and Bute Council, at its meeting held on 24th April 2025, established a SLWG to take forward the exploration of alternative governance models for the area. This was in response to the increase in meetings being held at a national level and the ongoing pace of development. The SLWG was put in place to act as a sounding Board and to facilitate ongoing dialogue with elected members outwith the formal committee process, allowing Council officers to engage and contribute to national meetings on an agile and flexible basis.

The first meeting of the SLWG was held on 16th May 2025, where it was noted that *"early engagement with NHS Highland was imperative and agreed that appropriate NHS Highland non-executive Board members and officers be invited to attend the next meeting."*

The extended/joint SLWG will continue to act as a sounding board, providing advice for both the membership of the SLWG and to the respective partner bodies on the examination and assessment of the current options identified, with the aim of coming to a common view on a preferred option for further development and consultation.

From an Argyll and Bute perspective the following terms of reference are in place, as agreed by the Council in April 2025:-

1. Membership

Core membership will be minimum of 6 elected members (to be appointed by Council, along with the positions of Chair/Vice Chair who will be Councillors), Chief Executive, and the Executive Director with responsibility for Legal and Regulatory Services (supported by other officers as appropriate).

- Councillor Jim Lynch (Chair/Leader of Council)
- Councillor Ross Moreland (Vice Chair/Depute Leader of Council)
- Councillor Dougie McFadzean
- Councillor Gary Mulvaney
- Councillor Yvonne McNeilly
- Councillor Reeni Kennedy-Boyle
- Pippa Milne – Chief Executive
- Douglas Hendry – Executive Director

2. Purpose / Role of the Group

The purpose of the SAM SLWG is to undertake the development of a preferred option(s) for a SAM for Argyll and Bute, to include, amongst other things:-

- Act as a sounding board / provide advice to the Council's representatives engaged at a national level, to enable them to effectively engage with and take forward work arising from the national workplan and timescales
- Examine and assess the current options identified
- Development of an engagement and consultation strategy/programme for key stakeholders
- Commentary and recommendations on all reports going to Policy and Resources Committee and Council

3. Meetings and Reporting

An agreed series of SAM SLWG meetings and reporting requirements as follows:-

- The SLWG will provide update reports to the Policy and Resources Committee
- Recommendations will be made by the Policy and Resources Committee to the full Council in respect of any decision on the identification of a preferred option.
- Initial meetings of the SLWG to take place in May/early June to progress a review of current options
- Timeline for agreeing / approval of joint preferred option to be confirmed

4. Terms

The Terms of Reference are effective from the Council meeting held on 24th April and will be ongoing until the SAM SLWG has concluded its work, or by the Policy and Resources Committee.

5. Next steps

The next steps required to extend the SLWG are:

- NHS Highland to agree membership and confirm through its board meeting on 29th July 2025
- NHS Highland to confirm reporting arrangements of this SLWG and agree at its board meeting on 29th July 2025
- NHS Highland to endorse adoption of the extant terms of reference subject to addition of membership and reporting details by NHS Highland.

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Agenda Item 16

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**29 July 2025**
Title:	**Board Blueprint for Good Governance Improvement Plan - Update**
Responsible Executive/Non-Executive:	**Sarah Compton-Bishop, Board Chair**
Report Author:	**Nathan Ware, Governance & Corporate Records Manager**

Report Recommendation:

The Committee is asked to:

Take **Moderate Assurance** from this report, **Note** that informal oversight of progress delivery of the improvement plan continues to be undertaken by the Chairs group and Governance Committees and **Note** that 6-monthly updates are presented to Board for oversight.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Local policy

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

- Effective

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	X	Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well	X	Progress well	X				

2 Report summary

2.1 Situation

This report provides the Board with a six-month update on progress on delivery of the actions included in the Board's Blueprint for Good Governance Improvement Plan.

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2.2 Background

Scottish Government's Blueprint for Good Governance v.2 (DL (2022) 38) was issued in December 2022. NHS Highland Board carried out a self-assessment against the provisions of the Blueprint and agreed an Improvement Plan in July 2023. Since this time, governance committees have maintained informal oversight of progress in delivering the improvement actions and the Board has received six monthly progress updates.

2.3 Assessment

While the primary implementation phase of the Improvement Plan was from July 2023 to July 2024, it was noted that some actions would extend beyond this timescale. Appropriate Governance Committees considered progress on the Improvement Plan in November 2024 and May 2025.

The key themes emerging from the self-assessment exercise were: Performance, Finance and Best Value, Risk, Culture, Quality, Board Members development, SBAR development, and Engagement.

The plan contained 17 actions in total of which 12 are now deemed complete. The remaining actions relate specifically to quality of care, and risk appetite and management. The activities identified to bring these actions to a closure will extend beyond the lifespan of the current Improvement Plan.

Highland Health and Social Care Committee (HHSCC) maintains oversight of the Quality of Care actions and Audit Committee maintain oversight of Risk Appetite and Management.

Quality of Care - HHSCC

The outstanding actions relating to this Committee's remit focus on quality of care.

Feedback from a joint ACF and Board session in April 2024 had helped shape this workstream. Work was now underway to review how the organisation is working prior to introducing a quality framework through a measured and planned approach. Patient feedback and experience will be included in the framework dataset and the work is being benchmarked against the approaches other Boards have taken.

Further development of the Quality Framework/way forward was discussed at an EDG meeting in April 2025 through a paper. It was noted a quality lead post would be required to support next steps and once funding is finalised it would go out to advert.

Deputy Medical Directors & Associate Nurse Directors alongside AHP Leads would be among those involved in taking Quality forward. The embedding of Care Opinion continues and the Board's Clinical Governance
Manager is supporting this work. There has been an increase in the use of Care Opinion with more than 250 instances logged for NHSH services over the past 12 months. The appendix to this report details the progress that has been made for Committee members' information and oversight.

Risk Appetite and Management - Audit

The outstanding actions relating to this Committee's remit focus on reviewing and

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revising organisational controls in line with the risk appetite and cascading associated organisational training will be ongoing activity that will extend beyond the end of 2024.

1. **Board to reset is Risk Appetite:** The risk appetite work was completed and will be subject to review over time.

2. **Translation of revised risk appetite into workable processes for colleagues:** A board development session on risk appetite was held in March 2025 indicating next steps for incorporation of risk appetite into high-level risk register. Additionally, there is ongoing work in operational risk management including training in acute and development within the HSCP.

3. **Upskilling workforce in risk management knowledge & methodology:** A board development session on risk appetite was held in March 2025 indicating next steps for incorporation of risk appetite into high-level risk register. Additionally, there is ongoing work in operational risk management including training in acute and development within the HSCP. Acute services has appointed a lead for its Risk management and she is undertaking training with NHS Providers which will inform training of colleagues within the operational services. A risk workshop is being planned for 2025, at which training in risk management will be given to key staff within Acute. The switch from Datix to InPhase will be an opportunity to refresh risk systems. The appendix to this report now details the progress that has been made for Board members' information and oversight.

Future evaluation against the Blueprint for Good Governance

The Blueprint sets out three levels of Board governance evaluation according to the following:

- Appraisal of Board Members' individual performance
- Self-assessment of the Board's effectiveness
- External review of the organisation's governance arrangement

Board Self-Assessment

Scottish Government have advised they will contact Boards during 2025 regarding the timing of the next self-evaluation exercise. The Blueprint for Good Governance states that NHS Boards should review their effectiveness and identify any new and emerging issues and concerns on an annual basis.

A Head of Corporate Governance has started in post and ongoing consideration is being given to the effectiveness of governance arrangements by the Executive team, Board Chair, Vice Chair and Committee Chairs. Recognising increasing pressures on the organisation and staff, and the need to efficiently scrutinise large quantities of information, the concept of 'Frugal Governance' offers an approach which supports the reduction of duplication and more efficient use of committee time. Work is currently underway to identify how this concept can be applied in NHS Highland to enable delivery of our Governance Improvements Plan and uphold the standards as described in the Blueprint for Good Governance.

External Review

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To enhance and validate the Boards' self-assessment, an external evaluation of all NHS Boards' corporate governance arrangements will be undertaken in due course. Details of this will be shared with the Board once known.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	X
Limited		None	

Formal assurance reporting on delivery of the Blueprint for Good Governance Improvement Plan will be provided to the Board on a bi-annual basis. Board-level Assurance will be based on delivery against the whole plan. This report is being presented to the Committee for oversight purposes only.

Moderate assurance is offered to provide confidence that the actions are all being actively pursued and to reflect that on-going activity will be required to fully meet the objectives.

3 Impact Analysis

3.1 Quality/ Patient Care

3.2 Workforce

3.3 Financial

The provision of robust governance arrangements is key to NHS Highland delivering on its key objectives and to improving workforce, clinical and financial governance.

3.4 Risk Assessment/Management

A risk assessment has not been carried out for this paper.

3.5 Data Protection

N/A

3.6 Equality and Diversity, including health inequalities

There are no equality or diversity implications arising from this paper. However, the proposals will enable a more diverse range of skills and experience to be developed within the membership of the Board.

3.7 Other impacts

No other impacts

3.8 Communication, involvement, engagement and consultation

Through appointed Governance Committees & Chairs Group Meetings with associated updates to Board.

3.9 Route to the Meeting

The subject of this report has built on the report presented to the Board in July 2023 and elements of the appendix have been considered by Governance Committees.

4 List of appendices

The following appendices are included with this report:

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- Appendix 1 – HHSCC Blueprint for Good Governance Improvement Actions
- Appendix 2 – Audit Blueprint for Good Governance Improvement Actions

Appendix 1

DATE of MEETING	Exec Lead	Objective	Specific Action	Update for Update for November 2024 meeting	Update for Update for May 2025 meeting
CGC 7 March 2024 and 2 May 2024 **HHSC 6 March 2023 and 8 May 2024**	**Nurse Director** **Medical Director**	Establish and agree a plan to implement a Quality Framework arising from recent work undertaken with Amanda Croft.	Establish a clear definition, understanding and organisational prioritisation of quality that is underpinned by patient and colleague experience, and National Guidelines.	**Boyd Peters 23/10/2024:** The Quality framework has been formulated into a paper which has gone to EDG and now will be shared with the professional leadership and ACF in October, and will come to Board members before taking out further to pilot in services.	**Boyd Peters:** May 2025 Further development of the Quality way forward came to EDG in a paper in April 2025 "A Quality Framework for NHSH 20-25". A quality lead post is required to support next steps and once funding finalised will go to advert. Deputy Medical directors and Associate Nurse Directors & AHP leads among those who will be involved in taking Quality forward

CGC 7 March 2024 and 2 May 2024 **HHSC 6 March 2024 and 8 May 2025**	**Nurse Director** **Medical Director**	Ensure that patient feedback is consistently collected, effectively shared, responded to and utilised across all areas of the Board.	Ensure systems and processes are developed to improve in the collection, reporting and use of patient experience feedback across the Board	**Boyd Peters 23/10/2024:** We have further explored the expanded opportunities to use Care Opinion across the board area, and QR code feedback mechanisms as piloted in one department in acute with success. Further work will be needed and this will take time to mature.	**Boyd Peters May 2025** - Embedding of Care Opinion continues, with the board's Clinical Governance Manager supporting this work. There were more than 250 instances of Care Opinion being used wrt NHSH services in the past year.

Appendix 2

DATE of MEETING	Exec Lead	Objective	Specific Action	Update for July 2024 Board meeting	Update for May 2025 meeting
September Board Development Session	**Medical Director**	Board to reset its Risk Appetite	Board to refine the risk framework and refine the risk appetite statement in consultation with clinicians - to be brought back to a Board Development Session within 2023-24	**Boyd Peters 25.06.2024 -** complete - A session for the exec directors is planned now, late July.	Risk appetite work was completed and will be subject to regular review over time.
6 February 2024 and 21 May 2024	**Medical Director**	Translation of revised risk appetite into workable processes for colleagues	Review and revise organisational controls in line with revised risk appetite.	**Boyd Peters 25.06.2024 -** No change to the comments previously given.	**Boyd Peters 14.04.2025** A board development session on risk appetite was held in March 2025 indicating next steps for incorporation of risk appetite into high-level risk register. Additionally there is ongoing work in operational risk management including training in acute and development within the HSCP.

6 February 2024 and 21 May 2024	**Medical Director**	Upskilling workforce in risk management knowledge and methodology	Devise and cascade organisational training to support and empower colleagues to take appropriate decisions flowing from the revised risk appetite.	**Boyd Peters 25.06.2024 -** No change to the comments previously given.	**Boyd Peters 14.04.2025** A board development session on risk appetite was held in March 2025 indicating next steps for incorporation of risk appetite into high-level risk register. Additionally there is ongoing work in operational risk management including training in acute and development within the HSCP. Acute services has appointed a lead for its Risk management and she is undertaking training with NHS Providers which will inform training of colleagues within the operational services. A risk workshop is being planned for 2025, at which training in risk management will be given to key staff within Acute. The switch from Datix to InPhase will be an opportunity to refresh risk systems.

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Agenda Item 17

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**29 July 2025**
Title:	**Revisions to Committee Terms of Reference - HHSCC**
Responsible Executive/Non-Executive:	**Gareth Adkins, Director of People & Culture, Gerard O'Brien, Chair of HHSCC, Catriona Sinclair, Chair of ACF**
Report Author:	**Nathan Ware, Governance & Corporate Records Manager**

Report Recommendation:

The Board is asked to:

Take **Substantial Assurance** from this report and **Approve** the changes to ToR for Highland Health & Social Care Committee and the Area Clinical Forum for inclusion in the Code of Corporate Governance.

1 Purpose

This is presented to the Board for:

- Assurance
- Decision

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	X	Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well	X	Progress well	X				

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2 Report summary

2.1 Situation

This report asks the Board to agree revisions to Governance Committee Terms of Reference, namely the Highland Health and Social Care Committee and the Area Clinical Forum. Changes to this committees Terms of Reference last took place in March 2024 and March 2022 respectively.

2.2 Background

The Board last agreed revisions to the Code of Corporate Governance in March 2025.

The full suite of control documents includes Board Governance Committee Terms of Reference, changes to which require Audit Committee approval prior to seeking Board agreement on 29 July 2025.

2.3 Assessment

Since the annual update in March 2025 further revisions to Terms of Reference have been proposed by the Highland Health & Social Care Committee alongside the Area Clinical Forum. The changes below are shown highlighted in the appendices to this report.

Highland Health & Social Care Committee

The proposed change aims to adjust the quorum requirement to account for current vacancies on the committee, ensuring it reflects the actual number of active members rather than enforcing an unrealistic quorum based on full membership.

Area Clinical Forum

The proposed change aims to adjust the quorum requirement to account for current vacancies on the Forum, ensuring it reflects the actual number of active members rather than enforcing an unrealistic quorum based on full membership. Separate work is underway to source a new Chair in advance of the September meeting alongside work to fill current vacancies

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	X	Moderate	
Limited		None	

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3 Impact Analysis

3.1 Quality/ Patient Care

3.2 Workforce

3.3 Financial

The Code of Corporate Governance provides a framework which defines the business principles of the NHS Board and the organisation, in support of the delivery of safe, effective, person-centred care and Quality Outcomes. The provision of robust governance arrangements is key to NHS Highland delivering on its key objectives and to improving workforce, clinical and financial governance.

3.4 Risk Assessment/Management

A risk assessment has not been carried out for this paper.

3.5 Data Protection

This report does not involve personally identifiable information.

3.6 Equality and Diversity, including health inequalities

There are no equality or diversity implications arising from this paper.

3.7 Other impacts

No other impacts

3.8 Communication, involvement, engagement and consultation

The outcome of the Review of the Code of Corporate Governance will be communicated to the wider organisation as appropriate on completion and available on the NHS Highland website.

3.9 Route to the Meeting

The contents of this report have been discussed and considered by Highland Health & Social Care Committee during the May 2025 cycle & the Area Clinical Forum during the July 2025 cycle.

4 List of appendices

The following appendices are included with this report:

- Appendix 1 draft proposed ToR Highland Health & Social Care Committee – Changes Highlighted
- Appendix 2 draft proposed ToR/Constitution Area Clinical Forum – Changes Highlighted

Appendix 1

HIGHLAND HEALTH & SOCIAL CARE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board approval 29 July 2025

1. PURPOSE

1.1 The purpose of the Highland Health and Social Care Committee is to provide assurance to NHS Highland Board that the planning, resourcing and delivery of those community health and social care services that are its statutory or commissioned responsibility are functioning efficiently and effectively, ensuring that services are integrated so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care.

2. JOINT MONITORING COMMITTEE

2.1 In line with section 15(3) of the Public Bodies (Joint Working) (Scotland) Act 2014, The Highland Council and NHS Highland have established an Integration Joint Monitoring Committee (known as "The Highland Partnership Joint Monitoring Committee"), which has oversight of both integrated Adult Services and Integrated Children's services and monitors the carrying out of integrated functions (both delegated and conjoined).

2.2 In terms of section 29(1) of the Act, each Partner is responsible for the planning of the integrated and conjunction services for which it is the Lead Agency. This means that NHS Highland must lead on producing an Integrated Adult Services Strategic Plan and The Highland Council must lead on producing an Integrated Children's Services Strategic Plan with both plans taking account of the other and together being monitored by the Joint Monitoring Committee.

2.3 Within NHS Highland, governance of Integrated Adult Services and services delegated to The Highland Council and assurance of service delivery is provided at the Health & Social Care Committee through arrangements put in place and overseen directly by the NHS Highland Board.

3. COMPOSITION

3.1 The membership of the Committee is agreed by the full NHS Board and has a Non-Executive Chair.

Voting Committee members as follows

5 x Non-Executives, one of whom chairs the Committee and one of whom is the Council nominee on the Health Board
5 x Executive Directors as follows - Chief Officer, Director of Adult Social Care, Chief Finance Officer, Medical Director and Nurse Director
3 Representatives of Highland Council

The wider stakeholder and advisory membership (non-voting) will be as follows:

Staff Side Representative (2)
Public/Patient Member representative (2)
Carer Representative (1)
3rd Sector Representative (1)
Lead Doctor (GP)
Medical Practitioner (not a GP)
2 representatives from the Area Clinical Forum
Public Health representative
Highland Council Executive Chief Officer for Health and Social Care
Highland Council Chief Social Worker

The Committee shall have flexibility to call on additional advice as it sees fit to enable it to reach informed decisions.

3.2 Ex Officio

Board Chair

The Committee Chair is appointed by the full Board.

4. QUORUM

No business shall be transacted at a meeting of the Committee unless at least one Non-Executive Director being present (in addition to the Chair) and comprising a minimum of one third of ***active*** Committee members.

If the Committee is at full membership, a quorum is achieved with at least eight members present. However, vacancies should not be factored into the quorum calculation, so the required number may be lower as vacancies arise.

5. MEETINGS

5.1 The Committee shall meet at least five times per year. The Chair, at the request of any three Members of the Committee, may convene ad hoc meetings to consider business requiring urgent attention. The Committee may meet informally for training and development purposes, as necessary.

5.2 The Committee will be serviced within the NHS Highland Committee Administration Team and minutes will be included within the formal agenda of the NHS Board.

5.3 The agenda and supporting papers will be sent out at least five clear working days before the meeting.

5.4 All Board members will receive copies of the agendas and reports for the meetings and be entitled to attend meetings.

5.5 Any amendments to the Terms of Reference of Highland Health and Social Care Governance Committee will be submitted to NHS Highland Board for approval following discussion within the Governance Committee.

5.6 The Agenda format for meetings will be as follows:

- Apologies
- Declaration of Interests
- Minutes
  - Last Meeting
  - Formal Sub Committees
  - Formal Working Groups
- Strategic Planning and Commissioning
- Finance
- Performance Management
- Community Planning and Engagement
- Operational Unit Exception Reports

6. REMIT

6.1 The remit of the Highland Health and Social Care Committee is to:

- Provide assurance on fulfilment of NHS Highland's statutory responsibilities under the Public Bodies (Joint Working) Act 2014 and other relevant legislative provisions relating to integration of health and social care services
- Provide assurance on fulfilment of NHS Highland's responsibilities under the Community Empowerment Act in relation to Community Planning
- Contribute to protecting and improving the health of the Highland population and ensure that health and social care services reduce inequalities in health
- Develop the Strategic Commissioning Plan for integrated health and social care services and approve arrangements for the commissioning of services to deliver the agreed outcomes of the plan, ensuring the involvement of stakeholders and local communities
- Develop policies and service improvement proposals to deliver the agreed outcomes of the plan, within the available resources as agreed by the Joint Monitoring Committee
- Monitor budgets for services within its remit and provide assurance regarding achievement of financial targets
- Scrutinise performance of services within its remit in relation to relevant national and locally agreed performance frameworks, including the NHS Highland Annual Operating Plan and the Strategic Commissioning Plan for integrated health and social care services.
- Through the annual performance report of the Integration Authority provide an overview of North Highland Adult Services performance, in line with the 9 national outcomes for health and wellbeing to Highland Council as partners via the Joint Monitoring Committee
- Receive and scrutinise assurance from the Highland Council as to performance services delegated by NHS Highland under the Lead Agency arrangements.

6.2 The Committee will undertake an annual self-assessment of its work and effectiveness in accordance with NHS Highland and Good Governance values. This will inform the Annual Report to the Board.

6.3 The Committee is also required to carry out a review of its function and activities and to provide an Annual Report incorporating a Statement of Assurance. This will be submitted to the Board via the Audit Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit Committee in June.

6.4 The Committee shall draw up and approve, before the start of each financial year, an Annual Work Plan for the Committee's planned work during the forthcoming year.

7. AUTHORITY

7.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

7.2 In order to fulfil its remit, the Highland Health and Social Care Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

7.3 Delegated authority is detailed in the Board's Standing Orders, as set out in the Purpose and Remit of the Committee.

8. REPORTING ARRANGEMENTS

8.1 The Highland Health and Social Care Governance Committee is a Governance Committee of NHS Highland and is accountable directly to the Board.

8.2 The Committee will report to the Board through the issue of Minutes/Assurance Reports and an assessment of the performance of the Committee will be undertaken annually and presented by way of an Annual Report to the Audit Committee, then the Board.

8.3 As a committee of the Board and as indicated in the Standing Orders, the HH&SCC will escalate any risks or concerns that require a Board decision to the Health Board.

8.4 Establish a Strategic Planning and Commissioning sub-committee to fulfil the obligations set out in the legislation.

Green: Amendments Added
Red: Items Removed

NHS HIGHLAND AREA CLINICAL FORUM CONSTITUTION

Date of Forum Approval: July 2025
Date of Board Approval: July 2025

1. THE COMMITTEE

The Committee will be called the NHS Highland Area Clinical Forum.

2. DUTIES AND FUNCTIONS

Generally, to co-ordinate and formulate advice from all of the professions in Highland to the Highland NHS Board on matters of broad health care and in particular strategic issues. The Committee should be proactive as well as reactive on these issues.

- To escalate any issues to the NHS Highland Board if serious concerns are identified about the quality and safety of provision of care in the services delivered across NHS Highland. Specifically, this will provide a clinical perspective to NHS Highland Strategies and Plans and to the prioritisation of the use of resources.
- Supporting the NHS Highland Board in the conduct of its business through the provision of professional advisory committee (PAC) advice.
- Provision of a clinical perspective in the development of the Annual Operating Plan (AOP), the Strategic Plan and the strategic objectives of the NHS Highland Board.
- Ensuring effective and efficient engagement of professional advisory committees in service design, development and improvement, thereby aiming to increase the broader participation in the PACs by clinicians and professionals.
- Reviewing the business of the professional advisory committees to ensure a co-ordinated approach on clinical and professional matters across each of the professional groups.
- Taking an integrated clinical and professional perspective on the impact of national policies at a local level.
- Through the ACF Chair, being fully engaged in NHS Highland Board business.
- Sharing best practice and encouraging multi professional working in health and social care.

The Committee will not concern itself with the remuneration and conditions of service.

3. MEMBERSHIP OF THE COMMITTEE

The Committee will consist of ~~two~~ representatives from each of the following Advisory Committees (one of whom must be the Chair or Vice-Chair of their professional Committee).

Area Adult Social Work and Social Care Advisory Committee – 2 members
Area Dental Committee – 2 members

Area Healthcare Science Forum – 2 members
Area Medical Committee – 2 members
Area Nursing, Midwifery and Allied Health Professions Advisory Committee (represented by four members of that Committee including both the Chair and Vice-Chair) – 4 members
Area Optometric Committee – 2 members
Area Pharmaceutical Committee – 2 members
Psychology Advisory Group – 2 members

In addition, the following will also be members of the Committee:

- ***A clinical representative from each of the ~~4~~ following operational areas, via, the Argyll & Bute Health & Social Care Partnership, North & West Highland, South & Mid Highland and Raigmore Hospital.***

- The NHS Highland Employee Director

The above members will be eligible to vote at Committee meetings or in writing for planned written votes.

Deputies

In the event that a member cannot attend it is expected that a deputy will attend in his/her place, provided that the deputy is from the same Professional Advisory Committee or Operational Unit. The Deputy will have voting rights at that meeting.

Quorum

~~A quorum of the Committee will be seven members.~~ A quorum of the Committee will be eight members (one third) when the Committee is at full membership (24 members).

Should there be any vacancies, the quorum will be adjusted proportionally to reflect the reduced membership.

Attending

Persons other than members may be invited to attend a meeting for discussion of specific items at the request of the Chair or Professional Secretary. That person will be allowed to take part in the discussion but not have a vote.

The Area Clinical Forum should have close links with the Chief Executive and the Executive Directors to support the forum in developing, supporting and driving its business. In this respect there should be attendance from at least one Clinical Executive Director or the Chief Executive at meetings. This will also support the development of a culture of dignity, respect and inclusivity in relation to the working relationship with staff.

Non-Executive Board members will be invited to attend on a rotational basis

The Committee will reserve the right to seek opinion or advice from patient/public via Scottish Health Council who will signpost the Forum appropriately.

Non-Attendance

In the event that a member, or his/her deputy, does not attend for three consecutive meetings, the Chair will seek to understand why this is occurring. The member will be

expected to give the chair reasonable explanation for the non-attendance and if this is not forthcoming the chair can then terminate such membership by written notification to such member.

4. SUB-COMMITTEES

The Committee may appoint ad hoc Sub-Committees as appropriate to consider and provide advice on specific issues.

5. TENURE OF OFFICE

Members will be appointed by their respective Advisory Committees/Operational Units and can hold office, on the Area Clinical Forum, initially for up to four years, with re-appointment possible to a maximum of eight years. It is recommended, however, that the Advisory Committees review their nominations on an annual basis.

6. OFFICERS OF THE COMMITTEE

The Chair will be a Member of the Highland NHS Board functioning as a full Highland NHS Board Member. Only those Area Clinical Forum members who represent their Professional Advisory Committee will be eligible to hold the office of Chair. As with other Non-Executive Directors, this will be a ministerial appointment on the recommendation of the Chair of NHS Highland. The Chair will be elected for an initial term of four years and will be eligible for re-election for a second term of four years and therefore hold office for a maximum of eight years. Should the Chair of the Area Clinical Forum change, however, through for example resignation or retirement and a new Chair appointed, then this appointment needs to be further approved by the Minister, on the recommendation of the Chair of NHS Highland. The Chair will have discretionary powers to act on behalf of the Committee but in doing so will be answerable to the Committee.

The Chair of the Area Clinical Forum will be expected to participate in the NHS Board members development programme. The Chair will also be expected to link with the national ACF Chairs group on a regular basis.

The Committee will also elect a Vice-Chair every four years, and this person will be eligible for re-election for a second term of four years and therefore hold office for a maximum of eight years.

The Committee may choose to appoint two Vice Chairs for a period of four years, both eligible for re-election for a second term of four years, and therefore holding office for a maximum of eight years.

Officers will be appointable from within voting members of the Committee. It is recommended that the Chair and Vice-Chair(s) are appointed from different Professional Advisory Committees.

The Vice Chair may deputise for the Chair at Highland NHS Board meetings but will not have voting rights. Where two Vice Chairs are appointed, only one individual shall deputise for the Chair at Highland NHS Board meetings.

7. NOTICE OF MEETINGS

The NHS Highland Board Committee Secretariat will issue the agenda and relevant papers at least five working days before the meeting,

8. MINUTES

The NHS Highland Board Committee Secretariat will service the Committee and copies of the minutes will be sent to each member with the agenda and papers for the next meeting, if not previously distributed. Once draft minutes have been virtually ratified by the forum they will be shared with all other professional advisory committees to the Board.

9. MEETINGS

The Forum will meet at least five times a year. Meetings will be arranged to dovetail with meetings of NHS Highland Board.

Meetings will normally be held on Microsoft Teams ~~at Highland NHS Board, Assynt House, Inverness on the Thursday prior to a Highland NHS Board meeting,~~ but this can be varied at the discretion of the Chair.

The Committee has the right to alter or vary these arrangements to cover holiday months or other circumstances.

10. COMMITTEE DECISION

Where the Committee is asked to give advice on a matter and a majority decision is reached the Chair or Professional Secretary will report the majority view, but will also make known any minority opinions, and present the supporting arguments for both view points.

11. ALTERATIONS TO THE CONSTITUTION AND STANDING ORDERS

Alterations to the Constitution and Standing Orders may be recommended at any meeting of the Committee provided a notice of the proposed alteration is circulated with the notice of meeting and that the proposal is seconded and supported by two-thirds of the members present and voting at the meeting.

Any alterations must be submitted to the NHS Highland Board for approval before any change is made.

Updated: June 2025

NHS Highland

Meeting:	**NHS Highland Board Meeting**
Meeting date:	**29 July 2025**
Title:	**NHS Highland Board Risk Register**
Responsible Executive/Non-Executive:	**Dr. Boyd Peters, Board Medical Director**
Report Author:	**Dr. Boyd Peters, Board Medical Director**

Report Recommendation:

The Board is asked to:

Note the content of the report and take **Substantial Assurance** this report provides confidence of compliance with legislation, policy and Board objectives.

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 consideration of the updates to the risks contained within the NHS Highland Board Risk Register. The following risks are aligned to the governance committee in which they fall within, and consideration has been given to the strategic objective and outcome to ensure strategic alignment.

Immediate Updates	
Risk	**Update to Board**
1254 – Financial Position 24/25	Agreed for closure following FRPC closure approval.
1375 – Financial Position 25/26	Agreed for addition to the Board Risk Register following FRPC approval.
1279 - Financial Balance – Adult Social Care 24/25	Agreed for closure following FRPC closure approval.

1376 - Adult Social Care Financial Risk 25/26	Agreed for addition to the Board Risk Register following FRPC approval.
Pending Updates	
1182 - New Craigs PFI Transfer	Risk deferred to next FRPC to recommend closure as the transfer has now happened, and risk is therefore obsolete.
1255 - ADP 24-25 Delivery	ADP 25/26 has now been approved by Scottish Government. A new risk will be proposed at the next FRPC for FY 25/26.

Finance, Resources and Performance Risks

Risk Number	1254	**Theme**	Financial Position 24/25 – **CLOSED**
Risk Level	High	**Score**	16
Target Risk Level	High	**Target Score**	12
Strategic Objectives		Perform Well	
Governance Committee		Finance, Resources & Performance	

Risk Narrative

There is a risk that NHS Highland will not deliver its planned financial position for 2024/25 and that the brokerage cap set by SG will not be achieved due to:

1. Current underlying financial position represents a significant overspend against the allocation received and delivering the brokerage cap would represent in-year reductions of £84m (10%) and would impact the delivery of patient care

2. Identified risks presented in the finance plan may be realised and additional cost pressures presenting during the year may materialise

3. Inability to realise 3% reduction in spend in line with value & efficiency plans.

NHS Highland has not currently identified a financial plan that will safely deliver the £28.4m brokerage cap set

Mitigating Action	Due Date
Value and Efficiency programme is set out and plans are being progressed at pace, but there is a risk that they do not deliver at the required rate or that circumstances reduced the capacity available to focus on the work required. Bi-weekly meetings are in place to monitor the progress and identify and mitigate risk to the work streams.	Ongoing
There are a number of risks identified within the financial plan which could be realised throughout the year with no mitigation in place to offset costs	Ongoing
Limited assurance regarding the delivery of the Adult Social Care financial position	Ongoing

Regular reporting from A&B IJB monitoring financial position and previous assurance over delivery of the position gives greater assurance	
Monthly monitoring, feedback and dialogue with services on financial position.	
Ongoing dialogue with SG regarding the accepted financial position and the impact of non- delivery	
Finance plan needed to identify the actions required to deliver financial balance for ASC and agreed position with THC - HHSCP team have been tasked with setting out a detailed plan to progress towards financial balance.	Ongoing
Discussion with SG around a plan that can be agreed from a perspective of deliverability and monitoring, which will minimise the impact of not delivering a break-even position through brokerage.	Ongoing
Recovery plan in place to offset the reduced Value & Efficiency workstreams delivery to deliver planned opening outturn	January 2025 – update will be via the 12 month report

Risk Number	1375	**Theme**	25/26 Financial Risk – **NEW RISK**
Risk Level	High	**Score**	16
Target Risk Level	High	**Target Score**	12
Strategic Objectives		Perform Well	
Governance Committee		Finance, Resources & Performance	

Risk Narrative

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.

Mitigating Action	**Due Date**
Non-recurrent recovery plan identified, and the majority should be released within the first 6 months of the financial year	End September 2025
Recurrent savings plans being progressed at pace through VEAG meeting and will incorporate STAG benefits, to avoid double-counting	Ongoing
STAG financial assessment work to identify potential savings for Year 1 and beyond to evaluate input versus deliverables	End July 2025
A&B recover plan requested	End June 2025

Risk Number	666	**Theme**	Cyber Security
Risk Level	High	**Score**	16
Target Risk Level	High	**Target Score**	15
Strategic Objectives		Progress Well	
Governance Committee		Finance, Resources & Performance	

Risk Narrative
Due to the continual threats from cyber attacks this risk will always remain on the risk register. The management of risk of this threat is part of business-as-usual arrangements entailed with resilience.

Mitigating Action	**Due Date**
Migrating Varonis data management system from the current internally managed implementation to the new Software as a Service (SaaS)managed cloud version which brings greater functionality, increased automation potential, 24x7 monitoring and enhanced incident response capabilities.	September 2025
Integrate NHSH eHealth out of hours support capability with the NSS Cyber Security Operations Centre (CSOC) 24x7x365 monitoring, alerting and reporting function.	October 2025
Refresh the NHSH Information Security Management System documentation set using the national information Security Policy pack.	December 2025
Microsoft 365 security tools being implemented as part of MS 365 project.	December 2025
NHS Highland are in the process of rolling out Trend Deep Security Tool. This tool mitigates disclosed vulnerabilities in out of support operating systems.	December 2025

Risk Number	1097	**Theme**	Strategic Transformation
Risk Level	High	**Score**	16
Target Risk Level	Medium	**Target Score**	6
Strategic Objectives		Perform Well	
Governance Committee		Finance, Resources & Performance	

Risk Narrative
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 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.

Mitigating Action	**Due Date**
Implementation of NHS Highland's Decision-Making Framework.	Complete
Refresh and implementation of Performance Management Framework (alignment of IPQR with ADP, performance reviews and EDG performance dashboard) to monitor implementation of strategic design and change programmes.	Complete
Set-up of monitoring and assurance structure for strategic design and transformation of services, including reporting of portfolio progress against deliverables, key risks and improvement trajectories.	Complete – approach to strategic transformation priorities in development through Strategic Transformation Assurance Group (STAG).
Governance of strategic design programmes through a portfolio approach is embedded within the NHS Highland governance structure	Complete
Agreement of strategic design priorities within the current portfolio approach	Complete
Appointment of Senior Responsible Officers and embedding programme management approach to document, mitigate and escalate risk to achievement of strategic transformation.	Complete
Integration of financial planning into strategic change programmes to ensure any financial benefits can be achieved.	Ongoing and will be reviewed in line with transformation programmes quarterly.
Strategic change priorities will be assessed by a Professional Reference Group to ensure appropriate involvement to ensure change is clinically led.	Ongoing

Adoption of Strategic Change process that follows the Scottish Approach to Service Design – Double Diamond	Complete

Risk Number	1255	**Theme**	ADP 24-25 Delivery
Risk Level	High	**Score**	16
Target Risk Level	Medium	**Target Score**	8
Strategic Objectives		Perform Well	
Governance Committee		Finance, Resources & Performance	

Risk Narrative
Due to fragility of services and reliance on additional / unfunded resource to cope with current levels of demand and activity, there is a risk that ADP 24-25 will fail to deliver the outcomes being pursued to improve patient quality, care delivery and efficiency.

Mitigating Action	**Due Date**
Value & Efficiency Accountability Group (VEAG) established to monitor efficiency opportunities across system against agree priorities	Meeting fortnightly.
Annual service planning across Acute, HHSCP and corporate areas to maximise capacity, efficiency and sustainability being incorporated into annual planning cycle governance.	In process of being established.
Review associated governance of ADP deliverables across SLTs, STAG and VEAG underway.	Ongoing through STAG.

Risk Number	1279	**Theme**	Financial Balance – Adult Social Care – **CLOSED**
Risk Level	High	**Score**	16
Target Risk Level	Medium	**Target Score**	9
Strategic Objectives		Perform Well	
Governance Committee		Finance, Resources & Performance	

Risk Narrative
There is a risk that NHS Highland will not deliver its planned position of financial balance within the Adult Social Care delegated budget for 2024/25 due to: 1. Current underlying financial position represents a significant overspend against the allocation received with an opening deficit of £16.252m 2. Further reduction in Quantum of £7m 3. Inability to realise 3% reduction in spend in line with value & efficiency plans of £5.71m

Mitigating Action	**Due Date**
SLT review of cost reduction action being taken for Q4. Some areas still to quantify cost in relation to ASC plan against younger adult / complexity care packages	Complete
£2.3.9m achieved of VEAG schemes for ASC.	Complete
Further remedy required in Q4 and financial plan for in development for 2025/26. Finance Clinic held with CEX and DoF 06/01/2025. Monthly monitoring and review and progress against action identified in place	February 2025 - ongoing

Risk Number	1376	**Theme**	Adult Social Care Financial Risk 25/26 – **NEW RISK**
Risk Level	High	**Score**	16
Target Risk Level	High	**Target Score**	12
Strategic Objectives		Perform Well	
Governance Committee		Finance, Resources & Performance	

Risk Narrative
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.

Mitigating Action	**Due Date**
Expectation of a contribution towards eNIC for directly employed staff as a minimum	End August 2025
Recurrent savings plans being progressed at pace through VEAG meeting and will incorporate STAG benefits, to avoid double-counting	Ongoing

STAG financial assessment work to identify potential savings for Year 1 and beyond to evaluate input versus deliverables	End July 2025
ASC recovery plan and long term sustainable financial plan needed, supported by pump priming from the Transformation Fund available from THC	End September 2025

Risk Number	714	**Theme**	Backlog Maintenance
Risk Level	High	**Score**	12
Target Risk Level	Medium	**Target Score**	8
Strategic Objectives		Progress Well	
Governance Committee		Finance, Resources & Performance	

Risk Narrative
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 funding is provided to remove all high-risk backlog maintenance.

Mitigating Action	**Due Date**
Following successful approval of the BCIP, Scottish Government have now allocated backlog capital maintenance funding based on the risk priorities identified in the plan. As a result of the risks identified in the BCIP, it has been indicated that additional funding of £2.3m is to be received by the Board for additional fire compartmentalisation works to take place this financial year.	Ongoing
Discussions continue with Scottish Government and NHSH Estates on managing the existing risks and the ability to highlight emerging risks that may require funding.	Ongoing
As a result of the BCIP submission and anticipated subsequent funding allocation, this risk is to be reviewed as we move forward.	Ongoing

Risk Number	1182	**Theme**	New Craigs PFI Transfer
Risk Level	Medium	**Score**	6
Target Risk Level	Medium	**Target Score**	6
Strategic Objectives		Perform Well	
Governance Committee		Finance, Resources & Performance	

Risk Narrative
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.

Mitigating Action	**Due Date**
PFI hand-back Programme Board in place and actions are progressing in line with anticipated due dates. Meeting frequency increased to monthly as handover date is approached.	Established and meeting monthly.
Development sessions being progressed to model the future estate utilisation and service delivery model.	In progress through the Programme and will be ongoing until hand-back date
Working with Scottish Futures Trust.	Ongoing
Programme Management commissioned from independent intelligence.	
Programme structure in place.	
Issues identified at programme board will be escalated to the appropriate committees through the programme risk register.	Ad-hoc

Staff Governance Risks

Risk Number	706	**Theme**	Workforce Availability
Risk Level	Very High	**Score**	20
Target Risk Level	Medium	**Target Score**	9
Strategic Objectives		Grow Well, Nurture Well, Listen Well	
Governance Committee		Staff Governance Committee	

Risk Narrative
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 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. Strategic objective ‘to be a Great Place to Work’ included in board strategy ‘Together We Care’ and range of activities included in annual delivery plan aligned with strategic outcome of ‘plan well’ New methods of tested within overall approach to recruitment for specific workforce challenges such as national treatment centre including targeted recruitment

campaigns, featuring innovative advertising, attendance at key events such as recruitment fairs International recruitment team and processes developed in partnership with North of Scotland Boards	
Mitigating Action	**Due Date**
Further proposals to be developed for enhancing our overall recruitment approach to maximise conversion rates from initial interest to completed applications including options for on the day interviews, assessment centre approaches etc **November 2023**	Work ongoing to agree programme of work for talent and attraction including enhancing our recruitment processes Recruitment improvement project plan developed and project team in place – Formal update will be provided to EDG in January 2024 – This work has been delayed and will be tied into the proposal to review the models for recruitment we currently use. Further work will now be completed on strengthening existing self-service model and offering bulk recruitment where there are clear workforce plans developed and in place for services and/or job families. Work has been completed to test new approaches to recruitment including on the day interviews in social care settings. Feedback has been positive on new ways of undertaking recruitment. **Action Complete July 2025**
Strategic workforce change programme to be developed to link new models of care with workforce diversification and re-shaping our workforce to achieve sustainable workforce models which also support employability and improved career pathways within health and social care **November 2023**	Initial discussions complete on establishing a workforce diversification programme but further work required to set up programme – plans to have first meeting of workforce diversification in February 2024 Delays in this area due to competing demands including agenda for change non-pay

	elements of 23/24 pay deal including reducing working week. This will be picked up through establishing workforce planning groups in each operational area to feed into strategic workforce planning group. Workforce planning groups due to meet in coming months to review strategic programmes and discuss priorities for workforce development. Workforce groups now undertaking work to review strategic programmes. **Next update November 2025**
Refresh approach to integrated annual planning cycle across service performance, workforce and financial planning to ensure we have a robust annual planning process that maximises service performance and quality, optimises current workforce utilisation and skill mix deployment to deliver better value from available workforce **November 2023**	Integrated service planning approach agreed and first cycle to be completed by end of March 2024 e-rostering programme to be refreshed to include focus on effective rostering and become effective rostering programme Work is underway to complete our first cycle of integrated service planning. Agreement at EDG to pause further rollout of e-rostering system and re-focus on effective rostering to make best use of the system where it has been rolled out Effective rostering programme agreed by Health and Care Staffing Act programme board and underway. Integrated Service Planning cycle complete and awaiting outputs. First cycle of integrated service planning complete and proposal agreed for second cycle of integrated service planning for 2024-2025. We are gaining better insights from this process into workforce challenges and potential solutions and it is anticipated this will improve further through the second cycle with a more robust

	and detailed workforce plan developed during 2024-2025. Next cycle of integrated service planning underway in parallel to annual delivery plan development. Work continuing with integrated service planning. **Next update November 2025**
Delivery of safe staffing programme to embed principles of legislation including effective utilisation of available workforce, clinical and care risk management as well as support workforce planning within integrated annual planning cycle **March 2024**	Update provide to APF and Staff Governance on preparation for implementation of the act in April 2024. HCSA programme board meeting regularly overseeing action plan to embed and document/evidence existing processes and strengthen areas identified through self assessment 1st Quarterly report produced for staff governance committee and board Annual report developed and ready for submission to Scottish Government. Clear work plan in place for 2025/2026. Work continuing as planned. **Next update September 2025**

Risk Number	1056	**Theme**	Statutory & Mandatory Training Compliance
Risk Level	Very High	**Score**	15
Target Risk Level	Medium	**Target Score**	8
Strategic Objectives		Grow Well, Nurture Well, Listen Well	
Governance Committee		Staff Governance Committee	
Risk Narrative			
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 action. The focus of the planned actions to mitigate this risk is to address the barriers to compliance as rapidly as possible and revert to management of compliance through			

organisational performance management and governance structures including regular reporting to staff governance.	
Mitigating Action	**Due Date**
Improvement plan to be developed and delivered to reduce barriers to compliance with statutory and mandatory training and improve reporting processes. **September 2024**	Data has been updated to split reporting into bank staff and substantive staff. Substantive staff compliance at 79% and continuing to steadily improve. Bank staff should not be booked if training is not up to date and the lower compliance of 48% reflects that some bank staff are not actively working. PLT national work continues and is not expected to conclude until autumn 2025**.** **Next Update November 2025**

Risk Number	632	**Theme**	Culture
Risk Level	High	**Score**	16
Target Risk Level	Medium	**Target Score**	9
Strategic Objectives		Our People	
Governance Committee		Staff Governance	

Risk Narrative

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.

Mitigating Action	Due Date
Development of learning system to support skills development of leaders including: action learning sets, leadership networks, masterclasses, leadership and culture conferences/meetings, mentoring and coaching – **October 2023**	Refreshed leadership and management development programme now in place. Leadership networks will be launched as part of leadership conference planned for May 2025. Cohort training for key groups of managers being explored **next update November 2025**
Further development of staff engagement approach including board wide 'living our values' project – **December 2023**	Results of staff engagement approach reported to APF and due for discussion at SGC. Action plan proposed in relation to the findings of the engagement during 2024. Consideration of embedding annual cycle of staff engagement required. **next update November 2025**
Appraisal (personal development review - PDR) and PDP improvement plan approved in March 2024 to ensure all managers have PDR and PDP completed in 2024-2025	Short life working group in place to finalise details of PDR and PDP improvement plan including supporting materials, actions required and timelines. Plan launched with reports issued to managers and requirements to agree plans and trajectories for their areas. 1st two levels of management below director to be completed by December 2024 Further work has identified that there are around 2300 records of circa 11,000 (21%) where appraisals may have been undertaken but not fully signed off within Turas. Further instructions have been issued to managers which may result in an uplift in compliance rates. However, progress is still limited and further work with the executive team and

	senior management teams is required to ensure this is addressed in 2025. Discussions with staff and managers underway to understand barriers to PDP and appraisal completion. Early indications include: • Lack of staff engagement and understanding of purpose • Shortage of time for managers to complete appraisals potentially linked to high number of direct reports • Shortage of time for staff to complete appraisals linked to 'system pressures' **next update November 2025**

Clinical and Care Governance Risks

Vaccination uptake and delivery remain risks for NHS Highland. Adult vaccination uptake is close to national levels, but childhood uptake has fallen within Highland HSCP. Considerable work continues to be undertaken to improve the service and uptake including that relating to SG escalation and implementation of the recommendations of the PHS peer review. Action plan implementation is overseen by the Vaccination Improvement Group.

Risk Number	959	**Theme**	COVID and Influenza Vaccines
Risk Level	High	**Score**	12
Target Risk Level	Medium	**Target Score**	6
Strategic Objectives		Stay Well	
Governance Committee		Clinical and Care Governance	

Risk Narrative
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 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.

Mitigating Action	**Due Date**
Actions to increase uptake rate and other measures of performance and quality improvement are in place	Quality improvement work has been undertaken concentrating especially on infant vaccination within Highland HSCP. There has been a considerable quarterly improvement in 6 in 1 vaccination uptake within HHSCP. **Next Review April 2025**
Effective delivery model in place across Highland HSCP - Peer review has been undertaken and implementation group with action plan is in place	Submission made for flexibility in delivery model for Highland HSCP and this was accepted. Implementation details are being set up and timescale submitted to SG by end March 2025. **Next Review April 2025**
Implementation of autumn/winter 2024 COVID and influenza vaccinations - Details of delivery will depend on agreed delivery model	Programme is now almost closed, and uptake has been similar to national levels. Population uptake is slightly lower, staff uptake tends to be slightly higher. New delivery model is being worked up for Highland HSCP. **Next Review April 2025**

Risk Number	1353	**Theme**	Sustainability
Risk Level	High	**Score**	16
Target Risk Level	High	**Target Score**	12
Strategic Objectives		Progress Well	
Governance Committee		Clinical	

Risk Narrative
Sustainability of Services There is a risk that the Board will be unable to meets its duty to provide access to clinical and care services in and out of hours for its population due to increasing population with multiple needs combined with difficulties in recruiting and retaining workforce which will impact on patient care and experience. The distribution of this risk is variable with services such as vascular surgery, oncology, general practice, dental being examples of our highest sustainability risks.

Mitigating Action	**Due Date**
Re-configure service delivery, in line with regional or national work eg national task & finish groups for vascular and for oncology	Ongoing
Assistance/Pathways from other boards via service level agreements and mutual aid arrangements.	Ongoing
Digital solutions to allow remote/virtual care	Ongoing
Maintain service through locum cover where not possible to recruit to substantive post and seek mutual aid arrangements where locum cover is not achievable	Ongoing

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

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. List of appendices

None as summary has been provided for ease of reading