NHS HIGHLAND BOARD	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk/
MINUTE of BOARD MEETING Virtual Meeting Format (Microsoft Teams)	**29 July 2025 – 9.30am**

Present

Alexander Anderson, Non-Executive
Emily Austin, Non-Executive
Graham Bell, Non-Executive
Elspeth Caithness, Employee Director
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
Jennifer Davies, Director of Public Health
Fiona Davies, Chief Executive
Albert Donald, Non-Executive
Karen Leach, Non-Executive
Philip Macrae, Non-Executive
Joanne McCoy, Non-Executive
Gerard O'Brien, Non-Executive
Dr Boyd Peters, Medical Director
Steve Walsh, Non-Executive
Dr Neil Wright, Non-Executive

In Attendance

Gareth Adkins, Director of People and Culture (from 12pm)
Kristin Gillies, Interim Head of Strategy & Transformation
Elaine Henry, Deputy Medical Director
Arlene Johnstone, Interim Chief Officer, Highland Health and Social Care Partnership
Richard MacDonald, Director of Estates, Facilities and Capital Planning
David Park, Deputy Chief Executive
Nicki Sturzaker, Head of Communications and Engagement
Katherine Sutton, Chief Officer, Acute
Nathan Ware, Governance & Corporate Records Manager
Dominic Watson, Head of Corporate Governance

1.1 Welcome and Apologies for absence

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

The Chair expressed gratitude to Dr Tim Allison, who had made significant contributions to public health in Highland, particularly in raising the profile of health inequalities and promoting physical activity through initiatives like Active Highland. She noted that his expertise and advocacy had left a lasting impact on NHS Highland and its partners.

The Chair thanked Catriona Sinclair, whose term as Chair of the Area Clinical Forum had ended, highlighting her dedication, leadership, and the positive impact she had made in strengthening engagement between the Forum and the Board. The process to appoint a successor was underway.

Additionally, the Chair welcomed Dominic Watson, the Head of Corporate Governance, and highlighted his previous role, where he had led a Governance Team in navigating complex governance matters and Nicki Sturzaker, the new Head of Communications and Engagement, brought over 20 years of strategic communications experience across multiple sectors and was a Chartered Public Relations Practitioner and CIPR Fellow.

Draft

Apologies for absence were received from Catriona Sinclair, Janice Preston, Heather Bain, Pamela Stott and Evan Beswick, it was noted that Gareth Adkins would join in the afternoon.

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.

1.3 Minutes of Previous Meetings and Action Plan

The Board **approved** the minutes as an accurate record of the meeting held on 27 May 2025.

The Board **noted** the Action Plan and **agreed** to amend the dates of Actions 33, 35 and 42.

1.4 Matters Arising

None

2 Chief Executive's Report – Update of Emerging Issues

The Chief Executive provided an update on the Waiting Times Reduction Initiative work underway in response to Scottish Governments expectation across all Boards in Scotland, and she confirmed NHS Highland was committed to reducing the longest waits in the system. Further updates were provided in relation to the Vascular Service Provision; Lochaber Service Redesign; Capital Investment and Estates Strategy.

She took the opportunity to congratulate Chelsey Main, who was announced as the 2025 Nursing Support Worker of the Year at the Royal College of Nursing Scotland Nurse of the Year Awards. She also congratulated the Neo-natal Unit for achieving the UNICEF Gold Award through the Baby Friendly initiative.

During discussion the following points were raised:

- Board Members noted the transfer of New Craigs to NHS Highland and asked about any remaining PFI contracts. The Director of Estates, Facilities and Capital Planning confirmed that Invergordon Hospital and Mid Argyll Hospital were under PFI arrangements, with Invergordon scheduled to return by 2028.
- Board Members asked whether a cost-benefit analysis had been carried out on ending PFI contracts early. The Director of Estates, Facilities and Capital Planning confirmed this had been included in the review process and an update would be provided to the Finance, Resources and Performance Committee.
- Board Members welcomed the positive updates shared in the Chief Executive's report and emphasised the importance of recognising such achievements, particularly in light of the wider challenges facing the NHS.
- The Chair highlighted the challenges faced in Vascular Services and extended thanks to Mr Wolf for his support prior to his departure and to the team for their continued work in supporting the service.
- Board Members sought clarity on the timeframe to a sustainable vascular service. The Chief Executive confirmed a precise timeline couldn't be confirmed as national discussions on the future model were still ongoing. The Medical Director added that NHS Highland continued to contribute to these discussions and were working to maintain safe local services.

The Board **noted** the update.

3 Governance and other Committee Assurance Reports

a) Audit Committee minutes of 13 May, 19 June 2025 and draft minutes of meeting of 24 June 2025

The Chair of Audit Committee highlighted there were no new internal audit reports in May, but work had begun on the children's services audit, which remained on track to report in September. Progress on closing cyber security audit actions was noted with reassurance provided by the Head of eHealth. She noted that concerns had been raised about overdue actions in complex care packages and adult social care with updates from the Chief Officer at the June meeting. The committee also reviewed its annual report and contributions from subcommittees.

b) Finance, Resources and Performance (FRP) Committee agreed minute of 6 June 2025 and summary of meeting of 11 July 2025

Draft

The Chair of FRP Committee highlighted the committee received a budget update which included a draft response to Scottish Government that outlined risks to achieving a 3% cost reduction and a balanced adult social care position. He added that the Quarter four Annual Delivery Plan update was endorsed and IPQR performance was reviewed with improvements noted in outpatient and Treatment Time Guarantee data.

The Chair noted at the 11 July meeting the committee reviewed the Month two financial position and received a positive update on the NHS Highland Digital Delivery Plan. However, committee raised concerns around the resource impact of the national Digital Front Door project. He added the risk register was reviewed with financial risks from the previous year closed and new ones opened for the current year.

c) Staff Governance Committee agreed minute of 6 May 2025 and summary of meeting of 1 July 2025

The Chair of the Staff Governance Committee highlighted that committee had received a presentation covering the Finance Directorate, which outlined improvements in appraisal rates (60%) and statutory/mandatory training (over 96%), along with operational successes in procurement and travel. The Staff Governance Monitoring Group had progressed towards its first meeting and updated training figures had been shared following the separation of bank and permanent staff data. The committee also reviewed staff governance risks, with plans to align this work to the Board's strategic risk review. Until the revision was complete, risks continued to be reviewed at each meeting.

d) Highland Health & Social Care Committee (HHSCC) agreed minute of 7 May 2025 and summary of meeting of 2 July 2025

The Chair of HHSCC highlighted the committee had reviewed the year-end financial position for the partnership which had aligned with earlier projections. Looking ahead to 2025–26, the delivery of a 3% savings target across the partnership had been recognised as a significant challenge requiring ongoing staff input. Other updates included resourcing challenges within the community across areas such as Care Homes and updates on the implementation of improvement recommendations by the Care Inspectorate for the Sutherland Care at Home service and ongoing concerns around general dental services, which continued to require close monitoring.

e) Clinical Governance Committee agreed minute of 1 May 2025 and summary of meeting of 3 July 2025

The Chair of Clinical Governance Committee highlighted that the committee received updates on the ongoing pressures within end-of-life services, recognising this was a national challenge, it was noted efforts were being made to ensure continuity of care and assess any impact in Argyll and Bute. The committee had also received an information governance report which highlighted challenges around subject access requests due to the introduction of electronic patient records. She added that committee had welcomed increased promotion of Care Opinion as a valuable feedback tool and noted ongoing efforts to improve complaints handling through staff training.

f) Area Clinical Forum agreed minute of 9 January 2025

In the Chairs absence, the Governance and Corporate Records Manager highlighted the Forum had received updates on the progress made around the confidential contacts options appraisal alongside insights into an upgrade to the integrated patient record systems within acute. No new risks had been escalated in although concerns remained around maintaining morale and recruitment in hard-to-fill specialties. He noted the Forum met in July, with productive discussions around the chair election process, the constitutions revisions and planned membership refresh due to several vacancies. The Director of Midwifery led a valuable discussion around public protection. Discussions also took place around JobTrain complexity and recruitment challenges with the Director of People and Culture planned to attend the September meeting.

g) Argyll and Bute Integration Joint Board (IJB) Minute 28 May 2025

It was noted the IJB held their meeting in Oban which marked the start of a plan to rotate meetings across Argyll and Bute. The Board had received a petition from residents regarding the stalled development of Thompson House due to funding issues which highlighted the importance of local services and the challenges of delivering care on the islands. The complexities around impact assessment completion in relation to budget decisions continued to be challenging particularly as current guidance was often unclear and inconsistently interpreted but work was underway to improve the reporting process. He added that the Board had considered representations from carers' groups across Argyll and Bute, acknowledging the unique challenges they faced and the importance of their involvement and plans were agreed to revisit the topic in future development sessions.

The Board:

- **Confirmed** adequate assurance had been provided from Board governance committees and Area Clinical Forum.

- **Noted** the Minutes and any agreed actions from the Argyll and Bute Integration Joint Board.

4 Finance Assurance Report – Month 2 Position

The Board received a report from the Director of Finance which detailed the financial position as at Month 2, 2025/2026. The Board were invited to take limited assurance as the board has aligned with the Scottish Government expected position but still presented a position which is significantly adrift from financial balance.

It was confirmed that the Boards original plan presented a budget gap of £115.596m, when cost reductions/ improvements were factored in the net position was a gap of £55.723m. Following feedback on the draft Financial Plan, a revised plan was submitted in line with this request in June 2025 and this revised plan has been accepted by Scottish Government.

The Director of Finance spoke to the circulated report and highlighted for the period to end May 2025 (Month 2) an overspend of £12.729m was reported with this forecast to increase to £40.005m by the end of the financial year.

She noted the forecast position was predicated on the assumption that further work would enable delivery of a breakeven position within Adult Social Care by 31 March 2026. Key cost pressures included high drug spend, supplementary staffing, locum costs, and out-of-area placements, with similar trends seen across acute, both partnerships, and support services. A savings target had been identified and was under bi-weekly review, with ongoing efforts to improve delivery and reporting, alongside the capital plan that detailed spending against the core allocation and confirmed project-specific funding.

The Board Chair highlighted the value of illustrating progress against value and efficiency targets across service areas, noting it provided a clear and helpful visual for tracking assurance throughout the year.

Having **examined** the draft Month 2 financial position for 2024/2025, the Board **considered** the implications and **agreed** to take **limited assurance** from the report.

5 Budget Setting Update

The Board received a report from the Director of Finance detailing the 3-year financial plan 2025/26 to 2027/28 for approval and to provide an update on further actions required to reduce the financial gap to the SG requirements.

The Board was invited to take moderate assurance that a plan had 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 Adult Social Care and IJB position.

The Director of Finance spoke to the circulated report and noted the March plan had been submitted for budget approval, subject to further work to meet the Scottish Government's £40 million deficit target. An updated position based on the 2024/25 outturn showed improvement in the recurrent position and progress on savings and STAG workstreams. She advised the report had included the full response to the Scottish Government and a copy of their acceptance letter.

During discussion the following points were raised:

- Board Members sought further information relating to the New Craigs RAAC funding. The Director of Estates highlighted there was a commercial settlement agreement in place as part of the handover process. He advised the buildings were at end-of-life and would be demolished, with works commencing next month and no ongoing liability for the site.
- Board Members questioned the sustainability of the financial position, given the use of non-recurrent measures early in the financial year to meet the target, and how the risk was being managed. The Director of Finance advised the Scottish Government requested early use of non-recurrent measures and changes to funding allocations had reduced financial flexibility, making risk management more challenging and placing greater pressure on delivering 3% savings this year.

The Board **examined** and **considered** the content of the report, **agreed** the budget and outlined approach and **agreed** to take **moderate** assurance.

The Board took a break at 10.56am and the meeting resumed at 11.11am

6 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 were 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:

- CAMHS waiting lists continued to reduce, with performance rising to 79.5% in March.
- Emergency Department (ED) performance improved to 82.6%, above the national average of 71%.
- Vaccination uptake had increased but MMR remained below national average.
- Delayed discharges continued to be challenging and remained above target, but work was underway to improve the position.
- He highlighted that Outpatient performance was misreported as 61% and the actual reportable figure was 39%, close to the national average of 41%.
- Treatment Time Guarantee (TTG) continued to improve and sat at 65.4% with NHS Highland ranking 5th of 15 Boards, above the national average of 56.3%.
- Cancer services remained stable with 31-day performance at 91% and 62-day at 76%, both remained above the national average.

During discussion the following points were raised:

- Board Members noted that 76 Significant Adverse Event Review (SAER) actions were still outstanding and asked for clarity on the longest-standing item. The Medical Director explained that many recommendations were difficult to implement organisation-wide, but work was underway to identify the best approach, particularly as some improvements had already been made since the original recommendations.
- Board Members sought clarity around ED access, specifically the reference to 38 patients waiting over 12 hours and whether this was monthly, quarterly or another reporting period. The Chief Officer for Acute confirmed ED performance was measured daily, but the data was aggregated and presented weekly in the IPQR.
- Board Members highlighted the reduction in MMR uptake and asked if there was a known reason for the decline. The Director of Public Health advised that the downward trend was being seen nationally, and that Public Health Scotland was conducting exploratory work to understand the causes and identify actions to improve uptake.
- Board Members noted there had been no improvement in Drug and Alcohol Recovery Service performance, which continued to decline and asked whether any remedial action had been taken. The Chief Officer for HHSCP confirmed a digital recovery support service had been commissioned, with a start date of 18 August 2025 which would help identify challenges and inform improvement efforts.
- The Chair sought clarity on how the full range of improvement efforts within the IPQR, including non-visible work, had been communicated to the Scottish Government to ensure a balanced view rather than one that appeared overly critical or one-sided particularly in relation to Planned Care. The Deputy Chief Executive advised that reporting tracked planned activity against actual delivery whilst including rising demand to articulate the pressure placed on capacity helped, but National discussions were underway to assess the best way forward when interpreting performance data.

The Board:

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

7 Director of Public Health Annual Report – 6 Month Update

The Board received a report from the Director of Public Health that detailed the initial six-month progress against the recommendations from the Director of Public Health's 2024 Annual Report, which had been presented and accepted by the Board in January 2025.

Draft

The Board were invited to take **moderate assurance** that there had been progress in establishing the internal mechanisms to support delivery and progress in tackling health inequalities as per the recommendations. Given the developmental nature of this work, it was expected to take time to become fully established and mature and would require review as the development of the new organisational strategy progressed.

The Director of Public Health spoke to the circulated report and highlighted broader developments were underway including the organisational strategy refresh and the establishment of a new Population Health and Planning Committee, which would lead future strategic development and governance. She added that National frameworks such as the Population Health and Service Renewal Frameworks were also being considered in shaping the Board's future direction.

During discussion the following points were raised:

- Board Members expressed their ongoing concern around the Board's role in corporate parenting and delivering on the promise and requested it be revisited in future discussions. This would be added to the Board Action plan with an update provided in due course.
- Board Members sought clarity on progress made with the vaccination improvement programme and how health inequality principles were applied. The Director of Public Health confirmed that they'd been considered, and uptake varied across different groups due to factors such as access, health literacy and other vulnerabilities. The approach involved using multiple data sources to identify where targeted efforts were needed, with a focus on equity rather than equality to ensure improved outcomes across all communities.
- Board Members asked how NHS Highland could better co-ordinate and share resources across the Community Planning Partnerships and other partners to enable a more cohesive and effective system. The Director of Public Health advised that selecting appropriate data to monitor progress and provide assurance was important and emphasised the need to understand the impact any input or activity would have on outcomes. She added that alignment with system-wide measures was essential, reinforcing the importance of collaborative working across Community Planning Partnerships.

The Board:

- Took **moderate assurance**.
- **Noted** the content of the report and the summary update on progress in relation to the recommendations of the 2024 Director of Public Health Annual Report.
- **Noted** the report recommendations would be key in developing the strategic framework.
- **Noted** future updates would be assured via the Population Health and Planning Committee.

8 Board Strategy – Planning Policy Frameworks and Performance Reporting

The Board received a report from the Interim Head of Strategy and Transformation outlining its approach to shifting focus toward improving population health, with an emphasis on prevention and reducing health inequalities.

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

The Interim Head of Strategy and Transformation spoke to the circulated report and highlighted:

- The Annual Delivery Plan (ADP) had been approved by Scottish Government in early July 2025 and was recognised as a robust framework for delivering the Together We Care strategy which would continue to be monitored whilst developing the new strategy.
- The ADP had evolved to support local planning and priorities, with the Operational Improvement Plan (OIP) identified as the main delivery mechanism for national priorities.
- The OIP focused on four key areas: planned care, unscheduled care, digital access, and prevention. It was noted the ADP had been aligned to all OIP deliverables which would be reflected in future iterations of the IPQR.
- A new strategic framework was under development, incorporating a population health lens. A draft model had been shared and was scheduled for further development and governance integration in autumn 2025.

During discussion the following points were raised:

- Board Members sought clarity on whether a success methodology had been agreed to appropriately measure health improvements by means of early intervention. The Director of Public Health confirmed no single, straightforward methodology existed. Instead, early intervention varied by condition and population group, so success depended on identifying early markers and tailoring responses accordingly. She recognised there was a need for a more systematic and equitable approach to embedding it across services.
- The Chair asked how planning and approval would work going forward, given the evolving role of the ADP and the introduction of the OIP. The Interim Head of Strategy and Transformation confirmed the ADP remained the main planning and performance tool with the OIP used internally to ensure alignment with national priorities; she noted that both plans were monitored and cross-checked.

The Board:

- Took **moderate assurance** from the report.
- **Noted** the three Health and Social Care Reform Frameworks published in June 2025: the Service Renewal Framework (SRF), Population Health Framework (PHF), and Operational Improvement Plan (OIP).
- **Noted** that the NHSH Annual Delivery Plan had been approved as a robust foundation for 2025–26.
- **Noted** that Annual Delivery Plans had been considered within this evolving context and had remained a valuable tool for supporting local planning and aligning with a broad range of national priorities.
- **Noted** that in 2025–26, Scottish Government focus had been on the delivery of the Operational Improvement Plan, which included reducing waiting times, improving patient flow, and expanding access through innovation. This and the other Frameworks had been governed by the SG Reform Executive.
- **Noted** that Chief Executives had been required to provide a consolidated progress report on OIP delivery to SG Executive Group meetings.
- **Noted** the current position statement, as the OIP had developed.
- **Noted** that as the strategic framework and 10-year strategy had developed, delivery plans and performance reporting had continued to serve as assurance mechanisms to the relevant governance committees.

The Board took a break at 12.32pm and the meeting resumed at 1.03pm

9 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 noted that some risks relating to last years financial challenges had been replaced to reflect the new financial year alongside the addition of a new risk, risk 1353 which related to the sustainability of services that would be monitored by the Clinical Governance Committee.

During discussion the following points were raised:

- The Chair asked whether NHS Highland had reviewed how other Boards record similar risks to ensure alignment and improve articulation. The Medical Director confirmed this exercise had been undertaken, particularly during the development of the Board's risk appetite. He added that variation existed across Boards and NHS Highland's risk register had been tailored to align with its strategy and governance structures.
- The Chair sought clarity on whether Risk 1182 that related to the PFI transfer of New Craig's would be closed. The Director of Estates, Facilities and Capital Planning confirmed that the risk remained open until the quarterly review was completed, to ensure all aspects of the transition were fully addressed.
- Board Members questioned why a new sustainability risk was required when existing risks already covered similar themes. The Medical Director advised this risk related to clinical concerns whilst others related to the workforce challenges.
- The Chair of Clinical Governance Committee clarified that the risk was to articulate the sustainability of clinical and social care services across the system may be compromised, impacting the ability of professionals to meet their responsibilities and uphold standards of care reflecting a recurring theme raised through the Clinical Governance Committee. An action would be added to the Board Action Plan to ensure the Corporate Risk Register was updated.

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

10 Whistleblowing Quarter 4 Report

The Board received a report from the Director of People and Culture on the Whistleblowing Standards Quarter four activity covering the period 1 January – 31 March 2025. The report gave assurance on performance against the National Whistleblowing Standards in place since April 2021. The Board were invited to take **moderate assurance** on the robust process in place but noting the challenge of meeting the 20 working days within the standards.

The Director of People and Culture spoke to the circulated report and highlighted one new concern had been received, one case remained open, and one case review had been closed. He confirmed the new case was being assessed to determine whether it fell under whistleblowing standards. It was noted the report also included updates on previously reviewed cases and he confirmed that one additional case had been closed since the report was written.

The Board **noted** the content of the report and took **moderate assurance** on the robust process in place noting the challenge of meeting the 20 working days within the standards.

11 Whistleblowing Annual Report

The Board received a report from the Director of People and Culture that summarised activity against nationally agreed Key Performance Indicators and provided an overview of the learning outcomes from cases concluded during the year. The report was produced as part of a requirement for every NHS board to produce quarterly reports and annual reports. The Board was invited to approve the annual report and take **substantial assurance** based on the content demonstrating compliance with reporting requirements under the standards.

The Director of People and Culture spoke to the circulated report and confirmed there were a small number of formal cases submitted and around 180–200 contacts made via the Guardian service, often enabling early resolution. He highlighted it was difficult to draw broad learning from the limited cases, but the report outlined common themes that aligned with ongoing strategic work.

During discussion the following points were highlighted:

- The Chair asked how achievable the 20-day target outlined in the standards had been, given that other Boards had faced similar challenges. The Whistleblowing Champion confirmed that the issue had not been unique to NHS Highland and discussions were underway nationally to determine the most appropriate way forward.
- Board Members sought clarity on how they could increase their visibility in response to concerns about senior leadership presence. The Director of People and Culture confirmed that a deep-dive exercise had been carried out, and that work was underway to review the current approach in collaboration with the Head of Corporate Governance and the Head of Communications and Engagement. An action would be added to the Board Action Plan to ensure the results of the review were shared upon its completion
- Board Members asked whether there had been any plans for Independent National Whistleblowing Officer (INWO) to produce an overarching report for NHS Scotland to identify key learning across all Boards. The Director of People and Culture advised that no such report was planned, primarily due to capacity constraints within INWO.
- The Chair noted that Board Whistleblowing Champions met informally and asked if a joint report with the INWO could potentially be considered. The Whistleblowing Champion clarified that whilst the meetings were informal, he proactively shared any key learning with NHS Highland at the earliest opportunity.

The Board:

- **Noted** the content of the report
- Took **substantial assurance** based on the content and format of the annual whistleblowing report which demonstrated compliance with our reporting requirements under the standards.
- **Approved** the report for submission to Independent National Whistleblowing Officer

12 Health & Care (Staffing) Act Quarter 4 Report 2024-25

Draft

The Board had received a report from the Director of People and Culture detailing the main 2024/25 End of Year Report (covering Quarters 1 to 3) and had provided an overview of developments and assurance activity during Quarter 4 (1 January – 31 March 2025). Its purpose had been to ensure a complete account of implementation progress across the Act's inaugural year.

The Board were asked to take **moderate 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 had been consistent with the assurance rating applied across Quarters 1 to 3 and had remained valid following assessment of Quarter 4 activity.

The Board **noted** the content of the report and took **moderate assurance** in relation to the delivery of its statutory duties set out in the Health and Care (Staffing) (Scotland) Act for the Quarter 4 period of 2024/25.

13 Workforce Monitoring Report

The Board received a report from the Director of People and Culture detailing the annual publication required to demonstrate NHS Highland had met the requirements set out in the Public Sector Equality Duty to gather, use and publish employee information. The information within the report had considered the workforce position for the period 1st January to 31st December 2024.

The Board were asked to take **substantial assurance** that the report had demonstrated compliance with the Public Sector Equality Duty, Specific Duties Scotland requirement as noted.

The Chair had asked whether mechanisms were in place to cross-reference known HR issues arising from breaches of protected characteristics, such as complaints related to racism. The Director of People and Culture confirmed that no formal mechanism currently existed and noted that such concerns would more likely be addressed initially through the organisation's bullying and harassment policy.

The Board **noted** the content of the report and take **substantial assurance** that the publication of the report had demonstrated compliance with the Public Sector Equality Duty and Specific Duties Scotland requirement to gather, use, and publish employee information.

14 Argyll and Bute Integration Scheme Review – Approval of Changes and Consultation/Engagement Strategy

The Board received a report from the Director of People and Culture which detailed the proposed steps to meet the legal requirement under section 44 of the Public Bodies (Joint Working) (Scotland) Act 2014 to complete a review of the current Integration Scheme for submission to Scottish Ministers by 23 March 2026, including the establishment of a Working Group. The Board were asked to take **substantial assurance.**

The Board:

- Took **substantial assurance**.
- **Agreed** the revisions detailed within the updated Integration Scheme (Appendix 1) and the summary revisions document (Appendix 2).
- **Agreed** arrangements for the joint consultation exercise had proceeded as set out within point 2 of the assessment section of the report, and the Consultation and Engagement Strategy detailed in Appendix 3.
- **Agreed** if the consultation feedback had suggested no further changes to the Scheme and had voiced no opposition to the proposed changes, the two Chief Executive Officers had been authorised to approve the draft revised Integration Scheme on behalf of the Council and the NHS Highland Board prior to submission to the Scottish Government for approval.

15 Single Authority Model Update

The Board had received a report from the Director of People and Culture detailing the background and context for establishing a joint short life working group between Argyll and Bute Council and NHS Highland.

The Board were asked to take **substantial assurance** and to approve the establishment of a joint short-life working group initiated by Argyll and Bute Council which NHS Highland subsequently joined, to progress an options appraisal for a single authority model and associated work

Draft

The Director of People and Culture spoke to the circulated report and highlighted the work had been driven by Scottish Government's public sector reform agenda with the aim of improving service delivery and outcomes. He noted the report included current proposals and draft terms of reference which were to be further developed by the joint group.

During discussion the following points were highlighted:

- Board Members asked for clarity on how the public would be consulted on the proposed single authority model, emphasising the importance of engaging communities in Argyll and Bute early in the process. They also raised questions about the potential impact on NHS-employed staff, expressing concern over the lack of detail regarding future employment arrangements and the associated risks.
- The Director of People and Culture confirmed that partnership working would be essential, particularly if any proposed models had implications for the workforce. He added it was the role of the Short Life Working Group to explore available and emerging options. He emphasised the importance of engagement with both staff and communities once a clearer direction of travel had been established in line with ministerial expectations around pace and ambition.
- The Chair added that the proposed single authority model presented a valuable opportunity for the Board and paid tribute to the significant work undertaken by Argyll and Bute Council to date and noted the recently issued parameters provided by Scottish Government had enabled the NHS Highland to begin to consider the potential range of models through its own lens. She highlighted the potential to improve outcomes for communities, particularly in rural areas and emphasised the importance of strong leadership, effective governance and early engagement with staff and communities, recognising that the process might lead to significant changes in service delivery.

The Board **approved** the establishment of a joint short-life working group initiated by Argyll and Bute Council which NHS Highland would subsequently join, to progress an options appraisal for a single authority model and associated work and took **substantial assurance**.

16 Board Blueprint for Good Governance Improvement Plan - Update

The Board had received a report from the Governance and Corporate Records Manager, on behalf of the Board Chair detailing a six-month update on progress on delivery of the actions included in the Board's Blueprint for Good Governance Improvement Plan.

The Board were asked to take **moderate assurance** that the report provided confidence that actions were being actively pursued and to reflect that on-going activity will be required to fully meet the objectives.

The Governance and Corporate Records Manager spoke to the circulated report and highlighted the Board had approved its Blueprint Improvement Plan in July 2023 and had agreed that governance committees and the Chairs Group would provide informal oversight of relevant progress and delivery elements at agreed intervals.

Outstanding actions overseen by the Highland Health and Social Care Committee (HHSCC) and the Audit Committee had been noted. For HHSCC, these actions specifically related to the quality framework, which had been discussed at an EDG meeting in April 2025. A quality lead post had been identified as necessary to support the next steps, and once funding was finalised the role would be advertised.

The second action focused on embedding Care Opinion, with ongoing work supported by the Clinical Governance Manager. It was noted that over 250 instances of Care Opinion had been used for NHS Highland services in the past 12 months, reflecting an increase in usage compared to previous years.

For Audit Committee, the outstanding action had related to risk appetite and management. Work had been completed to reset the Board's risk appetite, which was discussed during the March 2025 Board development session. Efforts were underway to embed this into the high-level risk register and operational processes which planned to include training across acute services and the Health and Social Care Partnership.

During discussion the following points were highlighted:

- The Chair highlighted the blueprint provided a snapshot of progress and noted that governance improvements had extended significantly within NHS Highland with the introduction of new non-executive directors and the Head of Corporate Governance.

- Board members sought clarity on whether Care Opinion had been implemented or was planned for roll-out to care home residents and their families, and whether this involved any associated costs. The Nurse Director confirmed that the functionality came with an additional cost, and that work was underway to identify the most suitable solution for the care home environment by way of an operational action.
- work was underway to identify the most suitable solution for the care home environment by way of an operational action.
- Board Members were not satisfied and highlighted the importance of gathering feedback from the care home setting given the recent care inspectorate report and recommended a Board action was noted so progress could be tracked and appropriate assurance provided. This would be added to the Board Action Plan so an update can be provided in due course.
- Board members asked whether the Blueprint Improvement Plan applied to the Argyll and Bute Health and Social Care Partnership (HSCP), as the report had only referenced NHS Highland and the Highland HSCP. The Chief Executive confirmed the original blueprint exercise had been led by the former Chair of NHS Greater Glasgow and Clyde and focused solely on NHS services. She added that the Highland HSCP had been included because of the lead agency integration model in place.

The Board:

- Took **moderate assurance** from the report.
- **Noted** that informal oversight of progress in delivering the improvement plan continued to be undertaken by the Chairs Group and Governance Committees.
- **Noted** that six-monthly updates would be presented to the Board for oversight.

17 Revision to Terms of Reference – Highland Health and Social Care Committee and Area Clinical Forum

The Board had received a report from the Governance and Corporate Records Manager, on behalf of the Board Chair, outlining amendments to the Terms of Reference for the Area Clinical Forum and the Highland Health and Social Care Committee.

The proposed changes had aimed to ensure that quorum was calculated based on active membership, in response to ongoing committee vacancies. It was noted that a membership refresh was underway. The Board had been asked to take **substantial assurance** from the report and had approved the revised Terms of Reference for both committees.
The Board took **substantial assurance** and **approved** the revisions to the Highland Health and Social Care Committee and Area Clinical Forum Terms of Reference.

18 Any Other Competent Business

No items were brought forward for discussion.

Date of next meeting – 30 September 2025

The meeting closed at 2.23pm

Draft

NHS Highland Chief Executive's Update

September 2025

Fiona Davies,
Chief Executive NHS Highland

Summer Visits & Ministerial Engagement

Over the summer months, I had the privilege of visiting our teams across some of our more remote locations - from the residential care homes in Badenoch & Strathspey to the primary care practices serving Alness and Invergordon, and the dedicated services in Fort William and surrounding areas. What struck me most during these visits was witnessing firsthand the unwavering commitment of our colleagues who continue to deliver compassionate, high-quality care despite facing significant operational pressures.

I met with Karen MacCallum and her team at the Telford Centre who are maintaining a lovely, homely atmosphere for their residents with reduced staffing levels, and Jennifer Moncur and Gillian Jamieson at Mhor Health Pharmacy who have built something truly special from the ground up in Spean Bridge, serving their community with innovation and dedication.

Despite the staffing, infrastructure or complexity issues that can characterise service delivery in the Highlands, I met dedicated leaders and staff who are using their skills, experience and local knowledge to bring optimism and improvement to our services.

Top Row L-R: Mhor Health Pharmacy, Spean Bridge; The Wade Centre, Kingussie
Bottom Row L-R: Telford Centre, Fort Augustus; Grant House, Grantown on Spey and Mains House, Newtonmore

At Grant House, I saw how dedicated staff are managing with closed beds due to staffing difficulties, while our care at home teams in Lochaber are dealing with 600 hours of unmet need. Yet what continues to inspire me is how our colleagues demonstrate their values of compassion, care and person centredness to ensure they maintain their focus on patient, clients and their families.

Throughout the summer, we were also privileged to welcome several ministerial visits that showcased the breadth and innovation of our services across the region. Cabinet Secretary for Health and Social Care Neil Gray, alongside local MSP Kate Forbes, joined Louise Bussell and myself for an important visit to Skye, where we toured Broadford Hospital, Home Farm Care Home, and Portree Hospital. The discussions were particularly valuable as we explored urgent care services, the ongoing challenges in recruiting staff with Advanced skills, and how we're strengthening our integrated working with Scottish Ambulance Service and community partners.

The ministerial engagement continued with visits highlighting some of our most innovative work - from Neil Gray and Jenni Minto witnessing our transformative Hospital at Home initiative at Lorn & Islands Hospital in Oban, where patients receive hospital-level care in the comfort of their own homes, to Jenni Minto, Maree Todd, and Jamie Stone experiencing our midwifery-led maternity services at Caithness General Hospital.

Top Row L-R: Cabinet Secretary for Health and Social Care Neil Gray visiting Portree Hospital, Skye; Jenni Minto, Minister for Public Health & Women's Health visiting Caithness Maternity Unit, Wick
Bottom Row L-R: Cabinet Secretary for Health and Social Care Neil Gray visiting Lorn & Islands Hospital, Oban and Maree Todd, MSP for Caithness, Sutherland and Ross at Caithness Maternity Unit, Wick

These visits - both my own and those of our ministerial colleagues - reinforced my respect for the resilience and professionalism of our workforce, particularly those working in our most geographically isolated services. From the positive feedback residents and families give about the care they receive, to the creative solutions like prescription collection lockers in Fort William, our teams are not just maintaining services - they're finding ways to improve them. While we must continue to address the systemic challenges around recruitment, infrastructure, and resource utilisation, these engagements provided invaluable opportunities for our political representatives to see firsthand the dedication of our teams and hear directly from patients and families about the real difference our services make to their lives, while ensuring they understand the challenges we face in delivering healthcare across such diverse and remote communities.

Strategic Progress Update
Operational Improvement Plan Update
The publication of the Government's three national frameworks in June has provided clear direction for our transformation journey, and I'm encouraged by the tangible progress we're making across key areas. The additional investment in Planned Care is already translating into real improvements - we're creating new outpatient and treatment slots and making meaningful progress in reducing those unacceptable waits over 52 weeks for treatment.

Our work on shifting the balance of care particularly excites me, especially within our Urgent & Unscheduled Care portfolio. The development of a frailty assessment area at Raigmore Hospital and our expanding Hospital at Home services represent exactly the kind of fundamental shift I believe healthcare needs - moving care closer to people's homes while maintaining clinical standards and embedding realistic medicine principles. These initiatives embody my vision of a system that prioritises dignity, independence, and community-based care.

Digital transformation continues to advance with our Operating Theatre Scheduling Tool expanding across General Surgery, while our Digital Dermatology programme progresses into phase 2. The upcoming Digital Type 2 Diabetes remission solution represents something profound - the potential to help people not just manage their condition but potentially reverse it entirely. For me, these digital initiatives demonstrate how technology can improve both patient experience and clinical outcomes.

Population Health Framework
Our recent meeting with senior colleagues from Public Health Scotland reinforced something I've believed for a long time - that as a health board, our responsibilities extend far beyond clinical services. We employ over 11,000 people who live in and care deeply about our communities, and we are an anchor organisation with the power to influence social determinants of health through how and where we spend our resources.

The Population Health Framework gives us the mandate to work differently, to think systemically about wellness rather than simply responding to illness. Our Board's approval of recommendations on health inequalities has led us to refresh our organisational strategy, moving beyond "Together We Care" toward something that addresses the conditions in which people are born, live, work, and age.

This isn't just policy implementation for me - it reflects my fundamental belief that true healthcare transformation requires us to be the kind of health service that creates conditions for people to thrive. Working with partners across councils, police, fire and rescue, and community organisations, we're developing an approach where being in good health is as central to our mission as treating illness. The governance and programme plan for our refreshed board-wide strategy is in development, and I'm personally committed to ensuring this framework shapes how we measure success - not just in clinical outcomes, but in the health of population.

Vascular Services - Collaborative Progress Summary
The September meeting with Executive leaders from across East and North Scotland marked a significant step forward in implementing the preferred Target Operating Model for vascular services. Bringing together Chief Executives, Medical Directors, Acute Service Directors and Planning Leads from NHS Boards across Grampian, Tayside, Fife and Lothian, we built the shared understanding essential for moving from planning to delivery. The session reaffirmed our collective commitment to this clinically ambitious model while acknowledging the complex practical realities each Board faces in the current healthcare landscape.

Our discussions focused on translating vision into action, establishing guiding principles that ensure future service design remains patient-centred, clinically sustainable, and aligned with broader system reform priorities. We agreed on three key workstreams moving forward: exploring cross-Board working priorities led by our clinical directors, establishing shared definitions and infrastructure requirements through our planning teams, and maintaining strategic oversight through Chief Executive engagement with the NHS Scotland Executive Group. The transparency and collaborative spirit demonstrated throughout these discussions gives me confidence that we can navigate the inherent complexities of multi-board service redesign.

The establishment of an NHS Scotland-wide System Oversight Group by November represents more than governance structure - it embodies our recognition that delivering high-quality vascular care requires us to think and act as a system rather than individual organisations. While implementation will undoubtedly require joint working, pragmatic problem-solving, and sustained commitment from all parties, I'm encouraged by the shared determination to work through challenges together. This collaborative approach, maintaining focus on our clinical teams' expertise while prioritising patient

outcomes across Scotland, reflects the kind of system leadership that complex healthcare transformation demands.

Urgent and Unscheduled Care Progress
I am pleased to report on the significant progress we are making across our urgent and unscheduled care (UUC) programmes for FY 2025/26. Under our robust governance structures, we have secured £5.7m of Scottish Government funding to drive these critical improvements, with £3.5m contingent on demonstrable delivery evidence.

I want to highlight the momentum we are building across our key service areas. Our emergency care transformation is advancing well - we have successfully established non-admission pathways for multiple conditions, and I am particularly encouraged by the progress of our Same Day Emergency Care (SDEC) service expansion, which is benefiting from strong professional lead collaboration. We are actively recruiting Allied Health Professionals for our ED front-door model, while our teams continue their focused work on pathway redesign targeting those diagnoses with above-average length of stay.

Our system-wide initiatives are showing real promise. The Discharge to Assess planning in East Ross, our Hospital at Home service expansion in Inverness, and the frailty-focused programmes at Raigmore all demonstrate the kind of innovative thinking and delivery I expect from our organisation. However, I must emphasise that recruitment and reablement capacity remain critical dependencies that require our continued attention and investment.

Alongside these service developments, we continue to advance our Flow Navigation Centre (FNC), strengthening its integration with Raigmore ED and the Highland Hub. While we have made solid progress on governance frameworks, pathways, and staffing design, I am mindful that estates, IT infrastructure, and workforce capacity present ongoing risks that we must actively manage.
I acknowledge that our performance data continues to reflect the system-wide pressures we face, particularly around A&E wait times and bed occupancy. However, I am reassured by the stability we are seeing in other key indicators, and I believe our strategic approach is beginning to show results.

Looking ahead, I am particularly excited about the whole system workshop we are hosting on 24 September in Caithness. This will bring together colleagues from across acute, primary, community, and social care to examine key data and develop a truly shared understanding of demand, patient flow, and capacity across our system. The workshop will provide an invaluable opportunity for our teams to share insights, discuss challenges openly, and explore practical improvement opportunities. Using structured discussion and Quality Improvement tools, we will identify priority actions that are locally owned and deliverable. This collaborative approach exemplifies our commitment to strengthening urgent and unscheduled care services in Caithness, ultimately improving outcomes for our patients while better supporting our dedicated staff across the system.

I remain confident in our trajectory and our team's dedication to improving urgent care for the people of Highland.

Fiona Davies, Chief Executive NHS Highland

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**

NHS Highland	NHS Highland na Gàidhealtachd

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name **of Committee**	**Audit Committee**
Date of Meeting	**9 September 2025**
Committee Chair	**Emily Austin**

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

- December Audit Meeting – Advised extended to 3 hours due to length of anticipated agenda.

ASSURE

- Internal Audit Progress Report – Noted Remote Access Review Report scheduled for December 2025 Meeting. Key themes discussed. Otherwise on track.
- Children's Services Transition Arrangements – Work involved acknowledged. Audit rating and 6 improvement actions noted. Progress noted and further discussion to take place on associated action timescales and learning taken.
- NHS Highland Resident Doctor Compliance – Review findings noted. Noted specific area of focus and the large number of recommendations arising. Root Cause Analysis activity referenced. Strong discussion held.
- Management Actions – Reported progress noted. Care at Home actions noted as ongoing. Primary Care actions. Update on Cyber Security actions noted.
- Risk Management Update – Noted as Standing Item. Governance and assurance framework aspects noted as under discussion with Head of Corporate Governance. Executive responsibility noted as passing to Deputy Chief Executive.
- Counter Fraud Update – Substantial assurance taken. Process for investigations outlined for benefit of members. Noted relevant staff training aspects. Submission noted and agreed.
- Information Assurance Group Six Month Update. Substantial assurance taken, noting reporting period as February 2025 to August 2025. Associated risk levels discussed and acknowledged.

ADVISE

- Update on Completion of Adult Social Care Services Review Actions – Noted progress made to date.
- Risk Management Training – Action to remain open.
- Potential for Deviation from SFIs (Payments) – Noted as remaining open, subject to further discussion.
- Counter Fraud Update – No update on NHSH Counter Fraud assessment activity. Discussion noted as ongoing. Will be raised with Counter Fraud colleagues.
- Audit Scotland National Reports – Noted.

- Lochaber Redesign Project – Noted respective bank account to be established as per normal process.

RISKS

- None Noted.

ACTIONS

- Gifts, Hospitality and Sponsorship Policy – Agreed draft Policy for publication. Communications elements highlighted as key consideration.
- Formal Request for Financial Write-Off – Agreed and substantial assurance taken.
- NHS Highland Resident Doctor Compliance – Noted questions raised relating to action timescales and monitoring etc. Agreed further update be provided to December meeting by representative from Acute Services.
- Management Actions – agreed Jill Mitchell be invited to December meeting to update on Primary Care actions if current timescale not met.
- Risk Management Update – Agreed in depth discussion be scheduled for December 2025 meeting, including relevant reporting metrics. Development Session approach suggested.
- Scheduling of Tender Waiver Updates – Agreed be discussed at next agenda planning meeting.

LEARNING

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	**11 July 2025 at 9.30am**

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 Dr Jennifer Davies, Director of Public Health Mike Hayward, Deputy Chief Officer (Acute) (For Katherine Sutton) Richard MacDonald, Director of Estates, Facilities and Capital Planning Gerard O'Brien, Non-Executive Director Dr Boyd Peters, Board Medical Director Steve Walsh, Non-Executive Director
In Attendance	Kate Cochrane, Head of Resilience Sarah Compton-Bishop, NHS Board Chair Arlene Johnstone, Interim Chief Officer (Highland HSCP) Bryan McKellar, Whole System Transformation Manager Brian Mitchell, Committee Administrator Iain Ross, Head of eHealth Elaine Ward, Deputy Director of Finance Nathan Ware, Governance/Corporate Records Manager Dominic Watson, Head of Corporate Governance

1 STANDING ITEMS

1.1 Welcome and Apologies

An Apology for absence was received from Committee member D Park. Apologies were received from non-Committee members K Gillies and Dr N Wright.

1.2 Declarations of Interest

There were no formal Declarations of Interest.

1.3 Minutes of Previous Meetings held on Friday 6 June 2025, Associated Rolling Action Plan and Committee Work Plan 2025/26

The draft Minute of the Meeting held on 6 June 2025 was **Approved.** The Committee further **Noted** the Rolling Action Plan and associated Committee Work Plan for 2025/26.

2 FINANCE

2.1 NHS Highland Financial Position (Month 2) Update and Value and Efficiency Update

E Ward spoke to the circulated report detailing the NHS Highland financial position as at end Month 2 and advising Scottish Government had indicated there would be no brokerage available to NHS Boards in 2025/26, with the NHS Highland Plan forecasting a £40m overspend at financial year end. The report outlined planned versus actual financial performance to date as well as the underlying data relating to Summary Funding and Expenditure. Key Risks and Mitigations were outlined, noting recurring sustainability funding pressures to date. Updates were also provided on overall funding receipt, Highland Health and Social Care Partnership; Adult Social Care; Acute Services; Support Services; Argyll and Bute; wider overall 2025/26 Financial Plan position; Cost Reduction and Improvement Activity, and associated targets; Value and Efficiency aspects; Supplementary Staffing; Subjective Analysis and Capital spend position. The report proposed the Committee take **Limited** assurance.

The following was discussed:

- Supplementary Staffing. Questioned impact of national activity in terms of reducing demand and pay rates and increasing applications for substantive posts. Advised pay rates were nationally set and unaffected, with continued challenges in terms of attracting agency staff. A number of agency staff had been engaged.
- Assessment of In-Year Position and Pressures. Advised further consideration being given as to presentation of relevant data, recognising certain contributory elements could only be included and fully factored in at financial year end despite mature monitoring and tracking arrangements. Provision of further clear guidance on targets for managers in relation to savings activity and wider financial performance was under discussion. In year pressures were assessed and considered in line with usual financial monitoring processes.
- Adult Social Care. Assurance sought in relation to current pressures, development of a management action plan and associated actions. Advised revised Risk for current financial year would be considered later on the agenda. Relevant issues and anticipated mitigations were being actively considered in association with Highland Council, with further discussions ongoing on a range of associated matters.
- Care Home/Care at Home/Independent Sector. Advised associated risk elements recognised within overall NHS Highland financial risk assessment. Further recognised within relevant Partnership Risk Registers.
- Additional Funding for National Priorities. Advised many associated funding allocations based on performance delivery. Trajectories had yet to be agreed for some activity.

After discussion, the Committee:

- **Examined** and **Considered** the content of the circulated report.
- **Agreed** to examine and provide data in relation to recent engagement of agency staff.
- **Agreed** to take **Limited** assurance.

2.2 NHS Highland 2025-28 Financial Plan Addendum Letter

H Cooper spoke to the circulated letter from the Director of Health and Social Care Finance, outlining the response to submission of the revised NHSH Financial Plan for 2025-26 and acceptance of the Plan as submitted.

After discussion, the Committee Noted the content of the circulated letter.

3 CAPITAL ASSET MANAGEMENT PLAN UPDATE

R MacDonald spoke to the circulated report**,** providing an update to the Committee on the NHS Highland Capital position at Month 2. It was advised, as at Month 2, 50% of the capital budget had been released to budget holders to enable capital projects to progress. As in 2024/25 progress was being monitored through monthly monitoring reports, monthly one to one meetings with budget holders and through the Capital Asset Management Group (CAMG). As at Month 2, the year to date spend had been £0.666m. Full detail of projects and associated expenditure were also detailed. It had been confirmed additional Capital funds would be received through the National Infrastructure Board for medical equipment replacement and through the Business Continuity Plan for estate projects. In relation to Medical Equipment Purchasing, several orders had been placed but spend would not be realised in the ledger until the goods were delivered in the latter part of the calendar year. In relation to the planned projects with Estates and eHealth, little spend has been incurred due to most schemes remaining in the design stage, although it was expected spend would increase from Month 4. In regard to IFRS 16, in Month 2, a lease for office space had been approved for use by Medical Education and the Fleet Approval Board had advised the lease of one new vehicle had been approved. The report proposed the Committee take **Moderate** assurance.

The following was discussed:

- Longer Term Capital Allocation Discussions. Advised as to positive movement in relation to release of additional capital allocations in year, based on a two-year cycle. Longer term investment was under discussion at national level.
- Lochaber Service Redesign Activity. Confirmed relevant Capital funding was not part of the wider NHSH formula allocation for 2025/26 and was subject to a separate allocation.
- Funding for Backlog Maintenance. Advised as to specific projects within the current plan, outlining the overall funding position for 2025/26. Further advised as to current progress.

After further detailed discussion, the Committee:

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

4 DIGITAL HEALTH AND CARE UPDATE

I Ross spoke to the circulated report proving an update on progress with the NHS Highland Digital Delivery Plan for 2025/26, overseen by the Digital Health and Care Group. Specific updates were provided in relation to system support and resilience; digital records programme; Primary Care activity; Community Care activity; Social Care activity; hospital care; and a range of associated core supporting projects including data network upgrades, Lorn & Isles Hospital laboratory system, replacement of the Radiology system in North Highland, upgrade to SWAN2, replacement of PACS and introduction of MedsIDL. Progress updates were also outlined in relation to a number of other digital projects. An update on the associated capital funding position for 2025/26 was provided. The report proposed the Committee take **Substantial** assurance.

There was discussion of the following:

- Social Care Activity and Pilots. Advised these were progressed in association with Highland Council. Discussion was underway on a digital strategy for Adult Social Care.
- Financial Benefits Realisation. Advised discussion was ongoing in relation to this aspect with finance colleagues. This included aspects such as change management and associated benefits realisation, and relevant transformational change in the workplace components. An update on development of benefits realisation assessment methodology matters was provided.

- GP IT Contract Provisioning. Advised contract was subject to financial remodelling considerations at national level. NHS Boards to bear the share of any additional costs. The financial impact of national discussions on local NHS Boards was recognised.
- Digital Front Door. Advised much work to be taken forward in this area. The potential impact on the wider digital programme required to be assessed.

After further detailed discussion, the Committee:

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

5 BUSINESS CONTINUITY/RESILIENCE UPDATE

K Cochrane spoke to the circulated report providing an update on NHS Highland's resilience activities over the previous year. The report provided assurance that NHS Highland continued to meet its duties as a Category 1 responder under the Civil Contingencies Act 2004; that resilience arrangements were being developed, tested and used across the organisation to support service continuity and emergency response; that recent incidents and exercises had informed system development and staff preparedness; and that internal governance processes were ongoing for key documents, including the Board's Major Incident Response approach. it was advised a separate report would be brought forward once the Major Incident Response documentation had been considered by the Executive Directors' Group. Specific updates were provided in relation to key developments and activity relating to live incident response; training and exercising activity; and Statutory and Strategic Engagement. The report proposed the Committee take **Substantial** assurance.

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

6 RISK REGISTER – LEVEL 1 RISKS

6.1 NHS Highland Board Risk Register

H Cooper spoke to the circulated report providing the Committee with an overview extract from the NHS Highland Board Risk Register; awareness of risks being considered for closure and/or additional risks to be added. The report covered NHS Board Risks that were reported through this Committee, and Staff Governance Committee for governance and oversight. It was recommended that Risks 1254, 1255 and 1279 be closed. It was further advised the Risk relating to the ADP for 2025/26 was to be updated, the Risk relating to New Craigs would be closed in the coming month and the Risk relating to Strategic Transformation would be revisited. The report proposed the Committee take **Substantial** assurance.

The Committee:

- **Noted** the report content.
- **Agreed** to the closure of Risks 1254, 1255 and 1279.
- **Agreed** to take **Substantial** assurance.

6.2 Finance Risks 2025/26

H Cooper spoke to the circulated report, advising that as part of the budget setting process for NHS Highland a financial risk had been highlighted and a significant proportion of this risk related to Adult Social Care delegated services. The overall risks for 2025/26 had been

refreshed and provided for agreement. The report proposed the Committee take **Substantial** assurance.

After detailed associated discussion, the Committee:

- **Noted** the circulated report content.
- **Agreed** the financial risks as detailed.

7 2025/26 and 2026/27 Meeting Schedules

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

1 August 2025	13 November 2026
12 September 2025	4 December 2026
3 October 2025	8 January 2027
14 November 2025	5 February 2027
5 December 2025	12 March 2027
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	

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

8 ANY OTHER COMPETENT BUSINESS

Members were advised an update on the Operational Improvement Plan would be brought to the next meeting.

9 DATE OF NEXT MEETING

The next meeting of this committee was to be held on Friday 1 August 2025.

The meeting closed at 11.00am

NHS Highland	NHS Highland na Gàidhealtachd

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name **of Committee**	**Finance, Resources and Performance Committee**
Date of Meeting	**12 September 2025**
Committee Chair	**Alex Anderson**

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

None.

ASSURE

- **Draft NHS Highland Financial Position 2025/26 (M4) Update and Value and Efficiency Update** – Limited. Discussed elements relating to non-pay aspects, ASC funding discussion approach, and Value and Efficiency activity oversight. Noted Q! response letter from Scottish Government.
- **15 Box Grid Update (Q1)** – Moderate. Discussion held on level of detail required for self-assessment activity.
- **Integrated Performance Quality Report and Work Plan Update** – Limited assurance taken after detailed discussion on performance and future role of Population Health and Planning Committee.
- **Operational Improvement Plan Update** – Substantial. Noted ongoing discussions on future reporting framework requirements.
- **Planned Care Update and Spotlight** – Presentation received and Moderate assurance taken after discussion of number of internal and national aspects.
- **Capital Asset Management Plan Update** – Moderate.

ADVISE

- **Risk Register (Refresh of Level 1 Risks) Update -** advised Executive leadership to move to Deputy Chief Executive. Reporting requirements being reviewed.

RISKS

None highlighted.

ACTIONS

- **Draft NHS Highland Financial Position 2025/26 (M4) Update and Value and Efficiency Update** - Agreed future reports include improved data relating to achievement of Value and Efficiency activity and associated financial impact. Agreed to share additional detail also provided.

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	**1st July 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
Philip MacRae, Non-Executive, (Chair)
Gerry O'Brien, Board Vice Chair
Janice Preston, Non-Executive Director
Steve Walsh, Non- Executive (Vice Chair)

In Attendance:

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
Fiona Davies, Chief Executive
Arlene Johnstone, Interim Chief Officer, Highland Health and Social Care Partnership
David Park, Deputy Chief Executive (until 10.58am)
Richard Macdonald, Director of Estates, Facilities and Capital Planning
Katherine Sutton, Chief Officer, Acute
Dominic Watson, Head of Corporate Governance
Gayle MacRae, Equality, Diversity and Inclusion Lead, Item 4.2
Bob Summers, Head of Occupational Health & Safety, Item 5.4 & Item 5.5
Derek McIlroy, Guardian Service, Item 5.8
Julie McAndrew, Guardian Service, Item 5.8

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and thanked S Walsh for chairing the previous meeting. Apologies were received from N Wright.

1.2 Declarations of Interest

There were no declarations of interest.

2 ASSURANCE REPORTS & COMMITTEE ADMINISTRATION

2.1 MINUTES OF MEETING HELD ON 6th MAY 2025

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

2.2 ACTION PLAN

Action 136 – Staff Governance Monitoring – This item is on the agenda, action now closed.

2.3 COMMITTEE WORKPLAN 2025-2026

The Chair confirmed he would discuss outstanding actions in the next agenda planning meeting.

Action: Update on progress against the Statutory Mandatory Training plan to be provided at forthcoming agenda setting meeting.

Committee Members noted the workplan

3. MATTERS ARISING NOT ON THE AGENDA

3. Staff Governance Monitoring Group Update
1 Update from Gaye Boyd, Deputy Director of People

The paper had been to the Area Partnership Forum where it had been agreed that a Staff Governance Standards Monitoring Group would be set up, this group would continually review NHS Highland's work in relation to meeting the Staff Governance Standards.

A workplan would be created and this group would report to the Area Partnership Forum and Staff Governance Committee. It was noted that as staff side had not had an opportunity to collectively review the paper they would provide nominations for the new group in due course.

The Committee **noted** the report and took **substantial** assurance.

Spotlight Session

4.

Finance

4. Heledd Cooper, Director of Finance
1

The Director of Finance spoke to the presentation wherein it was highlighted:

- Teams that were originally part of the People and Culture directorate had now moved to Finance which included the Payroll team, Safe Haven team, Travel team, E-Health Procurement and Community Equipment Stores
- Within the workforce profile it was noted that 38% of staff were over 55 years old with 13% of staff over 60 years old, 73% of the workforce were female, this had increased due to the integration of the added teams, 17.5% of staff worked part-time. The skill-mix of the workforce had changed with an increase of band 4, band 5 and band 6 job roles, there were now fewer band 2 and band 3 roles within the workforce.
- Work was ongoing to update the equality and diversity data held for the team in order that further support could be provided if required.
- Sickness absence was below average with it being noted that the main categories of sickness for May 2025 had been anxiety/depression and chest & respiratory problems. 23% of sickness was due to long term absence.
- Completion of statutory and mandatory training sat at 95% with new team members being given the time and space to complete necessary training and appraisal rate completion sat at 94%
- I-Matter results showed that the overall Employee Engagement Index (EEI) had remained static at 77. The number of recipients had increased from 150 to 189. Respondents had decreased from 89% to 74%. The highest scores related to direct line management and

support and being clear about roles and responsibilities. It was noted that the key themes would be identified to reset the improvement plan going forward.

- Organisational Development focus was on improving finance/procurement sites with a finance and procurement training programme to be rolled out for 2025/26. It was noted work was underway to promote work experience placements and other opportunities in NHS Highland. Career pathways had been drafted for two teams, namely procurement and transport; which were based on NHS Lothians model. There had initially been three placements through Highland Council, which resulted in two individuals securing permanent roles. At the time of reporting, two placements were ongoing, selected from a pool of 120 applicants. The Modern Apprenticeship programme had also delivered two placements in procurement and one in finance.
- The Financial Management team had a newsletter called “Make that Change”, a Teams channel had also been established, and this would be rolled out across the whole department. The first newsletter had been viewed by 40 staff from an audience of 80. There had been 39 ideas submitted with ten being taken forward after consideration.
- It was noted that by May 2025, the procurement team had reduced its average daily backlog of requisitions from 550 in May 2023 to just 56. In May 2024, the backlog had already dropped to 104. The team had consistently processed over 100% of incoming requisitions, and the remaining backlog in 2025 consisted mainly of complex cases requiring input from multiple stakeholders.

Committee Members commended the Director of Finance for the improved completion rates of statutory and mandatory training, as well as appraisals. The Whistleblowing Champion had also praised the presentation and asked how the Whistleblowing service had been promoted within the team. The Director of Finance had explained that transparency had been key to integrating new teams and that she held well-attended quarterly team meetings, where the Guardian Service had presented.

Information about the service had been regularly shared, supported by strong internal communication. The Director of People and Culture had also commended the Director of Finance for successfully integrating the new teams into her directorate.

Committee Members asked whether sharing case studies from staff who had completed appraisals could help ease anxiety for those unfamiliar with the process. The Director of Finance agreed and explained that merging teams with similar responsibilities into one directorate had improved service planning and delivery, with positive staff feedback. She confirmed that case studies could be developed to support staff.

In response to a query about sickness absence related to back pain, the Director of Finance noted that many staff were desk-based and that some had accumulated overtime and annual leave prior to integration. To improve work-life balance, overtime had been stopped and staff were encouraged to take leave, which was expected to reduce absence rates. The Director of People and Culture added that musculoskeletal and mental health issues were the leading causes of sickness absence across all Boards.

4.2 Health and Wellbeing Update

Gaye MacRae, Equality, Diversity and Inclusion Lead

The Equality, Diversity and Inclusion (EDI) Lead spoke to her presentation wherein it was highlighted:

- The Health and Wellbeing Oversight Group had been set up in 2023 and was now chaired by G MacRae. The group met every six weeks and was attended by staff side colleagues, managers and professional leads.
- The group reported both to the Area Partnership Forum and the Staff Governance Committee and was noted the Health and Wellbeing Strategy was published in 2025 with a review planned by 2027.
- Themes identified covered Wellbeing, Leadership and Equality. The strategy aligned with Annual Delivery Plan, the Together We Care Strategy, the Anchor Plan and national

drivers. It was noted the Oversight Group would oversee the action plans for each workstream.

- Some of the work underway or completed included: The launch of new Employee Assistance Programme, Leadership and Management Conference, Wellbeing Roadshow, Updated website, Staff Benefits, Men's Health Week, Stress at Work Project Group and the launch of the Staff Networks programme.
- The Employee Assistance Programme was provided by Health Assured and had been launched in February 2025. Proactive engagement sessions had been held across NHS Highland teams with a mix of online and face to face sessions. 89 colleagues had joined the session on the day of the Leadership Management Conference.
- 115 colleagues had contacted the service since launch with 532 people registered with the Wisdom app. The main counselling call themes were anxiety and addiction, and the Health and Wellbeing Oversight Group would be looking further into these themes.
- The Wellbeing Roadshow had been ongoing since the 12 June and feedback was very positive with approximately 130 colleagues having attended. Plans to have a second phase with different locations were ongoing.
- The Leadership and Management Conference had taken place with the theme of building a culture of care, compassion, wellbeing and inclusivity. Recordings from the conference had since been uploaded to YouTube enabling further engagement. Feedback forms had been sent to attendees.
- Occupational Health support staff had launched a new Workforce Psychology Service which was available in person or using Near Me. Work was ongoing in respect of developing training for managers in the support that Occupation Health could offer.

The Whistleblowing Champion queried the next steps to be taken after the Leadership and Management Conference. The Director of People and Culture explained that this would be covered in more detail later in the agenda.

Committee Members sought clarity around the support provided to staff who were an unpaid carer. The EDI Lead explained that an Unpaid Carers Staff Network had been launched in May and had been very successful. A toolkit had been created for managers and was available on the Intranet. The Director of People and Culture highlighted the need for awareness of the many policies that NHS Highland had in relation to support that was available to staff.

Committee Members asked about Occupational Health's capacity to support staff as awareness sessions increased and also queried the inclusion of addiction in sickness absence data. The Director of People and Culture clarified that addiction was not recorded as a formal absence reason, but anonymous data from the Employee Assistance Programme provided insight into support needs, reflecting wider societal trends. The EDI Lead confirmed that increased Occupational Health referrals had been factored into ongoing planning.

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 provided an update and explained the Leadership and Management Conference had been a huge success and was currently being evaluated, the development programme was progressing well. The Health and Wellbeing update had been well received at the last Area Partnership Forum where it had prompted good conversation; and had been well received by partnership colleagues.

During discussion the following points were raised:

- Committee Members had raised concerns about the leadership conference and the optional nature of training for managers, questioning how assurance could be provided when attendance was not mandatory. They also queried how insights from exit interviews

could be accessed to support learning. Regarding whistleblowing, members noted that during the Whistleblowing Champions recent visit to Argyll and Bute, staff had been reluctant to engage due to the location chosen for discussions. It was suggested that offering an online meeting in advance could have allowed staff to raise concerns more comfortably ahead of the visit.

- The Director of People and Culture explained that leadership programmes were being refreshed with positive engagement, and that where management capability issues were identified, supportive improvement plans were put in place. He emphasised the importance of developmental support in areas where concerns had been raised.
- The Director of Finance acknowledged the concern about optional training but noted that part of her role was to ensure lower-level managers had the resources and knowledge to perform effectively. Training uptake was monitored, and action was taken where performance gaps were identified. She added that responsibility for developing managers also rested with senior leaders, not solely with the Director of People and Culture.
- The Whistleblowing Champion had queried how information about training modules was being shared across the organisation, noting that uptake appeared low. The Director of People and Culture had committed to investigating further and reporting back to the committee. He also emphasised the importance of not only promoting the training but ensuring staff had time to participate.

Action: Director of People and Culture to investigate the circulation of information regarding the leadership training modules to managers.

The Committee **noted** the report and took **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 report wherein it was highlighted:

- The positive movement within the report such as absences which had reduced from previous years.
- Vacancy Time To Fill had continued to reduce in the number of days taken to complete.
- The recorded absence reasons figures had started to increase once more with work being done to reduce these figures. It was noted that this could be related to absences that were reported but not to the direct line manager.
- The e-learning training metrics had been split as it had been noted that bank staff numbers had been included in the completion rates. As a result, the figure sat at 78.1% which showed a higher number of completions for substantive staff. A different mechanism was now in place to monitor the bank staff completion rate of training.
- A Short Life Working Group (SLWG) would look at how to improve the completion of appraisals and would report back in August.

The Chair asked whether appraisal processes applied to bank staff and if data was available. The Director of People and Culture confirmed that bank staff were included, noting two types: those solely on the bank and those with substantive contracts with the challenge being the ability to track the data sufficiently for staff solely on the bank.

Committee members queried the reported turnover figures, seeking further context. The Director of People and Culture agreed that “target” was not the right term, as turnover figures were for monitoring purposes only.

Committee members also asked about tracking internal staff movement. The Director of People and Culture agreed to compile a glossary and work with the Deputy Director of People to support clearer reporting.

Action: Director of People and Culture/Deputy Director of People to compile glossary.

The Committee **noted** the report and took **moderate** assurance.

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

The Director of People and Culture asked committee if the frequency of the report was appropriate suggesting a less frequent reporting cycle to committee. The Chair queried the reworking of the Level 2 risks and the governance arrangements in place around this work. Citing the three risks that had been updated and the risk level associated he queried whether a reassessment of the work done in relation to these would be appropriate.

Committee Members agreed they would not be comfortable with less frequent risk reporting citing the importance of being aware of the progression of the risks. The Director of People and Culture highlighted that the high-level risks within the report were Board level risks and as such would require to be discussed at Board moving forward. In relation to the reassessment of risks it was noted that the new Head of Corporate Governance had started in post and risk management would be refreshed going forward.

The Director of People and Culture added that a workshop within the People and Culture Directorate had been held on operational risks. The workshop had covered several areas including health and safety, and he assured the committee that a process of review was underway.

The Committee **noted** the report and took **moderate** assurance.

5.4 Health & Safety Annual Report
Report by Gareth Adkins, Director of People and Culture

The Director of People and Culture thanked the Head of Health & Safety and his team for the work done within the report, with it being highlighted:

- There had been a lot of positive improvement work done in relation to the different operational areas and their reporting.
- There had been good progress in the governance of the subgroup that had been established in the different areas.
- Workshops had been held this year focusing on different areas and a very positive workshop had been held in relation to lone working covering what had worked well and what required improvement.
- A three-year strategy was being developed in partnership with the various groups which would bring more clarity to the organisation in relation to the areas where improvement was required.
- There would be a focus on compliance with risk management which was one of the key elements going forward.

During discussion the following points were raised:

- Committee Members queried the health and safety requirements for staff working from home, specifically in relation to the Display Screen Equipment Project Charter and how compliance would be monitored. The Head of Health & Safety explained that national policies addressed both the physical and mental health aspects of home working. It was noted that policies for both office and home working were being reviewed and updated, as the current legislation was outdated. Work-related stress was also under review in collaboration with Health and Wellbeing to avoid duplication of efforts.
- Committee Members asked whether there were measures in place to ensure staff could raise concerns and feel heard. The Head of Health & Safety responded that a Health &

Safety Leadership course, delivered twice a year, included leadership and civility training. Feedback from the certificated course had been very positive, and it was hoped this would support the softer aspects of health and safety. It was also noted that staff had several avenues to raise concerns, including the Guardian Service.

- The Director of People and Culture highlighted the importance of understanding how health and safety data was used to inform improvement plans. They emphasised that strong health and safety practices were needed at local levels, not just operationally, and that risk assessment was a key part of this, requiring the involvement of all staff.
- Committee Members raised concerns about the consistency and reach of learning across the organisation, citing lone working and risk assessments as areas where many staff were still unaware of their responsibilities.
- The Director of People and Culture assured committee that the data being collected was robust, referencing the annual report reviewed by the committee. In response to the example of risk assessments, they acknowledged the need for consistency across the organisation and noted that significant work was ongoing through workshops, a short life working group (SLWG), and staff side involvement to provide assurance to the committee.

The Committee **noted** the report.

5.5 Health & Safety Strategy and Plans
Report by Gareth Adkins, Director of People and Culture

This was discussed under item 5.4

The Committee **noted** the report and took **moderate** assurance.

5.6 Whistleblowing Q4 Report
Report by Gareth Adkins, Director of People and Culture

The Director of People and Culture spoke to the circulated report which covered the period up until April 2025. It was noted that one concern had been received, one case remained open and one existing case was planned for closure. It was highlighted that the concern previously raised had been reviewed and was no longer classified as a whistleblowing matter. This would instead be progressed through standard workforce policy procedures. The associated action plans, as referenced in the appendix, had been reviewed and remained active.

The Whistleblowing Champion queried what could be taken from the low numbers of whistleblowing cases given the avenues staff could raise concerns.

The Director of People and Culture advised the cases raised had been complex and had involved larger concerns. He noted there were some cases where the issues raised were concerns the Board had been aware of and active engagement was ongoing between management teams however frustration in the process had led to a case being raised.

Committee Members highlighted the number of staff looking for a higher level of manager visibility could be an area of dissatisfaction raised subsequently impacting staff appraisal figures given it was currently 23%. The Director of People and Culture confirmed this was a small sample of data but acknowledged the point raised and assured committee that work was ongoing to address this.

The Committee **noted** the report and took **moderate** assurance.

Whistleblowing Annual Report
Report by Gareth Adkins, Director of People and Culture

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

- It was challenging to generalise the learning from the cases as the numbers were low and each case was very different however the themes identified were being addressed through the appropriate strategic programmes.
- There remained a challenge around providing sustainable services through the Health and Care Staffing Act due to workforce availability, but this was faced by all Boards. These resourcing challenges also impacted the proposed Quality Framework.
- Quality of service and developing a Quality Framework was also a challenge due to staff availability and ability to deliver the services.

The Chair queried the bureaucracy of the process of whistleblowing and whether the experience of the whistleblowing process by those who had gone through it was captured by the organisation.

Committee Members highlighted staff frustrations with the whistleblowing process, noting delays in action and limited feedback. It was suggested analysing the past four years of data to better understand the system's effectiveness. The Whistleblowing Champion suggested the need for an ongoing review give persistently low reporting numbers.

The Director of People and Culture assured the committee that the Independent National Whistleblowing Officer (INWO) provided a route for staff to escalate concerns if dissatisfied with outcomes.

The Chief Executive acknowledged challenges in understanding why some staff chose not to use the service and proposed benchmarking data against other Scottish Boards, particularly those of similar size.

Committee Members cited a 2023 case where staff felt whistleblowing recommendations had not been implemented, with feedback indicating the situation had deteriorated. They questioned the effectiveness of the process. The Director of People and Culture disagreed, stating that work was underway and progress had been made. He supported benchmarking and offered to share reports via the Whistleblowing Practitioners Forum.

The Chair requested that the Director return to the committee with a plan to provide further reassurance, potentially including benchmarking data.

Action: The Director of People and Culture to provide a further plan of assurance to committee such as benchmarking data against other Boards.

The Committee **noted** the report and took **substantial** assurance.

5.7 **Guardian Annual Report**
Report by Gaye Boyd, Deputy Director of People

J McAndrew spoke to her presentation wherein it was highlighted:

- The Guardian Service had been in operation within NHS Highland for five years and in that time almost 1000 concerns had been received. The numbers had been consistent over the past five years with approximately 200 concerns per year reported.
- There were no significant changes in the themes of the concerns raised with the highest numbers reported under Behaviour and Relationship and System and Processing Management issues. The number of concerns relating to Bullying and Harassment were the same as the previous year and sat at 30.
- There had been a slight decrease in concerns raised relating to management issues in the past year.
- The main theme identified was Behaviour and Relationship concerns at 27% of calls which were mainly around how staff interacted with one another, inappropriate behaviours and breakdown of working relationships which also could have affected patient safety and had been identified as a common thread throughout the theme.

- Patient safety concerns were slightly higher than last year; however NHS Highland patient safety concerns were lower than the national average.
- There was a 14% decrease in escalated cases with approximately 65% of cases still known within the organisation. Of the cases that were escalated 97% of cases were responded to within one day. The style of feedback from managers varied considerably, some managers responded positively thanking the member of staff for raising the concern whilst other managers acknowledged the concern but were reluctant to address the concern and slow to respond to the request for feedback.
- Community was the directorate with the highest number of concerns raised with almost a third of all concerns raised from within this directorate. Staff were reluctant to escalate concerns with their names perhaps due to staff working in smaller areas and in smaller teams.
- There was more work to be done in relation to tackling incivility and poor behaviours with pockets of teams where instability and poor behaviour was having a huge effect on staff. There was a mixed understanding from managers in relation to reasonable adjustments under the Equality Act with many concerns raised around poor comprehension of reasonable adjustment both during the recruitment process and those already employed by the organisation.

The Chief Officer A & B HSCP queried the variation in relation to the application of reasonable adjustments citing that organisational support was available through Occupational Health to identify what adjustments would be required. It was not the ask of the organisation to have managers make judgments in relation to this. J McAndrew explained that in many cases the advice from Occupational Health was ignored, in other cases staff were not being referred to Occupational Health and were unaware of the support available to them.

Committee Members queried whether staff who were raising concerns had a perceived detriment to themselves or whether it was lived experience. D McIlroy explained that when staff wished to raise a concern the reaction of the manager was incredibly important so many staff may be put off raising concerns due to previous experience, highlighting the amount of worry within staff in voicing their concerns.

Committee Members explained that many managers who had been given advice by Occupation Health regarding reasonable adjustment took the view that as these were recommendations they were not committed to implement them. She went on to explain that as these adjustments fell under the Equality Act, failure to implement them would raise a case of discrimination against the manager.

The Director of People and Culture explained that there was a national policy soon to be released in relation to reasonable adjustments but additional work was required to ensure balanced conversations took place between management and staff. It was suggested putting in a Standard Operating Procedure (SOP) to support managers as it could become complex depending on what level of support staff required under the Equality Act.

The Committee **noted** the report and took **substantial** assurance.

5.8 **Workforce Monitoring Report 2025**
Report by Gaye Boyd, Deputy Director of People

The Deputy Director of People spoke to the report wherein it was highlighted that there were seven projects under the Equality, Diversity and Inclusion (EDI) Oversight Group, these groups had been identified through the EDI strategy. There was a workstream in place to identify the reasons staff did not complete EDI questionnaires and a campaign was due to be rolled out to increasing the understanding of this going forward.

The Committee **noted** the report and took **substantial** assurance.

Health & Care Staffing Act Q4 Report

Report by Gareth Adkins, Director of People and Culture

The Director of People and Culture confirmed the report was for information prior to being submitted to Board as it had been reviewed at the previous committee meeting.

The Committee **noted** the report and took **moderate** assurance.

6. Items for information and noting

6.1 Area Partnership Forum update of meeting held on 13 June 2025

The Committee **noted** the Area Partnership Forum update would be presented at the next meeting.

Health and Safety Committee Minutes of meeting held on 3 June 2025

6.2

The Committee **noted** the Health and Safety Committee Minutes of meeting held on 3 June 2025.

Any other Competent Business

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

7.1 The Chair would highlight to the board:

- the Staff Governance Monitoring Update
- the methodology being used to refresh the Strategic Risk Review
- the improvements in relation to the Statutory and Mandatory training.
- The positive impact on the Finance Directorate or the recent organisational change process.

8. Date & Time of Next Meeting

The next meeting is scheduled for Tuesday 2nd September 2025 at 10 am via Microsoft Teams.

9. Future Meeting Schedule

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

4 November 2025
13 January 2026
3 March 2026

Close of Meeting 1.05pm

NHS Highland	NHS Highland na Gàidhealtachd

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name **of Committee**	**Staff Governance Committee**
Date of Meeting	**02 09 2025**
Committee Chair	**Philip MacRae**

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

The Chair would highlight to the board:

- The People and Culture Portfolio Board Update, including strategic workforce developments.
- Continued progress on Statutory and Mandatory Training compliance.
- The Strategic Risk Review, with moderate assurance taken on refreshed risk registers.
- Whistleblowing Q1 Report, noting challenges with timescales due to case complexity.

ASSURE

Assurances taken on:

- People and Culture Portfolio Board Update
- Statutory and Mandatory Training Update
- Integrated Performance and Quality Report
- Communications & Engagement 6-monthly Update
- Strategic Risk Review
- Whistleblowing Q1 Report

ADVISE

The Committee advised on the importance of feedback regarding the draft Social Media Policy and Checklist presented during the Communications & Engagement update.

RISKS

The Committee reviewed strategic risks and took moderate assurance from the refresh of People and Culture risk registers and the ongoing work to finalise level 2 risks. The complexity of whistleblowing cases was noted as a challenge to timely resolution.

ACTIONS

- Provide feedback on the draft Social Media Policy and Checklist.
- Continue monitoring progress on Statutory and Mandatory Training compliance
- Maintain oversight of whistleblowing investigations and associated actions.

LEARNING

The Spotlight Session featured updates from Argyll & Bute HSCP and the Leadership Development Programme. These sessions highlighted local service developments and strategic workforce planning, including leadership initiatives and organisational development priorities.

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 2 July 2025 with attendance as noted below.
- **Note** the Assurance Report and agreed actions resulting from the review of the specific topics detailed below.

Present:
Thomas Brown, Lead Doctor (GP)
Louise Bussell, Nursing Director
Cllr Muriel Cockburn, Non-Executive
Claire Copeland, Deputy Medical Director
Jennifer Davies, Director of Public Health
Fiona Duncan, Chief Social Work Officer, Highland Council
David Fraser, Highland Council
Arlene Johnstone, Interim Chief Officer for Highland HSCP
Fiona Malcolm, Highland Council Executive Chief Officer for Health & Social Care
Philip MacRae, Non-Executive
Joanne McCoy, Non-Executive
Kaye Oliver, Staffside Representative
Gerry O'Brien, Committee Chair, Non-Executive
Simon Steer, Director of Adult Social Care
Elaine Ward, Deputy Director of Finance (until 3.00pm)
Neil Wright, Non-Executive
Mhairi Wylie, Third Sector Representative (until 2.38pm)

In Attendance:
Natalie Booth, Board Governance Assistant
Rhiannon Boydell, Head of Integration, Strategy and Transformation, HHSCP
Jennifer Davies, Deputy Director of Public Health (from 2.30pm)
Kristin Gillies, Interim Head of Strategy and Transformation (Until 2.30pm)
Andy Grant, Social Worker
Nathan Ware, Governance & Corporate Records Manager
Dominic Watson, Head of Corporate Governance

Apologies: Cllr Christopher Burt and Sarah Compton-Bishop

1.1 Welcome

The meeting opened at 1pm, and the Chair welcomed the attendees. He welcomed A Johnstone in her current role as Interim Chief Officer and expressed congratulations to her for being appointed as the new Chief Officer when P Stott retires at the end of September 2025.

The meeting was quorate.

1.2 Declarations of Interest

There were no declarations of interest.

1.3 Assurance Report from 7 May 2025, Action Plan and Workplan

The draft minute from the meeting of the Committee held on 7 May 2025 was **approved** by the Committee as an accurate record.

The Interim Chief Officer provided a brief update on each item mentioned on the Action Plan:

- Action 7 – Draft Commissioning Strategy. This action was in progress. The Interim Chief Officer had been reviewing operational delivery, and an update was expected at the January meeting. Item will be added to January 2026 agenda and this action closed.
- Action 8 – Strategic Report on National Insurance Contributions. This action was closed. No additional funding had been received from the Scottish Government, and it was agreed that updates would be provided if new information arose.
- Action 9 – Report on Use of Personal Assistants. This action was closed. It had been addressed in previous papers, and it was agreed that future updates on the expansion of Option 2 services would be included within commissioning and neighbourhood care development work.
- Action 10 – Carer's Strategy. This action was in progress. It had been scheduled for the September meeting, where an update with the action plan and timetable would be provided. Item will be added to the September 2025 agenda and this action will be closed.
- Action 11 – Care Governance Update. This action was in progress and an update would be provided at the March 2026 meeting. Item will be added to the March 2026 agenda and this action will be closed.
- Action 15 – On Agenda for the meeting and could be closed.

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 Annual Delivery Plan 2025/26 Update

Report by Elaine Ward, Deputy Director of Finance and Kristin Gillies, Interim Head of Strategy and Transformation

The Interim Head of Strategy and Transformation provided a presentation to the committee and highlighted the submission of the Annual Delivery Plan (ADP) was in line with national guidance. Key areas of focus had included Care Well, Home First and Last, and Adult Social Care, with deliverables and KPIs set for 2025–26 and 2027–28. Updates were being developed for future performance reviews and IPQR submissions. Additional highlights included work on Primary Care, Urgent and Scheduled Care, and digital transformation, with recent funding supporting virtual care initiatives. She emphasised the need to align various workstreams and systems to maximise efficiency and productivity.

During discussion the following points were raised:

- Members noted that bids for additional funding had been submitted and Hospital at Home was due to begin in December, they questioned whether progress was on track to meet the planned deadlines. The Chief Officer noted that a further update could be provided at the September meeting.
- The Interim Head of Strategy and Transformation noted that a late government request for an improvement plan covering planned and unscheduled care could not be included in the ADP, but the team intended to update deliverables following confirmed funding for hospital at home, frailty, and virtual beds.
- The Deputy Medical Director advised the Hospital at Home progress had depended partly on confirmation of funding, which had recently been received. The model was being developed with a stronger focus on primary and community care which was considered more appropriate for Highland.
- It was noted that the funding was non-recurrent for the Hospital at Home programme which was contingent on delivery. The ADP would be updated accordingly, with further discussions needed to finalise plans across Highland and Argyll and Bute.

The Committee:
- **NOTED** the NHS Highland financial plan for 2025/2026, and
- **ACCEPTED substantial** assurance.

2.2 Finance Report – Month 12 2024/2025 Year End position & 2025/2026 Financial Plan Summary

Report by Elaine Ward, Deputy Director of Finance

The Head of Finance for HHSCP advised they were not going to provide a summary for Month 12 2024/2025 but presented slides to introduce the 2025/2026 Financial Plan Summary. The financial plan submitted to Scottish Government (SG) in March 2025 was not accepted and they indicated that a resubmission was necessary. A revised plan was submitted in June 2025 and accepted by SG detailing a net financial deficit of £40.005 million. The cost reduction and improvement programme retained three percent recurring efficiency assumption, with an additional £10.2 million of recurring actions included. Further detail was provided in relation to Adult Social Care; Value & Efficiency Schemes Proposal; 15 Box Grid; Risks; and Targets.

It was noted that the cost reduction schemes had detailed plans being developed and moved into delivery. A Month-3 report was expected to be presented to the committee to provide a full update on progress against the cost reduction and improvement programme.

During discussion the following points were raised:

- The Chair highlighted funding received in relation to employer National Insurance contributions was for directly employed staff only, with no funding for other staff groups. He noted this as a key financial risk alongside the wider funding gap and the need for operational budgets to break even.
- The Head of Finance for HHSCP advised funding allocation short fall risks were being monitored at both Board and National levels.
- The Chair sought clarity on the approach to delivering the 3% efficiency target and managing in-year budgets, and the Chief Officer confirmed that Heads of Service had been asked to submit delivery plans, which would be collated and overseen through a central framework.
- Members raised concerns about the savings section of the report, noting that the "Time to Care" initiative had been paused due to significant challenges, and there were ongoing uncertainties regarding the Tara project and the effectiveness of the voice recognition software.

The Committee:

– **NOTED** from the report the financial position at month 12 and the associated mitigating actions, and

– **ACCEPTED limited** assurance.

3. PERFORMANCE AND SERVICE DELIVERY

3.1 Highland Health and Social Care Partnership - Integrated Performance and Quality Report (IPQR)

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

The Head of Integration spoke to the circulated report and confirmed that while discussions were still ongoing, progress had been made in refining the data presented. She noted the executive summary indicated a relatively stable position and highlighted delays predominantly sat in delayed discharges, but they were showing signs of improvement. A previously noted peak had reduced significantly, with figures dropping from 198 to as low as 179 in recent weeks. She added that this trend aligned with earlier predictions that the spike would decline over time.

There had been a major update in how adult social care figures were presented which consolidated multiple bar charts into a single, clearer overview. This new format included familiar metrics such as long-stay placements and care-at-home clients now presented more accessibly. Additional data on occupancy, average length of stay, and service hours were now more prominent. It was noted new reporting had been added to show the relationship between delayed discharges and delays linked to care homes and care-at-home services to help improve clarity.

During discussion the following points were raised:

- Members asked for clarification on why some metrics that were not meeting their targets were still rated green. They felt that such metrics should be marked amber or red, even if performance was improving, and suggested that directional arrows might be a more appropriate way to show progress.

- Members asked when the care home commissioning strategy and related elements would be delivered, highlighting that December had previously been mentioned as a target for the strategy and whether the other elements such as the market facilitation plan would align with that timeline.
- The Interim Chief Officer explained that the work was ongoing but complex and added that a Chief Executives meeting had been scheduled to help clarify timelines. She suggested that December would be a more realistic point to provide a fuller update. The Interim Head of Strategy and Transformation added that whilst the strategy might be presented in December, implementation would likely align with the new financial year to ensure the right steps were in place.
- Members observed an increase in Self-Directed Support (SDS) alongside a decline in care at home clients and sought clarity on whether this was due to people choosing SDS or a whether it reflected staffing shortages. The Director of Adult Social Care explained it was difficult to identify and whilst a rise in SDS figures is positive, it was important to ensure underlying unmet need was properly supported in the community.
- Members highlighted they were keen to ensure committee received an update on unmet need once the reporting metric was defined and accurately measured and suggested an update by December.

The Committee:

- **CONSIDERED** the performance identifying any areas requiring further improvement and in turn assurance of progress for future reports.
- **NOTED** the report and **ACCEPTED limited** assurance and noted the continued and sustained stressors facing both NHS and commissioned care services.
- **CONSIDERED** further indicators that are required to support the assurance for the Highland Health and Social Care Partnership.

3.2 Transformation Overview 2025/26

Report by Arlene Johnstone, Interim Chief Officer for Highland HSCP

The Head of Integration, Strategy and Transformation, HHSCP spoke to the circulated report and provided an overview of the transformation programme and outlined how the workstreams had aligned with the Joint Strategic Plan and the Joint Strategic Needs Assessment. She highlighted the governance structure for the Assurance Groups, Strategic Transformation Assurance Group (STAG), Value & Efficiency, Unscheduled Care, and Adult Social Care. It was noted that under each Assurance Group was different workstreams that each had their own working groups taking forward various elements of redesign. She also highlighted how transformation work within the HSCP aligned with the wider health and social care system. An Unscheduled Care Group had been formed to provide oversight and assurance linking to the STAG workstreams and the connection to the Portfolio and broader system-wide initiatives.

During discussion the following points were raised:

- The Chair emphasised the importance of district-level engagement in shaping strategic plans and targets. They highlighted the need for clear feedback mechanisms to avoid key elements being overlooked in a complex system.
- The Head of Integration, Strategy and Transformation, HHSCP advised the District Planning Groups met quarterly in alignment with the Strategic Planning Group. Using standard agendas to shape and prioritise local plans based on relevant workstreams, which were then fed back into the strategic planning process to support two-way influence and oversight.
- Members queried whether ongoing group activities were regularly reviewed for alignment with strategic priorities and whether outdated projects were being challenged. The Chief Officer confirmed that a review was underway to assess current structures and delivery, with clearer links between strategy, delivery, and performance reporting expected by year-end.
- Following a query regarding how learning from district groups and local plans were shared wider to ensure learning. The Chief Officer advised that a workshop was being organised through the Strategic Planning Group, exploring alignment between the Joint Strategic Needs Assessment and the existing plan to identify any outstanding actions required for full implementation.

The Committee:

- **NOTED** the report.
- **ACCEPTED moderate** assurance in that transformation work is occurring, is managed, monitored, connected and has oversight.

3.3 Learning Disability Services

Report by Arlene Johnstone, Interim Chief Officer for Highland HSCP

A Grant provided an overview of learning disability services in NHS Highland and highlighted the range of support available, including community nursing teams, specialist medical staff, and a joint transition social work team for young adults.

He noted that while around 1,200 people in Highland were known to have a learning disability and there were likely 200–300 more who were not yet connected to services. A key focus of the service has been the delivery of annual health checks for people with learning disabilities and by utilising a nurse-led model, 326 checks had been offered, with 224 completed. He advised these checks often led to referrals to other services, such as dietetics, audiology, and speech and language therapy.

He also discussed efforts to improve employability for people with learning disabilities, referencing a successful pilot shop in Invergordon run by the Isobel Rhind Centre, where 72% of attendees were actively involved.

Members praised the work that had taken place, particularly the pilot shop in Invergordon and other community initiatives.

The Committee:

- **NOTED** the progress achieved in delivering Annual Health Checks to people with a Learning Disability and implementation of the DSR locally with real results in relation to Cluster development solutions.
- **SUPPORTED** the actions to enable individuals with a learning disability to lead full and active lives in their own homes in community settings with opportunities to contribute as well.
- **NOTED** the risks associated with the provision of support to individuals with complex needs and the work which has been progressed in this area to support complex transitions out of hospital and the preventative work which is also occurring.
- **ACCEPTED moderate** assurance.

3.4 Primary Care Services Update, including an update on the current position on the Primary Care Improvement Fund

Report by Jill Mitchell, Head of Primary Care

The Head of Primary Care spoke to the circulated report highlighting it was divided into three sections covering community optometry, dentistry, and general practice. Key developments included the rollout of the Community Glaucoma Pathway and the OpenEyes electronic patient record system, both progressing well. Dental recruitment and access remained a priority, with concerns were highlighted in Skye, West Ross, and Caithness, alongside efforts to reduce the paediatric General Anaesthetic Provision waiting list.

She advised that in general practice, GP recruitment had improved significantly, reducing reliance on locums, and several enhanced service contracts had been reintroduced. Progress was also noted in the Primary Care Improvement Fund, with funding supporting services aligned to the care closer to home agenda.

During discussion the following points were raised:

- The Chair queried the impact of delays in transitioning to the new Vision system, and the Head of Primary Care confirmed that the pause caused disruption and affected planned IT improvements for board-managed practices.
- Following a question regarding how the paediatric GA waiting list compared to national trends, and the Head of Primary Care explained that it was not included in national reporting, making comparisons difficult, but noted that staffing and bed availability were key limiting factors.
- Members requested further details on the new commissioning process for enhanced services and its potential impact, and the Head of Primary Care explained that while services were optional for practices, the board took

responsibility where needed, with most services agreed except for diabetes which remained under discussion with acute colleagues.

- Following a request for details on commissioned services, the Head of Primary Care explained that the board had moved to a new commissioning model based on item-of-service fees, work was underway to assess activity levels, financial implications, and impacts on secondary care.
- Members agreed to a future development session focused on enhanced services in general practice, highlighting the complexity and opportunities within the current commissioning framework.
- The Committee Chair queried whether the Primary Care Improvement Fund was progressing with the delivery of the intended outcomes. The Head of Primary Care highlighted progress within Pharmacotherapy and First Contact Physiotherapy; Community Support Workers; Community Mental Health Services; Vaccination Services; Community Treatment and Care; and Seatac.
- Committee Members were advised that Scottish GP representatives at the BMA had entered a formal dispute with the Scottish Government over GMS contract funding, amid concerns that well-funded demonstrator sites may not have delivered the expected outcomes.

The Committee:

– **NOTED** the update.
– **ACCEPTED moderate assurance** from the report.

The Committee took a Break between 2.51pm and 3pm

3.5 Sutherland Care at Home

Report by Arlene Johnstone, Interim Chief Officer for Highland HSCP

The Director of Adult Social Care spoke to the circulated report and highlighted:

- The planned Care Inspectorate visit in April identified significant deficits in the Sutherland Care at Home service, resulting in an Improvement Notice initially set to expire on 27 May but extended to 13 July due to the need for full compliance.
- An oversight group had continued to monitor progress against a detailed action plan. Key areas of focus included medication training and practice, staff support, management, systems compliance, administration, and staffing levels. He noted significant progress had been made across all areas, with most actions either fully completed or on track. One outstanding issue—out-of-hours care—was not a formal requirement but had moved from amber to green status.
- The Chief Officer maintained twice-weekly oversight to ensure rapid escalation of any issues, which had been instrumental in maintaining momentum and responsiveness.
- Assurance visits by the Adult Social Care team had been strengthened, with longer, more detailed engagements across operational teams. Lessons from the Sutherland experience were being applied more broadly, including improvements to the CM2000 system for remote oversight and standard documentation compliance.
- HR and finance processes had been refreshed to ensure clarity around staffing complements across teams.
- It was noted that while internal confidence was high, the outcome of the Care Inspectorate's final assessment could not be predicted and there was no margin for error as any missed actions could jeopardise compliance.
- It was confirmed that a close-out report would be brought to the Committee in September, allowing time to reflect on the inspection outcome. The Director of Adult Social Care added that an additional report on broader changes to social care assurance mechanisms, including governance and internal service review processes would be presented alongside the Sutherland report in September.

During discussion the following points were raised:

- Members asked whether the Director of Adult Social Care was providing moderate assurance that everything that could be done was being done or assuring the Committee that actions were being taken. The Director of Adult Social Care confirmed that the assurance being offered was everything reasonably possible was being done, resulting in a moderate assurance being provided. He highlighted it was not a reflection of uncertainty in effort, but rather a recognition that the outcome of the Care Inspectorate's assessment could not be predicted.
- Members queried what the impact would be if full compliance was not achieved, and what contingencies were in place, including timescales and implications of potential deregistration. It was noted if the Care Inspectorate deemed compliance insufficient, they could pursue emergency cancellation of registration. In such a case, NHS Highland would need to identify an alternative provider or extend the remit of an existing one. He emphasised that NHS Highland was currently the only provider in the area and that options were limited. However, the relationship with the Inspectorate remained collaborative, not adversarial.

- Members sought clarity around the sustainability of the current level of support and intervention in Sutherland was, and what the implications were for other areas. It was acknowledged the current level of resource such as redeploying professional staff and care response teams was not sustainable long-term. He added that recruitment and planning were underway to stabilise the service and develop a sustainable support model. However, he cautioned that this had come at the cost of reduced support to other pressured services.
- Members referred to upcoming changes in assurance and governance structures and asked how these would reflect on both Sutherland and NHS Highland as a whole. The Director of Adult Social Care confirmed a report would be brought to the Committee in September, covering both the Sutherland close-out and broader governance developments. He stated that work was ongoing to standardise systems, processes and service expectations across NHS Highland, despite current resource constraints.

  The Director of Adult Social Care added that lessons from Sutherland were already being applied across other services. Rather than self-inspecting, teams were being encouraged to reflect on whether similar issues existed in their areas. This approach aimed to foster open dialogue and proactive improvement without creating a punitive environment.

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

3.6 Sir Lewis Ritchie – Final Progress report on the Independent Review of Skye, Lochalsh and South-West Ross Out- Of-Hours Service

Report by Arlene Johnstone, Interim Chief Officer for Highland HSCP

The Nursing Director spoke to the circulated report to advise Sir Lewis Ritchie had submitted his final report and would attend a Board Development session in August to discuss it further. She confirmed that substantial assurance had been received regarding the report's submission and content, following engagement with Sir Lewis. However, only moderate assurance could be given in relation to the ongoing implementation of recommendations from the previous report. It was noted that the Lewis Ritchie Steering Group would continue under the same name, reflecting the community's preference for continuity. Two new co-chairs had been appointed, and the group was scheduled to meet the following week.

The Committee formally recorded its thanks to Sir Lewis Ritchie for his significant personal contribution in producing the final report and acknowledged the importance of building on the improved relationship with the community.

During discussion the following points were raised:

- The Nursing Director acknowledged that while trust had been built with parts of the community, concerns remained. It was noted that the Board would continue to engage through the continuation of the Sir Lewis Ritchie Steering Group, despite it sitting outside formal governance structures.
- The need for the Sir Lewis Ritchie Steering Group to integrate effectively with district and strategic planning structures, without disrupting existing governance arrangements was noted by Committee Members.
- Members queried whether support for the group would set a precedent for other areas. The Nursing Director advised different engagement models had been established based on different needs and circumstances of localities. Arrangements reflected long-standing community involvement and would continue alongside efforts to build trust through district planning groups.

The Committee:
- **NOTED** the final report,
- **ACCEPTED 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.

3.7 Chief Officer's Report

Report by Arlene Johnstone, Interim Chief Officer for Highland HSCP

The Interim Chief Officer spoke to the circulated report and advised that preparations were well underway for the national switch from analogue to digital telecare systems, with 50% of users already upgraded and full completion expected by March 2026.

Community-led wellbeing hubs in Sutherland and Caithness continued to be supported, with ongoing discussions to ensure their sustainability. The redesign of services on the North Coast had progressed, with approval from the Council allowing the project to move into the next phase of planning and delivery.

She also celebrated the success of Chelsea Main, a support worker in the forensic mental health service, who had been named the 2025 Nursing Support Worker of the Year. On inspections, the Chief Officer noted the joint inspection of adult services had concluded its fieldwork phase, with inspectors praising the high level of engagement and highlighting strong examples of early intervention, shared purpose among staff, and effective partnership working. She noted there were areas of improvement identified, particularly around information sharing for unpaid carers.

It was noted the New Craigs handover to NHS Highland was on track, with no risks identified alongside a smooth transition plan for staff and patients.

During discussion the following points were raised:

- The Committee Chair reflected on the North Coast redesign, suggesting it was an opportunity to assess whether planned benefits were being realised and to identify any unintended consequences. They also highlighted the importance of effectively signposting support for unpaid carers, noting some staff who were carers themselves were unaware of available resources.
- Committee members had raised concerns about the shift to digital services, particularly during power cuts, and had asked whether learning from other boards could support contingency planning. The Interim Chief Officer confirmed that business continuity plans had been activated during a previous network outage and were under review, noting the need for shared learning considering the national digital switch-off.
- Committee members queried the impact of the digital outage in early June on services reporting into the Community, noting it had not been mentioned in the report. The Interim Chief Officer advised there was no significant impact, as teams had responded effectively using business continuity plans, reverting to paper-based processes where necessary, and the network had been restored by mid-afternoon.
- Members suggested digital switch-off and related learning become a standing item on District Planning Partnership agendas to support shared experience across Highland. The Interim Chief Officer noted she would review the suggestion and ensure wider engagement with the District Planning Partnership.

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

4 COMMITTEE FUNCTION AND ADMINISTRATION

4.1 Temporary Revision to Terms of Reference

Report by Nathan Ware, Governance and Corporate Records Manager

The Chair spoke to the circulated report and explained the proposed changes were intended to ensure quoracy was based on the actual number of members, rather than an unrealistic target that did not account for existing vacancies.

The Committee:
- **Approved** the proposed changes, and
- **ACCEPTED substantial** assurance.

5 AOCB

DATE OF NEXT MEETING

The next meeting of the Committee will take place on **Wednesday 3 September 2025** at **1pm** on a virtual basis.

The Meeting closed at 4.52 pm

NHS Highland	NHS Highland na Gàidhealtachd

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name **of Committee**	**Highland Health and Social Care**
Date of Meeting	**03 September**
Committee Chair	**Gerry O'Brien**

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

Actions are underway to manage service pressures, including repatriating a high-cost out-of-area placement and exploring a local low secure unit. The adult social care plan was approved, a consultant vacancy filled, and several locum posts converted to permanent roles to strengthen workforce stability.

ASSURE

Assurances taken on:

- Finance Report – Month 3 2025/206 (Limited)
- Integrated Performance and Quality Report (Limited)
- Highland Health and Social Care Partnership Annual Report (Substantial)
- Vaccination Improvement Plan Update (Moderate)
- Highland Drug & Alcohol Recovery Service (DARS) Summary Report (Moderate)
- Police Custody Healthcare (PCH) / Sexual Assault Referral Centre (SARCS) Forensic Medical Examiner (FME) Service Summary Report (Moderate)

ADVISE

Adult Social Care Financial Plan: There will be the development of a two-track financial plan for adult social care: one focused on immediate grip and control to stabilise the budget, and another on longer-term transformation supported by the Highland Council Transformation Fund. The plan is being reviewed by senior leadership and will be socialised with stakeholders.

There will be a revised version of the IPQR and HSCP KPIs was expected for the next committee meeting, incorporating relevant indicators and forming a three-tier performance framework for strategic, mid-management, and frontline levels.

RISKS

1. **Financial Position and Budgetary Pressures**: There is a forecasted £40 million overspend by March 2026, highlighting risks in adult social care.
2. **Supplementary Staffing and Cost Drivers**: Ongoing reliance on agency and bank staff, particularly in in-house care homes, leads to high supplementary staffing costs due to recruitment challenges and patient acuity.
3. **Financial Impact and Recruitment**: The new model for police custody healthcare and forensic medical examiner services is projected to deliver a

positive budget variance and reduce overspend, but recruitment for permanent FME staff is still underway.

ACTIONS

The Committee Chair and Chief Officer for the Highland HSCP would meet to discuss topics and dates for the Committee to hold development sessions.

The Chief Officer for the Highland HSCP would create a briefing paper to be circulated to Committee members summarising recent activity linked to the Carer Strategy intended outcomes.

LEARNING

Updates were provided to the Committee on the Drug and Alcohol Recovery Service and the Police Custody Healthcare and Forensic Medical Examiner Service Transformation.

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	**3 July 2025 – 9.00am (via MS Teams)**

Present
Karen Leach, In the Chair
Louise Bussell, Board Nurse Director
Muriel Cockburn, Non-Executive Board Director
Liz Henderson, Independent Public Representative
Joanne McCoy, Vice Chair and Non-Executive Director

In attendance
Sarah Buchan, Director of Pharmacy
Peter Cook, Head of Medical Physics
Dr Claire Copeland, Deputy Medical Director
Stephanie Govenden, Consultant Community Paediatrician
Evelyn Gray, Associate Nurse Director
Bryan McKellar, Whole System Transformation Manager
Brian Mitchell, Board Committee Administrator
Mirian Morrison, Clinical Governance Development Manager
Gerry O'Brien, Non-Executive Board Director (Observing)
Heather Richardson, Head of Operations
Iain Ross, Head of eHealth
Leah Smith, Complaints Manager
Katherine Sutton, Chief Officer (Acute)
Nathan Ware, Governance and Corporate Records Manager
Dominic Watson, Head of Corporate Governance
Dr Neil Wright, Non-Executive Board Director (Observing)

1.1 WELCOME AND APOLOGIES

Formal Apologies were received from Committee members E Beswick, A Christie, B Peters and C Sinclair. Apologies were also received from Non-members E Henry, K Gillies and A Johnstone.

1.2 DECLARATIONS OF INTEREST

There were no Declarations made.

1.3 MINUTE OF MEETING THURSDAY 1 MAY 2025, ROLLING ACTION PLAN AND COMMITTEE WORKPLAN 2025/2026

The Minute of Meeting held on 1 May 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 continued relevancy and associated scheduled due dates, and the Plan updated for the next meeting. This would in turn inform an update of the current Work Plan.

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) Executive Summary

H Richardson spoke to the circulated report, providing the Committee an Executive Summary of the position in relation to NDAS and advising the service remained under significant pressure including in relation to the existing waiting list position and ongoing level of service demand. The existing staffing level position was outlined, noting increasing external scrutiny of assessment activity levels. A monthly Neurodevelopmental Programme Board had been established, to provide a governance framework for all activity underway in relation to the Children's system. A twin track improvement strategy was being taken forward in relation to stabilisation of the existing service and short-term recovery of the legacy waiting list and a longer-term plan to deliver a Highland service model to meet the national ND specification. Matters relating to clinical, financial and political/reputational risks were also reported. It had been recommended a business case outlining the variety of options, as detailed in the circulated report be submitted to the Executive Directors Group on 23 June 2025 outlining the workforce required to meet current demand and address the backlog and the investment needed to reduce the current waiting list.

Members welcomed the report, and discussed the following:

- Children's Services Plan. Noted work had commenced on producing a new Plan, with H Richardson Co-Chair of the Children's Services Planning Board. This provided an opportunity to contribute to and influence any future direction of travel.
- Activity Relating to "The Promise". Questioned where relevant activity areas linked. Advised Programme Board Work streams were considering a number of associated aspects from a dual governance perspective.
- Reducing Current Demand Level. Advised a range of activity underway in this area in association with Highland Council. Agreed to provide greater background detail in future reporting.
- National Position. Advised recent letter penned by Society for Heads of Psychology outlined the wider national position. Detail of the letter would be shared with Committee members, subject to clarification of the formal position in relation to other NHS Boards.
- Executive Director Group Consideration. Agreed an update be brought back on relevant discussion outcome. Assessment activity was continuing at this time.

After discussion and acknowledgement of the work of those in the service, the Committee:

- **Noted** the reported position.
- **Agreed** future reporting provide improved detail in relation to reducing demand levels and greater clarification of the wider national position.
- **Agreed** this matter currently remain on the agenda for future meetings.

1.4.2 Vascular Services Update

E Gray advised substantive Consultant arrangements had ended on 30 June 2025, with two locums currently providing relevant cover. High level national considerations were ongoing in relation to the national position and a formal decision expected in relation to transitioning to a Hub and Spoke model. Mutual aid arrangements with four other NHS Boards in Scotland were continuing on a

rotational basis. Access to multi-disciplinary teams by non-critical patients remained an area of concern. A lead for Aortic Aneurysm screening activity was being sought. External support arrangements for those patients remaining on relevant pathways, and matters relating to review of governance of joint working arrangements were being actively considered.

There was discussion of the following:

- Hub and Spoke Model Governance Arrangements. Emphasised the need for detailed, informed and appropriate consideration of these aspects. Current considerations were noted.
- Activity Timeframes. View expressed greater clarity required, recognising the challenges currently being faced and discussions underway including at Chief executive level. This would assist relevant communications activity.

After discussion, the Committee otherwise Noted the reported position.

2 SERVICE UPDATES

2.1 Primary Care Workforce Survey Update

C Copeland advised activity was being taken forward as part of the Primary Care Improvement Strategy. It was stated clarity was required as to relevant reporting arrangements. It was further reported a GP Clinical Lead for workforce had been appointed. The importance of associated clinical and care governance assurance considerations was highlighted.

The Committee Noted a further update would be provided to the next meeting.

2.2 Adult Social Care/Commissioned Services Update

It was advised that reporting on this aspect was included in considerations relating to the update under Item 2.1. The Committee so **Noted.**

2.3 Revised Radiation Safety Committee Annual Report 2024

P Cook spoke to the circulated report providing an annual update on the status of radiation safety and compliance within NHS Highland. The report had also been presented to the Health and Safety Committee. 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 staffing, and replacement of equipment. The report proposed the Committee take **Moderate** assurance.

The following was discussed:

- Service Delivery and Safety Assurance. Concern expressed in relation to service provision to other areas given the challenges reported. Advised as to role and remit of Radiation Safety Committee, this relating to compliance with relevant Health & Safety and Clinical Governance safety requirements.
- Equipment Purchase and Associated Staffing Considerations. Advised as to improved funding position relating to equipment purchase, and matters relating to associated planning requirements and arrangements.

After discussion, the Committee Noted the circulated Annual Report and **Agreed** to take **Moderate** assurance.

3 EMERGING ISSUES/EXECUTIVE AND PROFESSIONAL LEADS REPORTS BY EXCEPTION

There were no matters raised in relation to this Item.

4 PATIENT EXPERIENCE AND FEEDBACK

M Morrison spoke to the circulated report providing the committee with an update on Complaints case studies and learning to identify areas of learning and ensure processes and policies were sufficient and work effectively. There was also circulated a complaint performance report focused on the volume of complaints received and the performance against the relevant 20-day target, and a Care Opinion activity update for February to March 2025. The report proposed the Committee take **Moderate** assurance.

The following was discussed:

- Care Opinion Entries. Advised relevant site included a tracker system for individual postings. Activity was ongoing in relation to further improving internal processes and reporting.

After discussion, the Committee Noted the detail of the circulated Case Study documents, associated updates and **Agreed** to take **Moderate** assurance.

5 CLINICAL GOVERNANCE AND PERFORMANCE DATA

M Morrison introduced the Item and circulated report. B McKellar then referred members to the circulated data, providing both an executive summary and detail in relation to the relevant NHS Highland position relating to the nationally agreed Cancer Quality Performance Indicators. Specific detail was outlined in relation to Bladder QPIs 2(i) and 3; Testicular QPI3; Endometrial QPI 3, Ovarian QPI 4 and 10(i); Prostate QPIs 4a and 4b; Colorectal QPIs 5 and 7a and b; Colorectal QPI 8; and Breast QPIs 6(i) and (ii).

There followed discussion of the following:

- QPI 10(i). Noted declining performance. Noting associated workforce challenges had impacted performance, agreed the need for improved current trend data detail.
- Wider Ongoing Workforce Concerns. Questioned if persistent challenges could indicate an increasing future concern requiring consideration of support arrangements across NHS Boards. The importance of learning taken from the position in relation to Vascular services, and co-learning in relation to associated Cancer Network discussions was emphasised. Governance aspects were also highlighted.
- Plans and Mitigations. Detail in relation to effectiveness of specific action plans, and progress of associated timelines was requested. Noted regular updates on Cancer performance and associated aspects were presented to the EDG, and used to targets areas performance improvement was required.
- Overall NHSH Performance. Advised an improved position was being reported, and work with relevant teams was continuing to be taken forward in relation to aspects including theatre access, North Cancer Alliance discussions, and engagement with the National Cancer Network.

M Morrison then spoke to the detail of 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; 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 remained poor, with improvement activity being actively monitored by the EDG. The report proposed the Committee take **Moderate** assurance.

There was discussion of the following:

- Complaints Response Performance and Staff Training. Advised as to relevant training activity for response officers and associated resource pack distribution. Complexity of response requirements and associated process improvement considerations were also highlighted.
- Falls Activity. Advised as to a reduction in falls with harm and activity of the Inpatient Falls Activity Steering Group. Updates were also provided in relation to a number of targeted activity areas. There was reference to activity relating to delirium screening aspects.

After discussion, the Committee Noted the report content and **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

L Smith 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 recruitment for Campbeltown and 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 Service, Dementia Inpatient Bed Pathway, resource challenges, Psychiatrist Vacancy in Kintyre and Islay, communication, position regarding lack of Consultant Learning Disability Psychiatrist, position regarding lack of Community Learning Disability Nurse cover for Argyll and Bute, and Oban Rural General Hospital. Other updates were provided in relation to Tissue Viability and Adverse Events activity. There was reference to SPSO Investigations; Mental Welfare Commission, Fatal Accident Inquiry, and HSE Inquiry activity; and unannounced HIS inspection of Oban General Hospital. It was reported the Argyll and Bute Clinical Governance Team was engaging with a number of developments to support clinical governance processes as indicated. The report proposed the Committee take **Moderate** assurance.

The following was discussed:

- Partnership Working. Members welcomed future reporting on relevant aspects.
- Initial Referral Discussions (IRDs). Noted number had increased significantly. Confirmed these related to discussion where child protection concerns were raised. Noted many discussions held by School Nurse and Health Visiting staff, impacting on their wider preventative activity. Child Protection Nurse resource concerns were raised and noted.

After discussion, the Committee:

- **Noted** the content of the circulated report.
- **Noted** an improvement update relating to Child Protection Nurse resourcing would be provided in the next report.
- **Agreed** individual levels of assurance be separated out in future reports where appropriate.
- **Agreed** to take **Moderate** assurance.

6.2 Highland Health and Social Care Partnership

C Copeland spoke to 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, with a focus on Community QPS assurance. 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 data, 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. Issues being highlighted were in relation to activity around the ADHD Waiting List; staffing within Community Hospitals; and Sutherland Care at Home Service. Positive updates were provided in relation to GP recruitment, and wider recruitment successes relating to Alness and Invergordon. Updates were also provided in relation to matters previously highlighted to Committee. There had also been circulated Minute of Meeting of the HHSCP Clinical and Care Governance Group held on 5 June 2025. The report proposed the Committee take **Moderate** assurance.

After discussion, the Committee:

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

6.3 Acute Services

E Gray spoke to the circulated report in relation to Acute Services, providing an Executive Summary in relation to Vascular Services; outbreaks and associated ward closures; concerns relating to the relocation of wheelchair services; the NDAS Service and the impact on Acute services of changes to the GP contract around enhanced services relating to Diabetes. Updates in relation to Hospital Acquired Infection (HAI), infection prevention and control activity and emergency access were also provided. A range of other aspects relating to quality and patient care were also highlighted, HEPMA rollout to Raigmore Hospital; new biochemistry, haematology and coagulation platforms; work on developing key performance Indicators as part of STAG activity, respiratory testing, replacement of biochemistry equipment, Belford Hospital redesign programme, National Treatment Centre performance, a reduction in the Paediatrics waiting list, an update on CAMHS Services, NDAS and adverse events. Data was provided in relation to Datix's, SAERs, inpatient falls; tissue viability; violence and aggression; Outpatient/Inpatient and elective care 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 20 May 2025, and other associated appendices. The report proposed the Committee take **Moderate** assurance.

The following points were raised in discussion:

- Diabetes Services. Noting wider concerns relating to this subject it was advised relevant discussion was ongoing in relation to aspects including relevant patient pathways. Updates would be provided as part of future reporting. The impact on services in Argyll and Bute was also questioned.
- Relocation of Wheelchair Services. Advised main area of activity was workshop-related, with minimal impact on patients.

After further detailed discussion, the Committee:

- **Noted** the report content, associated Appendices and circulated Minute.
- **Agreed** an update on Diabetes Services in Argyll and Bute be brought to the next meeting of the relevant Clinical and Care Governance Group.
- **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 as to development of the relevant clinical care pathway in relation to end of life care; recent child death review activity; planned changes to the integration arrangements and the associated impact on reporting and governance pathways; and work underway to progress arrangements so that children have an equal access to forensic care on a par with adults. There had also been circulated minute of meeting of the ICYPCGG held on 30 April 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 actions previously highlighted to Committee.
- **Agreed** to take **Moderate** assurance.

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

L Bussell spoke to the circulated report and advised NHS Scotland published data for the period April 2024 to March 2025 was due to be published in July 2025. 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. 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 had notified NHS Highland this equated to a case number of 75 for CDI and ECB, and 53 for SAB by end of March 2026. The aims for antimicrobial prescribing were awaited. Aspects relating to quality and patient care, workforce, finance and risk assessment/management activity were also highlighted. There had also been circulated a Control of Infection Committee (COIC) Annual Report for 2024/25. The report proposed the Committee take varying levels of assurance across a number of areas, as indicated.

The Committee:

- **Noted** the report content and circulated COIC Annual Report 2024/25.
- **Agreed** to accept the levels of assurance being offered in the circulated report.

8 ANNUAL DELIVERY PLAN UPDATE

B McKellar spoke to the circulated report and gave a brief presentation providing an overview as to progress in developing the NHS Highland Annual Delivery Plan (ADP) currently awaiting Scottish Government approval prior to being presented to the NHS Board for approval. An Executive Summary across each Well Theme had been developed, as circulated and would be used to communicate internally with key stakeholders. Deliverables were being progressed. The report proposed the Committee take **Substantial** assurance.

The following points were discussed:

- Activity Tracking. Advised a master tracker document was in place, with the Strategy and Transformation Group in regular discussion with relevant Senior Responsible Officers and actions subject to quarterly review and reporting.
- Population Health Framework. Advised ADP included range of associated aspects across a number of Well Themes. This would be an increased focus of future Annual Delivery Plans.

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

9 SIX MONTHLY UPDATES BY EXCEPTION

9.1 Area Drug and Therapeutics Committee Six Monthly Update

S Buchan spoke to the circulated report updating the Committee on recent activity and the Area Drug and Therapeutics Committee's (ADTC) plans for the remaining year. It was reported leadership and organisation of the ADTC continued to improve, with agenda setting meetings reflecting local and national priorities as well as emerging issues. The ADTC continued to evolve and develop its strategic objective priorities, as indicated, as well as engaging in discussions at national level on access to and affordability of medicines and national prescribing strategies. The Highland ADTC also continued to work closely with the national ADTC Collaborative Forum, promoting the need for Once for Scotland approaches to new medicines accessibility. The report proposed the Committee take **Moderate** assurance.

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

9.2 Information Assurance Group Six Monthly Update

I Ross spoke to the circulated report, covering the period from January to June 2025, outlining work being undertaken by the Information Assurance Group (IAG) and providing assurance NHS Highland was operating compliance with applicable Information Security and Data protection legislation. Detailed updates were provided in relation to regulatory audit activity; Caldicott Guardian activity; Adult Social Care; Corporate Records; Clinical Records Management, Freedom of Information activity; Subject Access Requests; Policies ratified; other significant IAG agenda items and areas of discussion; and reportable incidents during the reporting period. A network outage was reported. Detail was also provided in relation to recently discussed topics including Community Optometrist access to aspects of the Care Portal, and the potential for utilising AI products moving forward. The report proposed the Committee take **Substantial** assurance.

There was discussion of the following:

- Subject Access Requests. Noted number of requests increasing, especially from patient legal representatives. This represented a greater awareness of access rights in this area and was increasing the associated workload. The matter was being actively monitored. System process improvements had been introduced. Further detail was to be provided in the next report.
- Electronic Patient Record (EPR). Noted the complexity involved in demonstrating compliance with Subject Access Requests as the EPR evolves. It was suggested this may eventually reduce the number of Requests being received as well as providing wider benefits realisation. Members also noted a reported significant increase in Requests being received at GP level. Interface arrangements with Primary Care colleagues were referenced, along with matters relating to the potential arrangements for records scanning activity.

After discussion, the Committee Noted the report content and **Agreed** to take **Substantial** assurance.

10 PHARMACY SERVICES STRATEGIC PLAN 2025-2030

S Buchan spoke to the circulated draft Pharmacy Services Strategy 2025/30, advising this was the first co-produced Strategy document for NHS Highland in this area, developed across three areas of relevant practice. She updated members on relevant engagement activity and workshop events outcomes, and associated consultation arrangements. She highlighted a focus on improving patient care, supporting staff and embracing digital innovation. Strategic Aims related to improving population health, enhancing the quality and equity of care across Highland, and ensuring the delivery of better value through patient-centred services. There were seven associated Key Themes,

with nine work streams developed and subject to deliverable outcomes, as indicated. Each Work Stream would have a relevant Accountable Lead Officer, based on a cross-sector approach and would be subject to individual timelines. She stated a focus on deliverable outcomes would be key moving forward and outlined imminent activity around aspects such as production of an associated timeline-based delivery plan, delivery of a series of launch Webinars, development of resource hub to include feedback routes, and a series of face-to-face update visits. Senior Leadership Team discussion to date was also highlighted. During discussion members welcomed the co-production of a Pharmacy Strategy, addressing both Primary and Secondary Care.

After discussion, the Committee:

- **Noted** the presentation content and circulated draft Strategy document.
- **Noted** an updated Strategy and associated Summary document would be circulated to members following the meeting.

11 CALENDAR OF MEETING DATES

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

4 September 2025
6 November 2025
8 January 2026
5 March 2026
7 May 2026
2 July 2026
3 September 2026
5 November 2026
7 January 2027
4 March 2027

12 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.

13 ANY OTHER COMPETENT BUSINESS

There was no discussion in relation to this item.

14 DATE OF NEXT MEETING

The Chair advised the Members the next meeting would take place on 4 September 2025 at 9.00am.

The meeting closed at 11.45am

NHS Highland	NHS Highland na Gàidhealtachd

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name **of Committee**	**Clinical Governance Committee**
Date of Meeting	**4 September 2025**
Committee Chair	**Karen Leach**

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

- **NDAS Service –** Progress against challenging position noted, including by NDAS Programme Board. Use of Whole Family Wellbeing Fund and associated communications workstream noted. Update received on prioritisation activity.

ASSURE

- **Dentistry State of Play and Impact on Acute Services** – Item deferred.
- **Patient Experience and Feedback –** Moderate.
- **Clinical Governance Quality and Performance Data/ Annual NHSH Complaints Report –** Moderate.
- **Argyll and Bute Update –** Moderate.
- **Highland HSCP Update –** Moderate.
- **Acute Update –** Moderate, noting aspects relating to Diabetes Services and wide recruitment. Acknowledged Breast Baby Feeding Gold Status Award.
- **ICYPCGG –** Moderate, noting current service and staffing considerations.
- **Infection Prevention and Control –** varying levels of assurance outlined taken.
- **Annual Delivery Plan 2025/26 and Scottish Government Operational Improvement Plan Update** – Substantial, recognising range and level work of all staff members involved.

ADVISE

- **Primary Care Workforce Survey –** Noted to be taken forward as part of Primary Care Strategy activity.
- **Partnership Governance Discussion** – Noted as ongoing dialogue with deep dive.
- **Vascular Services Update** – Noted presentation and summary of progress. To be removed from agenda as no longer to be Standing Item.
- **Public Protection Infrastructure** – Noted strong support to date, recruitment to first Lead position of three, and involvement of Director of Midwifery.
- **Patient Experience and Feedback** – Noted options to replace Care Opinion being considered. Paper to be submitted to EDG on continued use.
- **Research, Development and Innovation Annual Report 2025** – Noted the range of activity involved, ongoing and planned activity, and wider impact elements.

RISKS
• None highlighted.
ACTIONS
• **Organ and Tissue Donation Committee Six Month Update –** Deferred. • **Duty of Candour Annual Report –** Deferred. • **Realistic Medicine Annual Update –** Deferred.
LEARNING
• **Receipt of Committee Papers** – Again highlighted need for Committee reports to be submitted timeously.

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MINUTE of MEETING of the AREA CLINICAL FORUM	**3 July 2025 – 1.30pm Microsoft TEAMS**	

Present
Catriona Brodie, Area Pharmaceutical Committee
Linda Currie, NMAHP Advisory Committee
Helen Eunson, NMAHP Advisory Committee
Grant Franklin, Area Medical Committee
Alex Javed, Area Healthcare Science Forum
Joanne McCoy, Non-Executive Director
Colin Pettinger, Area Optometry Committee
Eileen Reed-Richardson, NMAHP Advisory Committee
Catriona Sinclair (Chair)
Andrew Strain, Area Medical Committee
Allyson Turnbull-Jukes, Psychological Committee
Gillian Valentine, NMAHP Advisory Committee

In Attendance
Isla Barton, Director of Midwifery (Item 4.1)
Louise Bussell, Nurse Director
Nathan Ware, Governance and Corporate Records Manager

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting, apologies were received.

1.1 DECLARATIONS OF INTEREST

There were no declarations of interest.

2. DRAFT MINUTE OF MEETING HELD ON 9th January 2025

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

3. MATTERS ARISING

3.1 New Area Clinical Forum Chair Process

The Governance and Corporate Records Manager confirmed the current Chair's terms was due to end therefore the election process had been initiated quickly to keep things moving and ensure a new Chair was in place by the September meeting. He noted there were plans to formalise the approach for future elections, with more details to be shared with forum members in due course. Members who were interested had been asked to send a brief personal statement on their proposed plans for the Area Clinical Forum by the 18th July 2025. He added that members could nominate others, provided the nominee had agreed in advance.

It was noted there had been one expression of interest to date, but others were encouraged to come forward.

The Forum **noted** the update.

3.2 Adjustment to Area Clinical Forum Constitution and Membership Update

The Governance and Corporate Records Manager spoke to the circulated report and highlighted that the proposed amendments to the Constitution aimed to base quoracy on active membership. This was intended to avoid quorum issues caused by vacancies, as recently experienced by the Forum. A broader effort had also been underway to refresh the membership and fill all vacancies as soon as possible.
The Forum **noted** the update and **approved** the proposed amendments to the constitution.

3.3 Appointment of Vice Chairs

The Chair confirmed that historically there had been one Vice Chair, later expanded to two to help balance workloads and accommodate other commitments. However, she noted there had been no Vice Chair in place for the past 12 to 18 months, which had made it challenging for the Chair to manage responsibilities and develop agendas without support.

Members were encouraged to consider the Vice Chair role, especially if they weren't ready to stand as Chair. It was highlighted as a valuable opportunity to contribute more actively to the committee's work, support the Chair, and help maintain continuity when the Chair was unavailable.

She added that the role was less time-consuming than the Chair position and a useful stepping stone for future leadership. Interested members were invited to speak with the Governance and Corporate Records Manager or the Chair to explore the opportunity further.

The Forum **noted** the update.

4. ITEMS FOR DISCUSSION

4.1 Public Protection Team

The Director of Midwifery spoke to the circulated presentation and highlighted A review of health's role in public protection was initiated following a leadership change, leading to a joint inspection that highlighted both good practice and areas for improvement. It became clear that health's contribution to adult support and protection needed strengthening, particularly in clarifying roles within the Health and Social Care Partnership. A national framework was introduced to support self-assessment and benchmarking, though Highland was slightly behind in completing this.

To address identified gaps, ring-fenced funding was secured to recruit an Adult Support and Protection Lead and two Band 7 practitioners with board-wide responsibilities, including MAPPA. These roles were previously misaligned under child protection, causing concern among staff. Interim leadership was maintained through bank staffing, and recruitment attracted strong interest, signalling positive progress.

Governance structures were being strengthened with the formation of a Public Protection Health Group. Highland's nominated officer model was praised, and national networks were being utilised to support local practice. While the final team structure was still under discussion, significant steps had been taken to enhance public protection, with a clear focus on staff safety, accountability, and alignment with national expectations.

During discussion the following points were raised:

- Members queried whether the board-wide MAPPA plan had been linked to the Argyll and Bute Senior Leadership Team. The Director of Midwifery highlighted there was a board-wide approach being implemented to ensure consistency and parity across regions, with efforts to align different MAPPA pathways and join up local systems.
- Members suggested a future update once the team is appointed, to clarify roles, engagement routes, and how the resource can be accessed and shared with local committees and clinical groups. The Director of Midwifery supported ongoing engagement, emphasised the need for visible leadership, clear pathways, and robust systems to ensure safety, and offered to return at key points to maintain alignment.
- Members asked whether contracted services such as pharmacy, optometry, dentistry, and GPs were included in the remit. The Director of Midwifery confirmed they were, noting recent inclusion of primary care in discussions. Members stressed the need for consistent communication and raised concerns about governance differences. She acknowledged the challenges and highlighted the opportunity to embed clear, inclusive structures and confirmed dedicated roles would help clarify responsibilities.

Action: Committee to receive an update once the team is appointed, to clarify roles, engagement routes, and how the resource can be accessed and shared with local committees and clinical groups.

4.2 JobTrain & Recruitment Challenges

The Associate AHP Director for Argyll and Bute HSCP raised concerns about the high volume of unsuitable job applications, which were placing an unsustainable burden on clinical teams. Despite discussions with the recruitment team, the issue was attributed to the national system and remained unresolved. A collective SBAR was proposed to escalate the matter, as it was impacting service delivery and consuming significant resources.

During discussion the following points were raised:

- Members echoed concerns about high applicant numbers for healthcare roles, noting that many candidates had failed to meet essential criteria, and even when they did, shortlisting became time-consuming—highlighting a widespread recruitment challenge across departments.
- Members noted that the issue of unsuitable batch applications appeared to be a national problem and suggested exploring whether it was already being addressed. The Associate AHP Director for Argyll and Bute HSCP confirmed the Jobtrain platform did not automatically sift applications, which highlighted a key concern discussed at a national workforce meeting.
- Forum Members suggested the Director of People and Culture attend the next meeting so they could provide feedback on JobTrain and identify any possible solutions as a result.

Action: Chair to reach out to the Director of People and Culture to attend the next meeting to provide an update on JobTrain challenges where appropriate.

The Forum **noted** the updates

5. MINUTES FROM PROFESSIONAL ADVISORY COMMITTEES AND EXCEPTION REPORTS

5.1 Area Dental Committee meeting – 12th February and 9th April 2025

There were no additional comments.

5.2 Adult Social Work and Social Care Advisory Committee meeting – no meeting held

5.3 Area Pharmaceutical Committee meeting – 17th February and 21st April 2025

The Vice Chair spoke to the circulated minutes and confirmed the committee's recruitment material was refreshed in advance of this year's election process which had seen 20 people stand for the 15 seats evidencing the success of the refresh.

5.4 Area Medical Committee meeting – 11th February and 8th April 2025

The Chair spoke to the circulated minutes and confirmed across recent meetings of the GP Subcommittee, Hospital Subcommittee, and Area Medical Committee; members had formally acknowledged the significant contribution of Bernard Wolff to healthcare in the NHS Highland. His resignation had also highlighted the serious challenges facing the organisation, particularly the lack of urgent vascular care provision.

It was noted that while some interim arrangements had been made such as bringing in interventional radiology services from other areas the absence of local urgent vascular care remained a live patient safety issue.

Members agreed it was important for this concern to be minuted, as it reflected broader risks to service provision and had been consistently raised across multiple committees.

He added that vaccination delivery was due to change to a hybrid model where GP Practices would work collaboratively with NHS Highland to deliver vaccinations across the community.

5.5 Area Optometric Committee meeting – 31st March 2025

It was noted there had been ongoing work to enable community optometry access via the OpenEyes system which was expected to be rolled out in the next financial year.

There had been a specialist supplementary eye care service launched which was funded by Scottish Government with a planned go live date of 1st August. This introduced enhanced fees for prescribing optometrists and would support community-based treatment of certain eye conditions.

5.6 Area Nursing, Midwifery and AHP (NMAHP) Advisory Committee meeting – 6th February 2025

The Chair spoke to the circulated minutes and highlighted they'd been reviewing its advisory structure due to ongoing challenges in achieving broad representation across a large and diverse staff group. Discussions had taken place with the Nurse Director and Corporate NMAHP teams, as well as through national meetings, which highlighted that most Boards had split their advisory committees into separate nursing/midwifery and allied health

profession groups to improve focus and engagement.

To avoid losing the benefits of joint working, it was agreed to engage more widely through existing structures to gather views on a revised structure. She added that there had been discussion around increasing representation, particularly for nursing and midwifery and any changes would require a review of the Constitution and formal approval by the committee.

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

5.8 Area Health Care Sciences meeting – no meeting held

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

6 Asset Management Group – Minutes of meetings held in February and May 2025

The Forum **noted** the minutes.

7 HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE – Minute of meetings held on 5th March and 7th May 2025

The Forum **noted** the minutes

8 Argyll and Bute IJB minutes

There were no additional comments.

9 Dates of Future Meetings 2025

4th September
6th November

10 FUTURE AGENDA ITEMS

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

11 ANY OTHER COMPETENT BUSINESS

Forum Members thanked the Chair Catriona Sinclair for her leadership and input as Chair of the Area Clinical Forum over the past few years.

12 DATE OF NEXT MEETING

The next meeting will be held on 4 September 2025 at **1.30pm on Teams.**

The meeting closed at 3.07pm

NHS Highland	NHS Highland na Gàidhealtachd

SUMMARY REPORT OF GOVERNANCE COMMITTEE MEETING

Name **of Committee**	**Area Clinical Forum**
Date of Meeting	**11 09 2025**
Committee Chair	**Allyson Turnbull-Jukes**

KEY POINTS FROM DISCUSSION AND ESCALATION

ALERT

The Chair would highlight to the board:

- Discussion on the visibility, role, and remit of the Area Clinical Forum (ACF).
- Members highlighted the need for greater clarity on the forum's advisory role, membership, and its relationship with operational and management structures.
- Agreement that the ACF should have a stronger, more proactive advisory voice to the Board and operational teams, not just respond to Board requests.
- NHS Highland Annual Review scheduled for 18 November 2025 at Aviemore.
- Members are asked to suggest topics for discussion with the Chair and Chief Executive.
- Attendance (in-person or virtual) to be confirmed by members.
- Advisory committees reported challenges with representation especially from Secondary Care.
- Recruitment issues raised; plan to improve filtering and use of "knock out questions"
- Bid submitted to Scottish Government to expand Long Covid service.

ASSURE

ADVISE

RISKS

ACTIONS

- Members to provide feedback on topics for the annual review.
- NMAHP group to trial splitting and update terms of reference.
- Recruitment team to issue guidance on filtering applicants.
- Chair to follow up on vacant representative roles and clarify committee structures.
- Further discussion on prevention and public health to be included in future agendas.

LEARNING

- Ongoing issues with high applicant numbers and lack of effective filtering in the recruitment system.
- Discussion with Gareth Adkins (NHS Highland) about national and local solutions, including the use of “killer questions” and clearer personal specifications.
- Agreed to pilot improved filtering in selected areas and report back at the next meeting.

MINUTES of MEETING of ARGYLL AND BUTE HSCP INTEGRATION JOINT BOARD (IJB) held ON A HYBRID BASIS WITHIN THE QUEEN'S HALL, DUNOON AND BY MICROSOFT TEAMS on WEDNESDAY, 17 SEPTEMBER 2025

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

Evan Beswick, Chief Officer, Argyll and Bute HSCP
Fiona Broderick, Staffside Lead, Argyll and Bute HSCP (Health)
Linda Currie, Associate Director AHP, NHS Highland
David Gibson, Chief Social Worker/Head of Children and Families and Justice, Argyll and Bute HSCP
James Gow, Head of Finance, Argyll and Bute HSCP
Rebecca Helliwell, Depute Medical Director, Argyll and Bute HSCP
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)
Kirstin Johnston, Networks and Volunteering Lead (for Takki Sulaiman, Chief Executive), Argyll and Bute Third Sector Interface
Kirstie Reid, Carers Representative, NHS Highland
Fiona Thomson, Lead Pharmacist, 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
Eilidh Gallagher, Head of Primary Care, NHS Highland
Jane Fowler, Head of Customer Support Services, Argyll and Bute Council
Nikki Gillespie, Head of Service, Complex Care and Registered Services, Argyll and Bute HSCP
Hazel MacInnes, Senior Committee Officer, Argyll and Bute Council
Caroline Robertson, Head of Adults – Hospitals and Community Care, Argyll and Bute HSCP
Mandy Sheridan, Service Improvement Officer, Argyll and Bute HSCP
Angela Tillery, Principal Accountant, Argyll and Bute Council

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Elizabeth Higgins, John Lyon and Takki Sulaiman.

Prior to the commencement of Business, the Chair invited Kenny Mathieson, public representative to make a statement to the Board.

Mr Mathieson made a statement on behalf of himself and carer representatives Tracey White and Kirstie Reid, advising that they felt like they were treated as outsiders and not Board members, that their points were not listened to and their questions were not answered by Officers.

The Chair, on behalf of the Board, noted the statement made and advised that this matter would be picked up out with the meeting.

Councillor Ross Moreland joined the meeting at this point.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTES

The Minutes of the meeting of the Argyll and Bute HSCP Integration Joint Board held on 28 May 2025 were approved as a correct record.

4. MINUTES OF COMMITTEES

(a) **Argyll and Bute HSCP Strategic Planning Group held on 12 June 2025**

The Minutes of the meeting of the Argyll and Bute HSCP Strategic Planning Group held on 12 June 2025 were noted.

(b) **Argyll and Bute HSCP Audit and Risk Committee held on 20 June 2025**

The Minutes of the meeting of the Argyll and Bute HSCP Audit and Risk Committee held on 20 June 2025 were noted.

(c) **Argyll and Bute HSCP Finance and Policy Committee held on 24 June 2025**

The Minutes of the meeting of the Argyll and Bute HSCP Finance and Policy Committee held on 24 June 2025 were noted.

(d) **Argyll and Bute HSCP Clinical and Care Governance Committee held on 14 August 2025**

The Minutes of the meeting of the Argyll and Bute HSCP Clinical and Care Governance Committee held on 14 August 2025 were noted.

(e) **Argyll and Bute HSCP Strategic Planning Group held on 21 August 2025**

The Minutes of the meeting Argyll and Bute HSCP Strategic Planning Group held on 21 August 2025 were noted.

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 May 2025.

Decision

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

(Reference: Report by Chief Officer dated 17 September 2025, submitted)

6. FINANCE

(a) BUDGET MONITORING - 12 MONTHS TO 31 MARCH 2025

The Board gave consideration to a report providing a summary of the financial performance for the 2024/25 year.

Decision

The Integration Joint Board –

1. noted that the HSCP overspent its budget by £1.8m;

2. noted that the overspend related to Older Adult Social Care budgets;

3. noted the HSCP had utilised all of the available £3.05m in pension fund savings to fund its overspending;

4. noted that general reserves had reduced from £7.8m to £2.6m with total reserves increasing by £0.9m to £20.7m; and

5. noted savings of £5.1m had been delivered, 77% of target.

(Reference: Report by Head of Finance dated 17 September 2025, submitted)

(b) BUDGET MONITORING – 4 MONTHS TO 31 JULY 2025

The Board gave consideration to a report providing an early indication of financial performance for the first four months of the 2025/26 financial year.

Decision

The Integration Joint Board –

1. noted that the HSCP was reporting that it had overspent its budget by £1.5m as at month four;

2. noted an overspend of £1.5m was forecast and that management were working to bring spend back in line with budget;

3. noted recovery restrictions remained in place; and

4. noted savings of £4.9m had been delivered, 56% of target.

(Reference: Report by Head of Finance dated 17 September 2025, submitted)

Fiona Broderick left the meeting during consideration of the following item of Business.

(c) **BUDGET OUTLOOK AND MEDIUM TERM FINANCIAL PLAN 2026/27-2028/29**

The Board gave consideration to an updated budget outlook for the 2026/27 financial year and the following two years.

Decision

The Integration Joint Board –

1. noted the budget outlook for 2026/27 to 2028/29 and noted the risk and uncertainty in respect of funding settlements;

2. noted the forecast budget gap of £18.2m for 2026/27;

3. noted that work on the savings plan was continuing in partnership with the Council and NHS Highland;

4. noted the scale of service reduction that was likely to be required to achieve financial balance;

5. noted that oversight of the budget process would continue to be undertaken by the Finance and Policy Committee; and

6. noted that expenditure control measures and financial recovery actions continue to be implemented.

(Reference: Report by Head of Finance dated 17 September 2025, submitted)

7. STRATEGIC RISK REGISTER REVIEW

The Board gave consideration to a report providing an opportunity to review the Strategic Risk Register.

Decision

The Integration Joint Board –

1. noted that the Strategic Risk Register had been reviewed by the Leadership Team and the Audit and Risk Committee;

2. reviewed and approved the Strategic Risk Register and Risk Appetite; and

3. noted that a Board Development session to review the Risk Appetite had been scheduled for November 2025.

(Reference: Report by Head of Finance dated 17 September 2025, submitted)

The Chair ruled and the Board agreed to re-order the Business and to take items 9 and 10 of the agenda before item 8 to allow the opportunity for the Deputy Director of People to join the meeting to present the report.

8. CHIEF SOCIAL WORK OFFICER REPORT 2024-2025

The Board gave consideration to a report presenting the Chief Social Work Officer report for the year 2024/2025

Decision

The Integration Joint Board –

1. noted the content of the Chief Social Work Officer Annual Report 2024/2025;

2. noted the key activities outlined in the Chief Social Work Officer Report 2024/2025;

3. acknowledged the continued commitment of Social Work and Social Care staff in the delivery of services; and

4. noted that the Report would be submitted to the Office of the Child Social Work Adviser to the Scottish Government.

(Reference: Report by Chief Social Work Officer dated 17 September 2025, submitted)

9. CHILD POVERTY ACTION PLAN REVIEW 2024 - 2025

The Board gave consideration to a report presenting the Child Poverty Action Plan Review for the year 2024/2025.

Decision

The Integration Joint Board noted the content of the Child Poverty Action Plan Review 2024/2025.

(Reference: Report by Chief Social Work Officer dated 17 September 2025, submitted)

The Chair, on behalf of the Board noted that Mandy Sheridan, Service Improvement Officer, would shortly be retiring and it was likely that this would be the last time she would attend the Board to present. He thanked her for all her work on the preparation of the Child Poverty Action Plan Review this year and in previous years.

10. Q1 WORKFORCE REPORT 2025/26

The Board gave consideration to a report detailing the workforce data of the Health and Social Care Partnership as at 30 June 2025; providing the current demographic position, highlighting trends and advising of changes and progress made, as well as actions taken to address the areas of concern.

Decision

The Integration Joint Board noted the content of the submitted report.

(Reference: Report by Deputy Director of People dated 17 September 2025, submitted)

The Chair ruled, and the Board agreed, to adjourn the meeting from 3.20pm to 3.30pm for a comfort break.

11. FAIR ACCESS AND THRESHOLD OF CARE PROPOSAL

The Committee gave consideration to a report providing a broad community and professional response to the information collated from the public consultation on proposed changes to the delivery of Care at Home services.

The Board were advised that the Finance and Policy Committee held on 16 September 2025 had considered the report and had recommended to the Board that the that the number of hours per week Care at Home threshold be set at 28 hours.

Decision

The Integration Joint Board –

1. noted the report;

2. agreed the recommendation from the Finance and Policy Committee that the number of hours per week Care at Home threshold be set at 28 hours;

3. approved the policy proposal based on the threshold being reviewed annually noting a requirement for the Integration Joint Board to support an option;

4. noted the risk in year if an option was not supported;

5. noted the potential for increased risk to care delivery/unpaid carers for those with highest need that required to be monitored; and

6. noted the supplementary actions generated by the consultation.

(Reference: Report by Head of Finance and Interim Head of Strategic Planning, Performance and Technology dated 17 September 2025, submitted)

12. DRAFT JOINT STRATEGIC PLAN

The Board gave consideration to a report presenting the consultation copy of the draft Joint Strategic Plan 2026-2031 for approval.

Decision

The Integration Joint Board –

1. approved the draft Joint Strategic Plan 2026-2031 for public consultation; and

2. endorsed the consultation and communication plan.

(Reference: Report by Interim Head of Strategic Planning, Performance and Technology dated 17 September 2025, submitted)

13. ARGYLL AND BUTE HSCP ANNUAL PERFORMANCE REPORT 2024/25

The Board gave consideration to a report presenting the Draft Annual Performance Report for the Health and Social Care Partnership for the year 2024/25 which set out how the Health and Social Care Partnership was improving on the National Health and Wellbeing Outcomes.

Decision

The Integration Joint Board approved the Draft Annual Performance Report for the Health and Social Care Partnership for the year 2024/25.

(Reference: Report by Interim Head of Strategic Planning, Performance and Technology dated 17 September 2025, submitted)

14. HEALTH & SOCIAL CARE PARTNERSHIP - PERFORMANCE REPORT - FQ4 2024/25 (JANUARY - MARCH)

The Board gave consideration to a report detailing performance of the Health and Social Care partnership for Financial Quarter Four 2024/25 with the performance outcomes being taken from the Integrated Performance Management Framework.

Decision

The Integration Joint Board –

1. acknowledged performance for FQ4 2024/25 (January – March 2025);

2. acknowledged the performance update on the National Health and Wellbeing Outcomes and Ministerial Steering Group Integration Indicators (Appendix 1); and

3. noted the Delayed Discharge Sitrep as of 31 March 2025 (Appendix 2).

(Reference: Report by Interim Head of Strategic Planning, Performance and Technology dated 17 September 2025, submitted)

15. REVIEW OF THE INTEGRATION SCHEME 2025

The Board gave consideration to a report providing an update on the review of the Health and Social Care Integration Scheme 2025.

Decision

The Integration Joint Board –

1. noted the proposed revisions detailed within the updated Integration Scheme at appendix 1 to the submitted report and the summary revisions document at appendix 2 to the submitted report, as approved by Argyll and Bute Council and NHS Highland Board at their meetings held in June/July 2025;

2. noted the arrangements that had been put in place for the joint consultation exercise as set out at section 3.4 of the submitted report and the Consultation and Engagement Strategy at appendix 3 to the submitted report; and

3. noted that a further update would be reported to the Integration Joint Board following the conclusion of the consultation exercise.

(Reference: Report by Interim Head of Strategic Planning, Performance and Technology dated 17 September 2025, submitted)

16. REVISED MEMBERSHIP ARRANGEMENTS FOR APPOINTMENTS PANELS RECRUITING HEADS OF SERVICE

The Board gave consideration to a report presenting revised arrangements for Head of Service Recruitment Panel Membership for the Health and Social Care Partnership.

Decision

The Integration Joint Board approved the revised arrangements for Head of Service Recruitment Panel Membership.

(Reference: Report by Head of Customer Support Services dated 17 September 2025, submitted)

17. DATE OF NEXT MEETING

The date of the next meeting was noted as Wednesday 19 November 2025 and it was noted that the next meeting would take place in the Helensburgh and Lomond Civic Centre.

Clerk to the Pharmacy Practices Committee
Assynt House,
Beechwood Park,
Inverness.
IV2 3BW
Telephone: 01463 – 706814
e-mail: nhsh.cpsoffice@nhs.scot

Nathan Ware
Governance & Corporate Records Manager
Assynt House
Beechwood Park
Inverness
IV2 3BW

Our ref: PharmList – Helensburgh Pharmacy
Date: 19th September 2025

Dear Nathan Ware,

NHS HIGHLAND PHARMACY PRACTICES COMMITTEE
HEARING TO CONSIDER THE APPLICATION BY Muaz Jamil and Daniel Frame, 1-3 East King Street, Helensburgh G84 7QQ.

In accordance with Schedule 3, Regulation 5(10) of the National Health Service (Pharmaceutical Services)(Scotland) Regulations 2009, as amended, NHS Highland convened a Pharmacy Practices Committee **3rd September 2025** to hear the application from **Muaz Jamil and Daniel Frame** to provide general pharmaceutical services at **1-3 East King Street, Helensburgh G84 7QQ.**

The Committee, having heard and considered all the evidence presented, unanimously agreed to **NOT GRANT** the application.

Yours sincerely,

Eleanor Rose

Community Pharmacy Business Manager to the Pharmacy Practices Committee

Enc.

Minute Report

Minutes of the Helensburgh PPC Hearing

Wednesday 3rd September,2025

PANEL MEMBERS

Karen Leach	Chair (Non-Executive Director NHSH)
Mark Sutherland-Fisher	Lay Member
Ian Gibson	Lay Member
Susan Paterson	Contractor Pharmacist
Catriona Sinclair	Contractor Pharmacist
Catriona Brodie	Non-contractor Pharmacist
Gayle MacDonald	Non-contractor Pharmacist

IN ATTENDANCE

Fiona Clark	Minute Taker

OBSERVERS

Fiona Macfarlane	Associate Director of Pharmacy (Community Pharmacy) & CD Governance
Eleanor Rose	Community Pharmacy Business Manager
Claire Fortey	Senior Administrative Assistant

INTERESTED PARTIES

Muaz Jamil/Daniel Frame	Applicants
Malcolm Mathieson	APC
Cameron Foy/Elizabeth Lambert	Helensburgh Community Council
Martin Green	M & D Green Community Pharmacy
Scott Jamieson/Stuart Mcbean	Boots Community Pharmacy
Mark Dickinson/Claire Cunningham	Rowlands Community Pharmacy
Ubayd Ali/Hamad Khalid	Cardross Community Pharmacy

1. Chairman's Address

The Chair welcomed everyone in person and on Teams to Assynt House, Inverness, introduced herself as non-executive director of NHS Highland for the purposes of this PPC Hearing for an application for a pharmacy at 1-3 East King Street, Helensburgh. G84 7QQ.

The Chair explained that she was also a member of the IDB, Argyll & Bute and a resident of Argyll & Bute, making everyone aware of that. For assessment of conflict-of-interest advice was sought from CLO and also, I have provided the objective test and see no reason as to why I cannot continue as chair for this meeting. Therefore, no issue with chairing this meeting. The panel and Board members introduced themselves to those present.

The Chair drew attention to the advice document in the folder which was sent in advance. Remember every party will only contribute through one identified person which. At the request of the applicant several supporting letters and emails were received and asked to be considered prior to the Hearing. These documents came to us after the CAR otherwise would have been included in that document. They were circulated to the parties and panel on 29th August and please check everyone has received and read these documents and had time to consider.

M & D Green received a zip file, one of which would not load correctly. APC received but had not gone to full APC. All others received. MD asked if he would like some time to read the missing file but declined. He wanted to make a request that communicating through email ensures the information is sent, doesn't ensure the information is received. All information pre-covid used to be sent in writing, covid changed all of that and were allowed to communicate by email but had encountered several issues at several Hearings when information had not been correctly received because it was sent by email. He made a plea that there is a return to sending copies of information by Recorded Delivery to ensure receipt of the applicant's information. The Chair advised this request would be relayed.

The applicant mentioned that they had a PowerPoint presentation towards the end of the presentation.

2. Applicant Presentation

Applicant -

Good morning everyone. Firstly, my name is Muaz, and I'd like to thank everyone in attendance today for allowing me to present the case to highlight that this application is both necessary and desirable to secure adequate provision of pharmacy services in the neighbourhood.

I am accompanied today by my best friend Daniel. Both Daniel and I are prescribing pharmacists and have experience working in various pharmacies across Scotland.

Daniel has worked in Helensburgh when the area was serviced by four pharmacies so that gave us first-hand understanding of the pressures experienced in the area.

I will frame this presentation around the legal test and begin by outlining our neighbourhood for this application. I will then proceed with information around the background of Helensburgh and highlight key demographic insights that shape the healthcare needs of the area. I will then present clear evidence, drawing on the Consultation Analysis Report which I will refer to as the CAR, statistical data, and letters of support. This will demonstrate why the current pharmaceutical provision in the neighbourhood is inadequate. Finally, I will outline our plans for Helensburgh pharmacy and explain how granting this application is both necessary and desirable to secure adequate provision of high quality pharmaceutical services, both now and into the future.

So firstly, the neighbourhood –

To the North – Where Sinclair Street meets Luss Road where we have physical boundaries of the Helensburgh reservoir to the left and the Helensburgh Golf course to the right.

To the West – Where Rhu Road higher meets Rhu Road lower.

To the East – The Alder gate development which is open fields from the A814

To the South – The A814 running along the waterfront.

Our neighbourhood is a very simple one to define due to the natural physical boundaries and 97% of people in the CAR agree with this. Helensburgh is a neighbourhood for all purposes, the bank, the post office, places of worship and supermarkets. These are all markers of this. People are drawn into this area, and residents don't need to leave for any purpose.

Helensburgh is the largest settlement in Argyll & Bute, home to a population of 14,127. Helensburgh neighbours Rhu, a village of around 1,900 people who use Helensburgh's amenities and access pharmacy services.

From a socio-economic point of view, Helensburgh's population is very mixed. Vivien Dance, a long-time resident puts it best in her letter of support – she says, "Helensburgh is a town with a very mixed population, with areas of deprivation and affluence". She also points out that our population is "more on the mature side" and the data actually supports this. Between 2002 and 2021, the number of residents aged 65 and over in Helensburgh and Lomond rose by 44%. Today 25.5% of Helensburgh's population is over 65. That is well above the Scottish average of 20%. Another 23% are aged 50 to 64, again higher than the national figure of 21.5%. These aren't just numbers, they represent people in the community, many of whom live with chronic health conditions and depend on regular medication.

Now, in terms of affluence, Vivian's knowledge of the area is also confirmed by the Scottish Index of Multiple Deprivation (SIMD) 2020 which identifies three data zones within Helensburgh that fall within the 20% most deprived areas in Scotland. This deprivation, when combined with an ageing population who are more reliant on pharmacy services, reveals a community with deeply embedded healthcare challenges. In such an area, services should be supported, not reduced.

Another key factor driving the growing demand for healthcare services in Helensburgh, is the ongoing expansion of it's population. Contributing to this, is the increase in naval personnel and their families. By 2030 it's estimated that 1,700 naval personnel and their families are expected as part of the Faslane expansion. 639 new naval housing have been approved in November 2024 and scheduled for completion by March 2026. This will place further pressure on already stretched local services. This anticipated growth underscores the urgent need to enhance access to pharmaceutical care, ensuring that all residents – both current and new can receive adequate support within their own community.

Today, Helensburgh is designated as part of the Helensburgh and Lomond Growth Area in the local development plan in that it's reflecting it's appeal as a place where people want to live, work and raise families. This is more than a planning designation, it's a reality supported by sustained housing growth. Examples include: 83 new homes at Duchess Gait completed in 2021, the Alder Gate development bringing 107 new homes completed in 2024 and the upcoming transformation of the Helensburgh Golf Course site where 300 homes are planned, 25% of which will be affordable housing.

The council have acknowledged that Helensburgh is a priority settlement for housing, citing high levels of need and demand. Councillor Robin Currie, Leader of Argyll & Bute Council at the time

stated that there is a pressing requirement for new housing developments in the area. Recent plans support this as the Lochside Press reports the council are planning to bring 1,800 to 3,600 homes to the area.

With all this growth, the pressure on local healthcare service is increasing rapidly.

Helensburgh is serviced by two GP practices. The Victoria Integrated Care Centre in Helensburgh offers outpatient services across 19 specialties. This is an indicator of the complex health needs of the neighbourhood which implies pharmaceutical demand is present. The town is also served by four Dental Practices, four Opticians and four Care Homes, and before the Boots closure, Helensburgh was served by four pharmacies.

For more than 20 years Helensburgh was served by four pharmacies. But, today, this is no longer the case. In November 2023, Boots made a commercial decision to close the Boots pharmacy on 47-49 Sinclair Street. Despite the town's growing and ageing population, despite the influx of military families, despite the clear and mounting evidence of current and future demand, the healthcare infrastructure in Helensburgh is weakening and the lack of adequate pharmacy provision has caused huge challenges for residents, and it has created barriers to access pharmacy services across the town. Jackie Baillie, the local MSP and Shadow Health Secretary has given her full support for this application given the concerns raised from her constituents about this lack of provision.

In an already expanding area, the Boots closure leads to further deterioration of the service residents receive and we can see examples of the impact this reduction has had on real people's lives. Daniel and I spoke to recovery volunteers Catherine and William at the Welcome in Recovery Group. They shared powerful stories of how gaps in pharmacy services have affected their health, lives and daily recovery.

One major concern was the loss of the needle exchange service, previously run by the small Boots branch that closed. When it shut, no replacement was put in place by other pharmacies. People began to share needles and used syringes started appearing on the streets and even the beach. Just like other services lost with the closure, there was no contingency plan made. Inadequate pharmaceutical services in such an area are a genuine risk to community well-being.

It is stated in the NHS Highland Pharmaceutical Care Services Plan that in view of recent pharmacy closures, the unmet need for additional community pharmacy provision may be required to be considered. Now I'd like to highlight that it is highly unusual for the Health Board to directly mention the potential need for a new pharmacy. The CAR responses support this statement in the Care Services Plan as the negative consequences specifically due to the Boots closure are mentioned over 200 times within the CAR.

The impact of the closure is undeniable. We hear it in the voices captured in the CAR, and we see it in the growing body of evidence – from heartfelt letters of support to professional endorsements showing that this closure was not in the public's interest, and it led to inadequacies in pharmacy services, damaging the local healthcare and neighbourhood.

In her letter of support, Sarah McCarthy, Practice Manager of 2020 Opticians, describes the strain on remaining services and delays in accessing care.

In her letter of support from Millig Medical Practice, Carole-Anne McIlroy highlights her awareness of the pressures since the closure and the resulting impact this has had to the General Practice.

It is not common for healthcare professionals to support pharmacy applications but as we begin to understand the depth of service gaps, we quickly realise why they are so vocal.

Five months after the closure in April 2024, the Community Advertiser published a powerful article describing the aftermath, and I quote – "chaos". Now, this was not an exaggeration. The disruption caused by the closure continues to reverberate across Helensburgh to this very day. The scale of public concern is clearly reflected in the CAR, with over 1,000 individuals taking the time to complete the questionnaire. On top of this, we have received twenty letters of support. These accounts highlight a clear and immediate consequence – the closure didn't just remove a building; it removed vital capacity and that loss is being felt every day by people who depend on these services.

I will proceed by now addressing the core services in Helensburgh. Firstly, the Pharmacy First service. In terms of accessing this service, the CAR repeatedly reveals how difficult it can be to obtain appropriate pharmacy advice, treatment and referrals.

Over 100 responses in the CAR highlight how difficult it has become to speak with a member of staff, with repeated mentions of teams being "too busy" or "run off their feet" or simply "unavailable". How can health interventions and Pharmacy First be delivered when patients cannot even speak to a healthcare professional? Several residents even shared that they are encouraged to purchase medicines over the counter rather than receive a Pharmacy First consultation. Some report they are unable to access smoking cessation support as they are told the pharmacy is too busy, others are wrongly informed that they are actually ineligible for the service.

It is clear that overstretched services have caused huge barriers to care.

One resident states in the CAR – "speaking to a pharmacist is almost impossible unless you're prepared for a long wait and then to feel that you're taking up their time because they are too busy".

The Pharmacy First services in Helensburgh are proven to be inadequate due to overwhelming workloads in the remaining pharmacies. Despite having two of the busiest pharmacies in NHS Highland for prescriptions their Pharmacy First output is contrastingly low.

In most recent published figures from March, M & D Green ranked tenth in the NHS Highland for Pharmacy First delivery while Boots ranked 22nd. Rowlands, well to fairly assess Rowlands, we compared them with pharmacies dispensing around 3-4,000 items in NHS Highland. Out of 23 pharmacies for Pharmacy First delivery, Rowlands ranked 20th. But here is what's crucial to understand :

The pre-cursor to Pharmacy First was a service called Minor Ailments. It had limited eligibility criteria unlike Pharmacy First, which is available to everyone living in Scotland. In 2020, under the Minor Ailments Service, pharmacies in Helensburgh were performing significantly better despite this limited eligibility criteria. M & D Green (Gordons at the time) was third highest for service delivery in NHS Highland while the two Boots pharmacies ranked fourth and the now closed Boots 7th highest.

Rowlands, when compared to the same pharmacies as before ranked tenth. So, in comparison, Pharmacy First usage has dropped considerably in the area, despite the wider eligibility. So how is it, that under a limited service, pharmacies were doing more and now with Pharmacy First open to everyone, they're doing less?

The key issue here is capacity. At the time of the Minor Ailments Service, Helensburgh was serviced by four pharmacies. This caused workload to be better distributed, allowing pharmacists time for consultations and treatment. Since the Boots closure, the three remaining pharmacies are overstretched and struggling to meet the growing demand. While the number of residents

are increasing, along with their needs, they have lost one entire pharmacy in the neighbouhood and that's one fewer team providing this vital frontline care. That loss is on top of the fact that all three remaining pharmacies have actually reduced their output due to capacity issues. This is not a reflection of poor staff or effort but a reflection of a system that is under strain.

Newcomers to the area especially highlight these inequalities within the neighbourhood when they're compared to their previous pharmacies. One newcomer shares: "Recently moved to the area from Glasgow and the pharmacy services here are noticeably inadequate. The waiting times at the pharmacy are much longer and I have been to all three so I can decide who I should use as my primary pharmacy. Compared to my old pharmacy, you need to wait longer, and you are encouraged to buy things over the counter rather than getting it on the Minor Ailments Service".

This widespread issue across all three pharmacies shows us that the service is not being adequately provide, it's not from lack of need or training but because pharmacies simply don't have capacity at the moment.

The CAR also reveals serious concerns when it comes to confidentiality during consultations. 80% of residents believe there is not adequate space to discuss confidential matters with close to 100 written responses sharing their concerns. The public's concerns about privacy are so great, many actually avoid using the pharmacies in the neighbourhood for consultations altogether. And, as we read the CAR, we begin to understand why this is the case. M & D Green in the pharmacy doesn't have a consultation room in their pharmacy. Instead, there is an exposed corner. You can clearly hear the consultation and even see who is inside. At Boots, the pressure of workload means that consultations often happen on the shop floor, where conversations can be overheard. This scenario is reported in the CAR several times. And, at Rowlands, even when the consultation room is used, patients have reported that you can still hear everything from outside the room because the consultation room is not closed at the top, it doesn't have a closed roof.

The only pharmacy in Helensburgh that had a private functional consultation room , and used consistently, was the Boots on 47 Sinclair Street. And that's the very one that was shut down.

How can vital services like Pharmacy First and Emergency Hormonal Contraception be delivered effectively under the current conditions?

Now let's think about what's happening locally here. Young women feeling anxious or distressed about where to access EHC, individuals struggling to quit smoking, patients trying to manage long-term conditions without timely confidential support – these are not rare scenarios but they're daily realities in an overstretched system. We can see from the CAR that females need to carefully plan where and when to access EHC to avoid being overhead during what should be a confidential private consultation. Delayed or inaccessible care leads to poorer health outcomes and greater pressure on the wider NHS services.

We also see inadequacies of pharmacy services in Helensburgh extend into another core service – unscheduled care service where we will move on to now. This core service is designed to provide emergency supplies of medication when a prescription has not come through in time and it helps people avoid dangerous treatment gaps. But based on multiple accounts in the CAR, this safety net is failing. Patients describe being denied essential medication for long-term conditions like heart disease, hypertension. In some cases, patients felt forced to ration their medication just to get by.

The CAR reveals a consistent pattern where patients are unable to access emergency medication and thats likely because pharmacy teams are under so much pressure managing routine dispensing they simply do not have the capacity to process urgent supply supplies. In

Helensburgh, access to unscheduled care through local pharmacies in unreliable and inconsistently delivered. This poses a very real risk to the health and safety of residents, and it's the residents in Helensburgh that are feeling this effect.

Now moving on to AMS Service. Dispensing acute prescriptions is one of the most fundamental pillars of community pharmacy and losing a pharmacy in the area has placed immense strain on each of the pharmacies and their staff, and it has rendered this service inadequate. In the CAR when talking about staff, pressure, strain and stress are common words used. The Boots closure has caused immense workload for all and in turn has failed the systems. Waiting times have increased so much that they have been mentioned over 200 times in the CAR.

The reduction to just three pharmacies has led to a collapse of pharmaceutical services in the neighbourhood. Overwhelming evidence points to a widespread unacceptable wait times with patients often waiting 40 minutes in line, only to be told their prescription isn't ready. In the CAR, one resident shared their experience of collecting emergency antibiotics from Boots. They said they waited 30-40 minutes with the pharmacist then requesting that they returned later to collect. This patient now leaves the area altogether for their prescription. This is simply unacceptable. Such queues have been reported in the CAR and to this day, six months on they persist.

At this point, the applicant was going to share an image on screen, however, MD objected as this he deemed was new evidence. The applicant agreed to explain the image he would have shared.

Such queues have been reported in the CAR which concluded in March and to this day, six months on they still persist. After residents were told of the Hearing on 6th August would be slightly postponed, they began to send us in images of queues in the pharmacies and it really highlights inadequacies so we could see queues from Boots pharmacy with 10, 15, 20 people standing in a line. That is also represented in the CAR. It proves that the pharmacies are not coping under this pressure. In M & D Green queues are so large they extend out the door and on to the street. For over a year, there was a notice on the window directing patients which way to queue on the street and that is noted in the letter from Vivian. Now, this notice has been removed. So, have the queues in the street stopped? Well, we can see that they haven't.

In the images that we had they are now queues on either side. All removal of the sign has done is to confuse people as to what side of the street they should stand on. I really sympathise with the pharmacy staff, who are doing their best under this immense pressure. Unfortunately, their management, present today, will seek to present a narrative that doesn't actually reflect the reality on the ground. This helps no one. Patients will see no improvement and the community will continue to suffer from substandard NHS services.

Beyond long waiting times, residents are often forced to make multiple trips just to collect a single prescription. It's a common and deeply frustrating issue. Patients arrive only to be told the GP hasn't sent the prescription. They go back to the practice, where staff confirm it has been sent to the community pharmacy. They return to the pharmacy, queue again in these long queues and may still leave empty-handed. This back-and-forth place pressure on GP practices and causes real distress to patients, many of whom just urgently need their medication. To be clear, we understand that sometimes multiple trips are unavoidable, medications need to be ordered, and stock availability does vary. That's reasonable. But what we're seeing in Helensburgh goes far beyond that. The CAR shows this is a widespread and systematic pattern across all three pharmacies in Helensburgh. Elderly residents with limited mobility are queuing and returning repeatedly. Patients with young children are juggling multiple visit's just to get basic medication. This is not a working service. This is a breakdown. And when people cant access their prescriptions reliably, that is a fundamental failure of the core service – one we cannot afford to ignore.

The lack of blister pack availability in Helensburgh is another persistent issue. This is a locally negotiated service that underpins AMS which is vital for many to manage medication independently. Elaine from Helensburgh & Lomon Carers and Katrine from Jean's Bothy both highlight this in their letters of support, describing a clear and local shortage, and the impact on vulnerable individuals. They note that a new pharmacy could help address this unmet need and improve safe, consistent medication management. When someone needs a dosette box but can't get one, that's not a small issue – it's a failure of the AMS and a sign of inadequate capacity. Simply put, if a person can't reliably take their medication, how can we say the AMS service is delivering properly with proper care?

Dispensing errors are a recurring theme in the CAR, and they are mentioned 29 times. These represent one of the most serious risks in pharmacy. While human error can never be eliminated entirely, the situation in Helensburgh shows a concerning trend. Since the closure of Boots on Sinclair Street, the remaining pharmacies have been under unsustainable pressure, and that pressure is reflected in dispensing mistakes.

In April 2024, a local pensioner spoke publicly about the repeated prescription errors; eleven months later residents are still reporting similar experience as seen from the CAR. These are not isolated signs or isolated issues, they are signs of a system under strain, with increased prescription volumes and reduced capacity. We asked Boots for comments regarding dispensing errors and discovered that Boots on Sinclair Street reported zero errors in 2023. In 2024, after the closure, that figure rose to 15.

To be clear, this is not a question of staff competence, but of capacity and pressure. With services overstretched, mistakes have become more likely. This raises important questions about patient safety, and it is reflected in the fact that some residents now avoid local pharmacies due to safety concerns.

Despite Helensburgh being such a focal point in Argyll & Bute, the inadequacies of current pharmacy provision in Helensburgh forces residents to travel well outside their own community to access core services. This raises a critical question for the PPC – what constitutes a reasonable and acceptable distance for someone to travel in order to access essential medication.

Today, people in Helensburgh are making round trips of over 8.5 miles just to reach a pharmacy in Cardross. One respondent states: "I live in sheltered housing in Helensburgh, yet I am having to use Cardross pharmacy for my medication. This is because all the local pharmacies are under so much pressure. I'd love to be able to use a pharmacy locally, but this is just not possible currently".

This isn't just a one-off. The CAR responses show that many residents are forced to leave their neighbourhood just to access basic pharmacy services. So, I ask the panel – is it reasonable to travel over 8.5 miles just for essential care? Especially those without cars – taking buses or trains, incurring extra costs, and adding to the environmental impact?

But it gets worse. The pressure in Helensburgh is so severe that even Cardross Pharmacy can't address the inadequacies. People are now travelling a 15-mile round trip to the Davidsons Chemist in Garelochhead. One respondent puts it plainly – "I don't often get prescriptions but when I do, I go to Garelochhead. The pharmacies in Helensburgh are too busy and I don't feel it's safe".

A pharmacy assistant from Garelochhead confirmed in the CAR that many Helensburgh residents rely on the pharmacy in Garelochhead.

Arlene Love, the former Practice Manager at Garelochhead Medical Centre, completed the CAR on the Practice's behalf. She wrote that this pharmacy is "welcomed and much needed" because "local pharmacies can't cope with the demand".

This is the reality of the pharmaceutical services in Helensburgh. Yet today, we'll hear from others claiming the current service is "adequate".

However, adequacy of services can be simply disproved as remarkably, there is another pharmacy that is servicing the area in an attempt to address the inadequacies of the pharmacies in Helensburgh. This pharmacy isn't ten or even twenty miles away. This pharmacy is 40 miles away from Helensburgh. Inveraray Pharmacy is making an 80-mile round trip to deliver hundreds of prescriptions to Helensburgh residents in an attempt to enable patients to receive the care they so desperately need.

There is mention of Inveraray Pharmacy around 30 times in the CAR. It is a stark reflection of the system's failure that a pharmacy requiring a two hour round trip is intervening to address deficiencies in Helensburgh. In the CAR one resident simply puts "If a pharmacy as far away as Inveraray is having to help out, there's clearly issues with the current pharmacies". This powerfully highlights the immediate need for intervention to support the pharmacies of Helensburgh and to enable access to adequate pharmacy services for the residents.

Despite pharmacies out with the neighbourhood trying their best to help with inadequacies, the complex needs of the neighbourhood is unfortunately still not being adequately met. The CAR provides undeniable evidence of the consequences, and this is not a case of isolate dissatisfaction – it is a picture of systemic strain.

The closure is mentioned over 200 times. The word pressure appears 134 times. Chaos appears ten times in the CAR, issue 68 times, problem appears 44 times and mistake twelve times. Most tellingly, statements that the pharmacies need help are mentioned around 200 times.

This isn't just language – it's the voice of a community under strain. Granting this application is the only way to secure adequate access of pharmacy services.

Now, having established the clear need in Helensburgh, we do need to consider how approving this application will impact the viability of the existing pharmacies. Some may argue that Helensburgh cannot support an additional pharmacy and that existing providers, particularly Rowlands, would be at risk. But this is not supported by evidence. Prescription demand has been rising year on year. Since 2021, monthly prescriptions from Millig and McLachlan practices alone have increased by over 4,000 items; that's enough to support a new pharmacy in it'self but despite this, the town has lost a pharmacy, not gained one.

For over two decades, Helensburgh successfully operated with four pharmacies. NHS Highland's own data reveals that M & D Green is the busiest pharmacy in the entire Health Board with Boots also being one of the busiest, this shows the huge demand in the area.

So, concerns about Rowlands Pharmacy and Rowland's viability are misplaced. Their dispensing volume, around 3,500 items per month, has remained stable for over a decade, even after the Boots closure. This is largely because Rowlands is already operating at capacity and relies on an off-site dispensing hub, which residents report causes multi day delays. The CAR includes numerous complaints about these delays, with carers also affected due to late MAR charts and medication. Additionally, the location of Rowlands limit's it's footfall as residents report difficulty accessing it.

Our proposed pharmacy is located closer to the former Boots site. This will relieve pressure from M & D Green and Boots which will improve access and help retain prescriptions that are currently

leaving the area. Let's not forget, Rowlands along with the other contractors operated sustainably when four pharmacies existed in the town for over 20 years. The claim that this application threatens viability is not supported by facts.

Approving this application will transform how residents access pharmacy services. Our unit, located just off busy Sinclair Street, is within walking distance of the practice and benefit's from free on-site parking. Patients will enter through a welcoming entrance with a wide ramp – making the pharmacy fully accessible to all. Inside, it will be bright and comfortable with space designed to accommodate everyone. At it's centre will be a fully private consultation room – a calm, confidential space where patients can receive care without fear of being overheard.

We will be open from 8.00 am to 6.00 pm, matching the GP hours. This means no more patients waiting 45 minutes after a morning appointment, and working people will finally have access to pharmacy services. The pharmacy will be run by both Daniel and I, giving residents immediate access to a prescribing pharmacist, alongside all core pharmacy services.

With the approval of this application, patient-centred care will be returned to Helensburgh. The needs of every patient will be heard and addressed, whether that means collecting medication in a timely manner, receiving an urgent supply when medicines have run out, accessing treatment through Pharmacy First Plus, or even obtaining advice as a carer. Our pharmacy will ensure reliable access to all core services. It will directly address each of the inadequacies and ease the pressure currently placed on the town's remaining pharmacies. Our aim is to restore balance across local pharmacy services, relieving the excessive workload so that collectively we can deliver safe, accessible and effective community care once again.

We believe we have provided the PPC with irrefutable evidence that the service in Helensburgh is inadequate. The only remedy to these inadequacies I have mentioned today is the approval of this application which 90% of residents support. Residents have actually made it clear that this application is necessary and desirable with even just last night before we went to sleep, we received a message from a Mrs. Macniven. She said "the sooner the better. All the pharmacies in Helensburgh are so busy, we definitely need this and look forward to you opening".

I would like to thank everyone for their patience this morning. vI appreciate this is quite a lengthy presentation with a lot of information to consider.

Thank you very much.

End of presentation.

3. Questions from IPs/Panel

M & D Green – You finished off your presentation there referring to your premises. Can I just check with you – do you own the premises?

Applicant – We don't currently own the premises, but we have an agreement, a legal agreement.

M & D Green – It currently looks like a newsagent. You mentioned in your application that you intend to refit the premises. Have you applied for planning permission? Building warrant?

Applicant – We have had an architect out and they have had a look at the building, and they are confident that we could get the area transformed as a pharmacy.

M & D Green – In your application you state that when you complete your refit you will be fully compliant with the Equalities Act. Can you tell me what you mean by that?

Applicant – Ensuring access for all. At the moment, there is a step into the shop. We will be installing a ramp. We will also have a consultation room. The shop fitters and architect we had out were confident we would be compliant with this.

M & D Green – We will start with your ramp. Where is your ramp going to be?

Applicant – There is a pavement outside the shop which is about 10 ft wide.

M & D Green – Do you think you will gain planning permission to put a ramp on to the pavement?

Applicant – We have contacted the council, and the council are more than happy to look at this.

M & D Green – Have you submitted a planning application to put a ramp outside your premises on to the pavement.

Applicant – When we contacted the council, they said this would need to go in once we gained approval of the application. At the moment this has not been submitted but have been in contact with the council who are more than happy that this will be absolutely fine. We also contacted the council regarding disabled access, and the council are happy to put a disabled bay outside the pharmacy as well once the application has been granted.

M & D Green – Do you know the dimensions of a disabled toilet?

Applicant – I'm not sure in a pharmacy.

M & D Green – Do you have a disabled toilet in the building at the moment and is it DDA compliant?

Applicant – It is not accessible for patients at the moment.

M & D Green – Is it DDA compliant?

Applicant – The shopfitters who came out along with the architect are confident we will comply with the DDA.

M & D Green – Do you have a consultation room in the building at the moment?

Applicant – There is space for a consultation room. We actually had the plans which were going to be on the screen today, but we were not able to show them so, yes,

M & D Green – You have a picture, a computer-generated image of the pharmacy on your Facebook page. Will your pharmacy actually look like that?

Applicant – The computer-generated image was from a sketch artist. It was just a rough sketch of the pharmacy.

M & D Green – So, it's not going to look like that?

Applicant – We're not sure as we still have to get the architect image. It might look like that; it might not look like that.

M & D Green – It looks quite open-plan. It looks large. It has a double front door at the front of the building. Apparently, the building has a supporting wall. How do you plan to remove that?

Applicant – It's just a generated image so it doesn't necessarily mean it will look like this.

M & D Green – You refer to this wide opening in your presentation as if it's a feature to the access of the pharmacy but there is a supporting wall exactly where you are proposing to put that door.

Applicant – The supporting wall has a glass window to the left and so it will still have a wide opening.

M & D Green – That is just a computer-generated image, it might not look like that?

Applicant – Yes.

M & D Green – Do you think that is misleading in any way?

Applicant – I don't believe so because we never mentioned that it was going to be like that. Structures change as the process happens. We just wanted to give a visual of how the pharmacy may look.

M & D Green – Are the premises large?

Applicant – It is large.

M & D Green – Can I ask what the square footage is?

Applicant – It's 60 metres square.

M & D Green – Do you consider that to be a large pharmacy?

Applicant – The premises are a good size. 645 square feet. I have actually worked in pharmacies that are smaller.

M & D Green – That is not the question – do you consider that to be a large pharmacy?

Applicant – I'm not sure how you define a large pharmacy. Pharmacies come in many different sizes and it's functional for that.

M & D Green – They do come in many different sizes, they come in small, medium and large. Do you consider that to be a large pharmacy?

Applicant – I consider it to be functional.

M & D Green – You have been very active in the area promoting the pharmacy, or the proposed pharmacy should I say. Did you meet with a number of community groups?

Applicant – In the CAR there was a list of who we met with. We wanted to make the consultation widely known, we wanted to meet with a number of people so they could share their experiences. We wanted to have as many people as possible have their voice heard.

M & D Green – Did you invite any of the Interested Parties to this meeting?

Applicant – They were public meetings.

M & D Green – Were the Interested Parties advised as to when those meetings might be so they could attend.

Applicant – The meetings were told to the Health Board, and they were all public meetings so anybody could attend.

M & D Green – Are you sure the Health Board were notified of when you were meeting with these groups.

Applicant – I am not sure, but they were all public. We were invited to Parish halls and anybody come in and have a chat.

M & D Green – In any event were there any Interested Parties at any of those meetings.

Applicant – Not that I recall but the meetings werent held by us personally, we were just attending them as applicants.

M & D Green – Is there a risk then that these meetings did not have a particularly balanced approach?

Applicant – Really it was just about raising awareness and directing people to have their opinions shared. Whether that was Yes, they wanted a pharmacy or No, they didn't think another pharmacy was needed. It was all about awareness.

M & D Green – Did you encourage them to make responses?

Applicant – We directed people to the questionnaire where they could have their voices heard.

M & D Green – If you application is granted; you have chosen an unusual location for your premises. It is probably closer to the Health Centre than anybody else's existing pharmacy. Do you expect that your pharmacy will be busy?

Applicant – We expect, because of the strains in Helensburgh is so great at the moment, we expect there to be patients will come to us so that they can receive an adequate service and what that will do is allow the others in the area to provide adequate service as well, lifting that strain

M & D Green – That's not what I asked. Do you expect your pharmacy to be busy?

Applicant – Do you want the numbers we think we will do?

M & D Green – That would do it.

Applicant – We think the numbers we will achieve will be about four to five thousand items per month, that is roughly the same as the old Boots was doing or five to five and a half thousand. Around that number.

M & D Green – You will be the closest to the Health Centre and you think you will do four or five thousand items?

Applicant – Being the closest pharmacy doesn't necessarily mean we will be the busiest.
M & D Green – It's currently what drives it.

Applicant – From my experience I wouldn't say so. There are pharmacies I have worked in which are very close to a Health Centre and they are not as busy as those out with. It's mostly prescriptions now rather than walk-in footfall.

M & D Green – If your application is granted do you think that will have an impact on the existing pharmacy provision in town in terms of their revenue?

Applicant – I think it will have a positive impact to the pharmacies because it will lift the strain currently placed on the current pharmacies with the repeat prescriptions which are getting processed. What that will do, it will give time for the pharmacies to provide adequate service and also provide the Pharmacy First service appropriately as well. At the moment, we can see consultations are not being done in the pharmacies, and referrals are not being done so once this strain on repeat prescriptions are removed then pharmacies will have more time to offer Pharmacy First service and that in turn will help with revenue.

M & D Green – You made reference to Pharmacy First there, do you know the average number of consultations of Pharmacy First in Scotland?

Applicant – I'm not aware.

M & D Green – You made lots of comments about Pharmacy First in your presentation so it might be helpful if you knew what an average pharmacy did for Pharmacy First.

Applicant – We have a list just not the calculation of what is the average.

M & D Green – You made the comments about Pharmacy First in the area without knowing.

Applicant – The Pharmacy First comments were on the items.

Chair – Sorry, can I interrupt, you need to ask questions, there are a lot of sweeping statements. Thank you.

M & D Green – Can I ask with the information provided late on Friday night about a newspaper article. I was a bit confused about the date. When was it from?

Applicant – It was from April 2024.

M & D Green – About a year and a half ago. That clears it up. Thank you. You made reference to having difficult accessing unscheduled care. Where is your evidence of that?

Applicant – It's in the CAR. Patients had submitted the questionnaire having said they were unable to access the service.

M & D Green – The 2020 Opticians made some comments to support your application, problems with patients accessing stock. Why would you think they would never think to approach a pharmacy. I haven't been approached by any of the Opticians. Why would that be?

Applicant – They are actually next door to the Boots pharmacy so a lot of the patients when they come out of the Opticians they go into Boots for convenience. They just walk round the next door down.

M & D Green – I mean in a professional capacity. A fellow professional experiencing difficulties with another professional. Why would they not, as a respect as a professional responsibility to go and speak to other professionals.

Chair – I don't think that would be a question you could answer. I think you would need to approach the Opticians.

M & D Green – The location of your pharmacy, the centre of town, it's not that far from any of the existing pharmacies, how far do you think you are?

Applicant – From Boots, 800 meters.

M & D Green – How long would it take you to walk?

Applicant – About a minute from the Boots on Sinclair Street.

M & D Green – How long would it take you to walk from Boots to Rowlands?

Applicant – Depends on mobility. Possibly four to five minutes.

M & D Green – How long from my pharmacy? Another minute?

Applicant – I'm not sure.

M & D Green – If you are a patient and you have a prescription in your hand and you walk into Boots and you see a queue, what would prevent you from walking round the corner, the two minutes' walk to Rowlands?

Applicant – With patients, all we can go with is what is noted in the CAR and patients are saying that it is hard to access Rowlands because of the distance, especially if they have problems with mobility. The other thing was because Rowlands have the off-site HUB stock levels are not the best which is reported in the CAR so patients tend not to use that pharmacy if they cannot get their prescription filled.

M & D Green – If I was a patient and I wanted to access Pharmacy First in Boots and there was a queue, again it's a two-minute walk to Rowlands, what would put me off?

Applicant – This is a comment in the CAR which says, "I am disabled and require walking aids, there have been days when I had to visit my pharmacy which is Boots, I have been unable to get parked close enough to manage the walk".

M & D Green – Do you see any impediment that for a patient presenting in Boots with a prescription or wanting to access Pharmacy First making the two minutes' walk round to Rowlands. Can you see any impediment?

Applicant – I don't think it's a two minute walk though because I have walked in Helensburgh many times to go to Boots and Rowlands and do not see that is an accurate representation, also, it does depend on the mobility as well and if one pharmacy has an enormous queue why should that patient be forced out of that pharmacy to go to another pharmacy. That highlights the sheer inadequacies if a patient leaves that pharmacy to go to another one and if Boots do not have the stock they would have to go to another pharmacy. This highlights the inadequacies that we have spoken about today.

M & D Green – No more questions madam Chair.

Chair – So we will move on to questions from Boots.

Boots – Do you and your business partner own any other pharmacies?

Applicant – We are part owners of two other pharmacies.

Boots – Do you mind me asking where they are?

Applicant – Falkirk and Stirling.

Boots – Are you superintendent of any of these pharmacies?

Applicant – I'm superintendent of both.

Boots – You said in your presentation that both yourself and your business partner would be working full-time in the pharmacy in Helensburgh. Any concerns about your other pharmacy in Falkirk, how you would manage that given the geographical distance?

Applicant – We currently have a part-time pharmacist and two pharmacists willing to come onboard with us full-time if the application is granted so that will allow us to work in Helensburgh.

Boots – You would work in Helensburgh and the pharmacists you would employ would work in Falkirk and Stirling?

Applicant – Yes.

Boots – Are there any other contract applications in Highland or any other Health Board at this precise moment in time?

Applicant – Not at the moment.

Boots – I'm a little confused on the viability part. You mentioned to Martin that your expectation would be around four to five thousand prescription item volume per month. Is that correct?

Applicant – Yes.

Boots – My understanding is that Rowlands is around three to three and a half thousand items.

Applicant – It fluctuates between four and four and a half thousand.

Boots – Would you say that was a very small volume prescription pharmacy already in Rowlands.

Applicant – Historically, when there were four pharmacies over twenty years, that was what their volume was. It has been that historically in the past twenty years.

Boots – Again, just asking the question, would you agree that that is a very low volume prescription items in Scotland.

Applicant – In NHS Highland there are twenty-two pharmacies that are doing less than four thousand items so albeit on the low side, it is not out with the norm, some are lower.

Boots – As Martin mentioned, you will be the closest pharmacy to the GP surgery and the distance between yourself, and Rowlands would be what?

Applicant – So just in terms of the fact we would be the closest to GP surgery, it does depend on where you park as well. The GP practice has underground parking …

Boots – The question was just around the distance between yourself and Rowlands, what distance is that?

Applicant – Sorry, I was just highlighting the fact that …

Boots – That wasn't the question though.

Applicant – Sorry, the distance between myself and Rowlands. Was that the question?

Boots – Yes.

Applicant – I'm not sure exactly what that distance is. If someone was to walk that, an elderly person, I would say it was a lot, yes.

Boots – Given it's a very short distance, if we say that, between your pharmacy and Rowlands, just curious how are you going to take four to five thousand prescriptions items a month and not impact the viability of Rowlands.

Applicant – Rowlands has been around three to three and a half thousand items a year and that is when they were four pharmacies in the area. Now there are three, their numbers haven't actually fluctuated but because of our distance to the other sites, our numbers will come from M & D Green pharmacy and also Boots pharmacy as well as the numbers that have been leaving the area so in combination that will allow pressures being lifted from M & D Green and Boots and also the numbers that have left neighbourhood when they come back to the neighbourhood.

Boots – Your patients you claim will only come from M & D Green and Boots?

Applicant – That is what we are projecting because historically that is what has happened when there were four pharmacies in the town.

Boots – Would it surprise you, the Optician which is next to us has never raised any concern with us around stock?

Applicant – I'm not sure about that.

Boots – Would you agree that Helensburgh is amongst the least deprived areas in Scotland?

Applicant – I would disagree with that.

Boots – Based on SIMD data you would disagree with that?

Applicant – There are three data zones in Helensburgh with 20% most deprived areas.

Boots – What would you say as a town, by comparison to other towns in Scotland it is one of the least deprived.

Applicant – It is the least deprived as a town but with very mixed areas of population and areas of deprivation as well.

Boots – You mentioned about the naval personnel and families. Where do the naval personnel and families access their healthcare?

Applicant – They can access healthcare in Faslane, however, the families also uses the town's facilities; if naval personnel were in town, they would access the facilities.

Boots – You spoke about needle exchange service. Again, I was a little confused on that. So, from what I heard in your presentation, the only pharmacy providing needle exchange service in the town was the Boots pharmacy which closed and once that closed there was no needle exchange provision in Helensburgh. Is that what the presentation said?

Applicant – Yes, that's right.

Boots – Who is responsible for making sure a community pharmacy within a population has access to needle exchange. Who makes that decision?

Applicant – I believe that is the Health Board which makes that decision.

Boots – So, the Health Board are responsible for making sure pharmacy provides that. I know that provision has been put in place so would it surprise you that this was transferred to the Boots store in Helensburgh, when the one closed, that was transferred to the other Boots store.

Applicant – According to the Health & Social Care Partnership it says that this was not transferred to the Boots store and when we understand what people are saying in the CAR and when they are sharing experiences …

Boots – Are you saying there are no needle exchange services in Helensburgh?

Applicant – From the accounts that we have heard and from the NHS Highland website that is correct. People are saying they cannot access needle exchange.

Boots – Again, just a little confused about consultation room. If I'm correct you said in your presentation something about the only appropriate consultation room being in the Boots which was closed. Is that what you said?

Applicant – No, not the only appropriate consultation room, the only premises that had a consultation space which was used consistently was the Boots in 47-49 Sinclair Street.

Boots – What's your evidence on that? What point are you making?

Applicant – In the questionnaire, in the consultation analysis report there are many mentions of consultation rooms not being used in Boots and they have shared their experiences in the questionnaire, and they told us in the questionnaire what was happening in the Boots and they are showing rashes on the shop floor and what not.

Boots – I would make you aware that Boots made considerable investment in the Boots store in Helensburgh and there is a new consultation room.

Applicant – I am aware of that and that has been done. However, unfortunately it is still not being used and that is because the pharmacist is so busy with queues of 10-15 people makes it difficult and I am assuming it is very difficult for the staff to take that person into the consultation room, spend time with them in the consultation room.

Boots – You have made a lot of comments about queues and service provision. Do you know how many complaints were raised with NHS Highland about Boots pharmacy in the last year?

Applicant – I believe NHS Highland do not retain complaints.

Boots – It's public information. Do you know how many complaints?

Applicant – No, I don't.

Boots – You spoke about EHC. Again, I was a bit confused about this. What evidence do you have that there are any concerns from the public around access to EHC?

Applicant – That's from the CAR.

Boots – What was the comment in the CAR related to EHC?

Applicant – "More services following an approachable sexual health services that's responsible".

Boots – Another point of confusion – you spoke about blister pack service being a local NHS service. Is that correct?

Applicant – Yes, a locally negotiated service.

Boots – For blister packs?

Applicant – No, it's the medicines compliance needs assessment.

Boots – What would a patient receive under that service?

Applicant – Medicines compliance needs service. They will receive a consultation to ascertain if a blister pack is appropriate for them.

Boots – So, you are saying there is an NHS service which provides blister packs to patients?

Applicant – No, the locally negotiated service is the care needs assessment and there is a questionnaire for the patient to ascertain if a blister pack is required for that patient.

Boots – Would it surprise you that we met with Carol-Ann from the GP surgery just two weeks ago and she raised absolutely no concerns with us around patients accessing medication or NHS services and in fact was very complimentary about the work we do?

Applicant – That is surprising because in the letters of support which we received as well as the information in the CAR.

Boots – I know we have spoken quite a bit about the size of your premises, but can I ask why we didn't get a layout plan?

Applicant – Sorry, I had a layout plan and that was meant to be shown visually today.

Boots – That completes my questions Chair. Thank you.

Chair – Can we now move on to questions from APC please.

APC – You mentioned the growing population and the Faslane at Rhu and Shandon. Is there any particular reason why you didn't include them within the boundary?

Applicant – Yes. So, Rhu could be considered a boundary within its own right. When we made the neighbourhood, the actual physical boundaries we also considered the community council's boundaries as well.

APC – One of the things we have frequently discussed is around challenges of staff, locums. How do you envision getting around that. You said you both plan working there but there will be significant training of staff so how are you going to deal with that?

Applicant - During the time this questionnaire has been running we have been approached by a few members of the public saying that they would wish to work with us if this application is granted.

APC – No more questions Chair. Thank you.

Chair – Moving to our people on Teams. Cardross Pharmacy.

Cardross – I understand this service is not a core service but there was a point made in the presentation so I would just like to clarify it. You guys are prescribing pharmacists; do you offer Pharmacy First Plus service in your other pharmacies?

Applicant – Yes, we do.

Cardross – The pharmacist who you are hoping to employ if this is granted, are they prescribing pharmacists?

Applicant – Yes.

Cardross – You are obviously hoping to offer Pharmacy First Plus in your new pharmacy?

Applicant – Yes.

Cardross – You also that Daniel had locumed when there was four pharmacies in Helensburgh. Have either of you locumed recently when the old Boots shut down?

Applicant – No. The mention of Daniel was in 2023.

Cardross – You mentioned Faslane and the expansion to Faslane, but you have not included that in the boundary so do you expect service from these patients?

Applicant – From Faslane, Rhu and Shandon people use the amenities in Helensburgh so we would expect them to use the service.

Cardross – You would agree, most likely they would use Garelochhead which is closer to Faslane would you say?

Applicant – Those in Rhu and Shandon use Helensburgh amenities.

Cardross – OK, but it's not within your proposed boundary that you are proposing to serve?

Applicant – No, that's correct but that doesn't exclude them from using the services.

Cardross – No, of course. You also made note of the golf course. Were you aware that application had actually been rejected?

Applicant – I have actually seen that the application was rejected. I believe sometimes that can happen with site, but another developer is looking to take over, which is quite common for new sites but at the same time, this application is not relying on new housing but just wanted to mention that Helensburgh is an area which is constantly developing.

Cardross – You have noted that people are drawn into Helensburgh for a number of reasons and the population was increasing but were you aware that over the last twenty years there has actually been a decrease in population of around 8% in comparison to Scotland, where there has been an increase of around 8%?

Applicant – So, the figure you are referring to is Helensburgh and Lomond. The figures were are looking at are just Helensburgh.

Cardross – You were saying there was a percentage increase in Helensburgh?

Applicant – When we looked at the census data, in 2001 in comparison to the data now, the numbers have remained very stable with, I believe, a reduction of 1% but as we look at the percentage of the increase in size of the practice, that prescription volume has increased. Also, the 2023 census of 14,127 people does include those who have moved into the area with the new development.

Cardross – You made note to an ageing population. An ageing population usually falls hand in hand with long-term condition prevalence. Were you aware that Helensburgh as a locality it' self actually has a much lower long-term condition prevalence in terms of national statistics?

Applicant – I have the national statistics here as well. Would you be able to tell me what the difference is?

Cardross – It's a difference of around 10%. So, 14-17% less long-term condition prevalence in comparison to Scotland.

Applicant – I don't have the data to hand but we can look at the numbers of Mallig and other Helensburgh practices and we can clearly see that the numbers are increasing year on year. From 2021 they have increased by 4,000.

Cardross – I have had a look at the open data from Public Health Scotland, the numbers to me seem relatively stagnant over the last five years. Where are you pulling that data from showing that there has been an increase?

Applicant – The data is from Pharmdata.

Cardross – The data that I am looking at is from Public Health Scotland, I think that is probably a bit more accurate actually showing perhaps a 2% increase of items over the last five years so I would say that is not a significant increase. Would you agree with that?

Applicant – As I said, our data is from Pharmdata, I cannot speak for your data as I have not looked at that.

Cardross – You also mentioned about how a lot of people are using services out with Helensburgh, travelling to Cardross, going to Inveraray and you have noted that from your CAR responses. Are you aware that the patients receiving care from Inveraray are actually transitioning back to Helensburgh and Cardross since the change of ownerships?

Applicant – Copy that.

Cardross – That's all from me thank you.

Chair – Thank you so moving on to Rowlands please.

Rowlands – Thank you for the opportunity to ask these questions. Quite a lot of my questions have already been addressed by some of the other interested members. Very quick question going back to the floor plans of your unit. If you have not submitted any floor plans, how do you think the committee can understand the unit in question is actually fit for purpose and capable of delivering the full range of contracted services that you are saying you are going to be delivering?

Applicant – The floor plans were meant to be shown today, and I was hoping to present them.

Rowlands – Would you say that submitting the floor plans would have been your priority considering the size of the unit?

Applicant – What are the concerns with the unit size, especially with having the architects and also shop fitters in who are very confident we could get it converted from a newsagent to a pharmacy?

Chair – Sorry to interrupt. Would it be helpful to show the floor plans since that is a question which has been raised

M & D Green – I cannot understand how my colleague left this to the eleventh hour not to sure this. It's one thing looking at them, it's another thing seeing detail in them, in particular.

Boots – Given how small the premises are, it's a major point.

Chair – Shall we carry on with your questions. While we get those printed, we will carry on with questions and come back to that one.

Rowlands – Whilst you were in the market for finding a suitable unit was there a more suitable unit available at the time of the application that did not leapfrog all our pharmacies within Helensburgh, one of more suitable size?

Applicant – I don't believe we have an issue with the size of our unit. We liked the locality of the unit, it's just off the busy Sinclair St, easy access, on-street parking, set of lights that people can use to cross to the unit, and in our eyes was very perfect. The old Boots unit was already occupied by Cancer Research I believe.

Rowlands – You referred to the on-street parking there. Can you just describe the parking in more detail with specifications to where the yellow lines are, the loading bays are only and obviously the availability of parking spaces with regards to cars parked there throughout the day because of current residents?

Applicant – Right outside the shop just beside the pavement there are cars parked there. Across the road there are double yellow lines although these lines are historic, and you can actually park there. The double yellow lines go all along East King Street and you can see that cars are actually parked on East King Street every time you visit Helensburgh that is the case. The council just haven't removed these lines yet.

Rowlands – Would you say, advising the panel that you have suitable parking but that involves parking on a double yellow line is a responsible thing to do?

Applicant – The double yellow line is historic.

Rowlands – But it is still there, it is still on the road.

Applicant – Correct, the people from the community know this, that they can park there and there are many in the CAR who highlight that parking is actually very adequate and it's an adequate unit as well.

Rowlands – From my experience of living in Helensburgh for 18 years, the parking wardens around Helensburgh are very aggressive and I think they would be nervous. Do you think it is a responsible thing to do to ask people to park on a double yellow line that is still painted on the road and has not been removed by the council?

Applicant – On the other side of East King St after Sinclair St, there are a row of lines which has always been used for parking. There is parking on that same street as well, which doesn't have any double yellow lines.

Rowlands – So that would involve crossing a pedestrian crossing at the second busiest junction in Helensburgh, is that correct?

Applicant – No, just directly outside the unit there is a set of lights, and you can use the lights to cross the road.

Rowlands – What specific area within Helensburgh are you referring to as being deprived? Do you know the names of these areas?

Applicant – There are three, two in the northeast.

Rowlands – And what are the names of these areas?

Applicant – I do not have the specific SMID codes for them at the moment.

Rowlands – You say that Colgrain and Churchill were mentioned in the areas? These are in the northeast.

Applicant – I don't believe so.

Rowlands – You don't believe so?

Applicant – I would need to check; I'm not 100% sure of the SMID codes.

Rowlands –Colgrain would be around Drumfork Road, Armstrong Road and Collins Road and Churchill area would be around Kent Drive, Cambertown Court, Hardy Hill that area.

Applicant – Sorry, are these to the northeast of Helensburgh?

Rowlands – Yes.

Applicant – I don't have the specific codes so I cannot look at the data zones.

Rowlands – You specifically refer to the northeast as an area of concern for deprivation. Can you tell me how many military personnel and housing is within that area.

Applicant – I am unsure of that.

Rowlands – Are you aware that Inveraray Pharmacy canvassed all accessible local towns, it was not just Helensburgh?

Applicant – Yes, I am aware of that. They had massive uptake in Helensburgh due to the inadequacies.

Rowlands – OK, that's not what you implied in your speech. I would like to know where you have evidence of lack of use of the consultation's rooms, specifically within Rowlands Pharmacy?

Applicant – In the CAR there is a question which is answered – I don't think it's the lack of use of the consultation room, it's when consultations are in the room, conversations can be heard out with.

Rowlands – I thought in the previous question there was a lack of use of the consultation room.

Applicant – That was the Boots Pharmacy.

Rowlands – Was that just specific to Boots Pharmacy?

Applicant – Yes

Rowlands – How many staff do you think you would need to consider to employ in a pharmacy considering all the services that you will be undertaking?

Applicant – Daniel and I will be working in the pharmacy; we will have two dispensers and a front counter.

Rowlands – So is that three additional staff?

Applicant – Yes

Rowlands – Wonderful. During the Facebook campaign in encouraging people in filling out the CAR report, you continually stated that you were going to have zero waiting times. Can you tell me what that means please?

Applicant – Daniel and I currently do it in the pharmacy we are working in now. What that means is when someone hands in a prescription, they get it dispensed there and then, and we have good stock levels and patients don't need to come back. We are more efficient with our systems, efficient with queues, efficient with dispensing.

Rowlands – When you are putting this on a Facebook or advertising this, and then asking people to complete the CAR, can you tell me what the public interpretation of zero waiting times would be?

Applicant – That you can walk into a pharmacy, hand a prescription over, receive that prescription and not need to come back or queue which is what we currently do in our other pharmacies.

Rowlands – Do you consider dispensing prescriptions is currently the main income in a community pharmacy?

Applicant – Yes

Rowlands – Would you say that any impact on the number of prescriptions being dispensed in a pharmacy could result in the viability of that pharmacy.

Applicant – We could see historically from over twenty years, four pharmacies in Helensburgh were viable.

Rowlands – I understand that but the opening a new contract in Helensburgh is no way to guarantee the numbers that will be specifically coming out of each pharmacy with the number of prescriptions. Would you be able to estimate the loss of prescriptions from each of the pharmacies?

Applicant – The estimation we have is from Boots Pharmacy and M & D Green Pharmacy and that will give us around four to four and a half thousand items, which will relieve the pressure. There will be no uptake from Rowlands because historically that's the case.

Rowlands – So your pharmacy being within 2.4 miles of Rowlands Pharmacy, you don't believe that Rowlands Pharmacy will lose any prescriptions with the opening of a new pharmacy and this new contract.

Applicant – I cannot say definitively that there won't be any prescriptions, there may be a few to relieve pressure but a pharmacy has never had to close due to a new pharmacy application and we can see that in the twenty years that Helensburgh was serviced by four pharmacies, the numbers from Rowlands have been very stable.

Rowlands – Do you intend to offer a delivery service to the local community?

Applicant – Yes, we do.

Rowlands – Going back to the parking issue near your pharmacy do you think this may be a problem and cause disruption at this busy junction?

Applicant – I don't believe parking is a major issue as discussed and also previously I mentioned that we have contacted the council regarding a disabled bay, and they are more than happy to arrange this once the application is approved.

Rowlands – That's all of the questions I have at the moment. Thank you very much.

Chair – Are people content that we now have the layout, can share it on screen and around the room before we bring the Community Council in? If there are any specific questions about the layout we can go back to them. Would that be fair?

M & D Green – Would we have an opportunity to ask questions?

Chair – Yes, that should have been sent with the other information.

M & D Green – Does it have dimensions?

No response.

Chair to Applicant – Would you just talk us through this?

Applicant – Yes, this was provided to us from the architect. You can see the entrance, retail space, there is a corridor which has an advice hatch, for advice or supervision of medicine. You can see the dispensary and checking bench. At the moment the shop is the first section of this diagram so that is accessible to the public. As you go through the back you actually see the size which is quite substantial.

Chair – So, where the retail desk is and then that is the shop?

Applicant – Yes and the rest is the back.

Chair – Is everyone happy they have had a chance to look? I see this is a bit of a veering but I think it important everyone has an opportunity to ask questions. For the purpose of the Minute, it would be useful to go back to our Interested Parties in the order in which we started the questions with specific regard to the layout, not additional questions. Is that acceptable to everyone? We will then return to the Community Council for your questions including any about the layout.

There was agreement in the room and on screen.

M & D Green – You referred to the unit there as being substantial. I notice there isn't a scale on it but I am making the assumption that it is the size that you said when you answered the question earlier, it being approx. 600 square feet. For clarity, in your opinion, that is substantial?

Applicant – It is an adequate size for a pharmacy yes.

M & D Green – Adequate or substantial?

Applicant – We would be able to work in here absolutely fine so it's adequate.

M & D Green – You made reference in your presentation to the ease of access and on the image on your Facebook page it shows a computer generated image of the pharmacy with a double gated door in the middle of the pharmacy and in that image the floor has clearly been raised and this column which is right bang in the middle at the front of your drawing there has been removed. So, the image that you presented on your Facebook page would appear not to look anything like that. Would you not agree?

Applicant – Yes. The Facebook image was just an image on Facebook, it was never mentioned that the pharmacy would look like this, or this is the definitive picture of it, it was just an image produced by an artwork person.

M & D Green – Is the door shown in this drawing the existing door which is currently hanging in the newsagents?

Applicant – At the moment I believe it is.

M & D Green – Do you know what width that is?

Applicant – No, I do not have that.

M & D Green – You said in your application that following your refit the premises would be fully DDA compliant, and we potentially have a significant issue with the first hurdle, which is the front door. Do you know what size that is?

Applicant – With the shop fitters and architect coming out we are fully confident it will be fully DDA compliant. I do not have that measurement to hand, but they were certainly very confident.

M & D Green – So this drawing isn't to scale then? That door may not represent the size.

Applicant – I'm not sure of the size of the scale, this is just what I have received from the architect.

M & D Green – Going back again to your claim that this will be fully DDA compliant, can we look at the toilet and I will ask again, do you know what dimensions a DDA toilet needs to be and is that compliant?

Applicant – I do not have the specific dimensions.

M & D Green – If I helped you. At a minimum the toilet has to have a 1.5 metre square turning circle to allow access for a wheelchair and the doorway needs to be a minimum of 900 mm wide to allow a wheelchair to access. Is that toilet DDA compliant?

Applicant – The shopfitters were absolutely confident that the entire pharmacy …

M & D Green – That looks to me like the existing toilet, it doesn't look like a toilet the shopfitters are creating for you. Is that the case?

Applicant – So it is the existing toilet, that's right but when the shop fitters came in, they were very confident.

M & D Green – You mentioned about a ramp, but you haven't included a ramp on this drawing. This drawing would appear, unless I am reading it incorrectly, to still have the existing floor in which requires a step up. Is that the case?

Applicant – Yes. This is just the drawing of the premise not outside on the pavement.

M & D Green – No more questions from me Chair.

Chair – Any questions from yourself Scott with regards to the layout.

Boots – The size of the 24-hour collection point looks small. Is that accurate?

Applicant – On speaking to the shop fitters who have fitted many of them, this was drawn up in conjunction with the architect …

Boots – It's tricky without the scale to be honest. Just looking at it, it looks small to me. You mention about compliance aids packs in your presentation, the dispensary looks rather small to me and just for the benefit of the panel or lay members on the panel. Those prescriptions would come in for a month or 4 weeks. You'd make one week, and you normally deliver a week. So, you've got store 3 weeks essentially in the pharmacy. Do you have any concerns about the number of patients you can actually support with compliance aid packs given the constraints of the size of the dispensary?

Applicant – No, the ceiling is very high so there is storage space in the pharmacy.

Boots – Again, just in terms of the layout and how people will actually walk around, where would your pharmacist be predominantly, how would they get round to the consultation room, provision of substance use, those kinds of things which will happen on a daily basis. How would that work?

Applicant – You can see that the checking bench is facing the entrance so that predominantly where the pharmacist will be checking in. Of course, there will be two of us so one will be as the checking desk and the other at the dispensary dealing with patients.

Boots – No further questions from me Chair.

Chair – Thank you very much. Malcolm, any questions from you on the layout?

APC – You mentioned queues in your presentation is the retail point and the till at the door, do you envision that would cause any problem?

Applicant – No, the main reason for the queues at the moment is the pressures that the pharmacies are under. With the approval of this application issues will be lifted and pharmacies will be able to provide their service.

APC – No further questions Chair.

Chair – Thank you. Can we go back to Cardross?

Cardross – Just on the basis of the advice hatch, you made a note a few times about how you run the risk of having the consultation in an open space. Would you not say you are putting yourself in the same position here with an advice hatch?

Applicant – We can have a door which leads into that corridor and then you have the advice hatch there.

Cardross – Where would this door be sorry?

Applicant – The door could be at the start of the entrance to the corridor. Also, this is just for administration purposes, we could have the advice hatch elsewhere there is a perfectly large consultation space where we can have consultations.

Cardross – OK. Your robot, does that include space behind to block off, putting items in the robot for confidentiality purposes. Does that include that in the plans here?

Applicant – Yes.

Cardross – Would you envisage more than one staff member being on lunch at any one time because it is a very small staff room, the fridge opens out, there is not even much space to eat there. Would you say that was an adequate size for a staff room?

Applicant – I have worked in many pharmacies that have staff rooms of that size, and smaller as well so I would say it is adequate, and staff could always leave for lunch as well or have lunch in the consultation room if the consultation room is not getting used.

Cardross – But for now, you would say that would only take one or two people?

Applicant – At the moment, looking at that staff room right now, one or two people, yes.

Cardross – Nothing else from me. Thank you.

Rowlands – Yes, thank you I do have a couple of questions here. It's really about the safety of the dispensing of the MDS boxes. Obviously, you have provided them previously in the past, with you offering this service in this pharmacy and mentioning it during your advertising campaign, I am presuming that you are going to be making up a number of these boxes. How much room is allocated to the storage of these boxes and is that going to be at height as in one of the previous questions.

Applicant – There will be shelving put in place and they are high ceilings as well, that allows for a good storage space, and the number of dosette boxes which we do will depend on the needs of the patient as well.

Rowlands – OK, so my second question is regarding your claim for zero waiting times in relation to the amount of storage room you have in this pharmacy for stock. During your canvassing campaign and Facebook posts, one person actually commented how can you guarantee zero waiting time, and I will quote your answer here – "Hi, name of the patient, we currently have zero waiting times at a pharmacy we currently work at, and we do this with efficient systems being in place and very healthy stock levels". Could you tell me the amount of stock you think you will be holding within this pharmacy?

Applicant – I don't know the exact amount of stock we would be holding but like I said, a healthy amount to adequately provide the service.

Rowlands – And you think you will be able to hold enough stock within this pharmacy to guarantee a very efficient service, immediate dispensing and not have any balances, like it has been reported in the CAR report from other pharmacies?

Applicant – Absolutely and also balances are natural as well, but it is about limiting these, and we are confident we can do that.

Rowlands – OK, I have asked enough questions for now, that's fine thank you.

Chair – Thank you very much. So, we will move on to Community Council, Helensburgh. I'm not sure which one of you is presenting or asking questions and obviously to include any in relation to the layout but your other general questions as well, thank you.

CC – Hi, my name is Cameron. Elizabeth is secretary of our Community Council. Just while you have the layout up – we don't currently have a robot service for collecting prescriptions so could you explain how that would work, I don't think it is anything any of us have experienced before?

Applicant – It's a 24-hour collection service. What happens is when the prescription is loaded into the robot the patient would receive a text message on their 'phone with a code. That code can be used 24 hours a day. The patient will put this on outside on the screen and the robot will dispense it out of the shelf.

CC – So is that something you would have to sign up for in advance?

Applicant – Yes, we wouldn't automatically put them in the robot, we would speak to patients and those who would like them in the robot, we would sign them up for it.

CC – Just generally, we are very focused about what is happening in and around Helensburgh. The two of you have been in Helensburgh quite a lot recently finding out some of the issues the community have been experiencing but I just wanted to know what your experiences are in other areas, how does the pharmacy service in Helensburgh compare to Falkirk, Stirling and other places you have worked?

Applicant – From all the evidence that we have presented Cameron, we can see that the pharmacy services in Helensburgh are inadequate, across every core service, patients are struggling to speak to a member of staff because they are so busy, waiting times are so long they extend into a queue at the door, the inadequacies in Helensburgh I havent actually seen anywhere else I have worked.

CC – That's all I have to ask at the moment.

Chair – Thank you very much. We will move on to questions from the panel. Does anyone have anything else from the room or from the teams they would like to ask before we move on.
M & D Green – I do have a question in relation to the floor plans is that ok?

Chair – I am being advised no and that may be my error so my apologies.

M & D Green – No problem I will just bring it up later.

Chair – Now we will ask for questions from the panel. We will start with me. Some of my questions have been answered as we have gone through. I just wondered if had a calculation of the amount of prescriptions that are leaving the area? You talked about the amount of prescriptions being picked up by other providers, Inveraray and everywhere else. Of the total prescriptions do you have a sense of what that amount.

Applicant – Yes, roughly around 700 to 1,000 items leaving the area.

Chair – What does that mean in total?

Applicant – So there are about 1000 prescription items a month that are leaving the area would go to these other pharmacies out with the area. And then in Helensburgh, Millig, Glasgow practise roughly dispensing 33,000 items and also Cardross patients as well registered to that practise.

Chair – Thank you, that was my only question. Ian, can I come to you.

IG – Can I just clarify the services you propose to provide that are not currently available. I picked up I think an earlier opening time? and a question was asked about delivery, there were questions about adequacy or inadequacy of Pharmacy First. Is there anything apart from the opening times which are different from what is being provided by the other pharmacies either in the town itself or Cardross.

Applicant – When we look at the Argyll & Bute Social Care Partnership, we can see that no pharmacies at the moment provide Pharmacy First Plus. We are both prescribers so we would be offering that service. Also, we would be looking at opening at 8.00 am, all the other pharmacies open at 9.00 am. The GP practice opens at 8.00 am so we would like to mirror them so when patients are requiring to get in before work they can get into the pharmacy as well.

IG – That was my only question.

Chair – If we could move to Mark, please who is on Teams.

MF – Obviously we have heard reference to people using pharmacies out with the area. Assuming someone has not got access immediately to a car, I know there is a train station in Cardross, is there a regular bus service that goes from Helensburgh through Cardross?

Applicant – There is a train service and there is a bus service, but I think the bus service is quite irregular.

MF – Do you happen to know what the cost of a train fare or a bus fare from Helensburgh to Cardross is.

Applicant – I don't have that to hand, no.

MF – Is there is direct public transport connection for example between Helensburgh and Inveraray or any of the other outlying pharmacies?

Applicant – There is not one from Helensburgh to Inveraray. Helensburgh to Garelochhead I think there is potentially one available and Cardross.

MF – Thank you, that's all I want to ask.

Chair – Moving to Catriona Brodie on Teams.

CB – I do have a question in regard to your current ownership of the building. You mention that you currently have agreement in place to take on the building. Can you clarify, will that be leaseholder or ownership.

Applicant – It's leasehold.

CB – Do you have a legal agreement in place with a renewing and repairing lease with permission to carry out the changes to the layout of the building as you suggest?

Applicant – Yes

CB – So you have that as confirmation currently.

Applicant – Yes, correct.

CB – Have you submitted to A & B council for pre-planning advice on your plans?

Applicant – So, pre-planning advice hasn't been submitted. I contacted the council, and they said once the application was granted then I should put the planning application in.

CB – Were you aware A & B council allow you to put in plans in advance so you can get their advice on the disability act and accessibility?

Applicant – No, I wasn't aware of that, it is really good to know. When I contacted the council, I was advised to wait until the application was approved. That's really good information to have.

CB – My last question relates to the accessibility of the property. I have personal knowledge of some of the regulations and looking at the picture on the front of the property, I think you would probably need a ramp which is about 2.5 metres long. Have you sought permission from the building next door because you would only need to go in one direction otherwise you would be blocking the collection point and the front door to the flat. Have you sought permission from the building next door in regard to the access?

Applicant – We have spoken to the son next door and also the Cargorm, which is after the close. We have good relationships with them as well. Formal permission to have this we don't have but I don't think that will be any issue.

CB – That's me, no further questions thank you.

Chair – So moving on to Susan Paterson who is also on Teams.

SP – I know the application is based on core services but are there any other private services that you are thinking you might offer to the people of Helensburgh?

Applicant – So, in terms of private services, our main focus has been core services, private services would be driven by patients that would request them, ear syringing is one of them when we would be able to remove earwax, that is a common one with the elderly population.

SP – Thank you.

Chair – Moving to Catriona Sinclair.

CS – I'm quite intrigued by your zero-waiting time. What is your priority when you receive a prescription from a patient?

Applicant – So, when a patient gets a prescription to a pharmacy, that becomes our priority and because there is two of us in the pharmacy, we don't envisage any issue getting that prescription dispensed, made up and checked.

CS – There are going to be two pharmacists at all times?

Applicant – Yes, that is correct.

CS – As well as two dispensers?

Applicant - Yes, that is correct

CS – And a delivery driver and a front counter person.

Applicant – Yes. They way we may hire may change depending on the uptake as well but yes that would be the plan.

CS – You are going to be nearest the surgery so I am going to be making an assumption there will be a fair amount of walk-in prescriptions for acutes so it is not uncommon, you will agree, for someone to walk in with three or four items. How long will they have to wait for these three or four items?

Applicant – This happens quite commonly where I work at the moment in Falkirk. We are actually beside three practices and get a lot of walk in prescriptions. Chest infection is very common, antibiotic and some steroids so with efficient systems in place, zero waiting, that prescription will be dispensed there and then, labelled there and then, checked there and then, clinical checks undertaken as well so Daniel and I are confident we can do that like we do in Falkirk and Stirling.

CS – How long do you think patients will wait?

Applicant – A few minutes.

CS – Your priority is speed?

Applicant – No, our priority isn't speed, it's efficiency so the relevant checks will be made of course on the PMR, checking for interactions so that may take longer but it's all about efficiency, not having patients have to come back and queue again so we will have a quick service and an efficient service as well.

CS – So am I right in saying someone will have to wait five/ten minutes to get that.

Applicant – If we need that time to do the relevant checks then yes that is correct.

CS – Thank you very much.

Chair – Gayle, your questions.

GM – I have one or two things written down, but I'm mostly concerned about staffing. As you know in a pharmacy you have to be trained, recruitment. Do you think there will be a delay delivering some of the services like Pharmacy First Plus given that you may have to take some time to train your dispensers and counter assistants which will take away from that initial, trying to get everybody in with the zero-waiting time?

Applicant – Some of the people who contacted us regarding a job at our pharmacy they actually already are dispensers, they just left the profession, and they were keen to come back if this application was granted. Of course, we will need to train our staff as well to make sure they are up to date with the current guidance and what the difference is between Pharmacy First and Pharmacy First Plus. We do not envisage that would hinder or cause any delays.

GM – Just another question, it was just around those mentioned in the CAR where patients are having to make extra trips for balances, there are times when we do unfortunately need to hold an item, but I just wonder about your stockholding. Do you have greater access to many wholesalers. We do sometimes have those rare high-cost items which we don't keep on the shelf so how would you work around supporting patients with those?

Applicant – We have eight to ten wholesalers so that ensures we would be able to access stock. Also, we have spoken to a few of the wholesalers who have told us that they receive twice daily deliveries in Helensburgh to ensure we can get stock efficiently.

Chair – one or two further questions as my prerogative

IG – What area are you proposing to deliver to?

Applicant – The Helensburgh area and also Rhu if required.

Chair – Thank you. Mine might not be quite so simple. Back to staffing, you talked about having yourselves as both pharmacists. How will that work for planned and unplanned leave?

Applicant – From the pharmacists that we have had, we will be able to use them as cover. We have a friend who is locuming at the moment so we can draw on them too.

The Hearing broke for a 15-minute lunchbreak.

Chair – We will move to the section of the Hearing which is where the Interested Parties present and I remind you that we are recording this for the purpose of the Minute on Teams. If I can invite Martin from M & D Green to give his presentation and then we will follow that with questions from the applicant, Interested Parties and panel. Thank you.

Presentation by M & D Green

Thank you Chair. I would like to begin by considering the neighbourhood and statistics relating to that neighbourhood. I'm not going to go through and redefine it again, but I do agree with the neighbourhood as defined in the Consultation Analysis Report, which effectively defines the town of Helensburgh. The population estimate for Helensburgh as presented in the CAR and according to the 2022 national records for Scotland is shown as 13,230. When I go on-line and check other records, e.g. the general records for Scotland, it has the census figure slightly different, the 2022 census figure is slightly higher at 14,127. That same record and on the same page on-line quotes the population at 2001 as 14,700 and 2011 at 14,220. So, over the past twenty years the population in Helensburgh has been relatively static but decreasing very slightly. The reduction in population over a twenty-year period being just over 4%. These records break the population down by age structure and without digging into deep detail, if we were to consider the population from 1-27 as young people it's 18%, those of working age between 18 and 64 is 56% and over 65, as the applicant has already mentioned is 25%. The percentage of young people in Helensburgh is slightly below the national average, the percentage of working age is pretty much bang on average for Scotland and those over 65 is slightly higher. So, the population in Helensburgh is in-line with national averages, slightly fewer younger people and slightly more aged over 65. Using the statistics from the Scottish Index of Multiple Deprivation which drags small areas of Scotland by deprivation uses a number of domains to define this ranking, these include income, employment, education, health, access to services, crime and housing. Ranking 1 is the most deprived data zone in Scotland and it goes all the way up to 6,976, which would then be the least deprived data zone in Scotland. Helensburgh is quite a big neighbourhood and is defined by twenty data zones. Breaking these data zones down there are 13 data zones which accounts for 65% of the population of Helensburgh within the top 40% of data zones with regards to deprivation and only three within the bottom 20. Statistics would suggest that Helensburgh has a relatively stable population of largely working aged people with most of that population in the top 40% by deprivation. More appropriately, Helensburgh is actually an affluent town. This isn't surprising as Helensburgh's history recognises the arrival of the Helensburgh/Dumbarton/Glasgow railway line as the catalyst for it's population growth in the mid-19th century. Helensburgh is an affluent commuter town. Most of the people in Helensburgh are of working age and the transport links with the central belt in Glasgow are strong. Not surprising that some prescriptions may go out with Helensburgh to be fulfilled as so does a lot of the

population. Population works and commutes and many people will take their prescription with them and fulfil them close to their place of work.

Currently, Helensburgh is provided by three pharmacies, ourselves, Boots and Rowlands. All within the town centre and all within about 200 yards of each other. This provides a pharmacy for every 4,000 of population, which in my opinion and experience is about right. I would estimate that a population of about 4,000 is required to sustain an average pharmacy. Introducing a fourth pharmacy pushes this figure down to 3,300 per pharmacy, which delivers less than average volume to sustain these pharmacies, assuming an equal distribution, which I suspect, will have been a factor in the closure of one of the Boots branches.

M & D Green acquired the entire share capital of D. Shannon-Stewart Ltd, the trading company of Gordons Chemist, Scotland on the 1st March. For the purpose of this application, the timing of the acquisition has not been helpful as the public consultation concluded only six days after completion and respondents will not have had the opportunity to experience the changes implemented and planned by ourselves as new owners. On acquisition Gordons Chemist was managed by a full-time pharmacist supported by regular locums Monday to Friday and always operated with two pharmacists. M & D Green have appointed a second full-time pharmacist to do away with the locum element and provide continuity of care and consistency with regular pharmacists. Emma, the newly appointed pharmacist is a prescriber. She became a prescriber in April and has received her prescription pad in August of this year. So Pharmacy First Plus is being delivered from the M & D Green pharmacy in Helensburgh from August. Catriona, the pharmacist who has always been resident in the pharmacy has enlisted on her prescribing training and commences in September. With a fair wind, she intends to support her portfolio around April time next year. The pharmacy is now also registered with NES as a training site and hosts a foundation year pharmacist. This foundation year pharmacist will be completing their prescribing training through their foundation year, and again assuming all goes well and passes her exams, she will complete her prescribing qualification in August of next year. So, a year from now, assuming everyone continues with their learning and passes their exams, there will be three prescribers in the M & D Green Pharmacy, Helensburgh.

Currently having two pharmacists in the pharmacy allows for staggered lunchbreaks to ensure there is a pharmacist available throughout the opening hours of the pharmacy. On taking over the business, all staff achievements have been assessed since the acquisition and further development planned to produce two ACTs to assist the two regular pharmacists who are there just now. All staff are encouraged and supported to receive and maintain the highest learning opportunities to get to their designated role. This regular enhanced staffing capacity will allow the pharmacist time to dedicate to patient advice and consultations. Once the Pharmacy First Plus activity funding is established later this year, pharmacist backfill will be provided to allow our prescriber dedicated consultation time for both walk in patients and those booking consultation appointments on the website or through the M & D Green App. M & D Green have also introduced a dedicated delivery van and driver to support those patients that have difficulty attending the pharmacy. This comprehensive delivery service is advertised on our digital media screens in the pharmacy, on information leaflets available at the counter and through an extensive leaflet drop of the entire area. Premises space has become a critical factor in delivering the evolving pharmacy contract in Scotland and Gordons Chemist were experiencing constraints at their premises at 52 Sinclair St. As such, they acquired by lease the adjacent premises at 52a Sinclair St. However, the two units are separated by a close, accessing residential property above. To combine the unit's, require the construction of an extension to the rear of both units to a former courtyard. This required careful design, planning permission and a building warrant. All of which Gordons Chemist attained. However, due to the considerable cost involved and their intention to exit the market they had not progressed with this work. Despite M & D Green only taking over on the 1st of March this year, that work is now complete. The extension is already built and just awaiting its completion certificate. This connects the two unit's, extending the footprint of the pharmacy from 807 square feet to 1,603 square feet. It approximately trebled the size of the

dispensary, increasing the workbench from 6 meters to over 18 meters, introduced a storage room for bulk buying stock and provides a fully compliant consultation room, and two dedicated treatment rooms to support consulting and prescribing services through the NHS contract and an extended range of private services.

The next stage of this work requires a further planning application which is submitted. It also requires a building warrant. The building warrant cannot be applied for until such time as the completion certificate is received for the extension. That will progress and the building warrant and planning system permitted that work will be completed around the turn of this year. The planning application which has been submitted for the next stage of the work also seeks permission to locate a 24/7 collection robot accessed through the rear of the premises where we currently have a large blocked out window. Permission will be required for this facility, but our architect does not foresee any particular issues. We have also replaced the pharmacy PMR system, introducing two additional workspaces, doubling capacity and significantly increasing connection speed with e-pharmacy. An issue largely unknown to the public but a significant problem affecting many pharmacies currently. In addition to the PMR system the Gordons EPOS system is being replaced with an integrated system which allows the PMR and delivery of NHS services, principally Pharmacy First to be accessed and delivered from the front counter. This has yet to be implemented but it is scheduled for installation in September this month.

The M & D Green App is being made available for all patients to download to order repeat medication, request a collection or delivery and book an appointment for a pharmacy service. The App is currently being re-built and due to be launched again in September and October. Most patients share their mobile number with us and receive text messages when their prescription will be ready and will soon be able to request a collection from the 24/7 collection point. All of this investment in extending service provision and increasing capacity requires significant up-front and ongoing financial commitment. If a new pharmacy contract was to be introduced to Helensburgh and particular a contract located so close to our existing premises and so close to the Health Centre, I would envisage our income would reduce to the extent that we would need to cut our costs. In running a business, particularly pharmacy, there are so many fixed costs and there are few costs that make a difference you can actually reduce unfortunately is staff. If a new contract is granted so close to our location, the first cost I will need to consider reducing is our staff costs. And the most likely, I would have to reduce the number of pharmacists that I employ at that site, severely limiting our capacity for consultation services and diluting their offering at the time.

I would like to consider what has probably prompted this application and that is the closure of Boots. In recent years Helensburgh has seen closure of one of the two Boots in town. Until fairly recently pharmacy closures were largely unheard of in Scotland. We have Control of Entry Regulations, introduced in 1987 and governed by the Regulations, the NHS Pharmaceutical Services Scotland Regulations. Prior to 1987 a prospective pharmacy did not need to consider the legal test we apply today, did not need to establish current pharmacy provision in an identified neighbourhood was inadequate and that a proposed pharmacy was either necessary or desirable to address that inadequacy. The four pharmacies that did exist in Helensburgh were established before 1987 and have never been subject to this legal test. Pre-1987 contractors could open anywhere and would compete to gain close proximity to sources of revenue, principally prescription volume and the concept of leapfrogging was common as pharmacies would try to locate as close as possible to GP practices causing clustering of pharmacies around surgeries. Control of Entry was not just established to control the number of pharmacies but also to promote the rational distribution of pharmacies, preventing clustering and encouraging prospective applicants to locate in the heart of communities to improve access. It is necessary for Health Boards to be able to control pharmacy numbers as each additional pharmacy brings additional cost to the NHS and it is necessary for Health Boards to control the location of those pharmacies.

NHS financial resources have never been as stretched as they have in recent years with no imminent prospect of improvement. Operating costs – people costs in particular have increased beyond belief, increasing by 60% in the last five years. Health Boards will see this in their own budgets; pharmacy contractors are no different. Where we are fortunate in Scotland is the Scottish government has continued to increase pharmacy funding year on year. This investment is not enough to keep pace with increasing costs. Pharmacy owners have to look at all ways to introduce efficiency into working practices to maintain service level and secure service provision, and progression going forward. This will involve introducing technology in the form of robots, digitising processes using websites, Apps and other digital platforms, centralising dispensing activities on off-site HUBs and upskilling technical staff to assume further responsibilities to reduce the need for pharmacist time. And in places where it is possible consolidation of resources from two locations into one, eliminating duplication of premises costs while retaining staff resource and capacity. In these extremely challenging financial times Health Boards must work with and support the contractor network to make efficiencies, but it will not be consolidation you will be seeing across the network, it will be administrations.

This application is attempting to capitalise on an efficiency applied by Boots to maintain, and I know we will hear from Scott soon, potentially improve the service provision in Helensburgh. The applicants have not tried to identify an area of Helensburgh out with the town centre where they may argue that the population find access difficult, they have in fact resorted to practices applied pre control of entry, clustering around the Health Centre and potentially even leapfrogging all existing contractors as their identified unit arguably sit's closer to the front door of the Health Centre than all other existing pharmacies.

I would contest that there is no greater proof of over-provision of service and lack of financial security than the closure of a contract. Re-instatement of that contract will only reinstate financial instability which if it cannot be mitigated with cost savings reintroduced the risk of another closure and Helensburgh returns to three pharmacies, just in a slightly different location and under different ownership. That is not what control of entry is about. There are a number of issues facing not just Helensburgh but pharmacy in Scotland, if not across the UK, and I would like to address some of them and put in context some of the comments made by respondents to the public consultation. Public opinion is important during these proceedings; however, respondents are often asked to comment without actually knowing all the facts or reasons behind what actually happens. Some respondents commented that they experienced difficulty on occasion fulfilling their prescription and may have to make a return visit to the pharmacy to obtain all of their medication. Unfortunately, this is becoming an increasing part of community pharmacies regular daily routine and is not specific to Gordons Chemist, M & D Green, Boots, Rowlands or any other contractor. Medicine shortages and product recalls have become an ever-present problem and affect all contractors and all locations. Introducing an additional pharmacy to the town will not alleviate this problem. The applicants will experience the same difficulties as the rest of us sourcing stock. I appreciate that this will be frustrating for patients but there is often very little any pharmacy can do. Shortages have been impacting on many common lines, often with minimal or no clinical alternatives to patients or prescribers. Some of the high-profile shortages like insulin, hormone replacement therapy, drugs to treat ADHD, pancreatic enzyme replacement therapy, these have even been featured in national news streams. However, on a weekly intermittent basis shortages continue to range from common antibiotics, cardiovascular drugs, even simple laxatives which pharmacy teams need to tackle on a daily basis, and the public may not be fully aware of. Currently 20% high value of the Scottish Drug Tariff is on an adjusted pricelist. These are lines which have increased to the point we can no longer purchase within the former drug tariff list. This is typically driven by demand in the marked outstripping supply and creating short supply which pushes up prices. This has become a significant and constant problem. Another pharmacy in Helensburgh will experience the same issues and will not resolve this problem.

I would now like to consider the applicant's proposed premises. I previously commented that Gordon's Chemist, which experienced limitations due to the size of the premises has now been addressed with the construction of an extension, linking our two adjacent unit's by doubling our footprint by approximately 800 square feet to approximately 1,600 square feet. I would like to make some observations on the premises proposed by the applicants. Firstly, the applicant makes no attempt to improve access to pharmacy services while locating in very close proximity to all existing pharmacies, prioritising access to the front door of the Health Centre over reducing travelling time for those on the outskirts of town. Having checked land registration for a plan of the proposed premises it would appear that the applicant's unit extends to approximately only 600 square feet. This is 75% of the size of our original unit in which we experienced restrictions due to space. This is further compounded as the unit is not open-plan or even a regular shape. It is a labyrinth of small rooms defined by small walls, many of which will be load-bearing. In Form A1, the Application for Inclusion in the Pharmaceutical List, Part 4B, the applicant explain that the premises will undergo a full refit and will apply with the Equality Act 2010. It is only my observation and subsequent discussion with my own architects that in order to comply with Section 29 of the Equality Act in applying for planning permission and the necessary building warrants to refit these premises, they would need firstly to address the step up to access the premises from the pavement. This might require a ramp, which is, in my view, unlikely to be granted on the pavement and may need to extend internally at an appropriate gradient with a turning square, (that doesn't sound quite right), but the dimensions are square, turning circle of 1.5 meter square with a turning pad at the top of the wheelchair ramp. All passageways, toilets and consultation rooms would need to be a minimum size and again both the toilet and the consultation room would need to have a turning pad of 1.5 meter square for wheelchairs. The applicants are proposing to provide these Equality Act compliant facilities from an irregular shaped unit of 600 square feet and will locate a 24-hr collection robot on the front of the premises, presumably from the sales area, reducing once again the available space.

To help patients visualise their proposed pharmacy they have included a computerised generated image of Helensburgh pharmacy on their computer Facebook page. It would appear from this image that they have removed the step up from the pavement, removed the wall holding up the front of the building replacing it with centrally positioned double doors into a spacious open-plan pharmacy. While I am a great believer in anything is possible, my architects advise that this will be quite an engineering achievement to achieve this image of a pharmacy. If it is a simple mock-up produced without planning consent, building warrant or sign-off by a structural engineer, it may not actually represent the pharmacy they aim to establish, and it may be a little misleading for those respondents to the CAR that think they are getting a large new pharmacy in town.

In terms of the Consultation Analysis Report which ran from the 20th October to the 6th March, it received 1,017 responses. By CAR standards, it was a decent response. However, with a population size of 13,200 taken from the CAR, the percentage response from the population was just over 7%. I contest that this is not representative of the population. When analysis of the comments made in the CAR if I were to focus on those comments which may be perceived as negative, there a number of recurring themes, and I would like to address them. Most negative comments described having to wait for a prescription, some even putting a time to this and quoting I think, 30-40 mins, which, in a perfect world is not ideal but at M & D Green patients do get served in time and choose to wait when handing in a prescription but 30 minutes would be rare and only in exceptionally busy times of the week, whereas there are equally times when there are no patients and minimal waiting times. This public expectation of community pharmacy of instant access healthcare is not made of any other healthcare provider in primary care. Helensburgh is blessed with very good prescription service from our Health Centre who turn repeats around in 24 to 48 hours. Across the country this can frequently extend to three to five days and in worse cases where I operate, up to ten days to generate the repeat prescriptions from General Practice. In recent years we have also experienced significant changes of working practices in relation to repeat prescriptions. Pre-covid many patients would collect their own prescription from their surgery and take them to the pharmacy. This is now rare. When ordering repeat prescriptions,

the vast majority are now allocated to a pharmacy and pharmacy staff collect these at agreed times in the day, presenting the pharmacy team with the day's workload at one time. Patients are advised to allow the pharmacy time to assemble their prescription, but this is often not the case. At M & D Green we are introducing a text messaging service, not previously available at Gordons, which will advise when a prescription is ready, avoiding any unnecessary visits. Additionally, when planning approval is granted, we will make prescription collection available 24/7 at an automated dispensing locker. Further respondents commented negatively on the availability of stock. One comment I picked up in particular, struck a chord, and couldnt understand why staff whilst in explaining a delay in the delivery of medication that the item was coming from Romford. This highlights another problem experienced by pharmacies, particularly in Scotland. We currently have one depot from each of the three national pharmacy wholesalers, Alliance, Phoenix and AAH, all located within Glasgow. None of these three depots are large enough to hold all lines in stock. Picking lines are allocated typically on usage. If you have been prescribed an unusual item, it might not be stocked anywhere in Scotland and must be sent from a central distribution point in England. As you can imagine, this causes some delay and if this is presented at the end of a week, may exceed a weekend and may run into the following week. Not ideal, but nothing that any pharmacy can do about it. I do not expect the public to be aware of this, or the extensive list of drug shortages explained earlier but these are problems experienced by all pharmacies and the applicant's pharmacy will be no different. Comments were made about access to delivery services. At Gordons a delivery service was always available, it was available four hours per day. Since taking over M & D Green have introduced a full-time driver and dedicated delivery van for Helensburgh. This service is advertised in the pharmacy, on our digital screens and leaflets on the counter, and we have conducted a leaflet drop once again of the entire area. Despite significant promotion of the service, we have added 55 additional patients to our delivery services since March. This is less than I might have expected but our monthly deliveries at the moment are around 1,200 per month. This is nowhere near capacity. An efficient driver will do double this volume, and if this volume is exceeded as is common across many M & D Green sites, we employ an additional driver and bring in an additional van to increase capacity. The delivery service is also offered to patients if there is a balance or missing item from their prescription; there is no need for them to make a return trip, and a missing item will be delivered by the delivery driver. Comments have been made and carried in the local newspaper that patients have difficulty arranging for medication to be dispensed in a compliance aid or dosette box. There is significant work in assembling a dosette box, and they take up a lot of time. When we acquired Gordons, they had a cap on the numbers of patients at 150 patients. This service, despite the number of staff hours it consumes, is not directly funded. From Day 1 we have removed this cap, they have been taking on new patients over the last six months and there are no restrictions to patients accessing compliance aids. Pharmacy First is readily available, is promoted in the pharmacy using the NHS Pharmacy First information leaflet, which is available on the front counter, and again on our digital screens. Checking back numbers, pharmacy pre-acquisition would record approximately 250 Pharmacy First consultations per month and our most recent submission for August, this number is now over 500, considerably above the national average, which sit's round about 300. Pharmacy First is not just available, it is thriving.

To sum up, Helensburgh population by size and demographic can sustain three pharmacies as evidenced by the recent closure of a Boots branch, all core national and extended services were readily available in the town of Helensburgh and residents have a choice of three providers. The applicants are proposing to open a small pharmacy, in close proximity to the Health Centre, within short walking distance of all three existing pharmacies. The pharmacy will not improve geographic access and will not offer any NHS service not already available in the town. The applicant's premises are small and will be difficult to re-construct to accommodate the demands or our evolving pharmacy contract. M & D Green have only recently become part of the pharmacy provision in Helensburgh and are making significant investment in service provision with grand plans to transform, in particular, concentration led services. We should at least be afforded time to demonstrate what can be achieved.

The committee today have a difficult decision to make. I would urge you to focus on the pivotal question – could three pharmacies in Helensburgh secure adequate provision of services for the population? I will contest that there is no greater evidence to the panel of over-provision than closure of a pharmacy. The reinstatement of that contract will only bring financial instability, cost cutting, disinvestment and risk of further closure. We are not here today to assess how well the applicants have approached their application or their enthusiasm for their proposed venture but the adequacy and security of existing service provision. I would urge the panel to maintain the security and stability of service provision to Helensburgh and respectfully request that you reject this application.

Chair – Thank you. We now invite questions from the applicant.

Applicant – Thank you for your presentation Mr. Green. You made mention of respondent's rate of the CAR being lower than 7%, in the grand scheme of things is that correct.

M & D Green – Relative to the size of the population. Yes.

Applicant – There was a recent application in Linlithgow that you were applying for where the response rate was 5.2%. You mentioned that that was significant at the time.

M & D Green – Linlithgow was an interesting application. It has broad similarities in fact to Helensburgh in that the population is much the same size, the population of Linlithgow being around 14,000 and Greater Linlithgow 17-18,000, and the pharmacy provision in Linlithgow is covered by two pharmacies.

Applicant – You mentioned that it was 5.2% which was statistically significant than a high percentage response so would you agree our greater 7% response rate?

M & D Green – It didn't mention significant statistical significance, what I said was it doesn't reflect the … it is not representative of the population, and I further back that up with there are many comments that are made through the consultation analysis report, and actually there are a lot of them which make positive statements, way more than those that have actually … that they think provision is adequate in the area. Way more.

Applicant – Do you agree that 79% of respondents say that the services in the area aren't adequate.

M & D Green – That is the statistics, however, what I'm saying is those that have taken the time to make comment, there are way more comments than 20%.

Applicant – You also made mention of the number of people in your pharmacy – I believe it was 4,410 people per pharmacy roughly in Scotland. In Helensburgh you see 3,300 is that correct?

M & D Green – Yes, if we were to re-instate a fourth pharmacy.

Applicant – Would you agree then that these numbers are comparing Helensburgh on its own as a population of 14,127?

M & D Green – Sorry, could you repeat that question?

Applicant – The number you came to of 3,300, that's the population of Helensburgh. Would you agree that Helensburgh is a focal point for Argyll & Bute in many areas like Shandon, Rhu, Kilcreggan, the population from these areas actually come into the area including pharmacy services, which would in turn increase this number?

M & D Green – I wouldn't disagree with that statement, but I would also add that as many people leave Helensburgh to work elsewhere as do come in to use Helensburgh. Helensburgh is an affluent commuter town; residents have access to cars and there is a very good train line from Helensburgh directly into Glasgow. Without having any evidence to back it up and no statistics I would suggest that there is as many people leave Helensburgh as do come in to use Helensburgh, potentially more.

Applicant – You mention the three prescribers will hopefully be the aim in M & D Green pharmacy in Sinclair Street. Does that highlight the high need for this service in this area and the high need in the population?

M & D Green – I am promoting prescribing across all pharmacies, across the M & D Green group, not exclusive to Helensburgh. I aim to have prescribing services in every pharmacy that I own, it is not exclusive to Helensburgh and it's not reacting to Helensburgh but it's consistent that what I am commenting on is your comment that you stated there is no Pharmacy First Plus service in Helensburgh. From next August that is factually incorrect.

Applicant – On the topic of Pharmacy First Plus. How would these consultations be happening currently, with the current consultation space.

M & D Green – There is a consultation space. Our premises at the moment do restrict what we can do. There is a private space, it's not ideal, that is why we have built an extension and will proceed with the refit of that pharmacy to instate a full consultation room and two treatment rooms so we will have three consultation stages.

Applicant – Do you agree we are here today to speak about current services.

M & D Green – No, I think we are here today to talk about the plans that I have for the pharmacy as well. You cannot discount what I am proposing to do with the pharmacy.

Applicant – So at the moment, consultations are happening in this space. Is this correct?

M & D Green – You can only work with the space that we have. I have only taken on the pharmacy since March. Planning applications take longer than that. I think I have demonstrated my commitment to extending the consultation services in the pharmacy.

Applicant – So, in terms of sizes, unit sizes, you make mention of the 600 square feet was a relatively small size for a pharmacy. In the recent application in Linlithgow the unit size was 528 square feet which is smaller than I propose. Can you explain that a bit more please?

M & D Green - That has no bearing on this application, but I will explain if necessary. My full intention is to relocate that premises at the first opportunity but as it stands that application has not been granted as it is subject to appeal, so it doesn't set any particular precedence. You need premises in which to establish a pharmacy contract and then the first thing I would do when I get in is relocate to more suitable premises.

Applicant – If premises are not suitable you can relocate?

M & D Green – Absolutely. The premises are an absolute restriction in terms of engaging with the contract.

Applicant - In your experience, have you ever come across an area that is serviced by a pharmacy 40 miles away?

M & D Green – Not that I could think.

Applicant – How would you describe the service since taking over in six months is that correct?

M & D Green – Yes

Applicant – How would you describe the service?

M & D Green – We have implanted a lot of change. Implementing a new PMR system, whilst absolutely necessary, it does set you back a little in the first instance but bringing in new staff, training new staff, you cannot turn around right away but if we were to consider, what I think you might be angling at, when we took over I referred to pharmacies these days with repeat prescriptions, working a slightly different way from that which we did, say five years ago. The pharmacy is presented with a large bundle of repeat prescriptions. Before we took over, the pharmacy may well not be working today on the prescriptions picked up from the surgery, that now happens on a regular basis. Every day, that day's prescriptions are cleared in that same day. Pre the 1st March, there was a backlog. The pharmacy team might not be working on that day's prescriptions on the day they were collected but that is a significant change and a significant improvement despite me not being able to make all the changes I intent to do yet.

Applicant – Yes, of course, I take your point. In terms of recent feedback that the pharmacy has had, as recent as the 15th August there is mention of the new systems not apparently working as they should, and the service was better when it was Gordons? Why would that be?

M & D Green – No-one has made a complaint to me. No-one has complained through the official channels with M & D Green to allow me to address them. I think what you might be referring to, some comments from a very limited number of people, on perhaps your Facebook page or on social media, whereas if someone has a genuine complaint and concern, there are official channels. We advertise how to make a complaint and how to make ourselves readily available, we haven't received any and I cannot address anything if someone doesn't come to me and raise a complaint and give me a specific issue.

Applicant – Do you still take into account complaints that are posted in response to your adverts and also complaints from members of the public to the community council which illustrated queues are large and coming out the door, queueing on the street?

M & D Green – What do you mean by posts on the internet and something to do with my adverts?

Applicant – The community advertiser advert that you had posted in Helensburgh, that is also posted on-line, and I believe this is where people can comment and comments were made about the service.

M & D Green – I am not aware of that.

Applicant – You made mention of the difficulty owning a pharmacy and running a pharmacy. Would you agree there has been a 4% global sum uplift?

M & D Green – Yes, there has. Also, it is not what we looked for. We looked for double that.

Applicant – I understand the Community Pharmacy for Scotland raised a manifesto on Monday there about the visions for pharmacies in Scotland and transforming this vision. In this manifesto it detailed how pharmacies can help prevent, detect and treat illnesses. How can these roles be taken on in Helensburgh when the core services are over-stretched?

M & D Green – I can only talk about M & D Green. How am I taking that vision forward? We have a prescribing pharmacist, we have two regular pharmacists, we have a trainee pharmacist.

The intention is at this stage to retain that trainee pharmacist if she chooses to stay with us so we will have three pharmacists from August next year. By the turn of the year, we will have a consultation room and two treatment rooms. When there is a pharmacist sitting in one of these consultation rooms or provide backfill from my relief pool to give them dedicated time to consult. That will take probably until January or February of next year because I will need to complete my refit. I am behind the vision of CPS – I'm not sure where you are angling with this?

Applicant – Another question – is it a sign of inadequacy if a pharmacy is queued out the door?

M & D Green – A pharmacy being busy is not a sign of inadequacy. If we were to consider that every busy pharmacy in Scotland is inadequate and therefore, we should re-instate or allow another pharmacy provider to come in, the network would be disseminated. There are busy times within the pharmacy, there are not always queues, there are times there are queues at times. We have put in measure to improve that, and we are intending to install, like yourself, a 24/7 automated robot which will take a lot of volume from those patients who don't need advice, they simply need to pick up a prescription. The increased size of the dispensary, increasing from 6 meters of workbench to 18 meters with two workstations to four workstations, the increased storage capacity and storage room will allow us significant capacity to address any times of pressure that currently exist.

Applicant - In the pharmacy in Helensburgh Mr. Green, it is the busiest pharmacy in NHS Highland as made mention of, and it's 4,000 items, do you agree that is because there is a lack of suitability and provision in the neighbourhood, not just your pharmacy but the others in the area as well?

M & D Green – No, I don't agree with you. I wouldn't discredit my colleagues in Helensburgh in that way, patients are strange. You tell patients that your prescription will be ready on Tuesday, but do you know what, we might not have it ready until Wednesday, but they will come in on Tuesday anyway. We happen to be the closest pharmacy to the Health Centre. Whilst we would all like the focus for patients to change to more consulting services, our proximity to the Health Centre is still the single biggest driver to your footfall of patients and your estimation to your proposed location you would only be delivering potentially 4,000 items, I would have to suggest that you are only doing 4,000 items and you are the closest to the Health Centre, you are providing a very bad service.

Applicant – In light of recent feedback that the pharmacy has received, through, as you said appropriate channels, would leaving a review on Google under the pharmacy, would that be an appropriate channel?

M & D Green – The appropriate channel would be to follow the complaints procedure that is advertised and displayed within the pharmacy to allow the pharmacy team to address any complaints that you have. Without giving team, the opportunity to address the complaint it is not an appropriate channel and is of less relevance.

Applicant – Usually when Google reviews are left you get a notification to let you know that that review has been left. Has that never come through the office?

M & D Green – No.

Application – Are you aware that Helensburgh & Lomond is the second highest for emergency contraception dispensed in NHS Highland in the most recent Pharmacy Care Services Plan. In light of that, do you think it is acceptable that Helensburgh lacks confidential space at the moment.

M & D Green – I have already accepted that we do not already have currently a consultation room, we have a private area. We do conduct EHC consultations, I do not have any figures but

from memory that is around about six per month, so we do conduct EHC consultations, however, we are putting in a consultation room and two treatment rooms to provide more than sufficient private space in the very foreseeable future.

Applicant – You mentioned that when Gordons were the operatives in the area, there was restrictions accessing appliance aids and since you have taken over this has been lifted, which is great, but do you think that could be a factor of the growing queues and the growing number of people that are saying services have deteriorated, because the workload has increased?

M & D Green – No. I have taken on additional staff and we have dedicated staff who focus on the assembly of dosette boxes, and actually since removing the cap, we have taken on more patients, we have not been overwhelmed with patients so I am actually thinking there is a perceived need for compliance aids and not an actual need but I might have expected there to have been a significant upturn in the number of patients requesting dosette boxes, there hasn't been.

Applicant – How would you explain the queues then, if it hasn't been additional workload?

M & D Green – Queues are there at busy times of the day. Patients present, and I will give you an example, last time I was in the pharmacy there was a queue of maybe six people. I went down the queue and three of them were waiting to hand in a repeat prescription request. I said, I will take that from you, I will take that from you, and they went away. People queue when there is no need to queue. It is often easily dealt with, and the queues are not ever present, the queues are only there at busy points in the day. Having taken over on the 1st April there was a particular pressure point I would suggest around the Easter weekend, which didn't form long after taking over the pharmacy as the GP practice was closed Friday, Saturday, Sunday and Monday, and then when you present on Tuesday, pharmacy's prescription file which you get is three times the size you get than it normally is but patients expectation now is greater. So, there have been significant pressure points since taking over, which are not representative of the vast majority of the year.

Applicant – In recent feedback from the 15th August, comment was made that a member of the public contacted you regarding increased waiting times and people being told to come back.

M & D Green – No member of the public has contacted me.

Applicant – Has a pharmacy every closed in Scotland due to a new contract?

M & D Green – There's not that I recall. There is not that many contracts granted in Scotland.

Applicant – No further questions Chair.

Chair – Can we now move on to questions from the Interested Parties please?

Boots – Thank you Chairman, thank you Martin for your presentation. Just coming back to the point about the 4% uplift which was received from the Scottish Government, would that offset the increase in national insurance costs?

M & D Green – No, it wouldn't.

Boots – I'm curious about what the applicant said, if the contract was granted it would only be M & D Green and Boots that were likely to lose business to them. I can't understand that. Can you understand any logic in that?

M & D Green – It doesn't make any sense. I don't know how you can determine how your patients might come from and in addition I would think that he has hugely underestimating the impact he would have on the rest of the network in Helensburgh if this location is granted as the pharmacy closest to the Health Centre.

Boots – In your experience Martin, with the number of pharmacies that you run, I believe the script volume, the prescription item volume for Rowlands is around 3,000 a month, if the pharmacy were to be granted and go on to open would you be questioning the viability of that pharmacy with the low prescription items.

M & D Green – In my experience, a pharmacy of that nature, if they are making any money right now, it will be minimal on 3,000 items.

Boots – Fantastic to hear about your level of investment that you are putting into the pharmacy in Helensburgh, not only on the premises but your staff, and the development of them. Again, given if the pharmacy were to go on to open what do you think the risks would be going forward to the level of investment you are going to make to Helensburgh currently?

M & D Green – You can't really withdraw investment that you have already committed to in terms of premises, the only variable investment that you can influence that has any kind of significant impact on the cost base of a business is your staffing. So, that would be the first thing and unfortunately one of the few things you can look at to make cost savings and it would be inevitable if a pharmacy were to open I would estimate that we would lose probably 25%, about 4,000 items if you wanted me to put it into items and I would need to reduce my staffing resource accordingly.

Boots – Have you ever come across a pharmacy that has zero wait times.

M & D Green – No. I think it is a fanciful concept.

Boots – Do you think the statement of zero wait times and an image of the new pharmacy on the Facebook page, which we have established is not what the pharmacy is going to look like, do you think that might have been misleading the population of Helensburgh?

M & D Green – Extremely misleading.

Boots – Have you ever come across a CAR that didn't include a Don't Know option for giving a response to?

M & D Green – No

Boots – Just coming on to NHS Pharmacy First Plus, which we are all advocates of, currently at the moment though, can that be considered inadequacy as part of the core service currently?

M & D Green – No, it's not.

Boots – That all thanks Mr. Chairman.

Chair – Moving on to Cardross.

Cardross – Thank you Chair, thank you Martin. Just a couple of questions I had. One was, you mention you are currently undergoing an extension. Do you have experience refitting pharmacies with any of you other pharmacies recently?

M & D Green – We have a rolling programme of refit's, so I effectively employ a shopfitter almost full-time, and they move from one project to the next so we are currently undergoing a refit in Edinburgh, which is ongoing, hopefully complete within the next two weeks.

Cardross – Do you see these similarities between your store in Helensburgh and one you have currently undergone a refit with increasing queues, obviously you are changing systems, changing how staff are trained, would you say that was quite common going through a refit from your experience?

M & D Green – Absolutely, premises now have become a critical factor in delivering the contract so a refit typically transforms the operation of a pharmacy, and the nature and extent of services that can be provided.

Cardross – There have been a lot of comments and views, and I'm sure you will agree that is just part n parcel of a busy high street shop in general, never mind a pharmacy. Would you say your retail side is quite busy?

M & D Green – Across the group or just in Helensburgh do you mean?

Cardross – Just in Helensburgh, just as an example.

M & D Green – The retail space is quite small, we focus mostly on healthcare in terms of proportion of the footprint it will represent, about 25%. Helensburgh is, however, quite an affluent population so despite the small retail space, it does ok but it still only represents may 5% of turnover.

Cardross – Would you say a considerable proportion or significant proportion of your queue could be buying things rather than requiring healthcare service for example?

M & D Green – Yes, that's correct.

Cardross – You also mention about the prescription volume, in conversation, that Helensburgh is one of the busiest in NHS Highland. Would you say it is one of the busiest in your group or the busiest in your group, do you have any other pharmacy which has higher item numbers?

M & D Green – Yes, I have several. It is a busy pharmacy, but I am certain it is within my top ten.

Cardross – So you say you have experience managing these sorts of numbers and how to operate a pharmacy of this size logistically?

M & D Green – Yes and grow.

Cardross – OK, thank you. That's all my questions.

Chair – Thank you so if we can move on to questions from Rowlands.

Rowlands – Hi, I think all the questions have actually been covered so I don't think I have any questions. Thank you.

Chair – Thank you very much. Community Council please?

CC – Hi, just a couple of questions on the population figures coming in and out of the town. One of the issues about the population size appearing to remain stagnant is that Faslane Naval Base was included at one point and then not included on the census data so that has given a slightly

misleading picture of the town size. Helensburgh is growing as a town and it is the only town in Argyll & Bute which is growing, and government council are desperate to increase the size of the town so would you consider the fact that there is about 7,000 people coming into Helensburgh at the base at Faslane matched with 7,000 people leaving the town to get services elsewhere. It seems an awful high proportion.

M & D Green – They both seem high, yes, I would imagine half of Helensburgh leaving on a daily basis.

CC – Most of the people living in Helensburgh, working in Helensburgh will they be expecting to get their services in Helensburgh?

M & D Green – I think the point I was making in my presentation is that Helensburgh has grown because it has become a commuter town, and many people will work and move out of Helensburgh. I couldn't put a figure to it, but many people will move out of Helensburgh to work on a daily basis. I'm sure that's the case.

CC – In terms of consultations, can I get a bit of an explanation as to how consultations are delivered at the moment because as far as I'm aware at M & D Green there is a partition near the counter so there isn't a private area as such, it is just a little bit of a wall.

M & D Green – That is correct. There is a screened off area so that is where our consultations of a sensitive nature are conducted, and I accept that is not ideal that is why I have invested significantly into extending the size of the premises which will introduce a full-size consultation room and two treatment rooms in the premise in 52a. We will have significant capacity to deal with all private consultations in the near future. And I couldn't really do it much faster; I have only been in since March and the extension is now built and complete and the refit will be complete within four months.

CC – Will your refit be fully disability compliant?

M & D Green – Yes, it is going through planning and to put some context next to this , it's already been approved but because we changed the size of the extension through the course of the build, in conjunction with building control, we have to now wait on a completion certificate and re-submit a new planning application because the original planning application has changed, so it has delayed somewhat unfortunately and have to go back to the start again but it was worth doing to gain that additional space from the extension but the plans have broadly already been approved by planning and they have to be DDA compliant.

CC – So, the other question I have to ask is about the robot service you were talking about. You said that would be through a blocked-up window at the back. The back of that shop has a checkered No Waiting zone in the Co-op car park. That is the turning area that you come from the station towards the Co-op entrance. That area is quite a dangerous point; there has been a number of accidents there. Would there be issues with more people queuing to access prescriptions where you have a very tight turning circle, people accessing the station from the platforms to the car park and the supermarket. It seems a very dangerous place to have a dispensing unit.

M & D Green – I don't agree. I think there is adequate space there. My architect who submitted the application on my behalf also agrees that there is adequate space for people to stand and access a dispensing robot. We will find out when we hear from planning but in my opinion, there is more than adequate space and now that is also the opinion of my architect.

CC – There was a death at that corner recently, someone was knocked over and killed.

Chair – Is that a question?

CC – It's an observation. That's all my questions thank you.

Chair – Thank you so moving on to questions from the panel and if I can start with myself. Can I ask, you have explained a lot around the improvements you plan to make and the possible benefit's this will bring to the people in the community. Can I ask how you communicated those changes with the population?

M & D Green – Any additional services we have introduced, for example, the comprehensive delivery service, we conducted a leaflet drop of the wider area, we have digital display screens in the pharmacy, one in the window and one inside the pharmacy which advertise all of our services and we also print information leaflets which we make available in leaflet holders on the front counter. When we undergo the refit, I will probably approach the local newspaper and run an advertisement feature in the paper when the refit is complete and invite the Advertiser in to see the new premises.

Chair – You talked about Helensburgh being a commuter town and the impact that might have on where people secure their prescriptions. Suppose my thinking around that is might you still be accessing a GP as a commuter in example Glasgow or are you more likely accessing a GP in the place where you live, therefore, is that commuting really making any measurable difference in the amount of prescriptions coming.

M & D Green – As a commuter, I think we are probably referring to not seeing their GP but fulfilling prescriptions. If you have a prescription in your bag or pocket you have a choice to have that fulfilled near your place of work but you may spend most of your week near where you live but the point I was making in particular with Helensburgh is that it is recognised as a commuter town so more than most other towns in the area will not be accessible because they do not have the railway line so that opportunity is afforded to more people in Helensburgh than perhaps other places in the area because of the rail link.

Chair – Thank you. I will hand you over to Ian please.

IG – You said that you took over on 1st March. When did the process start to take over?

M & D Green – The building work started in April.

IG – No, I was meaning, when did you know that you were going to be acquiring the premises?

M & D Green – The owners of Gordons Chemist accepted my offer for the business at the end of October last year.

IG – The process had obviously started a bit earlier than that?

M & D Green – Three months.

IG – Did you know about the closure of Boots at that point. Was Boots closed at that point?

M & D Green – Yes, it was. It had been closed for some time.

IG – Were you aware at that time of the uptake in activity?

M & D Green – I could see it, yes that is correct.

IG – According to our figures there was a 40% increase.

M & D Green – Yes.

IG – When you took over from Gordons did you know about this planning application for a new pharmacy?

M & D Green – I did.

IG – I don't think there is any dubiety about the CAR in that there are a few queues at times, and some people are making more of it and some people are making less of it. Is that a normal feature of the rest of your chain, there are queues at times?

M & D Green – In pharmacies that deal with that kind of volume there will be queues, there will be people in the pharmacy at all times. In Helensburgh they do queue. In many places they do not queue they just stand in the sales area because they are waiting on a prescription but in Helensburgh, they all form a big line, but queues are a common thing in busy pharmacies.

IG – I would be surprised, or would you be surprised that there was a queue when the activity had increased by 40%?

M & D Green – Would I be surprised?

IG – Yes.

M & D Green – Perhaps not but my intention is to increase the capacity of the pharmacy to alleviate any queues, or I would preferably refer to them as pressure points within the working week and we are not making a small difference to the pharmacy, we are making a huge difference to the pharmacy. We are doubling its footprint, doubling the number of workstations, increasing the staffing numbers, increasing the pharmacist numbers so I fully intend to significantly increase the capacity not just to address pressure points but introduce additional further services.

Chair – Mark, can we take you please on Teams.

MF – You gave us a fairly detailed analysis about the population and the existing pharmacies, and am I correct your hypothesis was that it would be difficult for a pharmacy to be profitable with fewer than 3,500 people being served by it?

M & D Green – What I had said was that a population of approximately 4,000 it would maintain a stable average pharmacy, fewer than that would be less than average.

MF – Do you accept nevertheless that there are a number of very successful independent pharmacies across the Highlands and Islands where they support populations of around 2,500 to 3,000 people? I live in an area of one of them.

M & D Green – Without knowing their accounts but I would hazard a guess they will be doing OK but will not be making fortunes.

MF – No, but you accept that they could be profitable.

M & D Green – Viable, yes, I accept they can be viable.

Chair – Thank you very much Mark. Moving on to Catriona Brodie.

CB – Thanks. Martin, can I just check you obviously own a fairly large chain and operate a number of pharmacies in Scotland, you've talked about the high number of pharmacists you are

intending on employing on a full-time basis. One of the things we are seeing in the APC quite a lot is concerns around availability of locums and recruitment and retainment issues, do you have a pool of pharmacists within your employment who may be able to help cover without having to look to locums, to ensure continuity of service?

M & D Green – Yes, I endeavour to use as few locums as I possibly can, I have a large relief pool, the number in the pool does fluctuate for many reasons but we have currently twelve relief pharmacists. I hesitate there because we kept on the vast majority of our pre-registration or foundation year pharmacists but not all of them passed, some will have to re-sit and will not be available to us until the next intake which will bring us up to over 15. I aim to sit with 15 locum pharmacists across the group.

CB – In your opinion, if the Helensburgh population had been made aware of your planned changes to M & D Green at the time of the consultation do you think some of the opinions of the patients may have changed?

M & D Green – I think if we had afforded the time to complete the planned improvements that we intend to make to the premises and the services, it would be quite transformational in terms of the comments that might have been received in the CAR.

CB – Thank you, that's all questions Chair.

Chair – Thank you very much, Susan please?

SP – No questions at this time, thanks.

Chair – Catriona on my right?

CS – You said that you have two ACTs in place. Can I just ask you to expand on to what that role does and how it has benefitted the business and the staff around them?

M & D Green – I am growing my ACTs, so I am developing my existing staff. For some peculiar reason, Gordons did not want to advance their support staff because they had lost so many to Primary Care, so they had stopped the progression of support staff attaining technician status. I have a completely different view on that and I need technicians within the pharmacy to support the pharmacists so that they can conduct consultations, do PGDs, they can take on Pharmacy First and free up significant pharmacist capacity, which I would hope in the fullness of time and I think evolution of public awareness our pharmacists will actually find themselves sitting in consultation rooms doing a slightly more complex consultation. Ideally, this technical staff will then be running the dispensary to allow the pharmacist to actually sit in the consultation room.

CS – Thank you Chair.

Chair – Thank you, Gayle?

GM – Just coming back to your delivery service, you obviously have a full-time driver which is good to hear. This is obviously not a core service I believe but most pharmacies in the area will deliver that. Can I just ask who it is eligible for?

M & D Green – There is no eligibility criteria.

GM – My understanding is that community pharmacies are so successful in bringing in patients to deliver the core services, how do your staff engage with things like Pharmacy First or Public Health Services for those who opt in for delivery service?

M & D Green – Although not ideal, if someone cannot attend the pharmacy then we can conduct a Pharmacy First consultation over the 'phone and if that results in a treatment that treatment can be delivered by the delivery driver. Our preference would be for that consultation to be face to face but for those who can't get out it can be done over the 'phone and then that treatment, if necessary, delivered by a driver.

GM – All my questions, thanks.

Chair – So that concludes our questions to Martin from M & D Green. I'm also going to ask everyone to stand up because I need to stand. We have five presentations by our Interested Parties to come and then summing up by our Interested Parties and applicant. It's 1.40 pm, my proposal is we carry on with Boots then have a break for lunch or if everyone thinks that's a terrible idea, we take a break now. What does everyone think?

Boots – I am happy to proceed.

CC – I would prefer a break just now. I have some care requirements for an elderly relative.

Chair – You would prefer a break now? Then if that's the case, can I suggest that we take twenty minutes for lunch? Is that sufficient for you Community Council people? We will be back at 2.00 pm.

Break for lunch.

4. Presentation by Boots

Chair – Can we move on to our presentation by Boots please.

Boots – In the interest of time, anything that Martin has covered I shall keep to an absolute minimum. Just to come to the neighbourhood, firstly in essence we agreed with the neighbourhood. Helensburgh is an urban town in Argyll & Bute with a transient population, three railway stations with direct links to Edinburgh and Glasgow so it does support that commuting and urban mobility. It is an affluent town with high levels of car ownership and good access to surrounding towns and cities for employment. The demographics, there is a slight difference in population, we had taken the 2022 census data which was 14,127, a little bit different from what's in the CAR but again I think Martin has covered these points in terms of the population per head of pharmacy, which would be in line with the national average. With those low levels of deprivation in Helensburgh we do kind of see higher statistics coming through for higher car ownership and higher own home ownership compared to the national averages. A fair bit has been said about population growth in Helensburgh, we did find some information which was an extract from Improvements Service in Collaboration with National Records for Scotland Networks at South council projections area population projections and that is stated for Helensburgh as a population increase between 2025 and 2030 of just 562 people.

Just moving on to the existing services provided in the neighbourhood, there are obviously three pharmacies all within the Town Centre, just a short distance from each other, notably I would say that the Boots pharmacy is open seven days a week and we do provide services on a Sunday. Moving on to the services which we provide, quite a lot has been said about NHS Pharmacy First. Just looking at our statistics for NHS Pharmacy First, we are broadly in line with the average pharmacy in Scotland and certainly the service is available to access for our patients. With regards to Pharmacy First Plus, independent prescribing, Boots is obviously moving that agenda forward; our pharmacist is due to submit her IP portfolio in December 2025 so we would hope to

have that up and running in 2026. We do provide EHC and bridging contraception and stop smoking service which comes under the banner of Public Health Service, Unscheduled Care, Gluten Free Food Service, ostomy and a range of local negotiated services. Just for clarity, the ones which came up in conversations for needle exchange, obviously the Health Board decide which pharmacy they want to offer that. It was the smaller Boots pharmacy and that has been moved to the larger Boots pharmacy when the smaller branch was closed. There is a MAR chart service, which is a locally commissioned service, as I understand that service is around providing a MAR chart service and original packs for the patient as I understand it, dosette boxes and compliance aids packs is not an NHS service as I understand it but I will be corrected if any of that information is wrong, and that wouldn't be an NHS service but we do provide that to patients in need. So, we do provide a number of patients with compliance packs and have capacity to take on more. We also service local Care Homes in the area and we visit those Care Homes every four to six weeks, which is above and beyond what the expectation would be in terms of what we would be asked to do but we see that as a kind of vital part of our service to the local community, and we do offer free delivery service, morning and afternoon, Monday to Friday, and we do cover emergency delivery over the weekend if that was necessary if a patient required an antibiotic.

What I find curious is a lot of the comments in the CAR, and when I look at the feedback that we get from our patients, so we actively pro-actively ask our patients for feedback on the service they receive from us and looking back to 1st September through to, the stats I had at the time of writing this, took us up to the end of July this year – we had 94 responses during that period of time and of those 94 responses, 70% of patients told us they were extremely satisfied. In our internal measure we don't actually get a point unless the patient said they were extremely satisfied with the service so that's why 70% came through as extremely satisfied, the rest came through as satisfied at 30%. I have received many comments from the public highlighting our friendly staff and I will read a small number, if you will indulge me on that – "I picked up a prescription, got a text to say it was ready, no queues, served by Kathy who offered to re-order, excellent service, professional and friendly staff, staff is very friendly and more like a family run store, everyone makes sure you are welcomed and happy". "I received a message to collect my prescription, same each month, ready as always, no problem." "I pick up my prescription every eight weeks, I don't need to do anything, they order it for me and text me when ready, great service and open on a Sunday". "This Boots store has been in my hometown for as long as I can remember, I know some of the staff go above and beyond to help, Boots is a way of life and a must in every town". "Staff in the store were friendly, items available quickly and wait time wasn't long, the time getting my prescription was quick and overall, a positive experience". "When I pick up prescriptions staff are always friendly and efficient, also when I want to buy something there is always a smile on the staff face and they are very helpful if I can't find anything".

Following the closure of the smaller Boots store, Boots has made significant capital investment in our pharmacies to ensure continuity of care for the local population. This demonstrates Boots commitment to pharmacy provision in Helensburgh by enhancing the standard of service for patients in the wider community. Instances of what that looks like, essentially the local store was fitted out, new shop floor layout, community dispensary and a new consultation room, which is used regularly by patients wishing to access that for a more confidential area. There is also the inclusion of a supervision area which has greater confidentiality to any patients who might be accessing our substance use services, and also in the background Boots has been working on implanting various automation technologies, which improves the efficiency of the dispensary and releases the capacity of the pharmacist to spend more time with face to face with patients and delivery of the services. So, as a result of these improvements, we have capacity for those all across prescription supply and NHS services. And again, just to address some of the points round about the headlines in the paper from previous year and around that, the factual evidence I have is the complaints gone to NHS Highland around our service and I can see that from July 23 through to December 23, the period just before the closure, there was one complaint which had gone to the Board. That did go up so from January 24 to June 24 there were ten complaints that went to the Board. I find that regrettable but during the closure of one pharmacy, I think we

are all human and don't tend to like change, an inevitably there would have been some disruption to some patients during that space of time but factually, that was ten complaints that went to the Board. Interestingly, that came right back down again so when I look at the figures from July to September 24 there was one complaint, September to October 24 there was one complaint and in the last six months from January 25 to June 25 there have been no complaints that have gone to the Board.

Just coming on to staffing so we have a Store Manager who is a trained pharmacy technician and is completing her accuracy checking training at the moment, which Martin has covered on what that person would do, we also have another part-time accuracy checking technician. We have a pharmacy technician, and we have ten dispensers with a combination of full and part-time working in the pharmacy. We have five customers advisers who will work on the healthcare counter in the shopfloor, and we have three store-based pharmacists; one full-time and two are part-time, and we have no vacancies at this moment in time. As I say, Helen is due to complete her IP training. Fingers crossed if all goes well, by the end of this year.

Just in terms of the premises, we have spoken about the level of investment that has gone in and we are full DDA compliant with a new consultation room recently fitted, lower healthcare counter for wheelchair access, automatic doors, there is no need for a ramp; there is direct access from the street, the dispensary has been refitted and as previously said, significant investment into the store.

A thing that has really come through strongly when I have been working with Stuart who is on Teams today and is our Area Manager, and Sarah who is our Store Manager, just how strong those local relationships are with other healthcare providers and GPs. I mentioned there was a recent visit to the GP surgery and we received great feedback from the GPs in terms of the level of service we provide to our patients who didn't raise any concerns with us around access or around access to medication or NHS services, they were very complimentary of the work that we do. Also, the team also maintain strong working relations with other healthcare providers, so they recently visited the Dumbarton Joint Hospital, which I know falls into the NHS GG&C but close by and the GG&C mental health service to explore opportunities for further support from them there. We had the great privilege of welcoming representatives from the local community council to visit the store recently to learn more about what we do behind the scenes in the pharmacy and again the feedback we received was they were very impressed with the way we conducted our business.

Just in relation to the other two pharmacies they obviously provide all NHS and core services to patients. Just moving on to access. It is an interesting one because I cannot see how granting the new pharmacy is really going to make any difference in terms of access for patients with it's close proximity to the other pharmacies. There is car parking available, public transport are pretty good I would suggest in terms of both buses and trains, and just moving on to the CAR, what was said about response rates and percentage of population etc I thought it was interesting that there wasn't a Don't Know option that was included in the CAR, and actually there were comments made in the CAR that actually said "should have Don't Know option because I don't know". One comment was "unsure as I don't have need of these at present". Normally, in my experience the CAR would have a 'Don't Know" option for those who felt they maybe didn't have sufficient evidence to answer 'Yes" or 'No" to the questions. Also, there is a significant amount of responses to the CAR which wouldn't be in support of it. Bear with me a second whilst I read a few out. "There isn't any need for another community pharmacy, Helensburgh is already fully covered for every service needed by patients in the area with capacity for further patients in the current pharmacies". "We don't need another pharmacy". "I strongly oppose another pharmacy; I would prefer dental services to Helensburgh instead" 'We area already well served in Helensburgh". "The three pharmacies in Helensburgh already do a fantastic job providing all the major services without being pushed to unmanageable levels". "There is no need for another pharmacy offering services already well covered". There are various others but just to highlight

the point that not everybody who responded to the CAR who would be included in the overall numbers is approving of it.

Moving on to viability, we mention the need to secure adequacy of services in the area which includes considering the effect granting the application would have on the stability and sustainability of local NHS pharmaceutical services. That is, the existing services available to the patients as well as long-term viability and security of the new pharmacy should the application be granted. We did close one of the pharmacies in Helensburgh, as Martin was talking about, and just to give context around the reasons behind that decision to close that pharmacy. During covid we experienced a massive workforce challenge and keeping a pharmacy open was increasingly challenging, particularly and even more so as we came out of covid and as the year following 2021 was probably one of the most challenging years I have ever experienced in my career as a pharmacist, just in terms of being able to keep pharmacies open for the required number of hours. Obviously, when you have two branches in one location that is part of the consideration of – are we better to protect the service by ensuring we can keep that pharmacy fully staffed and adequate as opposed to trying to spread too thinly to stay open, so that was part of it. Also, the increasing costs community pharmacies have faced, a lot of these costs have out with our control and the increase to salaries overall, national insurance increases etc. A business would look at consolidating their costs as much as they can to make sure they can protect that going forward but also I think there is a look towards the future and where is the pharmacy contract moving in Scotland, and what kind of size, what kind of space do we need in the premises do we need to meet that future demand, to be able to deliver on that, the development of IP services and therefore it makes sense to relocate to your larger premises to meet that future need. However, if the contract is to be granted, that similarly as Martin has already said, if there is a decrease in the volume of items and services that we are doing then the only cost saving we can look at is staffing costs so that is real people's jobs that may be at risk if the contract goes on to open. And, also looking at the model the applicant has put forward of two pharmacists, three team members, driver, the opening hours between 8.00 am that is going to be a high-cost model to run and I am sure given the prescription volumes that certainly cause us concern of a pharmacy with that prescription volume and the ongoing viability. Therefore, for the above reasons, primarily looking at the viability, the level of service that Helensburgh has with the pharmacies at the moment, the future investment that Martin is making into the M & D Green pharmacy and the investment into Boots pharmacy, we respectfully ask that the panel to reject the application.

Chair – Can we now have questions from the panel. If we can start with questions from the applicant.

Applicant – Thank you for your presentation Mr. Jamieson. You mention that your Pharmacy First prescription volume was in line with the Scottish average. Would you say that your prescription volume is above the Scottish average?

Boots – We have a high-volume prescription pharmacy.

Applicant – You also made mention of high satisfaction rates. With the levels of satisfaction that you mention, how would you explain the difference between the CAR where 21% of residents think it is adequate with 79% saying the provision is inadequate. How do we compare the two, how is there a discrepancy?

Boots – I think it is a very good question. We can obviously only go on feedback received from customers where we proactively reach out to get as much feedback as we can. You can see the overall response rates that we have. So our customers give us a very good insight into what they believe the service levels are like and then the other opportunity is for us to reach out to the other members of the community and healthcare providers so as I said, we reach out to the GP practice, meet with them, ask them if they have any concerns, anything we can do differently, they have been very positive, the other substance use centres that I have mentioned and of course we

invited the community council into the store so we could ask them. So, I think we have been quite surprised at some of the feedback in the CAR. We have certainly done everything that we can do in order to get as much feedback as we can to make sure the service is as good as it can possibly be.

Applicant – You mentioned that you received feedback from the medical practice. Do you have any statement from them about the feedback that we provided you?

Boots – Stuart unfortunately cannot speak but he is on camera, and Stuart with the Store Manager went to the practice and met with Carol Ann I believe and certainly the feedback that Stuart shared with me was very positive, they had no concerns about medication provision, no concern about access to NHS services, and certainly one of the things the GPs would raise would be if there was an issue would be access to NHS Pharmacy First, health services, unscheduled care. Those patients would inevitably go back to the GP as that would be increased workload for the GPs so certainly in my experience if that was an issue, the GPs would be raising that very quickly with the community pharmacies to address.

Applicant – How would you respond to the letter that we received from the Medical Practice that says 'I am writing to formally express our support, we are acutely aware of the increasing pressures since the Boots closure. Opening another pharmacy in the area is both timely and essential to meet the growing needs of the population. We strongly support this application".

Boots – I can only go back to the points raised before, we have gone back and visited them, no concerns have been raised.

Applicant – The next question is the size of the dispensary in Boots branch at the moment. Do you have that to hand?

Boots – I don't know the size of the actual dispensary, the size of the entire store?

Applicant – The dispensary is a very small proportion of that store, so it was just to see if you knew the dimensions of that dispensary.

Boots – Off the top of my head, no but remember there is a separate dispensary which supports our Care Homes.

Applicant – The patients do not have access to that dispensary?

Boots – The patients wouldn't have access to any dispensary, would they?

Applicant – In terms of prescriptions that are coming from the GP practice is that the one downstairs, is that right?

Boots – Yes.

Applicant – There is a comment in the CAR which says, "Since the closure of the secondary Boots location, pharmacies in the Town Centre have become too busy, it is difficult to get seen when needing over the counter medicines in a timely fashion". How do you respond to that?

Boots – Well again, it's the same answer I am going to give you. You could pull out several responses in the CAR, people have obviously put how they feel about it but in terms of what we see and the feedback that we get, the healthcare professionals we have reached out to, the community council, we haven't received any negative feedback.

Applicant – In previous Hearings, I think it was 2020 you gave great emphasis on the Pharmaceutical Care Services Plan and how at the time it did mention the need for any new pharmacies. Does the Care Service Plan still hold the same weight now as the new Service Plan that is out at the moment? Do you still hold the same weight of the Care Service Plan that you did in previous Hearings?

Boots – Which Hearings are you referring to?

Applicant – Newtonmore 2020.

Boots – That wouldn't have been me, that was my plus one.

Applicant – It was said in this Hearing that the Pharmaceutical Care Services Plan didn't mention the need for any new pharmacies. The current Pharmaceutical Care Services Plan does so does that hold the same weighting?

Boots – To be honest, I don't know the detail of the new current Pharmaceutical Services Plan, maybe I should, but at this precise moment I do not know it so wouldn't like to comment on it.

Applicant – It mentions that the unmet need needs to be considered regarding the closures of pharmacies in NHS Highland. Have you read that at all?

Boots – I have to be honest, I haven't read that Plan so therefore I am reluctant to comment because I don't know the detail of it, what it is referring to, the geographic location so forgive me but I will not comment on that one.

Applicant – You mentioned that the reason for the closure was consolidating the business. Is that a cost-saving initiative rather than a patient-centred decision?

Boots – I think there are two elements to it. Any business has to be profitable in order to look after the patients. As I said, there's two angles as I kind of said, there's a mixture between what post crisis we can have find a sale in and I appreciate that has listened now, as you know, we're not facing the same pressures, but particularly around when the decision when we move the closure. That was significant in people's minds. And you know the cost of hidden business fees. And I'm walking into it. But what that has enabled us to do is significantly invest into services that we've got. Again, looking forward to the future of the contract and where that's moving in terms of IP services and it will give us better premises to be able to improve so I would say it is a combination of both.

Applicant – The Chief Financial Officer, Mr. James Kehoe said that the company was consolidating its business in order to facilitate a sale, and the closures were part of a cost-saving initiative. Would you agree with that statement?

Boots – Sorry, who was it from?

Applicant – It was the Chief Financial Officer Mr. James Kehoe. It was published by the Pharmaceutical Journal.

Boots – It's above my paygrade, so yes, I would not want to contradict him.

Applicant – Would you say with the benefit of hindsight, that the closure was the wrong path to take.

Boots – No, not at all.

Applicant – Are you aware of the increased prescription errors as mentioned in the statement of 2023, 19 Sinclair St had zero prescription errors which then increased to 15 after the closure?

Boots – What I would say to that is there would be inevitable disruption when the teams moved across etc but I would also like to point out that any prescription error is regrettable, the first phase of any patient safety culture is reporting of an incident so that it is open and transparent, you could do a review of that and you can learn from it so where it was regrettable there was an incident I think that would say to me there is a very good patient safety culture in terms of being open and honest and transparent and to learn from those incidents.

Applicant – In terms of consultations, it has repeatedly been mentioned that they happen on the shop floor, how do you think that has happened?

Boots – Again, to go back to the discrepancies for some of the feedback that is in the CAR and if people put that down, they put that down for a reason but certainly when speaking to Stuart and Sarah, and the team in Helensburgh, they are very sensitive to the needs of the patient, making sure that the patient was comfortable in whatever environment. The consultation room is well used.

Applicant – In terms of needle exchange, you mentioned that the Boots branch currently open is a needle exchange pharmacy. However, a lot of patients are saying that there is no needle exchange pharmacy. I'm struggling to understand that. So, you say that the current Boots branch is a needle exchange pharmacy. Do you know the uptake of that at all?

Boots – I don't have the figures in front of me, but I know from talking to Stuart and Sarah we have patients accessing that service. We would again make sure that the patients accessing substance use service and the teams mentioned before, we would make sure that the teams there would know we were offering needle exchange and of course we do report the services that we do to the Health Board.

Applicant – What are the opening hours of the current Boots pharmacy?

Boots – 9.00 – 5.30 Monday to Saturday, 11.00 – 4.00 Sunday.

Applicant – Are there any lunchtime closures in there?

Boots – It would depend if there were two pharmacists in on that particular day so we would certainly wish to reduce that as we have one full-time and two part-time pharmacists so I would say categorically that we would not have a lunch-time closure. But as I'm sure you will be aware, the Health Board's pharmaceutical scheme model hours for which a pharmacy must open and within that there is provision for a pharmacy to close up to an hour for lunch if necessary.

Applicant – Just looking at the Argyll & Bute Social Healthcare Partnership which gives the list of opening hours and services provided, the opening hours are 8.45 am to 5.30 pm. Could you explain that please?

Boots – Well, you know, I don't have the resource there that you have so I cannot comment on that but certainly we would report our opening hours to the Health Board when we have to do so.

Applicant – In terms of locums, would you say that locums that Boots use you would trust their judgement as RP?

Boots – What do I trust the locum's judgement?

Applicant – In Boots, in the locums they bring into the pharmacy.

Boots – I'm not sure where you are going with this.

Applicant – There is a follow-up question which I will ask just for clarity so there was a locum that worked in the store which completed the questionnaire, and it states in the CAR that the current provision is not adequate and highlighted the dispensing errors and Pharmacy First not being utilised. How would you respond to that locum?

Boots – Can I just make sure that I have this correct? Are you saying that there was a locum who completed the CAR and that was their comments?

Applicant – That's what it says in the Consultation Analysis Report.

Boots – To be honest I think it is a really odd question. The motivation of the individual locum, how can I comment on that? It could be your best pal for all I know.

Applicant – My final question is – are you aware of any pharmacy closures due to a new pharmacy application being granted?

Boots – Not that I'm aware of but as Martin said there are not many granted.

Applicant – Thank you.

Chair – Can we move on to questions from the Interested Parties.

M & D Green – Thank you Chair. The branch of Boots that closed down was frequently referred to as the "wee Boots". What size was the premises?

Boots – It was quite small. 132.9 square meter was the total floor size.

M & D Green – The wee Boots was double the size of the premises the applicant is proposing to open, which is referred to as substantial. The applicant, strangely for this process, it is an unusual one, have selected premises which is very close to the front door of the Health Centre and has suggested that they would estimate that they would do 4,000 items a month. Given their location and proximity to the Health Centre if they were only achieving 4,000 items per month, what might that tell you about the service they were providing?

Boots – Given how close this is to the GP practice we would expect them to generate a lot more.

M & D Green – Would you expect that pharmacy to have a more significant impact on your prescription numbers and potentially the remaining pharmacies in Helensburgh prescription numbers than 4,000 items per month.

Boots – I think there is considerable risk it would do given the fact the close proximity to the GP practice.

M & D Green – At Boots, if there was a significant reduction in NHS revenue, would you be required to consider your cost base?

Boots – I think so, yes.

M & D Green – Is that cost base likely to focus on staffing resource and cost cuttings with staff?

Boots – Yes, it's the only place, the other costs are fixed.

M & D Green – That's all from me thank you.

Chair – Thank you. Can we now move on to APC.

MM – You mentioned the capital investment in the store with the new layout. When does that happen?

Boots – It happened in 2024. I believe some of that period the CAR would have been when there was some disruption to the pharmacy.

MM – Can you explain the efficiencies you mentioned.

Boots – Yes, we introduced efficiencies with the PMR system which will essentially take workload away from the team and from the pharmacist and is done through a spreadsheet and we have not reduced the number of hours along with those automated efficiencies, they remain in the pharmacy with the idea to benefit patients by improved services.

MM – No further questions Chair.

Chair – Thank you very much. Can we move on to Cardross please?

Cardross – Thank you. Just for clarification for me. One point – was it sustainable or viable to keep both pharmacies in your opinion, or the company's opinion rather, in such close proximity to each other, the two Boots I mean?

Boots – I don't think it was and, therefore, the decision to close one, part of that would be looking towards the future of the contract and the way in which that was going to go and when looking at both premises the larger one would have been the better one to do that.

Cardross – This is to do with a point earlier, I just wanted to ask someone with your experience, there are Boots in rural locations which may be viable with lower prescription numbers, do you know if there is any additional funding available from the pharmaceutical contract to stores in those locations to make these businesses viable that you are aware of?

Boots – There is a small pharmacy funding, but I would not believe that any of the pharmacies that we operate would receive that funding but to be honest I am not 100% sure.

Cardross – That's it from me thank you.

Chair – Thank you very much and finally Rowlands.

Rowlands – I just have two quick questions. About capacity. I am presuming with such a large store as Boots and the upstairs contained within that as well that expansion of professional services delivery isn't really an issue, expanding the services that you deliver. Is that correct?

Boots – There are no constraints on capacity at all in the store, in the pharmacy.

Rowlands – So, none whatsoever? Ok. Do you find it surprising that the applicants were able to identify a locum pharmacist on the CAR when 75% of responses were anonymous and no job titles or occupation were asked as a question.

Boots – I do.

Rowlands – That's all the questions from me thanks.

Chair – So if we can ask the Community Council.

CC – There has been a lot said about the control of entry for pharmacists going through this process and Hearings like this but there seems to be a lack of control of exit. A question about the closure of the wee Boots on Sinclair St, did you go through any consultation exercise prior to that closure?

Boots – I don't know in answer to your question.

CC – In principle, why would you not consult with the community if you were thinking about closing a local pharmacy?

Boots – It's a very good point and one I shall take back to the business.

CC – When the community council visited the revamped Boots with the new dispensing counter, we were told they had experienced an increase in business from Greens. Do you know whether that increase in transfer of patients happened before or after the takeover of Gordons by Greens.

Boots – I don't know to be honest. I do not have those facts in front of me.

CC – Final question – there has been a couple of mentions of robot dispensing machines by the others, does Boots have any plans for a dispensing machine like that?

Boots – In terms of a collection point, no we do not.

CC – That's all my questions.

Chair – Thank you very much. We will move on to questions for Boots from the panel. My question has been stolen by someone on the screen so I will move on to Ian.

IG– What was your staffing in big Boots before the closure in wee Boots?

Boots – In terms of pharmacists, one full-time and two part-time.

IG – What was the staffing after?

Boots – One and a part timer.

IG – So presumably, across the Boots in talking about the motivation for closing and the difficulty in recruitment, the word of a macro element which was referred to by the applicant about the strategy of the company which is well known if you read the financial pages in business, so Boots have decided to close a number of pharmacies as a strategic element. What was the process in Scotland of choosing these. Were you involved in that?

Boots – No, well above my paygrade.

IG – So in terms of operational input you weren't there when the decision was taken so there is no knowledge about the criteria used to decide. The reason why I'm asking is because the last two and the next are all to do because of Boots closing pharmacies and I am just trying to understand the process.

Boots – I certainly wasn't involved in the decision of which pharmacy were to close, however, the Director for Stores in Scotland was involved in that decision and from a UK perspective if you look at the volumes in England compared to the volumes in Scotland being closed, there were very few in Scotland closed. But inevitably it would have been made around viability, pharmacist

resource and the future direction of the contract. It would all be Scotland specific from that perspective, the Scottish contract funding and workforce issues and the future of the pharmacy contract in Scotland.

Chair – Thank you Ian. Mark please?

MF – We have heard a great deal in both your comments and those of the owner of Greens that the new pharmacy would have a great advantage because it is just right next door almost to the Medical Centre but I am looking at the street map of Helensburgh and isn't it the case that the proposed new pharmacy and what was Gordons the Chemist are actually basically equi-distant from the Medical Centre so it's not as if it is just next door in comparison to the others is that not the case?

Boots – I don't have a map in front of me to be honest. It is probably more a question for Martin.

MF – But you did refer to it? If I put it to you that there is really no difference in distance between the proposed pharmacy and Gordons, are you or are you not in a position to disagree with that?

Boots – I have no reason to disagree with it.

MF – Thank you. And, the other thing I was going to say is, understandably you picked out a number of responses in the CAR which were favourable but is it not the case that actually I can't see anywhere really in application and the responses which is critical of the staff, you or the other existing pharmacies employ. In fact, quite the opposite, they say they are good people, the work hard, they are just over-stretched, and clearly is that not something that goes to the heart of the matter whether there is adequate provision that in the CAR report and indeed in responses people say that the staff in the existing pharmacies are very good but there is not enough of them. There is just not enough pharmacy provision in the town to cope with the current demand. Is that not the case?

Boots – From my experience and the feedback we get from our customers that is not the feedback we receive.

MF – OK, thank you.

Chair – Thank you Mark, if we can move on to Catriona on the screen?

CB – You mentioned that you sought feedback from the Medical Practice as to the service you are providing, you mentioned specifically speaking with a GP. I wonder did you speak to the local Primary Care pharmacy team who are based out of the Victoria Centre in Helensburgh because obviously with the way that the Scottish GMS contract works now the vast majority of pharmacy related queries, issues, medication queries etc go directly to the pharmacotherapy team, the Primary Care pharmacy team who aren't based directly in the practice?

Boots – I don't believe we did.

CB – You obviously mentioned your consolidation, which I completely understand was not a personal decision on your part, is there a reason, that you are aware of, that Boots didn't opt to sell the branches they wanted to close as opposed to closing them completely and closing the contract?

Boots – I believe the decision making behind it would have been that we were confident that we could consolidate and the needs of the local community.

CB – So I understand it was an operational decision, do you think we would be sitting here today if the business had been sold as opposed to being closed.

Boots – I don't think I am in a position to answer that really. The panel here today is making a decision about adequacy.

Chair – Thank you Catriona, Susan?

SP – I just wanted to ask, and this might be business sensitive information that you wouldn't want to share but have Boots managed to retain the same number of script number in addition of the two stores or has there been an overall reduction?

Boots – Between the two there has been an overall reduction if you look at what was in the two branches, we haven't retained all of that.

Chair – Thank you Susan. Catriona?

CS – You said that your refit included a consultation room but there has been a lot of talk about consultation rooms so far. Do you have a full consultation room, private consultation room, that is a separate room now?

Boots – Absolutely.

GM – Just a quick question around prescribing. You have a colleague who is complete their portfolio in December, are these the pharmacists already or do you have plans for the business continuity to ensure that service can continue to be delivered even if that pharmacist is unavailable?

Boots – Absolutely, that is part of our ongoing people plan, and we are making great progress with our pharmacists who are upskilling to becoming IPs.

GM – Do you have any issues in the area with retention of pharmacists or any of your registered staff?

Boots – No, thankfully we have no vacancies and are in a good position.

Chair – We will next hear our presentation from Malcolm on behalf of the APC. Thank you.

5. Presentation by APC

The APC met and as part of our discussions re the boundary, one the questions we had was, was it big enough considering we noted that those in Rhu and Shannon come to access services. We also noted the increase in military accommodation. As part of those discussions, we also noted that patients have a choice; they can take their prescription to Glasgow etc so based on the fact that patients can travel into the area to access services as well as travel out so felt the boundary was right and we didn't have any objection to that.

In terms of the Consultation Analysis, we noted that there was a high volume of responses, letters of support and the committee felt there was general dissatisfaction from users at the time of the consultation indicating that there may not be adequate service within the area. So based on that at the time of our meeting that we would be in support of the application.

Chair – Thank you Malcolm. Can I invite questions from the applicant for Malcolm please and just remind everyone we are looking for questions and not statements.

Applicant – No questions, thank you Chair.

Chair – Questions from M & D Green?

M & D Green – Just to pick on your comments about the Consultation Analysis and the number responded in favour of the application what is your view that the consultation ended only six days after M & D Green acquired a pharmacy, made significant investment into developing the pharmacy and whether those responses may well have been different given more time to deliver those investments?

APC – Given that that wasn't actually discussed at the meeting, I couldn't comment on behalf of the committee as I haven't discussed it with the full committee.

M & D Green – On that basis, no further questions. Thank you.

Chair – Any questions from Boots?

Boots – Can I just check when this was discussed was the community pharmacy representation on the APC involved in that.

APC – Yes, we have community pharmacy representation on that committee.

Chair – Cardross please?

Cardross – I have nothing to ask, thank you.

Chair – Rowlands please?

Rowlands – I don't have anything to ask.

Chair – Thank you and finally Community Council?

CC – We don't have anything to ask either.

Chair – If we can now move to questions from the panel? I don't have any questions thank you. So, Ian?

IG – No

MF – None, thank you

CB – No, thank you

SP – No questions

CS – No questions

GM – No questions

Chair – Thank you very much. We will move on to the presentation by Interested Parties, can we invite your presentation from Cardross Pharmacy please.

Cardross - Thank you Chair. Thank you for allowing me the opportunity to present. Am I ok sharing my screen for the presentation or is it discussing through what I have?

Chair – If we could just present without the screen. Thank you.

6. Presentation by Cardross Pharmacy

Some of you are probably wondering why Cardross is an Interested Party as it is out with the neighbourhood and it is mainly because we have no GP service in the area, we are relying on the GP surgeries in Helensburgh to actually service the patients of Cardross. We have recently taken over the business from April of this year. There are four of us who have taken over, three of us are Independent Prescribers, we have another Independent Prescriber who is also part of the business employed, and we are actively providing that service since July having been taken over. Combined we have around 30 years of experience in the community pharmacy sector so we have quite a good understanding of what community pharmacy is in this day in age, and another key theme, we have also recently undergone a major refit to increase the dispensary size and hopefully improve efficiencies and this has allowed us to expand, we have two extra consultation rooms, and we provide all the core services as well as the advanced Pharmacy First Plus service and the Highland Travel Vaccination Service as well as private services too.

I would like to just discuss the neighbourhood. In particular, we do agree with the proposed defined neighbourhood of Helensburgh and of course we know there are three pharmacies that service that area as well as one pharmacy out with that has a major share from the Helensburgh surgeries. Since we have taken over, we have had quite a positive building of relationships with not just the GP surgeries but the local Health Board team in the Vic. We have taken on a pharmacy technician to become part of the pharmacy team, we have had a lot of positivity from these healthcare professionals to show that we are making an impact, not just in Cardross but in Helensburgh too.

Specific to the population it' self, I agree with everyone in terms of the population size. There is 14,127 according to the 2022 census, there has been a slight decrease over the years but nothing substantial but there still has been, in comparison to the national Scottish statistic, which is an 8% increase over the population, there is a bit of a difference there and there is published content from the Argyll & Bute council to show that there was further trajectory increase by a bit more and this could be for a number of reasons, the ageing population, the fact it is a commuter town, and younger populations are just moving out of the area for a number of reasons. And, in particular to the demographic it' self and the items dispensed within Helensburgh from data published on opendata.scot which is covered by Public Health Scotland shows that the prescribed amount of items has been relatively static. In 2020 there was around 26,500 items dispensed, and this has increased to around 27,500 items. It shows that there has not really been a significant increase in GP registrations and currently with the three pharmacies that we have in Helensburgh, this is in line with the Scottish average for pharmacy which is circa 7,600 items. If we actually took out the items dispensed by Cardross which services the Cardross patients, which is around 14% of these prescriptions in accordance with opendata, this actually leaves around 23,500 items, which is slightly below the national average of items per pharmacy and adding another pharmacy would actually decrease this to 5,900 items per pharmacy.

Just reiterating the points of affluence and the Scottish Index of Multiple Deprivation, around 67% of the Helensburgh population live in the two least deprived quintiles and 7% live in the most deprived, which is of course information that is not unknown. You get localised pockets within an area that have more deprivation than others but the fact there is nearly 70% in the two least deprived quintiles, this means it is considered to be a highly affluent area with high access to services including schools, healthcare, transport and shops. Usually highly affluent areas are also associated with better health outcomes which is evidenced by long-term condition prevalence data published in the 2025 Long-Term Conditions Scottish Government circular. Locally, there is around 14-17% less prevalence in long-term conditions in comparison to

Scotland overall which sits around 35-38%. In terms of the least deprived areas as well, around 80% of households have access to at least one car so generally transport is not an issue as well.

I have a summary of the core services which is also taken from opendata which shows the sum of the MCR registrations, which is our Medicine, Care & Review service. It is pretty stagnant across all pharmacies within Helensburgh, the sum of Pharmacy First Plus items has had a slight increase and the sum of consultations also a slight increase from data taken from 2023 all the way up until 2025 showing that these pharmacies are actually meeting their commitment for the Pharmacy First core service as well as MCR core service. I have more specific data here in terms of comparison to the NHS Highland and Scotland average and it shows that Boots from September 2024 until April 2025 were actually doing around 1,100 Pharmacy First across this time period and this is slightly above NHS Highland average of 900 and also in line with the Scottish average of 1,100 again highlighting that overall they are meeting the commitment of the core services in these areas.

In terms of the proposed site, I agree with Mark earlier that they do appear to be equidistant from M & D Greens and the new proposed site but the fact that it is on the same street, it is also a point in it' self that it is not really needed because there is no increase in accessibility and there is no increase in terms of ease of access, and the furthest away pharmacy within Helensburgh which is Rowlands, around 400 metre away, this is only around a 4.5 minute walk. This can actually mean that more pharmacies within the area can actually fragment and dilute care, it can actually increase risk in terms of patients handing prescriptions to very different pharmacies and it can cause errors which I have seen come up in areas where there is a high concentration of pharmacies.

On that point, with Cardross it' self, we are accessible to Helensburgh patients, we do not actively market to Helensburgh but as Martin mentioned earlier, Helensburgh is a commuter town, a lot of people do travel out and we do get patients that have come through the town to visit our pharmacy. It is a round trip of eight miles, but it is only a car journey of around seven minutes. Trains run very regularly, approximately an eight-minute train journey and the same with the bus, a journey of approximately 14 minutes than runs roughly every 30 minutes. We do have two dedicated drivers covering Helensburgh on a part-time basis covering full-time hours but because we are in Helensburgh so often as the surgeries are there, we do offer that service within the area anyway that covers all their needs in terms of delivering MDS trays and your normal prescriptions as well.

Before taking over, we were aware that Inveraray were responsible for servicing a lot of Cardross patients, but we have been in very close discussion with the healthcare team at the GP surgeries to take them over and they are slowly coming over as their cycles end so that point will be made redundant in a couple of months.

That is everything I have. Thank you.

Chair – Thank you very much for your presentation. Can we start with questions from the applicant please?

Applicant – It is great to hear about the services that you have adopted in Cardross. I just have a question around how that benefit's the residents of Helensburgh.

Cardross – As a say, it is a commuter town. A relative amount of the population does travel out and we do see a lot of the population in Helensburgh come in. We work very closely with the Health Board in terms of advocating for the Pharmacy First Plus service as well as the NHS Highland Travel Vaccination service so we do get a fair few patients that come through from

Helensburgh, and as I say, it is in quite close proximity, it's a short car journey away and a short journey on public transport so I don't see it puts them out in that sense.

Applicant – You mentioned that quite a few patients come into Cardross to use pharmacy services. Why do you think that is?

Cardross – As I say, they are possibly just passing through. Where our pharmacy is located it is on a main road and a road you have to pass through to get into Dumbarton and Glasgow, so they quite often just see the pharmacy, stop by and pop in. I wouldn't say it is necessarily a means of we can't get any service in Helensburgh so they will pop into Cardross, I think it is more so an act of convenience.

Applicant – It's a common theme in the CAR that residents are actually being forced out of the neighbourhood of Helensburgh and are coming into Cardross. In the CAR a patient says "long wait times for prescriptions in all three pharmacies and often items are out of stock. I have now moved out with the neighbourhood to Fraser of Cardross for my prescriptions". So, in light of that comment would you not agree that residents are using Cardross Pharmacy because of the inadequacies in Helensburgh?

Cardross – I can't deny that there will be some residents within Helensburgh that will prefer pharmacies out with. As I say, we are not terribly far from within Helensburgh but since the CAR has taken place there has been a changeover in owners, we all have the same sort of access to wholesalers and suppliers. It is impossible to keep stock in of everything at any one time. I don't know if there are many responses in the CAR like that, but I suppose you will get instances where a patient may be unhappy when that happens.

Applicant – Do you think that queues which extend out the door and on to the street is an example of inadequate service.

Cardross – Sorry, could you repeat that question please?

Applicant – Do you think the queues that extend out the door on to the street is a reflection of adequate service in Helensburgh?

Cardross – No, not necessarily, I think queues in general, as I said earlier, are part n parcel of a busy service whether that be a retail store, takeaway or a pharmacy. You get queues in all of these places. I think what is more important is how efficient the staff are in acting upon the queue, how fast they are at serving the queue, but it doesn't take away from how many people are actually waiting in the pharmacy. I think queues are a normal part of a busy business.

Applicant – There is mention in the CAR of waiting times are very commonly 30 to 40 minutes. Do you think that is an inadequate level of service.

Cardross – Between 30 and 40 minutes is an unusually long time but again it depends on the circumstance and when that was. It can happen in very busy periods.

Applicant – In terms of need of another pharmacy in Helensburgh would you be able to explain to everyone present today why the owners of Cardross approached the current occupier of that proposed unit and mentioned that they would be interested if this application was to fail.

Cardross – Yes, of course. I made that comment when I saw the document and I replied back to Eleanor, and I dont recall this happening if Im honest. I would like to know where that information came from. I think the email was dated in August and the last time we were around the premises was actually June/July and that was just to inspect the premises, we never offered to take over the premises for a pharmacy application, I can assure you of that.

Applicant – Would you be surprised to hear that a recent FOI to the Health Board reveals that there is another expression of interest for a new pharmacy in Helensburgh? That was submitted in late 2024.

Cardross – That would be a surprise to me, yes.

Applicant – No further questions Chair.

Chair – If we can move now to questions from Interested Parties and if we can start with M & D Green.

M & D Green – Thank you for your presentation. Apologies for repeating myself somewhat but I think it is a particularly strong point to get everyone's opinion on. Given where the applicant has proposed to locate their pharmacy, do you think their estimation of the prescription volume that they might take from the Health Centre of 4,000 items is accurate?

Cardross – No, I don't think that is accurate.

M & D Green – Can you put that in some context. Where might you hazard a guess, if you could try?

Cardross – I suppose to hazard a guess from the information that I know, they will probably take about 40% of the share that is dispensed out of the surgeries which is around 8-10,000 items.

M & D Green – Would you say that to be a significant amount of NHS income for any of the pharmacies in the area and including yourself in that to lose without having to make adjustments to your own business model.

Cardross – Yes, most definitely. Like yourself, we have made a lot of investments since taking over and we would have to look at the business overall if this application went through. I think it would have significant impact on all of us.

M & D Green – Thank you, no further questions.

Chair – Boots?

Boots – No questions from me thank you.

APC – Just one question. You mention transport links. Do you happen to know what it costs to get between the two for those who don't have a car?

Cardross – No, unfortunately I am not aware of the cost.

Chair – And Rowlands please?

Rowlands – I don't have any questions thank you.

Chair – Community Council?

CC – The population of Cardross at the moment is approximately 2,000.

Cardross – Yes, roughly there, about 2-2,500.

CC – According to Martin Green you guys must be struggling to make ends meet?

Cardross – No, that is the population, not the number of items. The number of items we do is around 5,000.

CC – What proportion of patients use GP services in Helensburgh as opposed to Dumbarton?

Cardross – So around 14% of the prescriptions dispensed in Helensburgh come to Cardross, which is around 3-3,500 and the rest would come from Dumbarton.

CC – Would the vast majority of your patients use the Dumbarton services.

Cardross – No, around 1,500 items would come from Dumbarton so that is less than what would come from Helensburgh. Helensburgh surgeries are closer.

CC – You mentioned that people changing pharmacies creates risk and a fragmented service, but patients are already changing pharmacies within Helensburgh at the moment so are you saying there is an existing risk.

Cardross – Yes, I think that risk gets compounded with an increase in concentration of pharmacies. People naturally will hop depending on queues and things for acute prescriptions, we don't have an advanced system where we can see a system level what prescriptions patients are getting at any one time unless you take the time out to actually go into their health record, which you just don't have the time for so this does lead to fragmented care and this does lead to things getting lost in communication and it does cause an increased risk, yes.

CC – So an additional pharmacy would lower that risk in a more stable service?

Cardross – No, an additional pharmacy would increase that risk. It's another point of access for a patient to visit in terms of fragmentation of care.

CC – I think the reason why people are moving around pharmacies at the moment is because they are not satisfied with the service they are getting so, they don't like standing waiting in queues, they don't like waiting for prescriptions, they don't like the changeover of access to compliance aids and so on. So, if the existing service is fragmented and disruptive, that in it' self is surely a risk.

Cardross – It would be a risk, but I can't comment on how many patients are actively moving around at the moment. I don't have that data to hand so I don't know if that is happening on a large scale, but I can assure you it would happen to a larger scale if another pharmacy was added.

CC – Boots told us that they have had an increase in patients transferring from Greens in the last year, so it does happen. You mentioned that you are not actively marketing in Helensburgh, but you did a leaflet drop in Helensburgh quite recently in July?

Cardross – Yes, we did a leaflet drop. One leaflet drops just to introduce us as the new owners of the pharmacy.

CC – So that is marketing in the town.

Cardross – To introduce ourselves as having taken over from Fraser who was obviously a pillar in Cardross and Helensburgh so just to left the residents know. We have done one leaflet drop and not marketed any more than that.

CC – Thanks very much. That's all.

Chair – Thank you. Moving on to questions from the panel. I don't have any questions that have not already been asked.

IG – No questions

MF – No I have nothing to ask

CB – I just wanted to double check, there has obviously been a lot of talk about the boundary. Do you know where the Cardross boundary ends on that side of Helensburgh? Does it meet roughly or is there a gap?

Cardross – I believe it meets roughly. There is no overlap.

SP – No questions thank you.

CS – No questions

GM – No questions.

Chair – So we will now move on to a presentation from Rowlands.

7. Presentation by Rowlands Pharmacy

Chair, members of the committee and Interested Parties. Thank you very much for letting me speak today. My name is Mark Dickinson, and I am here today representing Rowlands Pharmacy in Helensburgh, a long-standing and trusted provider of pharmaceutical care in this community.

I have personally lived within Helensburgh for 18 years and worked within Rowlands Pharmacy for the last eight years. My wife and I have three children and live within this beautiful town. I am part of the community here both personally and professionally. If I felt that as a member of the public that a new pharmacy contract was indeed required, then I wouldn't be here today. But I am here today. I know that if this contract were to be granted it would cause irreparable damage to the longest standing pharmacy in Helensburgh.

I appreciate the applicant's enthusiasm and intent to contribute to the local provision; however, I must respectfully submit that the application before you, does not demonstrate a clear unmet need. Nor does it present compelling evidence that a new pharmacy is either necessary or desirable within a defined neighbourhood.

We agree with the neighbourhood as described by the applicants, which is pretty straightforward indicative of the area that we currently serve and serve well. We also accept the population data submitted. Although the figures we found to be slightly different, the difference was minimal and insignificant. I do want to re-raise the point about the population data, this has been touched on by various contributors earlier, it is important to recognise that this figure includes what I would class as substantial number of military personnel stationed at Faslane Naval Base. Estimates suggested between 2 and 3,000 service members live in or around the town as part of their employment. Now, here is the critical point, although these individuals do contribute to the population data used in planning, they do not access any NHS services locally and this is under their employment contract. They receive healthcare through Navy GPs and are dispensed medication via the military pharmacy on-base. This creates an issue with the population figure that has been submitted. The data used includes individuals who are not allowed, under their employment contract, from accessing these NHS services. So, when we look at sufficiency, we need to adjust for that reality, if we dont we risk over-stating demand and that can lead to unnecessary duplication in allocation of resources across town.

Rowlands Pharmacy offers all core NHS services, all available PGDs, enhanced services such as travel vaccinations, private and NHS, private service is tailored to local demand. We are the only pharmacy in Helensburgh participating in the NHS travel vaccination service for Highland. We also utilise pill-pouch compliance aids and utilise off-site dispensing with medipac where suitable. Our capacity is not only sufficient, it is vastly scalable. The applicants have cited community analysis response as a key indicator of public support; however, I would urge the

committee to consider the limitations of that dataset. Of the 1,017 responses, 766 were completely anonymous, no name, no email, no address. While anonymity is a respondent's right, this level of opacity makes it difficult to verify the geographic relevance or demographic spread of the feedback. Moreover, the absence of timestamp prevents any assessment of whether any responses were clustered around engagements events which could skewer perception. One important point that seems to have been overlooked is supplier flexibility. Rowlands Pharmacy currently operates a full access to Pheonix warehouse, AAH warehouse and Alliance warehouse throughout the UK. They are the UK's largest pharmaceutical wholesalers. That means that we can source medication reliably, respond quickly to shortages and maintain continuity of care without delay. The applicants haven't clarified who their suppliers will be and if they are tied to a single wholesaler or limited by commercial arrangements that could restrict their access to stock especially during national shortages or supply chain disruptions. That is not just an operational risk, it directly affects patient safety and service reliability. In contrast, our model is proven, we build strong relationships across multiple suppliers giving us the flexibility to act fast and keep shelves stocked. That is part of what makes services within Rowlands Pharmacy not just adequate, but they are desirable. It is not enough to open a pharmacy, you need the infrastructure to deliver consistently, and we already have that in place. This will become quite relevant later.

With regards to our off-site dispensing, I wish to make things clear, so the panel and the applicants fully understand. Our off-site dispensing solution is not a replacement in pharmacy services, it is a supplementary tool used only when clinically appropriate and never for all prescriptions. This isn't about out-sourcing care, it is about enhancing capacity. The off-site model allows us to handle high volume of complex items efficiently whilst our pharmacy teams remain focused on face-to-face patient care. It's a strategic capability that strengthens our service, not a short-cut that undermines it.

Rowlands Pharmacy in Helensburgh has also proudly held it's place in the company's Prestige Best in Class List for 35 consecutive months. Now, you may not have heard of Best in Class, this recognises Rowlands pharmacy branches which consistently deliver exceptional service, earning positive feedback from our patients and having zero complaints. These are complaints or feedback which is given directly into the Superintendents department or other avenues such as NHS Highland. It is a reflection of our team's commitment to patient care professionalism and maintaining the trust within the community. Sustaining this standard month after month isn't easily achievable. We have managed it.

Within Rowlands we have a robust network of IPs within our region, west of Scotland region, with even more in training and at the stages of qualifying. Not even accounting for a trainee pharmacist who will be IPs in 2026. As a company we are constantly reviewing the service provision and have no issues having two pharmacists in one branch to support both items and services including Pharmacy First Plus where necessary. If this is something Helensburgh needed, then we will accommodate it.

I want to move on to a couple of comments about the closure of small Boots. Following the closure of small Boots in Helensburgh existing contractors absorbed displaced demand. At Rowlands Pharmacy we experienced no disruption and were fully prepared to deliver comprehensive pharmaceutical services to every patient who entered their premises. We welcomed all patients and upheld an exceptionally high standard of care throughout that period. It is important to notice or recognise that contractors like Gordons at the time, which is now M & D Greens, faced real pressure during that time. The sudden shift in patient demand created challenges across the network and any pharmacy team that would have felt that would have felt a similar strain. We at Rowlands commend our colleagues in other the pharmacies for adapting quickly and working to maintain care. That said, these pressures haven't lasted. Within a short

time, the local pharmacy network has adjusted, the service has returned to a stable, reliable level, patients were once again able to access care safely and consistently. This is reported continually through the patients who are coming into my pharmacy, and they are reporting about their experiences throughout Helensburgh. It is also worth pointing out that a newspaper article used to support this application published during that period of disruption, it captures a moment of concern but not the full picture. The article reflects a temporary situation; it is not an ongoing problem or a true gap in service.

I would also like to briefly consider the broader implications of introducing a new pharmacy contract into our community with long-established providers. Rowlands Pharmacies has built not only operational resilience but deep-rooted trust with our patients and local clinicians. That trust is not merely procedural, it is earned over years of consistent service delivery, clinical reliability and community engagement. A new contract, particularly one that duplicates existing services risks diluting dispensing volumes, destabilising the viability of the current providers. In a town like Helensburgh where demand is steady but not excessive, fragmenting that demand across additional outlets could lead to unintentional consequences, reduced staffing, diminished service hours or even closure of a pharmacy that has served a community faithfully for decades, and when viability is threatened, trust begins to erode. People may lose long-established relationships with familiar teams; GPs may find their referral pathways fractured. These are not abstract risks, they are real world outcomes.

I urge the committee to weigh, not just the potential of a new provider but the cost of destabilising those who have already proven their value in this community over many years.

I want to just go on to a couple of examples of concern. Not just about how the application is viewed by the public but also about whether the process has been fairly. I do know this might be contentious. First, regarding community engagement, whilst social media can offer insight into public sentiment, it is important to recognise the platforms controlled by the applicants may not reflect the full spectrum of use. There is credible evidence that comments expressing concern or asking difficult questions have been removed from the applicant's Facebook page. I am not here to speculate a motive but what I do believe is risk presenting a skewed picture of support and may discourage others from contributing openly under the community awareness test. Should the Board wish to explore this further I can provide name and contact details of individuals who have experienced this directly. Secondly, I would like to address a claim made publicly by the applicants that their dispensing service will operate zero waiting times, this has briefly been discussed. While I appreciate the aspiration towards efficiency, this statement fundamentally misrepresents the nature of professional pharmaceutical service delivery. Dispensing is a clinical process; it is not a transactional one. It involves accuracy checks, patient counselling, stock reconciliation and often liaison with prescribers. To suggest that this can be delivered with zero waiting times is not only unrealistic, it risks under valuating the professional standards that underpin safe and effective care. Such claims may create false expectations among patients who deserve transparency about what a new contract can reasonably deliver, and when those expectations aren't met, it is not just disappointment, it is a breakdown in trust. In the community there is trust in their pharmacies for generations.

I raise these points not to criticise ambition, in fact, I applaud ambition but to ensure that the committee's decision is grounded in reality and fairness, and a full understanding of how public perception is currently being shaped.

In summary the current pharmaceutical provision in Helensburgh is not only adequate, it is trusted, efficient and response to evolving patient needs. Introducing a new pharmacy risk fragmenting care, destabilising existing services and creating duplication without net benefit.

I respectfully ask the committee to consider whether this application truly reflects a gap in provision or whether it represents a commercial opportunity that could undermine the continuity and care that our community depends upon.

I am just wanting to ask before I finish up here, is there going to be an opportunity for a final statement?

Chair – Yes, we will have questions to yourself now Mark and then we will have the Community Council presentation, and then we will close this part of the Hearing with summaries by Interested Parties. So, you will have an opportunity to provide a summary.

Rowlands – Thank you and thank you for listening I do realise that that was quite a long presentation. I am willing to accept any questions anyone has.

Chair – Thank you very much Mark. We will move on to questions from the applicant.

Applicant – Would you agree that a pharmacy as far away as Inveraray providing services represents inadequacies in Helensburgh?

Rowlands – No, I do not. Inveraray is a very small town, there is not a large population, you have a pharmacy in that location possibly dispensing low numbers of prescription numbers. If they were attempting something new, it should always be phased businesses trying new models and their business model wanted to expand further out in the field, and they saw this as being a viable model then why wouldn't you? What I will say is that the patients that left our pharmacy and went to Inveraray Pharmacy were very quick to return. Not only that, we have over the period of time of Inveraray Pharmacy wanting to do prescriptions from Helensburgh to just now, I would say we have actually had a very small net increase in patients who have received a service from Inveraray and no longer wish to do that and have returned to Helensburgh. They have promises on their advertising campaign that was a leaflet drop within Helensburgh offering services that were quite difficult to delivery remotely and I think the patients were quick to realise that.

Applicant – Would you say that patients who feel that they need to leave the neighbourhood to go to Cardross and Garelochhead. The question would be – why are they not using Rowlands Pharmacy, why do they feel the need to leave the neighbourhood to go to Garelochhead and Cardross?

Rowlands – I think I made the point earlier on about the population in Cardross and them visiting the pharmacy in Cardross. It makes perfect sense. Ultimately, we are talking about potentially 15% of the prescriptions generated within Helensburgh are dispensed within Cardross. Now, that would make perfect sense, Cardross doesn't have a GP practice and it does make sense that Cardross has very kindly picking up all their prescriptions, dispensing them for these patients to collect locally. As for patients that are travelling out with Helensburgh and going to Cardross, I have no idea as to why that would be. We have, and I have proven, with the Best in Class, we have got a large list of letters handed into the pharmacy and handed into our Head Office indicating the exceptional service that we are providing. Now, if people were unaware of that then maybe that is something that we should be looking at with a further leaflet drop or advertising campaign or maybe attending community events more frequently.

Applicant – In terms of population as you mentioned, the population stagnating, the GP practice list has increased by 1,000 people since 2021. Would you agree with that?

Rowlands – I have certainly seen an increased number of prescriptions coming into the pharmacy, not massive amounts, after all you will be able to see the figures that we have seen, but generally over year-on-year the percentage prescription increase is probably in line with the percentage of prescriptions generated at the GP practices. I wouldn't say that I feel there is a

massive increase in the population within Helensburgh, but I do believe that the population that I see coming into the pharmacy is not in any way putting us under stress.

Applicant – Would you agree that Rowlands Pharmacy in Helensburgh is viable when Helensburgh was served by four pharmacies?

Rowlands – If it wasn't viable at the time then questions would have been asked, and we probably wouldn't be there at the moment. Viability is very fragile, prescription numbers in each pharmacy is very fragile. Take for example the closing of the small Boots, which was actually quite a large unit, the prescriptions when that pharmacy was closed, the vast majority of them, unless the patients specifically specified, was re-directed to the large Boots. Now, that was a directional pull/push on where the prescriptions were. We never saw a massive increase in prescriptions because of the small Boots closing, a lot were re-directed, some people didn't feel the large Boots had the feeling they wanted from a community pharmacy and they came to us of course, we had patients displacing to different pharmacies across Helensburgh but certainly I have not noticed any massive increase in the prescriptions we are seeing within the pharmacy. Now, that will be different if a new contract is opened because it is going to be so unpredictable as to who goes to this new pharmacy to try. Even if it was trying it for a short period of time it still may place question on to the viability of the Rowlands Pharmacy in Helensburgh. If there is a substantial drop in the number of prescriptions because of patients displacing themselves and rebalancing themselves across all four pharmacies, yes, that is going to put questions on to the viability of Rowlands Pharmacy.

Applicant – Do you feel that the location of Rowlands Pharmacy has limited the uptake of prescriptions since the Boots closure as we see it is largely the larger Boots and M & D Green?

Rowlands – I think M & D Green may have seen the larger increase because of their location to the old unit; it is directly across the road. As soon as you realise the small Boots is closed, you look across the road and you see another pharmacy. The large Boots got a lot of additional prescriptions automatically sent in that direction as agreement with NHS Highland Board at the time. Rowlands Pharmacy, even though you don't actually have to cross any major roads, is probably the same distance of walking from the three community pharmacies just behind where the old Boots unit used to be, did not see a massive increase in the number of prescriptions. Yes, we did see an increase at the time, and we accommodated all of the patients, we welcomed them with open hands. So, yes, there was a small increase but not a massive increase.

Applicant – In your presentation you used the phrase "moments of concern" when talking about the newspaper article but the CAR concluded eleven months after the article, it mirrors a lot of what is in the article, the same themes. How do you explain the phrase "moments of concern" eleven months later.

Rowlands – Well I can certainly say that we have not received any internal complaints. Nor have we received any complaints externally. The comments used within that newspaper article was directed primarily towards Boots and Gordons at the time, and I think they would be better placed to give you an answer on that. I don't think it is my place to comment on what they felt they were experiencing at the time. To be perfectly honest, we sympathise with them quite a lot because it is going to put pressure on any pharmacy with any immediate increase in prescription volume. You build a business model; you build a pharmacy to accommodate the needs and pressures that you are feeling in that pharmacy at that time. Any change on that will require infrastructure change within that pharmacy team. It will require additional staff, it may well require additional training, it may require additional needs on the shape of the shop floor or the dispensary in order to settle down and that does take time. It takes time to understand that need and I sympathised with Boots and Gordons at the time. We did not feel any of that pressure.

Applicant – Thank you. No further questions Chair.

Chair – Thank you very much, if we can move on to questions from the Interested Parties. If we can start with M & D Green.

M & D Green – To pick up I suppose on one of the themes, going through the questions so far, comparing the prescription volume that may have been managed at small Boots and given the proposed location of the applicant's pharmacy, do you think the applicant's pharmacy in its proposed location might do more prescription items than the small Boots did when it was there?

Rowlands – The single location of the proposed unit by the applicant is going to do substantially more prescriptions, yes. If you are looking at the distance between the surgery against Greens and the new unit was classed as equidistant, however, it is only equidistant if you are actually taking into account that somebody is leaving by the back entrance or the front entrance. If you are leaving by the front entrance, then the new unit is by far a lot closer. By leaving by the back entrance that would indicate that you would be either parking, which means you would have a car, or you are willing to walk through an open car park, which is the Co-op car park and that would make that equidistant for Greens pharmacy so on that idea that people would generally be walking out of the front of that building it would indicate that the proposed unit is a lot closer so, therefore, I would say that it would take a lot more prescriptions than the small Boots did.

M & D Green – The applicants proposed in one of their questions that you were viable while the small Boots existed and there were four pharmacies in town and that you would remain viable if there were four pharmacies again. Given the point that you have just made there around the location or proposed location of the applicants, I am sensing, perhaps you can acknowledge, that this pharmacy in this location could have profound impact on your viability?

Rowlands – It most certainly will. I don't even feel that I think if I see the comment, it would put viability into question, I think the very high percentage that we would already know the answer to that question.

M & D Green – It was raised earlier; I picked out as comments in the CAR about staff in the existing pharmacies being good but overwhelmed. Can you tell me if you are concerned about your staff being overwhelmed?

Rowlands – Absolutely not, no. In fact, over the last two years we have had considerable increases in staff training, in staff diversity in the roles that they are actually able to undertake, additional patient counselling for a lot of medicines that they can advise on over the counter. We have also vastly increased the services that we have been providing in the pharmacy, and we have been doing it with a smile on our face. To be perfectly honest, it is something that we take great delight in and it is something that, maybe we do have the opportunity in not being a heavily dispensing pharmacy that we can take time with all these additional services and it is good, but it is not going to pay the bills, we require the prescription numbers and that is what basically allowing us to stay viable but certainly our staff are not under immense pressure, no.

M & D Green – Do you have any caps on access to services?

Rowlands – No. We actually have both our off-site dispensing models which I briefly went into. Ultimately, these are in addition to normal dispensing activities within the pharmacy. We don't have any limit on the amount of prescriptions we can dispense, nor do we have any limit on any services that we provide either NHS or our own services e.g. the pill-pouch dosette box systems.

M & D Green – Do you experience regular long queues at the pharmacy?

Rowlands – We never have queues in our pharmacy. If anybody here has ever been in Rowlands Pharmacy in Helensburgh, you will notice the minute you walk through that front door, you are immediately served, with a welcoming face. Time is taken with each patient that walks into the pharmacy and any service that we are able to help a patient with is delivered. We do this by efficiently making sure that we are not bogged down e.g. dispensing processes, we make sure that everything is ready for the patient to completeness, and when the patient is coming in to collect the prescription. When they are coming in it very rare that they will walk away with balances and just like Greens are offering, if that was the case, we will always offer to deliver the balance. I am not a firm believer that people should be inconvenienced by returning to a pharmacy for a balance. We fully utilise the delivery services for that as well. We never have queues in our pharmacy.

M & D Green – If a patient was to attend either M & D Green or Boots at perhaps a pressure point in the day or week and find that there was a queue at either of those pharmacies, how long would it take them to walk around to Rowlands where there is never a queue?

Rowlands – I think both pharmacies are probably equidistant, I think they are probably about 0.15 miles away from the pharmacy. I would say it would take them approximately 1.5-2 mins. It's really not far.

M & D Green – What you're maybe suggesting there is that if there are queues at times in either of the pharmacies, that there is a choice currently only minutes away in Rowlands.

Rowlands – Absolutely, we would welcome these patients into the pharmacy. On occasions we do see this happening when they come into the pharmacy, we also help Boots and Greens if they are having trouble sourcing items from warehouses, they might not have access to. The three pharmacies in Helensburgh are close, we help each other out, we help the community, and we make sure the community gets what they deserve and that is just exceptional healthcare advice and service. But I do feel that what we offer in Rowlands is something unique in the services that we deliver and we able to help overflow at other pharmacies with ease.

M & D Green – Without disclosing any commercial information, I am getting a sense that Rowlands is not as busy as either Boots or M & D Green in Helensburgh, and I don't think that is any slight on the service provided at Boots but primarily down to location. On that basis, why would you not consider relocating the Rowlands Pharmacy into closer proximity to the Health Centre if the opportunity arose?

Rowlands – Is the question you are asking, would I consider leapfrogging?

M & D Green – Yes.

Rowlands – To be closer to the Health Centre, no. It's not something we would consider.

Chair – Questions from Boots please.

Boots – Mark, thanks ever so much for your presentation and great to hear the level of service you are providing. Just picking up on Martin's last question there, if Rowlands applied to move nearer to the GP surgery in order to increase your items volume and that was leapfrogging as you put it, would that meet the requirements for a minor relocation?

Rowlands – I would imagine so. I don't know if leapfrogging is even a term we use these days, I don't believe know if it is applicable but as a mark of respect you have to have, you have to have respect for your competitor as well as your allies in pharmacy. It is certainly not something that we would consider, yes it might achieve a larger prescription volume but really is it going to be the business model that we have built up within Helensburgh? Ours is service led, heavily reliant

on the money that we get from our prescription income, but it is really about the services that we deliver, it's not within our interest to do that, no.

Boots – I don't want you to give away any company sensitive information but we have spoken a lot about the volume of prescription items that you are doing in Rowlands, and I appreciate you work in that one branch but would you have an understanding of how that compared to the rest of Rowlands estate?

Rowlands – I do have a firm understanding of how it compares to the rest of Rowlands estate. We are probably one of the quietest branches, not only within the region but within the company. However, with regards to service delivery and by positive feedback and lack of negative feedback we are also one of the most noticeable pharmacies within the company. Even in Rowlands, in a company this size, everybody knows about Helensburgh. We put Helensburgh on the map, we put NHS Highland on the map, and we are a great advocate for what NHS Highland can offer the public. It doesn't get away from the fact that we are one of the smallest Rowlands pharmacies in the company.

Boots – If the contract were to be granted and go on to open, we have spoken a lot about viability and the potential impact on Rowlands specifically due to the fact you are low on volume in item prescriptions and you are further away from the surgery. If Rowlands were to go on and close as a result of that new contract application be granted Mark, you have lived and worked in Helensburgh for years. Can you just describe what kind of effect would that have on you and your team?

Rowlands – All my team live within Helensburgh. We are very passionate about what we do for our community in Helensburgh. When I am walking down the street or when I am going to the shop, people recognise me. Ok, I'm not going to give them medical advice, but they recognise me, they will pop in and see me, they will chat to me. It's not just being a healthcare professional within a town, it's being part of that community, and you feel that you are giving back to the community using your professional skills. Personally, if I lost that, I'm not going to gain that anywhere else. If the community lost that then they could potentially get a healthcare professional in who is delivering pharmaceutical services, it doesn't understand the people of this town and they don't understand the community as a whole. They have not lived within this community; they don't understand it. I think that is quite relevant to a lot of placed within Highland Health Board where there are lots of small communities that are all different. Helensburgh is no different than that. You have to understand this community. That's what I would say about that.

Boots – Thank you Mark. No further questions Chair.

Chair – Malcolm.

APC – Thank you for your presentation, Mark. I have no questions.

Chair – Cardross – Any questions?

Cardross – Would you say that you are at capacity there or do you have the ability to take on more patients?

Rowlands – Because of the automated systems we have plus the additional staffing levels that we have recently put in as an investment, we have substantial room for capacity, yes.

Cardross – What do you think the reasoning is behind why patients don't come to your pharmacy, it seems it is more of a convenience piece rather than inadequacy of service. What would your opinion be on that?

Rowlands – I think it is more the distance. We are ultimately the town's fringe pharmacy, aren't we? I'm not quite sure that is a term which is used these days either, but we are the pharmacy which is furthest from the GP practice. Just by human nature, people who are picking up a prescription will go to the closest pharmacy. If they don't have the item or too busy, they will go to the next pharmacy, so we, by nature, will be third in line for that. Acute prescriptions or chronic prescriptions, it doesn't really matter, it is basically ultimately where the patient would normally lay their hat first. They would normally maintain that business.

Cardross – The point has been made that you are longest standing pharmacy in Helensburgh, you have seen a slight increase in numbers, but it has been pretty static over the years, would you say that the pharmaceutical contract or even running a pharmacy operationally has changed even in the last five years?

Rowlands – Absolutely, absolutely. The pharmacy contract is very service driven now. Personally, that is the way it should always have been, however, what we are doing is we are building this service driven model on prescription items that are ultimately paying for that service to deliver it so you have to have the number of prescriptions to make your pharmacy viable, and then if that is the case you can then start delivering all of these additional services on top of that because you have financial grounding for that. That didn't used to be the case, it always used to be a prescription number game, and you were a lot more aggressive in trying to get these prescriptions. We have enough prescriptions currently, I would say at the moment in Rowlands Pharmacy to be able to have that financial grounding to deliver all of these great services. You remove that or take some of the prescriptions away from the base and all of a sudden it brings everything tumbling down. That's what my concern is.

Cardross – You made the point we are going more towards service based holistic healthcare within pharmacy, would you say that zero waiting times is possible in a service-based pharmacy provision?

Rowlands – No, it concerns me when people are stating zero waiting times, it's mainly the perception that the patients have. In Rowlands, as I have said, I have been working in Rowlands for the last eight years and one of the beautiful things is the clear trust that patients have in you. If we are flying around using these phrases that undermine the pharmacy process then we are at risk of breaking that trust, breaking that relationship that we have with our patients. Zero waiting times – that phrase concerns me and to advertise that in order to promote a new contract, that worries me as well. It's not about what the applicants thought they meant, it's about what the public believe that it means and that is worrying to me. It's just not feasible. Say for example the unit, you're going to have four people in there waiting for prescriptions and all of a sudden, the 5th person is going to have to wait outside, so the argument for queueing in the street just isn't there. Now, they have two pharmacist on, that's absolutely fine, but what happens if one pharmacist is in a consultation and you have another person asking for a consultation, maybe a Pharmacy First regular consultation, and you have all of these boxes to check and four people waiting on prescriptions, how is zero waiting time possible in that situation? That's a real-life situation and that is probably the bare minimum they will be facing if they are the pharmacy which is closest to the GP surgery. So, it concerns me. It concerns me on things being said that they may not be able to deliver on. I am a firm believer that if you say something in pharmacy and you say you are going to deliver a service then you have to deliver it to the utmost standard.

Cardross – Just on your comments on Inveraray Pharmacy. Are you aware that they changed ownership recently. Did the prescription changes happen in line with then that happened or was it before this?

Rowlands – It happened in line with the new owners, so I think that was just an idea of business model that they were doing at the time. I haven't heard that much about Inveraray recently, I'm not sure if they are still doing it to be honest.

Cardross – One last question which might be sensitive information, and you don't have to answer but whilst little Boots was open did you ever have concerns from Head Office about your prescription numbers, was it ever an issue back then? I know you mentioned you are one of the smallest pharmacies in the group but was it ever an issue back then?

Rowlands – As part of a larger company, viability is always on the decks, it's always on the table and you will know, look at what happened to Lloyds which sold all theirs, you have to ensure that your viability model is solid. Rowlands Pharmacy actually have sold quite a number of pharmacies, ok mainly based within England, but it just tells me, and it tells my Line Managers that every pharmacy is being monitored for its viability. There is absolutely no point in keeping a pharmacy open if it's not viable. It will just be bleeding money out of the company and then that removes services from different areas in the company so as soon as a pharmacy doesn't become viable, questions are going to be asked.

Chair – Thank you very much, if we can go to Community Council, please.

CC – Just a few questions. Before the Medical Centre moved to its current position, you were one of the closest pharmacies to the old Medical Centre. Why did you not consider moving at that point?

Rowlands – I'm afraid that was actually before my time in Helensburgh. I have been there eight years so and even when I moved here 18 years ago, the current set up was the same as what it is just now. So, unfortunately, I don't know the answer for you.

CC – Based on local knowledge, would you agree that most people use the back door of the Medical Centre because the back door is the area where the car park is, it's linked to the train station, the bus stop and the taxi rank so if most people are coming in and out of that back door, Greens would be the nearest pharmacy.

Rowlands – I absolutely agree, if they are using the back door. I understand there is a lift access at the back door as well. However, the front door is the front door, and you do see a large percentage of people walking in and out of the front door. I guess it depends on the way the person is actually getting there. I don't think one exit is used any more than the other to be honest. But the point I was making earlier was indicating that if people were coming out of the front of a building, then the new application unit would be closest. If they were coming out of the back of it then Greens would be closest, and I wasn't disseminating about the number of people walking out the front or out the back. Sorry if that was misleading.

CC – The other pharmacies in town talk about refurbishment plans or completion of refurbishment, do Rowlands have any plans to upgrade the facilities?

Rowlands – We have most recently upgraded our consultation room. You would have noticed on the CAR there was one comment about Rowlands, and it was the confidentiality in the consultation room. I'm not quite sure if that was directed at us but the last consultation room was of a smaller size and it did actually have a roof on it despite what the applicant indicate but that consultation room has recently been increased in size and in quality so noise echo doesnt happen as much so there is much more confidentiality but it does allow for us to deliver a lot more professional services in more comfort for the patients.

CC – That's all from me thanks.

Chair – Questions from the Panel.

Ian – No questions thanks

Mark – No questions thanks

Catriona – Thanks for that Mark. I just have one question. There has been a lot of talk about marketing and leaflet drops today, you mentioned that Rowlands has capacity for expansion in script numbers and service provision if necessary. Do Rowlands have any plans for advertising the residents of Helensburgh, the services available and making those who perhaps answered the CAR aware of what is available?

Rowlands – We do, on a reasonably regular basis. Some of it is just a blanket company leaflet drop with promotions etc, maybe the flu campaign is coming up, but we have requested on quite a number of occasions to have a leaflet drop separately for the services that we are delivering within Rowlands Pharmacy. A lot of these are more designed along the services that I feel people would like to know about e.g. the travel health service. That was one of the most recent ones because we were realising that people within Highland Health Board were getting directed to private clinics within Greater Glasgow area. I really didn't that was good considering we were able to deliver these vaccinations under the NHS, so I suggested we have a leaflet drop about that. As for just driving prescription numbers, no, we don't generally just give out a leaflet drop just begging people to come to our pharmacy and get their prescription. Of course, that goes hand in hand with delivering services but is normally about something we are quite passionate about at the time.

SP – No questions thank you.

CS – No questions thank you.

GM – Hi Mark, just a quick question around errors. This has come up quite a few times today. Have you noticed any increase in errors when the wee Boots closed and just explain your process for error reporting and how you manage it?

Rowlands – Error reporting – we have near mis errors, we have error logs, and we have a formally reporting tool for dispensing errors within the pharmacy. We have noticed no increase in dispensing error rate within the pharmacy. Indeed, if anything, it may well have fallen as we are actively using our off-site dispensing models and automated dispensing systems. For example, one of the most common errors reported in community pharmacy are in the making up of the MDS dosette box systems. Our pill pouch system has an error rate of 4 per 10 million items. Now that is an exceptionally low error rate for any form of MDS box system, so it is very safe. We also use our off-site dispensing where it is applicable, suitable and where time allows for is on the making up of our regular prescriptions. That has a similar error rate so our error rate in dispensing and accuracy within Rowlands Pharmacy is very low and have not noticed any difference since the small Boots has closed.

Chair – Thank you Mark. So, we will move on to our last presentation which is from the Community Council.

8. Presentation from Community Council

Can I start by saying that the feedback we received as part of the community council is that the staff, pharmacists in the town are all very well respected and people talk highly of the service they provide but the general perception is that services are stretched. So, we are very fortunate in the staff we have in the town, but Helensburgh used to have four pharmacies until the end of 2023.

We believe there is still a requirement for four pharmacies in the town. We don't believe that service has been adequate since the small Boots shut towards the end of 2023. People have discussed the disruption, the queues, the access of services out with the town, as far away as Inveraray, which given the issues with the Rest & Be Thankful, the road was closed there the other day for another land slip, causes significant reliability issues. We just feel it is not acceptable that someone in Helensburgh has to access services out with the area as far as Inveraray. There have been issues with the Greens takeover from Gordons, that has seemed to have increased waiting times and has, even according to the Boots pharmacist, seen an increase in patients drifting towards them over the last six months or so. The general feeling is that the town would like to see the reinstatement of a fourth pharmacy.

A few topics to talk about, opening times, the existing services at lunchtime are really poor, there is a perception that Boots is always shut at lunchtime so whether as discussed the pharmacist is available at Boots or not, that is not widely known, and most people who work, and have a some time off at lunchtime to go to a pharmacy would not go to Boots at lunchtime because the perception is that pharmacist wouldn't be there. We note that Rowlands takes a lunch break as well but apparently you are only entitled to a 20 mins lunchbreak at Rowlands rather than a full hour, according to your published opening times.

There aren't any services at all before 9.00 am so people can't access pharmacy before work, especially if they manage to get an early GP appointment so that can delay dispensing of medication until after work or the next day and there have been reports of issues at Boots where the doors start to get closed just after 5.00 pm and so although they don't shut until 5.30 pm the doors get shut and locked, and yellow signs put outside the door indicating that the premises are shut. People have the perception that one door is left open to allow people to leave, and people aren't encouraged to go in from just after 5.00 pm onwards. So, there is an issue of limited access to pharmacy services for people who are working full-time.

In terms of refillment times and capabilities of existing pharmacies, this has been discussed already today. There are reports of residents having issues gaining a full prescription all at once, having to get partially filled prescription and then having to return for remaining items. I note that a couple of the pharmacies have said that they will deliver on them but there is still a disruption and delivering medication to people at home I presume has an issue of leaving in a safe place.

The increase of use of HUBs and fulfilment centres can be OK for long-term prescription planning, but it does seem to increase the fulfilment of prescriptions. I think a standard 48 hours becomes 72 hours if things have to be fulfilled from outside the town from a HUB. We have heard of reports of people who have tried to visit more than one pharmacy to get a whole prescription filled so that they get it fulfilled there and then but it seems a bit odd and a lot of hassle. There is one person who turns up to community councils regularly whose partner has a heart condition, and getting the heart medication replenished regularly and quickly from one pharmacy seems to be a recurring issue.

The compliance aid issue. I believe there are still people using Inveraray Pharmacy for dosette boxes and people use other pharmacies the Vale of Leven and Dumbarton as well, and if you had a car, were able to drive around that is not so much an issue, but it does at to the time it takes to get your prescription filled.

There is talk of the wider area of Helensburgh and Lomond switching through Rhu, Shandon, Garelochhead and even over to the Rosneath peninsula, a lot of people in these areas will plan trips to Helensburgh to visit a GP, to do some shopping and to fill prescriptions if they have to so the catchment area for Helensburgh is actually quite large, it does cover a large geographical area. The issues of MOD personnel and the people at Faslane Naval Base accessing the MOD

medical services, GPs and pharmaceutical services is correct but people with pharmacies have families living in the town, families who will be using the local services in Helensburgh especially families with children attending schools.

There has been talk about complaints and a perceived lack of complaints from people. People do not normally formally complaint, they voice concerns, they give us anecdotes at community council meetings or they tell stories when asked about their own personal experiences but by and large they move their services around so if they are not happy with a particular service in one place they will take the next prescription to another place but the feeling in the town at the moment is that there are similar or other issues at different pharmacies in the town, even to this day.

Queues and waiting times are reported and they weren't common before the fourth pharmacy shut. We are not used to having to wait for our prescriptions, we are not used to having to queue for prescriptions, this is something that has occurred since the wee Boots shut in 2023.

There is a feeling that some of the refurbishments that have been made and improvements in the three remaining pharmacies are minor changes and not really addressing the inadequate provision of pharmacy services. All pharmacies in the town have small front of shop areas, none of them have large dispensing areas, even Boots, the large Boots which remains, the pharmacy counter is quite a long and narrow section where in most of the shop floors is given over to retail. The other two pharmacies are probably the other way round; they have a larger pharmacy dispensing area at the back and very very small retail areas in the front of shop.

Residents have raised concerns about safety, there is a perception of errors occurring when pharmacy services are stretched, when pharmacists are busy and when there are queues when there are maybe holiday weekends and so on, when people are particularly busy that is potentially when errors can occur and can be serious. We have also heard reports of residents having limited access to emergency prescriptions, if they have run out of medication, trying to access repeat prescriptions at short notice can be an issue.

Pharmacy First services, there are limited signs that this is actually being used and people are even aware of the Pharmacy First services in town and I think a lot of people might be reluctant to discuss their minor ailments at the counter, it may not be encouraged to go into a consulting room or a treatment room the way the current shops are set up. I myself had a nasty midge bite which I scratched too much and had a reaction and went to one of the local pharmacies to talk about it. I had to speak to an assistant at the counter who then relayed the message to the pharmacist at the back of the shop who then relayed messages back and forwards. No-one offered to have a look at my leg to see what it was like and see what the appropriate cream I should apply, it was just a kind of relayed conversation. We often hear that often people do have Pharmacy First needs and end up being referred back to their GP and it is their GP who should be dealing with it rather than the person in the pharmacy.

In terms of future requirements, there are reports of inadequate services at the moment but as has been mentioned, Helensburgh is a growing town, it is the only town in Argyll & Bute has potential to growth according to Argyll & Bute Community Council. The local authority just commissioned a new strategic plan to increase the whole area from Helensburgh eastwards by about 4-5,000 new homes. They will publish a consultation exercise in the Autumn this year but essentially they are going to have a whole new eastern flank to Helensburgh stretching from the Academy building and Morrisons Supermarket up all the way across to the top of the town at the Golf Course with a new access road linking to the council depot up beside the skating pond so 4-5,000 new homes is a huge expansion for a town this size. There are also plans for a whole new village at Kilgray, which would be the equivalent of the size of Cardross maybe from 13-14 years ago, and Cardross it' self is undergoing a huge expansion as well, there are plans for a lot more

homes in some of the greenbelt areas and the fields around Cardross. So, the concerns are that if the existing services are struggling to cope at the moment, such a major increase will be difficult to service over the coming years. There are also plans for a big business park at Craigendoran. This new business park will have a mix of service provision and that is going to increase the footprint of the town and bring people into the town so more people working in the area locally and using services locally.

The naval base it 'self as has been mentioned is undergoing significant expansion so Faslane will become the home of the submarine base for the Royal Navy, the permanent home of the submarines for the Royal Navy so there have previously been submarines based down south, they will all be based in Helensburgh so if you're in the submarine service, you are going to make your home in Helensburgh. The expansion means that they will have that settled port that they can come to bring up families and so on so the increase of MOD personnel will follow on with families coming as well, and for every MOD person employed at the base, there are contractors employed to do the construction work, maintenance work as well so there will be an increase in the contractors employed there.

The community's view is that we dont have an adequate service with the three remaining pharmacies, we want a reinstatement of a fourth pharmacy service, and we would support that new pharmacy application.

Chair – Thank you very much for your presentation. If we can move on to questions and if I can start with applicant, please.

Applicant – No questions thank you.

Chair – Questions from Interested Parties, if we can start with M & D Green.

M & D Green – Thank you Chair, thank you Community Council. We just recently heard from Mark at Rowlands stating that as a pharmacist he is not stretched in the pharmacy, his staff are not overwhelmed and he doesn't have any queues, and he is only, in his estimation, only two minutes' walk within the two busier pharmacies in Helensburgh. What, in your opinion, is the difficulty in making that two-minute walk along the street to access Rowlands Pharmacy?

CC – Yes, it's a strange one. I know if people have mobility issues, they will tend to stay in the same part of town so if they have accessed the Medical Centre they may pop along to the Co-op and then pop along to Greens on Sinclair St. Those services that are in that part of town make it easier for them to access those sorts of services. Parking in Helensburgh is challenging at the best of times and if you have a disability and mobility issues there are limited parking spaces around the town. I don't think there are disabled parking spaces in front of Rowlands. There is a bus stop nearby which maybe makes it more difficult to park nearby.

M & D Green – Do you think it's more about convenience then rather than the adequacy of provision given that Rowlands has significant additional capacity?

CC – I think if you have mobility issues, it's not about convenience. If you have mobility issues you can't walk across the town.

M & D Green – You mentioned about people not necessarily making formal complaints. How would you envisage a business address these issues that may occur if formal complaints are not raised with any detail.

CC – I think engaging with the community more so turning up to community events, engaging with some of the community social media posts and groups that are there. That might be a bit of

a minefield for many but there are lots of community groups in Helensburgh that meet face to face, different age groups, different issues so pharmacies engaging more with the town.

M & D Green – You made a comment which I have to ask you about and that is the changes and the proposed changes within the existing pharmacies are only minor changes. Perhaps you may be prepared that statement before you were aware of the extent of the changes that we are proposing to make at M & D Green, which doubles the footprint of the pharmacy, trebles the size of the dispensary, leaves the retail space the same size, introduces a consultation room and two treatment rooms. Now through my presentation you are aware of the extent of those changes do you still consider that a minor change?

CC – When will those changes be happening because you say it will be at least a year before they will be in place?

M & D Green – The process has started, the planning permission and building warrant are imminent and the work will be complete by early January. But the question I pose was, do you still consider the extent of those changes minor?

CC – I think we welcome enhanced services. Minor/major, I think there has been discussion about what these words mean to people so I'm not a medical professional so would not want to comment on whether one business's changes were minor or significant or whatever.

M & D Green – We have heard again from Rowlands that in particular given the proposed location of the proposed pharmacy, it may well have a profound impact on their revenue and therefore viability. As a community council would you have any concern that Helensburgh may return to three pharmacies?

CC – The feedback we have been getting is that people think there is a requirement for four pharmacies so we would be concerned if there were only three. There are only three now, we have had previously over twenty years of four pharmacies so we would see that the town survived perfectly well with four pharmacies, the four pharmacies complimented each other quite well, they offered slightly different range of services and patients would pick the pharmacy that suited them best. The feedback at the moment is that the three remaining are not adequate and we would like to return to having four.

Chair – Thank you. Boots.

Boots – Thank you for your presentation. I picked up on the fact that you said that patients couldn't access services and were referred back to their GP. Are you surprised that the GP didn't raise any concerns with us when we met with them?

CC – Did you meet with a GP or the Practice Manager.

Boots – No, we met with the GP.

CC – I think it is Carol-Ann the Practice Manager.

Boots – Sorry, correction, it was Carol-Ann we met with. I am sure Carol-Ann would have been there to represent the GPs and raise any concerns they have around any workload that community pharmacies were putting back on to GPs services.

CC – My own personal experience is that there is a bit of a disjoint between GP services and pharmacy services, and this is not a criticism of pharmacists at all or GPs, they each have their own responsibilities but it seems that these days GPs feel their job finishes when they sign a script and how that script is filled and the practicalities of getting that to a pharmacy, the practicalities of getting that filled and then to a patient isn't really the GPs concern. It may be

something that the NHS Board has to look at in the wider context, how to actually get the different frontline services to work better together but GPs don't really seem interested in how things work after they sign a script.

Boots – I think I misunderstood what you said, my understanding was patients couldn't access NHS services, our community pharmacy services such as NHS Pharmacy First Plus and then referred back to the GP. Was that the point you were making?

CC – Yes, generally Pharmacy First and Pharmacy First Plus are pushed back towards GPs.

Boots – Were you surprised then that Carol-Ann didn't raise any concerns with us around that?

CC – Yes, that was the point I was making that there seems to be a bit of a disjoint between what the GPs thinks happens and what pharmacies need to happen, and they don't communicate that well between themselves.

Boots – I think if the GP was taking on extra workload that should have been done by the pharmacy, I think they would have raised that with us when we met with them.

CC – Yes, I think they should.

Boots – Thank you, no further questions Chair.

Chair – Thank you. Malcolm

APC – Thank you for your presentation. No questions.

Chair – Cardross

Cardross – Just one or two questions from me. I wanted to ask about the complaints you have been getting about stock issues. I am sure you are aware, over the past couple of years, there has been a lot of national shortages in medications, Brexit has impacted the pharmaceutical market greatly, and that is just purely from a wholesaler perspective, you can't physically get the medication and that is why this is happening. Do you think a new pharmacy will plug that gap and how do you think they will plug that gap?

CC – I don't know that I could comment.

Cardross – You mentioned about a potential 4-5,000 homes new development. From my understanding, correct me if I'm wrong, there was a recent proposal at the Golf Course that was opposed by the community. Is that correct?

CC – So the Golf Course development was passed but the developer pulled out and has changed hands, so it has now gone to a different developer who I think are looking at the plans again. The stumbling block for that particular development is an ancient area of peatbog which has to be carefully managed, which makes it slightly more expensive to develop but that is only one area. The eastern flank development runs from the Golf Course all the way down towards the Academy and Morrisons and has other controversial elements to it like cutting through ancient woodland, crossing burns and drainage issues and so on but Argyll & Bute Council are keen to start consulting about the 4-5,000 homes this Autumn.

Cardross – So it's a discussion and a potential, it is not set in stone?

CC – The consultation will start this Autumn.

Cardross – You mentioned that Pharmacy First service awareness is limited from the viewpoints that you have heard from, but the data actually shows that Pharmacy First service within

Helensburgh is actually in alignment with the Scottish average so does that shock you in any way? I'm just trying to make sense of that.

CC – I think generally people might not be aware of the new style services that is coming out. It will depend on how people use medical services and pharmacies, what you are aware of, have become more aware, some of the details, through family members recently. Sorry, I rarely use the services myself, so I haven't heard of Pharmacy First before one of my relatives required additional medical support.

Cardross – So would you say it is more of an awareness issue rather than an inadequacy of service?

CC – I think awareness is a major thing, yes.

Cardross – That's everything I have thank you.

Chair – Finally Rowlands

Rowlands – Hi there and thank you very much for taking my question. Are you aware of the limited time parking restrictions in the centre of town where you are allowed to park for a duration of time and then cannot return to that parking space? Are you aware that the parking restrictions placed outside Rowlands Pharmacy?

CC – Yes.

Rowlands – Rowlands Pharmacy does have a parking restriction outside the property which allows for continual flow. The new contract has double yellow lines. Are you aware of the double yellow lines, are you aware of any parking up at the new application site that it will be easy for people to park at?

CC – The parking arrangements in Helensburgh at the moment are a result of what is called the chord project. That was developed in 2011/2012 when we revamped all the pavements and put the nice granite sets down and revamped the square, and at that point it was decided to get rid of the double yellow lines across the town. There was someone in the council who didn't like the sight of double yellow lines and wanted to have a controlled zone so when you come into the centre of Helensburgh now you enter a controlled zone where there is little signposts saying that you are in a restricted parking area so that controls the parking, not the double yellow lines. So, the whole town centre is covered by this controlled zone. Rowlands is covered by that but not the new pharmacy. The proposed new pharmacy is out with the chord area so they are not part of that restricted zone so they wouldn't be under the restricted parking time.

Rowlands – Wonderful, so would you say then that the double yellow lines that were mentioned during one of the earlier question sessions, opposite the new unit, would you say that that was valid double yellow lines and people will get parking tickets if they parked in that area?

CC – The intention was that the council would burn off those yellow lines.

Rowlands – I am talking about at this particular point in time.

CC – They don't count, apparently the parking attendant will not give a ticket for people parking in those areas. There are other areas where the double yellow lines were painted in some streets and then removed, it seems to be a little bit of a confusion at the moment at the community council roads department.

Chair – Moving on to questions from the Chair. My reflections of your presentation are really around how much of what has been described to us as perception rather than evidence and I

suppose that is where I am struggling a little bit because in order to make this decision, we need to base it on evidence and I found it quite difficult to find the evidence in your presentation. It is based on clear submission rather than perceived experiences. Is there more data available that you would have to hand today?

CC – Actual data, no. The community council did not do its own formal survey on this, so we don't have large numbers to give you on this. As a community council we are used to dealing with litter bins, drains, lighting faults and reporting them on to Argyll & Bute Council but I think the key topics that come up regularly in the town at the moment are, as well as bins, drains and lighting faults, the local Leisure Centre, the proposed new Co-op building on the waterfront and pharmacy provision. So, it is a topic in town at the moment. People do talk about it a lot, it has been brought up regularly at community council meetings and those that discuss it tend to bring up issues that they had and problems they have had rather than express a feeling that everything is OK and adequate.

Chair – Thank you very much, that is helpful. If I can move on to Ian, please.

IG – Thank you. Can you just clarify something for me, you mention the large, proposed housing development that the contractors changed, presumably it is still in the early stages of planning? Are there any other housing developments that have planning timescale to them within the town?

CC – I think the only large-scale development on the table at the moment is, two in Cardross, one at the Hill of Cardross at the Primary School and one down near the railway line so those are the two that have permission granted. They haven't started yet but those will be developed. The Golf Course development in Helensburgh it 'self is still something the developers are looking at.

IG – What scale are the two which have planning permission?

CC – Three or four hundred perhaps. Forgive me Cardross is not my area so it's not something I pay too much attention to.

Chair – Mark please

MF – No, I've no questions thanks.

CB – No questions

SP – No questions

CS – I am just wondering how many people attend your Community Council meetings.

CC – We currently have 15 members of the Community Council, and we meet the last Thursday of the month, and we regularly get 15-20 members of the public turning up. It depends very much on what is on the agenda, some things are more popular than others. We have had the room filled to capacity and standing outside at some meetings and sometimes there may be only a few members of the public turning up.

CS – Roughly 15-20 on average?

CC – Yes.

CS – If pharmacy has been on the agenda, have you had people standing outside for that?

CC – The standing outside was for the waterfront development.

Chair – And finally Gayle

GM – No questions.

Chair – Thank you for that. So that concludes our presentations, and we are now moving on to summaries and back to Interested Parties, and as is the usual way, we will go from last speaking to first speaking. Can I remind that new evidence can be given at this stage.

The Hearing took a five-minute break at this point.

9. Summaries from Interested Parties

Community Council

Thank you very much. As I said before the break the feedback that we have been getting from members of the public is that the current service is inadequate and members of the public of Helensburgh would like to see re-instatement of the fourth pharmacy in the town. The concern is that with the future expansion of the town, and extra 4-5,000 new homes in the area there will be increased demand for services along with the increase in naval families living in the town when the base expands and we would support the fourth pharmacy to be re-instated.

Chair – Thank you very much. Can we move to Rowlands please.

Rowlands

Helensburgh Pharmacy blends heritage and innovation proudly preserving it's original features like vintage medicine bottles and traditional pharmacy artefacts. Anyone visiting Rowlands Pharmacy in Helensburgh will not forget it. We deliver a full range of modern NHS services with professionalism and care. I do understand the time but please bear with me – we have a set of old weighing scales with a wicker basket seat, they are estimated to be around 100 years old, we don't use them any more of course but we keep them on display, not because they are antiques but because they are part of our story, they are a quiet reminder of just how long the pharmacy which I work in has been part of this community. I have had patients tell me they remember being weighed on these scales, these specific scales as children, many of them are now in their 80's, some are even over 100 years old. That kind of connection is not something you build over a few years, it is something that is passed down through generations and that is what Rowlands Pharmacy represents here, continuity, trust and care that stood the test of time.

We are not the biggest pharmacy in Helensburgh, we don't dispense the volumes that Boots and M & D Green currently do but we are still here, we are still viable and we are viable because we have consistently delivered patient-first care without standing feedback from the people who matter the most that's the patients that we have in Helensburgh. I need to be clear, that viability is fragile. If a new contract is introduced without clear evidence of unmet need, it risks diluting the funding in prescription volumes that keeps us going, and if that happens Rowlands Pharmacy in my town of Helensburgh is likely to be put into jeopardy. Not because we have failed but because the system may no longer support what we have proven to deliver over those years, and if we lose Rowlands, we don't gain anything. There is no net increase in provision, what we lose is a trusted well-loved pharmacy that has been serving Helensburgh for generations. That will be a really sad day, not just for us but for the Helensburgh community in which we serve.

Thank you.

Chair – Thank you very much. Cardross please.

Cardross

Thank you. I would just like to say thank you for allowing me to represent the views of Cardross Pharmacy and I will just further explain why we feel the application of a new pharmacy in Helensburgh is not necessary or desirable based on the evidence presented to you today.

It seems as though it is more observation/perception rather than changes in hard data. Cardross Pharmacy as well as all of the existing pharmacies within Helensburgh, based on the data, are committed and meeting all of the core pharmaceutical needs that the pharmaceutical contract has. Additionally, as explained there have been improvements, there have been increases in advanced services as well as meeting that additional needs and again those core pharmaceutical services such as Pharmacy First. Our refit in it 'self has an extended dispensary taking into account more space, increased efficiency and more consultation rooms for a private space to discuss these matters. We do provide care to many residents within Cardross and, of course, Helensburgh, and I believe maintaining that care will reduce the effects of fragmentation.

I would like to panel to consider one last question – has this application been made more on the basis of convenience or has it been made on the basis of pharmaceutical need? Convenience alone cannot be the basis for approving a new pharmacy and there is nothing to suggest, within the data, that our services within Helensburgh are poor or inadequate.

Thank you.

Chair – Thank you very much. Moving to our APC representative Malcolm.

Area Pharmaceutical Committee

This will be a quick summary. Based on the data we had when we met, we agreed with the boundary and felt that the information in the CAR response that there may be need for additional pharmaceutical services but that was based on information we had at the time.

Chair – Thank you very much. Boots please

Boots

We agreed with the boundary defined by the applicant however the population are not restricted to this neighbourhood, and they access pharmaceutical services out with the neighbourhood e.g. where they work. Helensburgh is amongst the lease deprived areas in Scotland and the average number of patients in Helensburgh today is broadly in line with the national average. The overall population increase predicted from 2025 and 2030 is predicted to be just about 562 people, just a reminder that is from Improvement Service in Collaboration with National Records for Scotland.

Boots pharmacy provides core, national and NHS services, offers a free prescription delivery service and is open seven days per week. We offer free compliance aid packs to those in need; our pharmacy team has great relationships with GPs and other healthcare providers. There has been significant investment into the premises with a new shop floor layout, new dispensary and a new consultation room. Patients have given us a satisfactory score of 70%, based on 94 responses over the last eleven months telling us they are extremely satisfied, and we have capacity to grow all our prescription supply and NHS services.

The applicant use of terms of zero waiting times and the visualisation of the pharmacy on the Facebook page that isn't actually what the pharmacy will look like, and I would go on to suggest that this has been misleading to the public and if the application were to be granted and go on to

open, given it's close proximity to the GP practice it would take up to 40% market share of the prescription items, which would be the equivalent of around 8-10,000 prescription items per month. This will have a significant impact on the existing pharmacies which will mean a reduction in staff and a reduction in premises investment and service development, and of course, the potential closure of Rowlands.

All that will be achieved by granting the application is the likely destabilisation of the pharmaceutical provision in Helensburgh and ultimately end up in a position with three pharmacies.

Chair – And finally our summary from M & D Green.

M & D Green

The applicants have identified premises which offer no improved geographical access for patients being within a few minutes' walk of all existing pharmacies, and do not propose to offer any additional NHS services not already available. The premises are small, inadequate for the demands of the current pharmacy contract, the proposed location would take significantly more than their suggest 4,000 prescriptions items away from the existing pharmacies impacting on revenue to the extent that would require cost reduction, typically reducing staff costs, diluting the current service provision and introducing serious risk of closure.

M & D Green, although just recently introduced to Helensburgh have immediately committed to expanding the premises and resources within the pharmacy. To implement significant change takes time, it will take I would guestimate, another five or six months to complete these changes but we believe given the commitment that we have already made that we deserve the time to demonstrate the extent of the improvements and impact that can be made.

Responses from the CAR, while I do not accept that they are representative of the population in Helensburgh, do not take these proposed changes into account and I would urge the panel to take these into account when considering the relevance of the CAR.

An additional pharmacy in Helensburgh is not only not necessary or desirable but will undermine the existing services, compromising the provision in the town. In order to maintain the security and viability of existing contract, the committee must reject this application.

Thank you Chair.

Chair – Thank you very much. Finally for our summaries, can I ask the applicant and a reminder no new evidence.

Applicant

We believe we have shown the PPC clear and compelling evidence that the pharmaceutical services in Helensburgh are inadequate and this application is both necessary and desirable to secure safe, adequate provision. The evidence presented was gathered for over a year. A newspaper article in 2024 and the Boots closure, the CAR completed six months ago heard the voices of more than a 1,000 residents. Also, to the many letters of support and the queues that have been sent to us as recent as last month, together they reveal deep-rooted failures across all core services so severe that in the CAR some residents have said that they have even considered moving away from the town. As we look at the evidence, we can understand why these inadequacies are present. Pharmacy demand in Helensburgh has increased, the prescription volumes have risen over 4,000 items since 2021, yet the town has lost a pharmacy. Boots in Sinclair St, dispensing over 5,000 items a month was shut down so it is reasonable to

suggest that our prescription volume would be similar to this as this has been the case for decades. The closure has resulted in the remaining three pharmacies absorbing the demand they cannot safely manage with residents reporting growing inadequacies across every core service. Despite this chaotic service, no-one here today has acknowledged the detrimental impact of the Boots closure. These inadequacies will only greaten as Helensburgh develops and continues to act as a focal point for serving these communities.

It would be unrealistic to suggest that these issues can be solved by simply changing the name above one of the doors. M & D Green has traded in Helensburgh for six months and residents say services have not improved and have in fact worsened. It can also not be claimed that spare capacity exists within the current pharmacies as over a year's worth of evidence shows the exact opposite. Residents face unacceptable waiting times often queues out the door, repeated trips, difficulty accessing services and even dispensing errors. These aren't signs of capacity, they are markers of a system under extreme strain. The benefit we have today is that we know the remedy for this as the pharmacies in Helensburgh functioned adequately with four pharmacies serving the town for decades.

Despite pharmacies out with the neighbourhood trying their best to service the area, the needs of the residents remain unmet, which is confirmed by the various forms of evidence we presented today. It is telling that a pharmacy as far away as Inveraray is intervening to service residents, a pharmacy which requires an 80-mile round trip. That is not an adequate service.

This application is not just desirable; it is necessary and has received overwhelming support from residents as well as local healthcare providers as we can see from the letters of support. The Pharmaceutical Care Services Plan makes it clear that unmet need must be considered following closures and the evidence before you demonstrates that this unmet need is both serious and long-standing. You also need to understand that there is another Declaration of Interest for a pharmacy in Helensburgh showing that this is a recognised need in the area.

Alongside the accounts we have provided, you have also heard today from the Community Council the lasting impacts these inadequacies have had. These are not just voices from Head Office but local people who live here and experience these challenges every day.

Viability has also been mentioned multiple times today. What we need to remember is no pharmacy has ever closed due to a new application. Helensburgh supported four pharmacies for decades.

On behalf of the residents of Helensburgh I respectfully ask the PPC to approve this application to ensure safe, adequate pharmacy services for this community.

I will just leave you with words of a resident "This afternoon along with what I counted to be over 20 people waiting nearly 40 minutes to be served at Boots in Sinclair St only to be told the prescription was not fully ready". This is simply unacceptable. Boots have closed a long-standing viable pharmacy up the road with no thought as to how this will affect the health and well-being of the community in Helensburgh. A new pharmacy is needed and I for one will certainly welcome one.

Thank you very much for your time and consideration.

Chair – Before we dismiss from this part of the Hearing, I want to note to everyone in the room that we did seek some advice around the information being provided in relation to expanded premises. We sought advice from the CLO just to confirm. The answer is that the PPC is entitled to take into account information provided by the parties notwithstanding that the position on the ground may have changed from the date of the CAR. However, in this case, the committee would

have to consider such matters as when the extended premises will be open to patients and also, will it's opening have an effect on services as an overall service provision in and to the neighbourhood. So, this is something that we will be taking into account when we make our deliberations.

Thank you to everyone for your contributions today. I very much appreciate that it has been a long day for everyone, and I personally would like to thank you for your honesty, clarity your presentations today and the respectful nature that you have asked each other questions.

It is now for me to check that you feel you have been given a fair Hearing as the applicant and Interested Parties.

All confirmed this to be the case.

Chair – We will now go on to make a decision. A written decision with reasons will be prepared and a copy will be sent to the applicant and Interested Parties as soon as possible but no later than 15 days from this date. A letter will be sent with the decision of the committee and for those parties who can appeal the process the timescale will be explained.

At this point the Hearing closed with a thanks from the Chair.

7. Decision

7.1 Neighbourhood

Rationale:

The Committee agreed that the boundary should be as proposed by the applicant. The Committee considered whether the boundary should be altered to encompass some of the surrounding villages such as Rhu and Shandon. However, the Interested Parties were in agreement with the suggested boundaries, therefore, these were not altered and should remain as proposed by the applicant.

Evidence:

Helensburgh Pharmacy (proposed pharmacy) catchment area covers a similar area to 20 small area data zone geographies as referenced in National Records of Scotland.

Following clarification that residents in surrounding villages would be free to access services from the proposed new pharmacy all Interested Parties supported the proposed boundary.

In response to the question: ***Do you think the area, outlined in blue in the undernoted map, describes the 'neighbourhood' where the proposed community pharmacy will be situated?*** 97% of respondents agreed and 93% of respondents lived within the boundary proposed.

Boundaries:

North – Where Sinclair Street meets Luss Road physical boundaries of the Helensburgh reservoir to the left and the Helensburgh Golf Course to the right.

South – A814 running along the waterfront.

West – Where Rhu Road higher meets Rhu Road lower

East – The Aldergate development and the open fields on the A814

Rationale:

The applicant's indicated pharmacy catchment area was estimated 15,000 people, however, discussions regarding this exact number led the panel to believe that the variance was insignificant.

The population of the Helensburgh area showed little change over recent years and predominantly of an affluent status with minimal deprivation.

Consideration of the town's ethnic population was not discussed, and no evidence was submitted.

Evidence:

There are 20 small area data zone geography in the proposed catchment area with a population totalling 14,318 people.

NHS Highland Intelligence Report March 2025.

The pharmacy catchment population registered with a GP is around 15,000 with 7,700 residents registered with the Millig Practice and 7,400 with the Helensburgh Medical centre. White 96.5%, mixed multiple ethnic groups 0.9%, Asian Scottish/Asian British 1.5%, African 0.3%. Caribbean/ black 0%. Other ethnic groups 0.5%.

7.2 Adequacy of existing pharmaceutical services

- ➢ Is the provision of pharmaceutical services to the neighbourhood from existing pharmacies adequate now and in the future?

Answer - **Yes**

Rationale: Consideration was given to potential future demand for core pharmacy services in relation to housing development, but it was considered these were not at a sufficiently advanced stage at this point.

- ➢ Was due consideration given to both the Pharmaceutical Care Plan and the CAR?

Answer – **Yes**

- ➢ Did the population of the neighbourhood think that services were adequate, did PPC agree and if so, why?

Answer – **No**

Rationale:

Until November 2023, the town was served by four pharmacies. One of the two Boots pharmacies was closed. On examination of the CAR, at the time of the consultation there was overwhelming evidence that the local population and a variety NHS healthcare providers considered the current service to be inadequate.

The PPC recognised the views of the community who responded to the consultation at the time were that pharmacy services were inadequate. The PPC is of the opinion that while there may have been a period of disruption due to the transition of ownership of M&D Greens and Boots reducing from two branches to one, there was and continues to be sufficient capacity within the three remaining community pharmacies in Helensburgh as indicated by evidence provided during the hearing.

1,017 responses were received to the CAR, and all were considered viable for inclusion in the report. Statistically, 21% agreed and 79% disagreed that the current core and national services

were adequate. A number of letters and emails supporting the opening of a new pharmacy were received, including from several health and social care providers. Problems with the current service reported by the Community Council representative mirrored many comments made in the CAR and covered topics such as long queues and long wait's, lack of privacy, shortage of stock leading to inability to obtain prescriptions in a timely manner, staff being seen to be overwhelmed and dispensing errors. The views expressed in the CAR and by various local organisations that the current service is inadequate were challenged. M & D Green supplied evidence of recent investment since taking over Gordons a short time ago. The investment will continue to be progressed following completion of planning applications already submitted. This will allow for an enhancement of service as a consultation room, and two treatment rooms will be available. Boots also confirmed that since closure of one of their pharmacies considerable investment had been made to alter the pharmacy thus giving staff additional dispensing facilities and the introduction of a consultation room. Given all of the above the panel agreed that current provision of services is adequate.

At the time the CAR was produced, the population felt there was insufficient provision. During the presentations given by Boots and M & D Green it was explained that in the last six months they had begun major upgrading and expansion, if not already completed. Due to these additional expansions the PPC did not agree that services were inadequate. In the current situation it could be considered that the CAR was out of date.

- ➢ Does the data relating to the demographics, social environment, economic opportunities and the health and wellbeing of the residents indicate a higher-than-average level of need for pharmaceutical services in this neighbourhood?

Answer - No. There is not sufficient evidence of a higher-than-average level of need for pharmaceutical services. The evidence available would suggest a generally lower than average level of need.

NHS Highland Intelligence Report March 2025.

- ➢ Is the provision of core service from the adjacent pharmacies meeting the population level of need for these services? YES

From evidence presented to the PPC the view of the panel is that there is currently an adequate provision of core services. The level of dissatisfaction expressed in the CAR could appear to be prior to the consultation. The timing of the consultation of the CAR was at the transitional period of change of ownership with Gordons to M & D Green and given a settling in period, services would resume resulting in adequacy of services to the area. All three pharmacies gave evidence of improvements on completion of their planned project.

There was strong evidence presented to the panel that the existing pharmacies in the town are meeting the population's need for all core services. The closure of Boots in November 2023 has resulted in Boots transferring the previously registered patients to the existing pharmacy at 13 Sinclair Street., this included the transfer of the needle exchange service. It was recognised that some patients had transferred to either of the other two pharmacies namely Rowlands and M & D Green, but this is not quantifiable. As demonstrated by the CAR, the evidence from the Community Council and the many letters of support received, this has led to a perception of inadequacies, however, this is not supported by the statistics coming out of Pharmacy Services, Scotland.

- ➢ Has the committee considered their responsibility under the Equality Act to reduce inequality?

Answer – Yes.

The committee considered issues of inequality highlighted in the reports and evidence presented to it. It considered the information received from all Interested Parties that they had, since the time of the consultation commenced, invested heavily in their business to ensure compliance with the Community Pharmacy contract as we see it today and moving into the future.

Due consideration was given to the Disability Discrimination Act (Equality Act 2010). Confirmation was given that the refurbishment of M & D Green, Rowlands and Boots, once completed later this year are currently or would be DDA compliant.

The panel did consider all aspects of mobility and access issues, but it was felt there was no clear evidence the proposed pharmacy could meet the requirements of the DDA as planning permission had not yet been secured.

- ➢ Does the difficulty that some residents have accessing services out with their local area contribute to making service provision inadequate?

Answer - No – Evidence was presented that approximately 80% of residents had access to a car. In addition, Helensburgh is well served with public transport links to neighbouring town.

- ➢ Do the delivery services meet the population need for pharmaceutical services?

Answer – Yes.

7.3 Securing Adequacy of Provision for the Future

In answer to the question - Is any existing pharmacy likely to close at a future date as a result of this application being granted? It was agreed YES.

Rationale:

a) Consider if any possible reduction in service provision which might occur is likely to be sufficient to cause any existing pharmacy to close?

Answer - investigation of current statistics, it was considered a very strong likelihood, Rowlands could be adversely affected if a new contract were to be agreed.

b) Is there any current unmet need for pharmaceutical services which if this were to be addressed would generate additional income for the pharmacies?

Answer - No

Evidence:

Public Health Scotland, Prescriptions in the Community. Scottish Health and Social Care Open Data.

Prescriptions in the Community - Datasets - Scottish Health and Social Care Open Data (nhs.scot)

7.4 Necessary/Desirable

Is it necessary to grant the application to make up for a shortfall?

Answer – No, the panel did not think it necessary to grant the application.

Is it desirable to grant the application which might result in over provision at the present time and into the future?

Answer – No, the panel did not think it desirable to grant the application.

Rationale:

8. Outcome of the PPC

The Chair invited members of the Committee to vote on the Application by Muaz Jamil and Daniel Frame to provide pharmaceutical services at 1-3 East King St, Helensburgh. G84 7QQ. The Committee unanimously agreed to NOT grant the Application.

Signed :…… Date : 17th September 2025

Karen Leach
Chair, Pharmacy Practices Committee

Agenda Item 4

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**30 September 2025**
Title:	**Finance Report – Month 4 2025/2026**
Responsible Executive/Non-Executive:	**Heledd Cooper, Director of Finance**
Report Author:	**Elaine Ward, Deputy Director of Finance**

Report Recommendation:

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

1 Purpose

This is presented to the NHS Highland Board for:

- Assurance

This report relates to a:

- Annual Operating Plan

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

This report is presented to enable discussion on the NHS Highland financial position at Month 4 (July) 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 July 2025 (Month 4) an overspend of £22.665m 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 £19.838m 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.

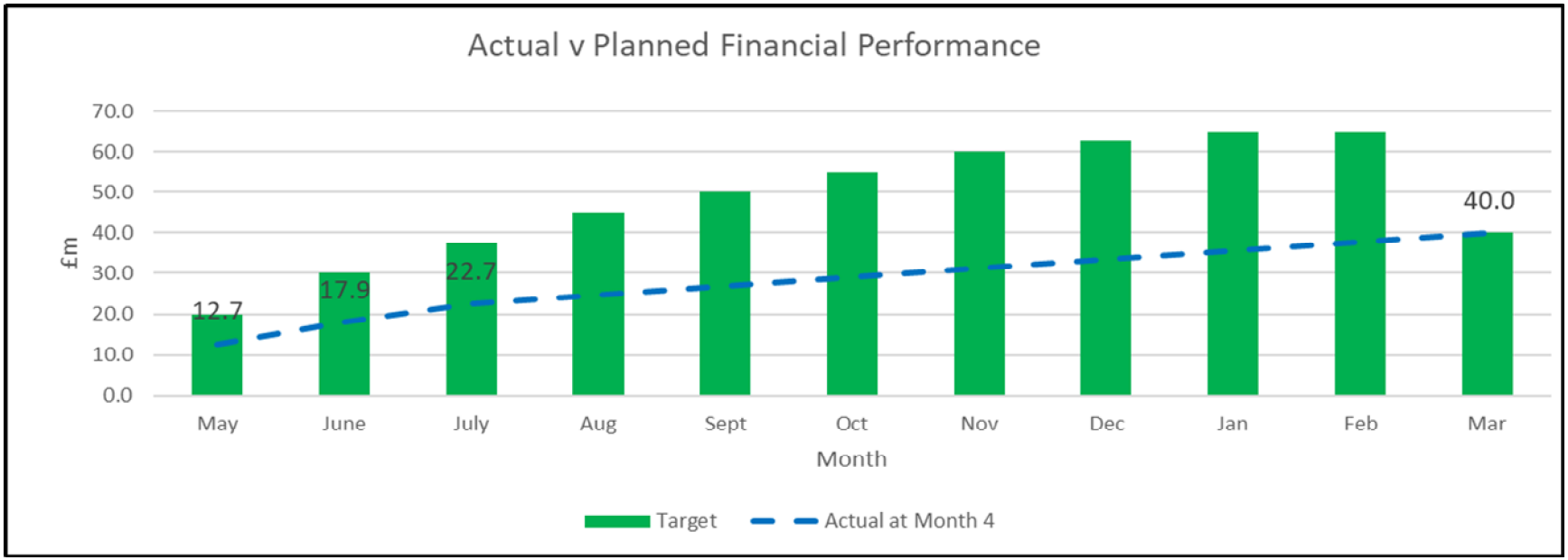
- EDG
- FRPC

4.1 List of appendices

Finance Report – Month 4 (July) 2025/2026

Finance Report –Month 4 (July) 2025/2026

MONTH 4 2025/2026 – JULY 2025



Target	YTD £m	YE Position £m
Delivery against Revenue Resource Limit (RRL) DEFICIT/ SURPLUS	22.7	40.0
Deliver against plan DEFICIT/ SURPLUS	14.8	0.0

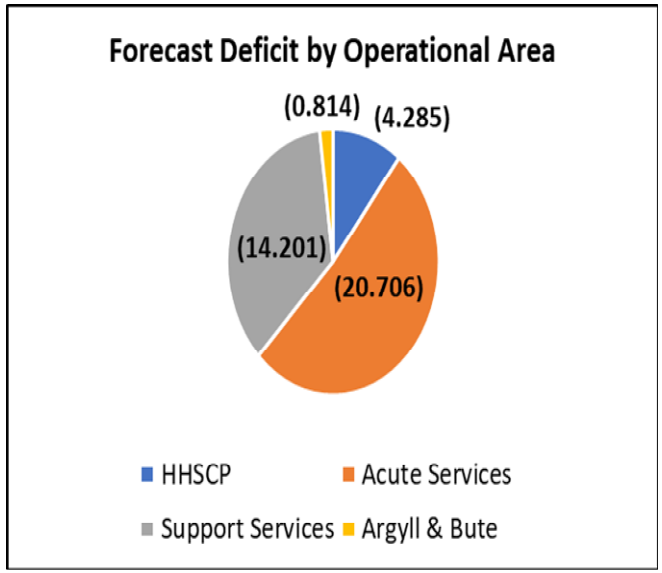
- No brokerage available in 2025/2026
- SG requested plan with a deficit no greater than £40m
- SG have confirmed that an allocation of £40m (non-repayable) will be made to cover the planned overspend – if the actual position is higher that this no further funding will be made available
- Current forecast is £40m worse than RRL but in line with SG request and revised plan submitted to SG in June 2025

MONTH 4 2025/2026 – JULY 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
1,336.372	**Total Funding**	425.907	425.907	-	1,336.372	-
	Expenditure					
503.153	HHSCP	165.983	178.725	(12.742)	527.275	(24.123)
	ASC Position to breakeven				(19.838)	19.838
	Revised HHSCP				507.437	(4.285)
339.432	Acute Services	112.264	121.147	(8.883)	360.137	(20.706)
192.372	Support Services	54.398	55.112	(0.714)	206.572	(14.201)
1,034.956	**Sub Total**	**332.645**	**354.984**	**(22.340)**	**1,074.147**	**(39.191)**
301.416	Argyll & Bute	93.263	93.588	(0.325)	302.230	(0.814)
1,336.372	**Total Expenditure**	**425.907**	**448.572**	**(22.665)**	**1,376.377**	**(40.005)**

MONTH 4 2025/2026 SUMMARY

- Overspend of £22.665m 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
- High risk assumption that ASC will deliver a breakeven position at the end of the financial year



MONTH 4 2025/2026 – JULY 2025

KEY RISKS

- ASC – At this stage there is no agreed plan in place to deliver breakeven by the end of the financial year
- Delivery of the Value & Efficiency Cost Reduction/ Improvement programme
- 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
- Potential impact associated with the cost of new drugs
- Financial impact of fragile services
- Potential impact of any trade tariffs
- 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
- Funding anticipated from Highland Council in respect of NI rate increase – amount to be agreed
- SG have confirmed a £40m allocation will be available to enable delivery of a breakeven position at year end – based on delivery of a position in line with the financial plan

MONTH 4 2025/2026 – JULY 2025

Summary Funding & Expenditure	Current Plan £m
RRL Funding - SGHSCD	
Baseline Funding	977.911
Baseline Funding GMS	5.291
FHS GMS Allocation	79.514
Supplemental Allocations	34.431
Non Core Funding	-
Total Confirmed SGHSCD Funding	**1,097.147**
Anticipated funding	
Non Core allocations	76.204
Core allocations	32.481
Total Anticipated Allocations	108.686
Total SGHSCD RRL Funding	**1,205.833**
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	**1,336.372**

FUNDING

- £1,336.372m of funding confirmed at end of Month 4
- Pay award allocation of £8.812m received – further allocation will follow on settlement of other uplifts

MONTH 4 2025/2026 – JULY 2025

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	HHSCP					
293.552	NH Communities	97.573	101.819	(4.246)	306.108	(12.557)
62.341	Mental Health Services	20.421	21.250	(0.830)	62.796	(0.455)
170.541	Primary Care	56.436	57.263	(0.827)	172.161	(1.620)
(23.281)	ASC Other includes ASC Income	(8.447)	(1.607)	(6.840)	(13.790)	(9.491)
503.153	**Total HHSCP**	**165.983**	**178.725**	**(12.742)**	**527.275**	**(24.123)**
	HHSCP					
320.797	Health	105.707	108.667	(2.960)	325.081	(4.285)
182.356	Social Care	60.275	70.058	(9.782)	202.194	(19.838)
503.153	**Total HHSCP**	**165.983**	**178.725**	**(12.742)**	**527.275**	**(24.123)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	425	1,542
Agency (Nursing)	322	846
Bank	890	3,546
Agency (exclu Med & Nurs)	163	848
Total	**1,801**	**6,783**

HHSCP

- YTD overspend of £12.742m reported with this forecast to increase to £24.123m by the end of the financial year
- ASC overspend forecast at £19.838 – this assumes delivery of £6.192m of V&E cost reductions/ improvements
- Drugs/ prescribing pressure forecast at £0.813m
- Locum costs of £0.863m contributing to overspend within Primary Care
- Supplementary staffing costs of £6.783m incurred to date
- High cost out of area placements continue to impact on the Mental Health position

MONTH 4 2025/2026 – ADULT SOCIAL CARE

Services Category	Annual Budget £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Outturn £000's	YE Variance £000's
Total Older People - Residential/Non Residential Care	65.316	21.776	21.284	0.492	63.179	2.137
Total Older People - Care at Home	40.188	13.413	14.907	(1.494)	44.687	(4.500)
Total People with a Learning Disability	53.377	17.833	20.069	(2.236)	61.144	(7.767)
Total People with a Mental Illness	11.628	3.878	3.474	0.404	10.192	1.436
Total People with a Physical Disability	10.260	3.431	3.829	(0.398)	11.352	(1.092)
Total Other Community Care	13.731	4.577	4.085	0.491	13.167	0.564
Total Support Services	(12.144)	(4.633)	2.186	(6.818)	(1.944)	(10.200)
Care Home Support/Sustainability Payments	-	-	0.224	(0.224)	0.417	(0.417)
Total Adult Social Care Services	**182.356**	**60.275**	**70.058**	**(9.782)**	**202.194**	**(19.838)**

ADULT SOCIAL CARE

- YTD an overspend of £9.782m is reported with this forecast to increase to £19.838m by the end of the financial
- Forecast assumes delivery of £6.192m of V&E cost reductions/ improvements
- The overall financial position for the Board assumes that ASC will deliver a breakeven position by the end of the financial year
- £1.639m of supplementary staffing costs within in-house care homes are included within the year to date position

MONTH 4 2025/2026 – ADULT SOCIAL CARE

NHSH Care Homes Supplementary Staffing

Care Home	Month 4 Agency £000's	Month 4 Bank £000's	Total YTD £000's
Ach an Eas	2	24	99
An Acarsaid	-	14	60
Bayview House	-	25	105
Caladh Sona	-	-	-
Dail Mhor House	-	-	-
Grant House	- 68	16	73
Home Farm	108	10	350
Invernevis	7	25	127
Lochbroom	-	18	68
Mackintosh Centre	-	4	8
Mains House	40	4	181
Moss Park	79	10	246
Melvich	2	5	22
Pulteney	-	23	105
Seaforth	-	26	96
Strathburn	-	-	-
Telford	-	12	52
Wade Centre	-	15	57
Total	**169**	**231**	**1,649**

- Ongoing reliance on agency/ bank staffing within Home Farm and Mains House
- Accelerating spend within Moss Park

MONTH 4 2025/2026 – JULY 2025

Current Plan £000	Division	Plan to Date £000	Actual to Date £000	Variance to Date £000	Forecast Outturn £000	Forecast Variance £000
91.673	Medical Division	30.298	35.199	(4.901)	103.608	(11.935)
27.298	Cancer Services	8.459	9.178	(0.719)	28.794	(1.497)
77.486	Surgical Specialties	26.094	28.115	(2.020)	82.107	(4.621)
41.730	Woman and Child	14.226	14.119	0.108	42.289	(0.560)
49.673	Clinical Support Division	16.400	17.149	(0.749)	50.330	(0.657)
(8.218)	Raigmore Senior Mgt & Central Cost	(3.023)	(3.029)	0.006	(8.147)	(0.070)
28.451	NTC Highland	9.311	9.301	0.009	28.100	0.352
308.094	**Sub Total - Raigmore**	**101.765**	**110.031**	**(8.266)**	**327.081**	**(18.988)**
15.204	Belford	5.083	5.193	(0.110)	15.835	(0.632)
16.134	CGH	5.416	5.923	(0.507)	17.221	(1.086)
339.432	**Total for Acute**	**112.264**	**121.147**	**(8.883)**	**360.137**	**(20.706)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	1,028	4,230
Agency (Nursing)	186	458
Bank	726	3,131
Agency (exclu Med & N urs)	128	487
Total	**2,069**	**8,306**

ACUTE

- £8.883m overspend reported year to date
- Forecast that this will increase to £20.706m by the end of the financial year
- Main drivers for overspend continue to be supplementary staffing costs
- Drugs costs appear to be stabilising across most areas
- £0.624m built into forecast in respect of non compliant junior doctor rotas
- £8.306m ytd spend on supplementary staffing

MONTH 4 2025/2026 – JULY 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					
5.979	Central Services	7.391	9.039	(1.648)	5.979	-
39.721	Central Reserves	-	-	-	53.324	(13.603)
45.604	Corporate Services	14.777	13.628	1.149	43.637	1.967
54.877	Estates Facilities & Capital Planning	16.771	16.078	0.693	54.653	0.223
16.894	eHealth	5.694	5.833	(0.139)	17.993	(1.099)
29.297	Tertiary	9.766	10.535	(0.770)	30.987	(1.690)
192.372	**Total**	**54.398**	**55.112**	**(0.714)**	**206.572**	**(14.200)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	2	9
Agency (Nursing)	-	(55)
Bank	281	721
Agency (exclu Med & Nurs)	71	62
Total	**353**	**736**

SUPPORT SERVICES

- YTD overspend of £0.714m reported with this forecast to increase to £14.200m by the end of the financial year
- With Estates, Facilities and Capital Planning the cost of provisions continues to be ahead of budget. 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
- Vaccination costs are now included within HHSCP

MONTH 4 2025/2026 – JULY 2025

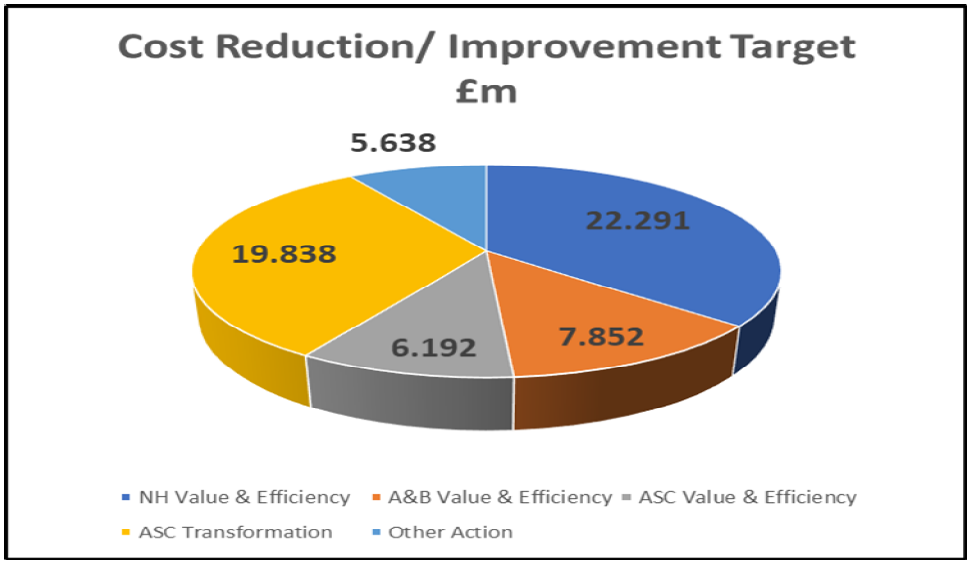
Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	Argyll & Bute - Health					
159.221	Hospital & Community Services	53.200	54.012	(0.813)	161.274	(2.053)
21.095	Acute & Complex Care	6.967	6.947	0.019	20.783	0.312
12.170	Children & Families	4.087	4.315	(0.228)	12.485	(0.315)
42.468	Primary Care inc NCL	14.448	14.394	0.054	43.302	(0.834)
24.717	Prescribing	7.916	7.643	0.272	24.499	0.218
11.790	Estates	3.900	3.963	(0.063)	11.790	-
7.880	Management Services	2.644	2.484	0.160	7.698	0.182
24.254	Central/Public health	0.827	(0.171)	0.998	21.400	2.854
(2.178)	Central Held Savings	(0.726)	-	(0.726)	(1.000)	(1.178)
301.416	**Total Argyll & Bute**	**93.263**	**93.588**	**(0.325)**	**302.230**	**(0.814)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	538	2,117
Agency (Nursing)	122	392
Bank	262	1,117
Agency (exclu Med & Nurs)	71	257
Total	**995**	**3,882**

ARGYLL & BUTE

- Year to date overspend of £0.325m reported with this forecast to increase to £0.814m by the end of the financial year
- Supplementary staff continues to be a significant driver for the position
- Out of Board cost per case charges and out of area long stay patient treatments continue to impact on the position
- Vacancies within a number of areas is mitigating slippage against cost reductions/ improvements of £1.466m and other areas of overspend

MONTH 4 2025/2026 – JULY 2025



Area of Cost Reduction/ Improvement	Target £000s
NH Value & Efficiency	22.291
A&B Value & Efficiency	7.852
ASC Value & Efficiency	6.192
ASC Transformation	19.838
Other Action	5.638
Follow up actions post March Fin Plan Submission	10.180
Total Cost Reduction/ Improvement Target	**71.991**

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

	Target £000s
Acute	9.688
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
Tertiar	1.094
Estates & Facilities	2.201
eHealth	0.639
Strategy & Transformation	0.127
TOTAL	**22.291**

Acute target increased to reflect Cath Lab and Private Patient pressure which cannot be mitigated at this time

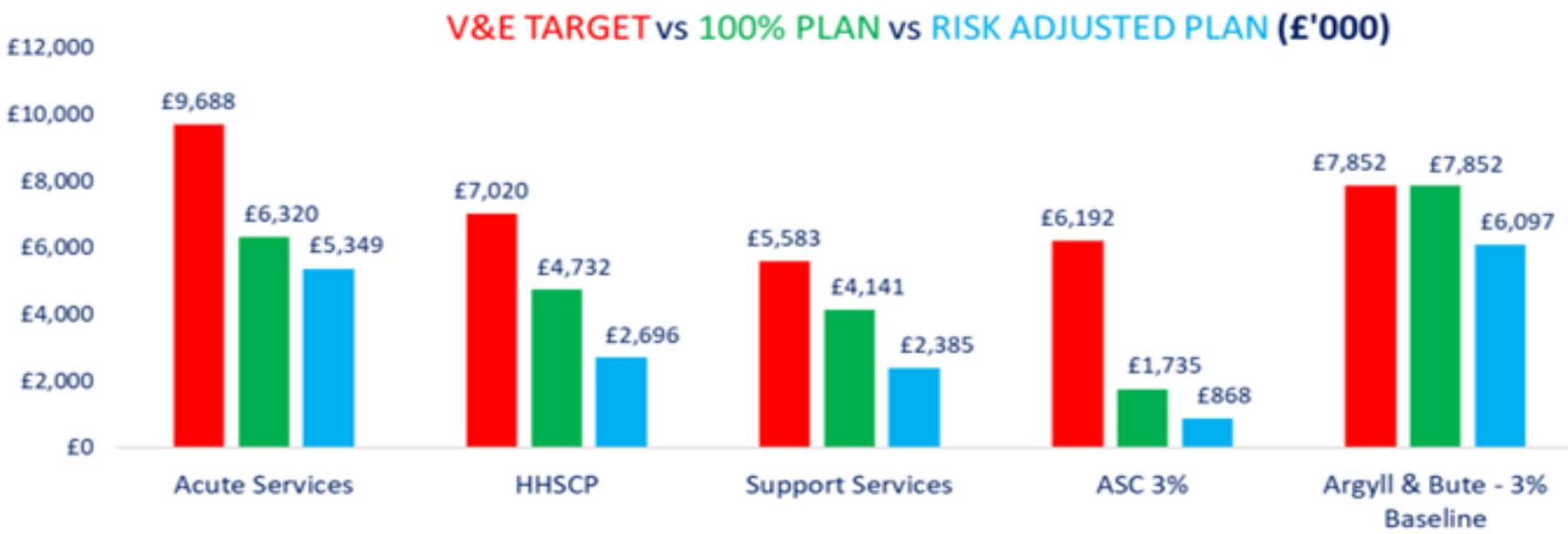
- Targets based on combination of budget and type of V&E scheme
- Targets will be within devolved budgets from start of year rather than held centrally and reallocated when plans are in place/ cost reductions or improvements delivered
- Work with Finance and Strategy & Transformation to develop more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

MONTH 4 2025/2026 – VALUE & EFFICIENCY

In the 2025–26 financial year, savings are reported on a risk-adjusted basis. This approach factors in the probability of risks impacting the achievement of the financial plan. The framework categorises risks into five types: Idea, Opportunity, Plans in Progress, Fully Developed, and Moved to Delivery.

2025-26 Value & Efficiency Plan (£'000)										
Reduction Programmes	100%			Risk Adjusted Forecast (RAF)			Savings Achieved			
	Allocated Target	Current Plan	Plan GAP	Allocated Target	Risk Adjusted Forecast (RAF)	Risk Adjusted Plan GAP	Allocated Target	Budget Savings Achieved	Cost Reductions Achieved	Current Savings GAP
Value & Efficiency - North Highland	**22,291**	15,194	-7,097	**22,291**	10,431	-11,860	**22,291**	1,546	804	-19,941
Value & Efficiency - Argyll & Bute	**7,852**	7,852	0	**7,852**	6,097	-1,755	**7,852**	3,353	0	-4,499
Total Value & Efficiency	**30,143**	23,046	-7,097	**30,143**	16,528	-13,615	**30,143**	**4,899**	**804**	**-24,440**
Value & Efficiency - ASC	**6,192**	1,735	-4,457	**6,192**	868	-5,325	**6,192**	0	25	-6,167
Total Value & Efficiency incl ASC	**36,335**	24,781	-11,554	**36,335**	17,395	-18,940	**36,335**	**4,899**	**829**	**-30,607**

MONTH 4 2025/2026 – VALUE & EFFICIENCY – TARGET, PLAN & RISK ADJUSTED PLAN BY AREA



Note: Due to hierarchy move HHSCP's savings target has increased to £7.020m (M3: £6.760m) and Support Services target has decreased to £5.583m (M3: £5.843m)
(Vaccination Service Scheme)

MONTH 4 2025/2026 – VALUE & EFFICIENCY RECURRING/ NON-RECURRING BREAKDOWN

NHS Highland

2025-26 Value & Efficiency Plan (£'000)										
Reduction Programmes as per Area and Recurrence	Value at 100%			Risk Adjusted Forecast (RAF)			Savings Achieved			
	Current Plan	Recurrent	Non-Recurrent	Risk Adjusted Forecast (RAF)	Recurrent	Non-Recurrent	Allocated Target	Recurrent	Non-Recurrent	Current Savings GAP
% of the Plan	% Rec/Non-Rec vs Curr Plan	73%	27%	% Rec/Non-Rec vs RAF	66%	34%	% Achieved vs Target	11%	5%	
Value & Efficiency - North Highland	15,194	11,551	3,643	10,431	8,349	2,082	22,291	1,986	363	-19,941
Value & Efficiency - Argyll & Bute	7,852	5,302	2,550	6,097	2,547	3,550	7,852	1,953	1,400	-4,499
Value & Efficiency (North Highland)	23,046	16,853	6,193	16,528	10,896	5,632	30,143	3,939	1,763	**-24,440**
Value & Efficiency - ASC	1,735	1,135	600	868	568	300	6,192	25	0	-6,167
Total Value & Efficiency incl ASC	24,781	17,988	6,793	17,395	11,463	5,932	36,335	3,964	1,763	**-30,607**

The total planned savings (100% plan) are £24,781m with £17,988m expected to be recurrent.

After adjusting for risk, the total expected savings drop to £17,395m with £11,463m being recurrent.

The savings plans from North Highland currently make up the largest contribution across all areas.

MONTH 4 2025/2026 – VALUE & EFFICIENCY – HHSCP

NHS Highland

Reduction Programmes	Target Allocated	Value & Efficiency Plan as per Scheme			Savings Achieved (All budget savings recorded on the ledger and YTD cost reductions)		
		Current Plan @ 100%	Risk Adjusted Forecast	GAP (Target less Risk Adj Forecast)	Savings Achieved	Recurrent	Non-Recurrent
HHSCP							
AHP Direct Engagement		50	25		0	0	0
Dental Redesign		851	851		851	851	0
HHSCP - Clinical Stores		5	3		0	0	0
HHSCP - Postages		10	1		0	0	0
HHSCP - Unfunded Posts		100	50		0	0	0
HHSCP Travel		59	6		0	0	0
MHLD Discharge Pathway		50	5		0	0	0
MHLD Notes Retrieval		5	0		0	0	0
MHLD Reduction in Costs / Out of Area Placements		425	193		0	0	0
MHLD Reduction in Drug Costs		10	5		0	0	0
MHLD Reduction in Travel and Transport (inc taxis and pool cars)		50	28		5	5	0
New Craigs Hospital - Supplementary Nursing Staff		410	205		0	0	0
Oral Nutrional Supplements (ONS) Direct Supply		5	3		0	0	0
Police Custody/ SARC/ Forensic Medical Examiner (FME)		100	100		28	28	0
Prescribing - Highland - HHSCP		1,179	992		430	430	0
Prescribing - Sustainable - HHSCP		0	0		0	0	0
Supplementary Staffing - Medical - MH -SUPP REDUCTION IN LOCUM COSTS		50	34		18	18	0
Supplementary Staffing - Nursing - HHSCP (Community Hospitals)		579	58		0	0	0
Supplementary Staffing Primary Care 2C		0	0		0	0	0
TARA HHSCP		144	14		0	0	0
Time to Care		500	50		0	0	0
Total HHSCP	**7,020**	**4,582**	**2,621**	**-4,398**	**1,332**	**1,332**	**0**

MONTH 4 2025/2026 – VALUE & EFFICIENCY – ACUTE SERVICES

NHS Highland

Reduction Programmes	Target Allocated	Value & Efficiency Plan as per Scheme			Savings Achieved (All budget savings recorded on the ledger and YTD cost reductions)		
		Current Plan @ 100%	Risk Adjusted Forecast	GAP (Target less Risk Adj Forecast)	Savings Achieved	Recurrent	Non-Recurrent
ACUTE SERVICES							
ACUTE - Junior Doctors Compliance		424	329		42	0	42
ACUTE - W&C - MyoSure		0	0		0	0	0
ACUTE - Women & Children -Test of change - Mrg		10	10		5	0	5
Acute Management Structure Review		66	66		66	66	0
Acute Medical Directorate 3%		479	238		0	0	0
Acute Surgical Directorate		401	112		0	0	0
ACUTE Theatres Optimisation and PLCV		25	2		0	0	0
Child Health Record Storage		3	2		0	0	0
Diagnostics - (Primary and Secondary Care)		0	0		0	0	0
Ferinject & PrAMS project		11	0		0	0	0
IT Equipment		2	1		0	0	0
Outpatient (Women's & Childrens) inductions		0	0		0	0	0
Prescribing - Acute Services		1,027	773		151	151	0
RGHs Contracts		237	237		125	125	0
Supplementary Staffing - Nursing - Acute		1,541	1,541		0	0	0
Supplementary Staffing Medical Locum - Acute		2,027	2,027		0	0	0
TARA Acute		0	0		0	0	0
Travel and Accommodation		20	10		0	0	0
Total ACUTE SERVICES	**9,688**	**6,272**	**5,349**	**-4,339**	**389**	**342**	**47**

MONTH 4 2025/2026 – VALUE & EFFICIENCY – SUPPORT SERVICES

Reduction Programmes	Target Allocated	Value & Efficiency Plan as per Scheme			Savings Achieved (All budget savings recorded on the ledger and YTD cost reductions)		
		Current Plan @ 100%	Risk Adjusted Forecast	GAP (Target less Risk Adj Forecast)	Savings Achieved	Recurrent	Non-Recurrent
SUPPORT SERVICES							
Building Lease Review		295	295		295	295	0
Corporate Teams		0	0		0	0	0
Directorate Savings Schemes - Corporate Services: Clinical Governance		0	0		0	0	0
Directorate Savings Schemes - Corporate Services: NMAHP		0	0		0	0	0
Directorate Savings Schemes - Corporate Services: People and Culture		0	0		0	0	0
Directorate Savings Schemes - Corporate Services: Pharmacy		0	0		0	0	0
Directorate Savings - Corporate Services - S&T		0	0		0	0	0
Directorate Savings - Corporate Services - sHealth		0	0		0	0	0
Directorate Savings - Estates, Facilities & Capital Planning		316	316		316	0	316
Directorate Savings: Finance		0	0		0	0	0
Energy Procurement		1,000	100		0	0	0
Fleet and Travel		314	267		0	0	0
NMAHP Corporate		100	79		17	17	0
Printing & Telephony		16	0		0	0	0
Printing, mail and communication services		0	0		0	0	0
Procurement Consolidation and Efficiency		1,570	1,178		0	0	0
Public Health Savings		250	25		0	0	0
SLA / Clinical Pathways expenditure review		0	0		0	0	0
SLA Income Review		0	0		0	0	0
TARA Corporate		0	0		0	0	0
Vaccination Service		150	75		0	0	0
Warehousing/Stores Optimisation		78	1		0	0	0
Waste Management		250	125		0	0	0
Total SUPPORT SERVICES	**5,583**	**4,339**	**2,460**	**-3,122**	**628**	**312**	**316**

MONTH 4 2025/2026 – JULY 2025
SUPPLEMENTARY STAFFING

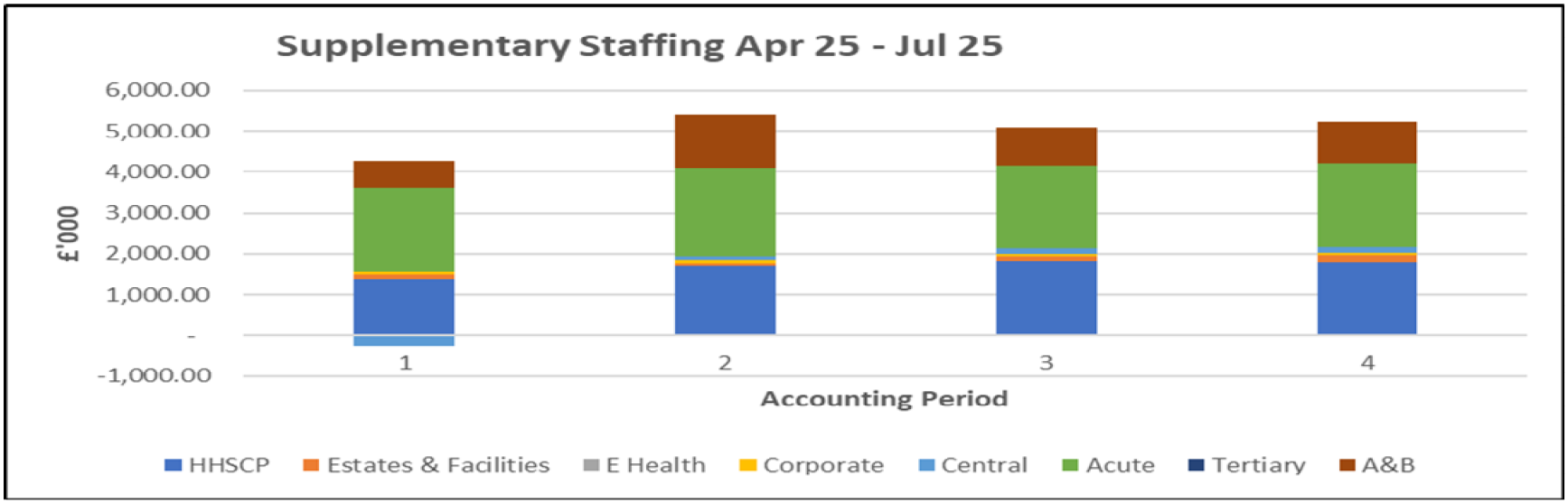
	2025/2026 YTD £'000	2024/2025 YTD £'000	Inc/ (Dec) YTD £'000
HHSCP	6,704	7,081	(377)
Estates & Facilities	457	579	(122)
E Health	1	5.70	(5)
Corporate	252	278	(27)
Central	105	7	97
Acute	8,306	7,996	310
Tertiary	-	-	-
Argyll & Bute	3,882	4,302	(419)
TOTAL	**19,707**	**20,250**	**(543)**

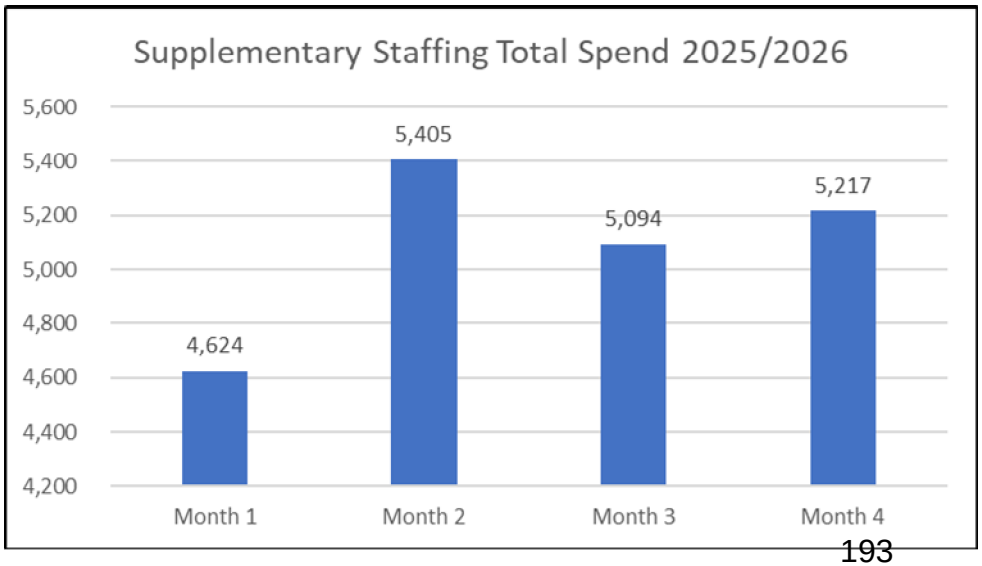
Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Pay			
138.150	Medical & Dental	46.291	48.138	(1.846)
8.157	Medical & Dental Support	2.519	3.139	(0.621)
241.545	Nursing & Midwifery	80.208	79.727	0.481
46.479	Allied Health Professionals	15.343	14.348	0.996
18.758	Healthcare Sciences	6.151	6.060	0.090
25.339	Other Therapeutic	8.239	8.370	(0.130)
51.273	Support Services	16.958	16.099	0.859
94.963	Admin & Clerical	31.453	29.958	1.495
3.490	Senior Managers	1.188	1.094	0.094
66.228	Social Care	22.014	19.650	2.364
(2.168)	Vacancy factor/pay savings	(4.269)	(2.540)	(1.729)
692.214	Total Pay	226.095	224.041	2.054

SUPPLEMENTARY STAFFING

- Recorded spend at end of Month 4 is £0.543m lower than at same point in 2024/2025
- Pay underspend of £2.054m reported at the end of month 4

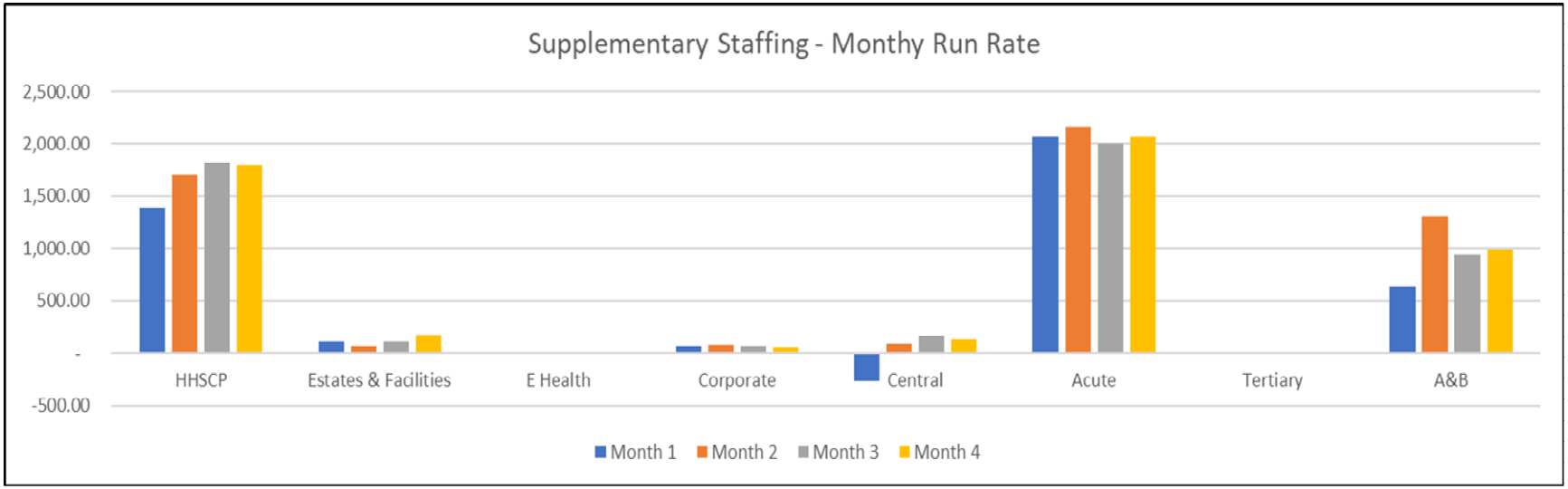
MONTH 4 2025/2026 – JULY 2025
SUPPLEMENTARY STAFFING

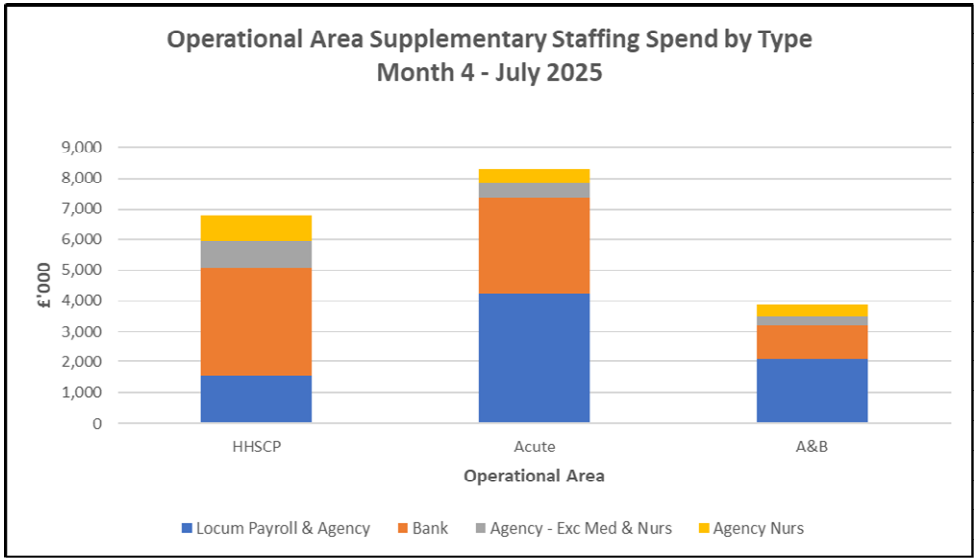




- Month 4 spend is £0.123m higher than Month 3
- Reductions across all areas except the HHSCP – this reflects increasing supplementary staffing use within Moss Park Care Home

MONTH 4 2025/2026 – JULY 2025
SUPPLEMENTARY STAFFING





- Month 4 reported spend is higher than Month 3 in Estates & Facilities, Acute and Argyll & Bute

MONTH 4 2025/2026 – JULY 2025

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Expenditure by Subjective spend			
692.214	Pay	226.095	224.041	2.054
141.404	Drugs and prescribing	46.102	46.407	(0.304)
60.518	Property Costs	18.531	18.341	0.190
42.144	General Non Pay	14.189	14.822	(0.633)
56.298	Clinical Non pay	19.168	21.707	(2.538)
160.668	Health care - SLA and out of area	60.657	63.050	(2.393)
140.167	Social Care ISC	46.851	51.587	(4.736)
120.850	FHS	40.272	40.173	0.099

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Drugs and prescribing			
55.956	**Hospital drugs**	**18.171**	**18.560**	**(0.389)**
85.448	**Prescribing**	**27.931**	**27.847**	**0.084**
141.404	**Total**	**46.102**	**46.407**	**(0.304)**

SUBJECTIVE ANALYSIS

- Pressures continue to be seen within most spend categories
- Vacancies across all staff groups continues to mitigate the high level of spend on supplementary staffing
- Drugs and prescribing expenditure showing a pressure of £0.304m at the end of month 4

MONTH 4 2025/2026 – CAPITAL

Budget (£000)	Scheme	Actual (£000)	Variance (£000)
	FORMULA		
500	Contingency	(20)	520
1,036	eHealth	38	998
1,786	EPAG	475	1,311
1,972	Estates	137	1,835
1,000	Fire Compliance	-	1,000
500	PFI - Mid Argyll	130	370
500	PFI - Easter Ross	116	384
7,294	**Total**	**877**	**6,417**
	PROJECT SPECIFIC FUNDING		
2,000	Esates - Lochaber	373	1,627
1,291	EPAG - NIB	-	1,291
888	EV Chargers	-	888
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	-	-
-	ACT Accommodation	24	(24)
3,000	New Craigs Buy Back	3,000	-
10,239	**Total**	**3,396**	**6,843**
17,533	**Total**	**4,273**	**13,260**

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
- Main areas of spend are on equipment and the Lochaber Redesign project
- Transfer of New Craigs reflected in position

Agenda Item 5

NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**30th September 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.

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 – 6th November 2025
- Finance Resource Performance Committee – 12th September 2025
- Staff Governance Committee – 4th November 2025

4.1 List of appendices

The following appendices are included with this report:

- Integrated Performance and Quality Report – September 2025 Board Meeting

Integrated Performance and Quality Report

NHS Highland Board Meeting

30 September 2025

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: July 2025

		NATIONAL TARGETS			PERFORMANCE AGAINST TARGETS	
Well Theme (Slide #)	**Area**	**Average 24/25 Performance**	**Current Performance**	**National Target**	**Activity (ADP) Target Set**	**Performance Rating**
Thrive Well (4)	**CAMHS**	71.5%	85.0%	90%	No	
Thrive Well (5)	**NDAS**	n/a	2074 waiting list	n/a	No	
Stay Well (6)	**Screening**	Various	Various	90%	No	
Stay Well (7)	**Pre-school Vaccination**	n/a	n/a	n/a	No	
Stay Well (8)	**Smoking Cessation**	n/a	n/a	n/a	n/a	
Stay Well (9)	**Alcohol Brief Interventions**	359	944 (Q1)	n/a	Yes	
Start Well (10)	**Breastfeeding**	n/a	n/a	n/a	n/a	
Stay Well (11)	**Drug & Alcohol Waiting Times**	n/a	n/a	n/a	n/a	
Respond Well (12)	**Emergency Access**	83.4%	82.3%	95%	No	
Respond Well (13)	**Delayed Discharges**	225	234 at census point	30% reduction (interim)	Yes	
Treat Well (14-15)	**Outpatients**	62.3%	62.8	95%	Yes	
Treat Well (16-17)	**Treatment Time Guarantee**	58.1%	65.4%	100%	Yes	
Treat Well (18-19)	**Diagnostics - Radiology**	56.8%	56.6%	100%	Yes	Activity is 9.95% above trajectory
Treat Well (20-21)	**Diagnostics – Endoscopy**	70.9%	63.4%	100%	Yes	
Treat Well (22)	**Diagnostics – Wait List Other**	n/a	n/a	n/a	n/a	
Journey Well (23)	**31 Day Cancer Target**	92.1%	86.1%	95%	No	
Journey Well (24)	**62 Day Cancer Target**	69.9%	65.2%	95%	No	
Journey Well (25)	**SACT Access and Benchmarking**	N/A	Average range = 25-28 days to start treatment	N/A		
Live Well (26)	**Psychological Therapies**	87.4%	89.8%	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 Key Performance Indicators across the health and social care system aimed at providing the Finance, Resource and Performance Committee with assurance around the performance monitoring of the board and linkages to key deliverables described in our Annual Delivery Plan.

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

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

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

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

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

Guide to Performance Rating

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

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Exec Lead
Katherine Sutton
Chief Officer, Acute

OIP

CAMHS (Child and Adolescent Mental Health Service)

Key Performance Indicators

Achievement of CAMHS national standard of 90% of patients < 18 weeks from referral to treatment by December 2025 (Tier 3).

Reduction of people who are currently on the Tier 3 CAMHS waiting list to <352 people by December 2025.

Service Summary & Feedback

During Q1 the HSCPs Integrated Performance Management Framework Indicator shows that all 90% of children in A&B were seen within 18 weeks of referral. As part of national activity and actions to meet RTT A&B CAMHs (in partnership with colleagues in North Highland) have developed comprehensive actions to ensure the national wait time target is met. Currently there is a review and service modelling of CAMHs services linked to the national specification.
Current staffing and capacity continue to challenge North Highland with 3.4 WTE lost in Psychological Therapies (40 new case allocations lost in Q1&Q2 and 2.0 WTE Band 6 & 7 nurses (22 loss of case allocations in Q1&Q2). New case allocation is dependent on discharge from case load and a proportion of new case allocations fall outside the scope of RTT reporting.

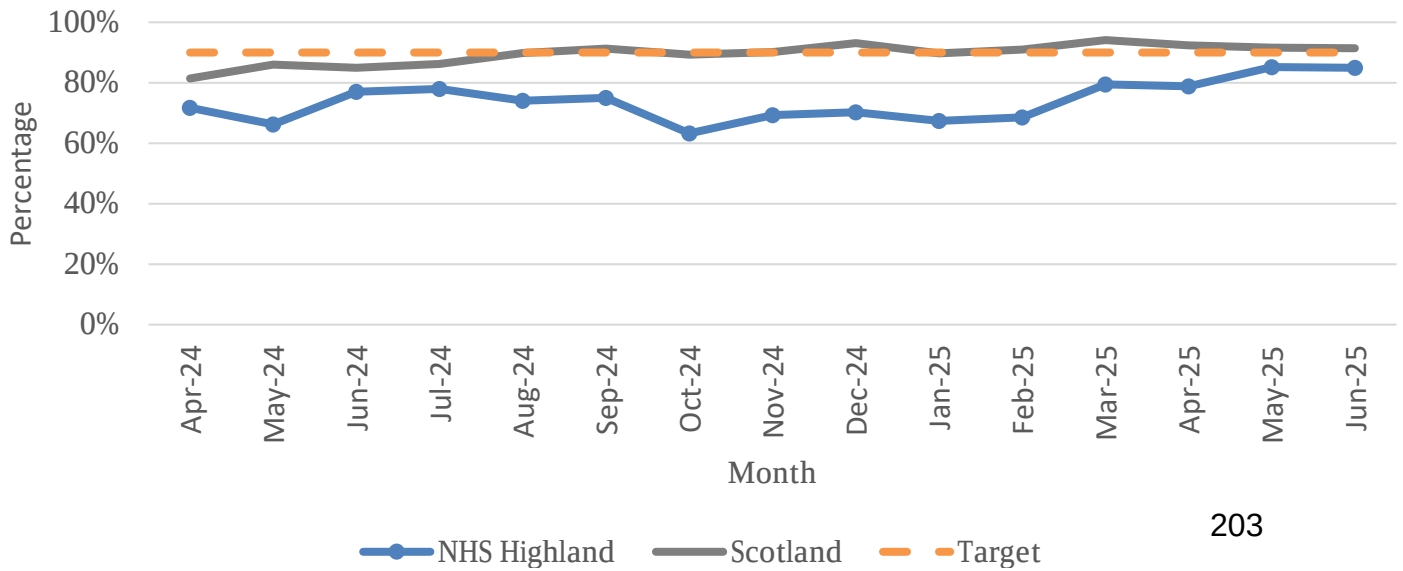
Service Risks

In A&B the relationship with the wider community paediatric service and the developing patient profile, neuro population (ADHD, ASD, ID, FASD). Redesigning around a model that combines neuro-development child health/CAMHs requires partnership working and means a service will carry broader clinical risk.
Approval of ATRs in North Highland will allow bank & secondment opportunities to be explored and recruitment into 2 replacement posts, which will increase capacity.
The service is still awaiting Trakcare upgrades which are expected to enhance waiting list oversight, improve reporting accuracy, support timely intervention and performance tracking.

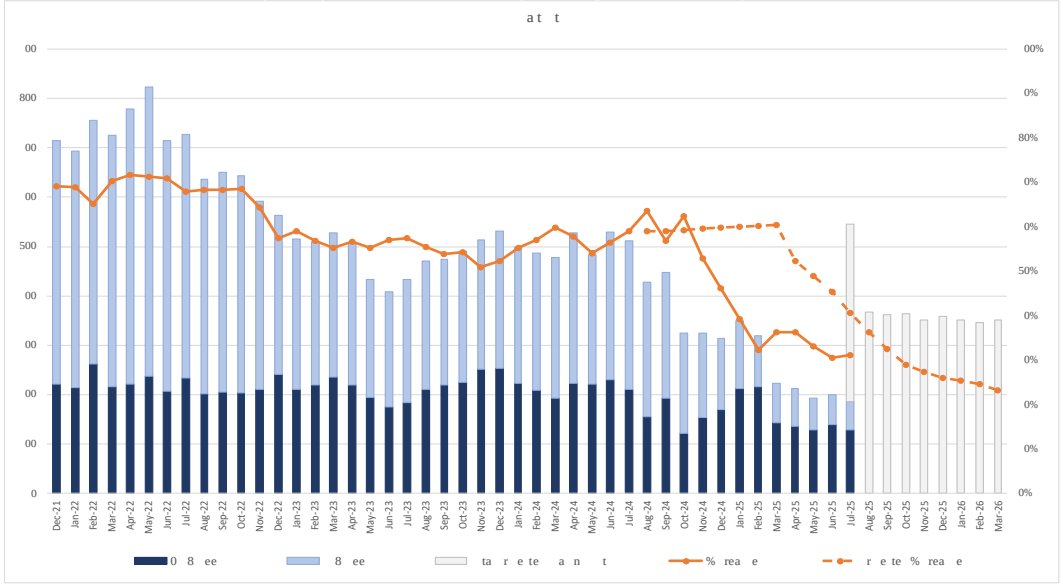
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	
Latest Performance	85.0%
National Average	91.4%
National Target	Full compliance to the National Service Specification by end of March 2026
National Target Achievement	n/a
Position	13th out of 14 Boards

CAMHS: Percentage of patients seen <18 weeks from referral



CAMHS Tier 3 Waiting List in Weeks
(Draft trajectories currently being reviewed by service)



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Exec Lead
Katherine Sutton
Chief Officer, Acute

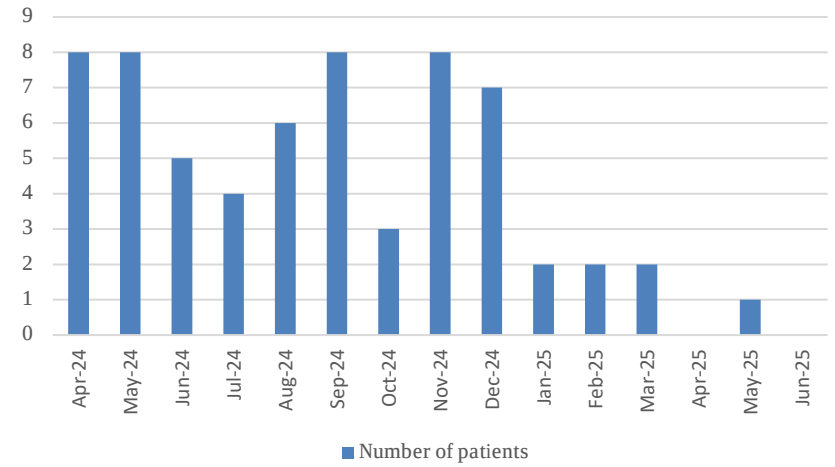
Neurodevelopmental Assessment Service (NDAS)

Key Performance Indicators		Service Summary & Feedback	Service Risks
Increasing percentage of NDAS patients seen within 18 weeks from referral, and towards meeting the national specification of greater than 95%.		The NDAS business case aimed at addressing the waitlist, clinical capacity and resource challenges has now been presented on two separate occasions to Chief Executives and Executive Directors. Discussions are ongoing at this senior level, with multiple strategic options under active consideration. While no final decision has been reached, the engagement at executive level reflects the seriousness with which the matter is being treated. New models are being developed in partnership with Highland Council which puts a e t a e mentt r t e ' an and in the education environment with NDAS supporting more complex assessments.	NDAS remains under significant pressure with >2050 children and young people on the on the wait list, some waiting in excess of five years. The service is unable to meet current service demands or address the growing legacy waitlist. NDAS continues to operate with a lone clinician, making the delivery of timely and safe assessments unsustainable. A second clinician, who will require training to deliver neurodevelopmental assessments, has been recruited on a fixed term basis (to end of financial year). No assessments are currently being undertaken within the service and to maintain some service continuity, any available budget is being directed toward accessing private assessments where appropriate (47 assessments in progress).
Reduction in the total number of patients on the NDAS waiting list compared to the current baseline by March 2026.			

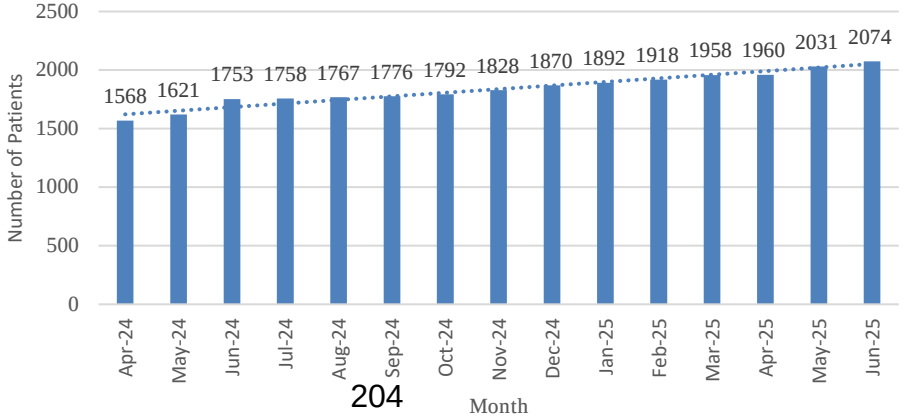
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	
Latest Performance	2074 on waiting list
National Average	n/a
National Target	Full compliance to the National NDAS Service Spec by end March 2026.
National Target Achievement	n/a
Position	n/a

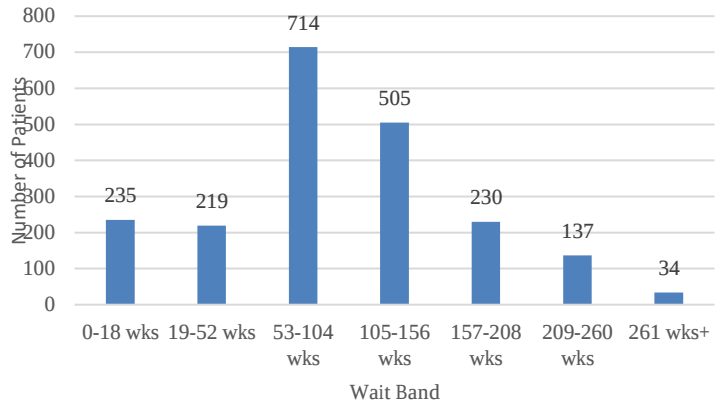
NDAS 1st New Appointment Only



NDAS Total Awaiting 1st Appointment (including unvetted)



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



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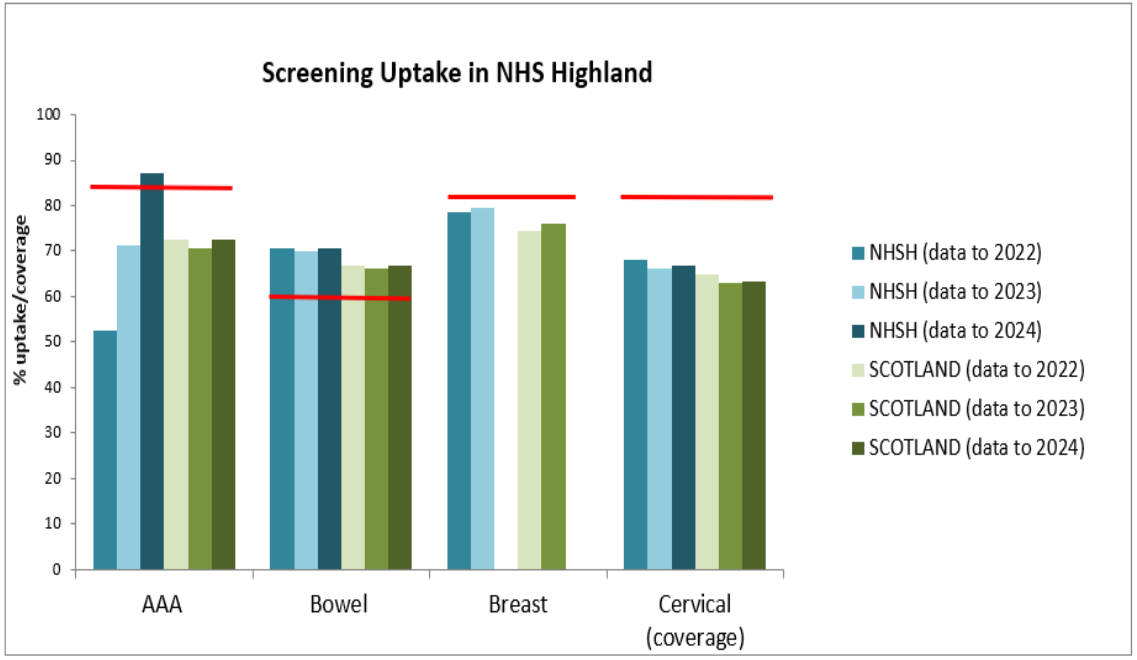
Exec Lead
Jennifer Davies, Director of Public Health

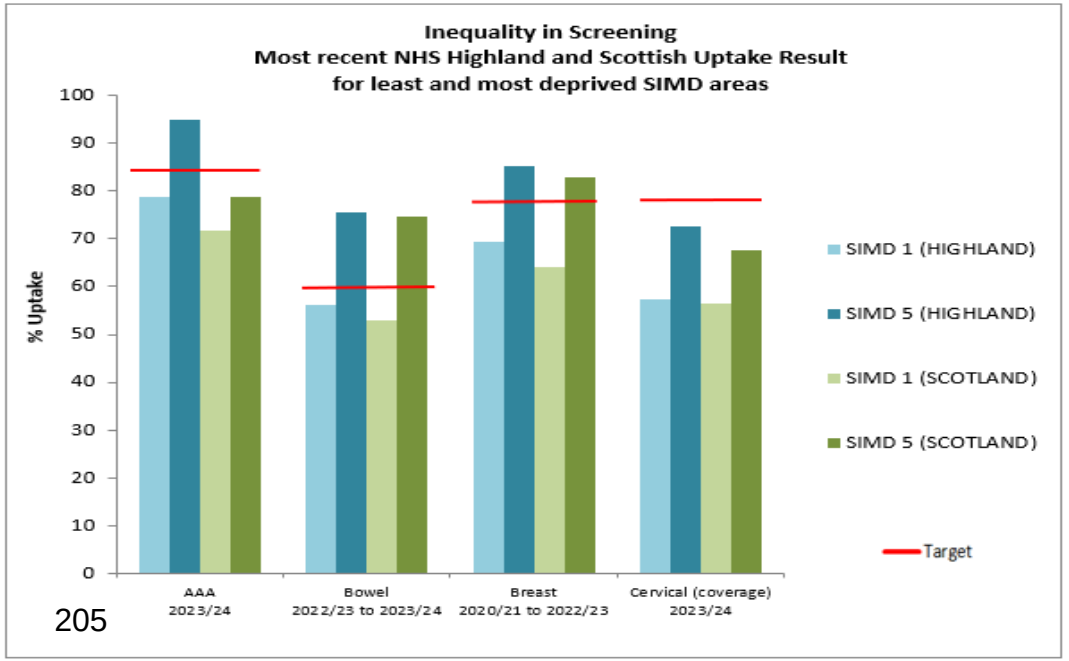
Screening

Key Performance Indicators		Service Summary & Feedback	Service Risks
Increase screening uptake across 4 screening programmes (AAA, Bowel, Breast, Cervical) to meet national targets.		• NHSH continues to outperform the Scottish average in participation rates for Bowel, Breast, Cervical, and AAA screening programmes, based on the latest verified data from Public Health Scotland (PHS). • Official figures are published annually with a one-year delay. As of March 2025, only two programmes have updated data available (up to 2024). The most recent cervical screening data, published in 2023, covers up to March 2022. Further updates have been delayed due to data quality issues. • Internal, non-verified management data supports similar trends for more recent periods. • For Diabetic Eye Screening (DES) and Pregnancy & Newborn (P&N) programmes, no official data is yet available, but internal monitoring suggests performance is in line with national levels.	Work continues to drive improvements within screening programmes. The NHS Highland Screening Inequalities Plan 2023-26 outlines focused activities to specifically address equality gaps and widen access to screening.
Monitor screening uptake by SIMD across 4 screening programmes (AAA, Bowel, Breast, Cervical)			

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

Performance Rating	
Latest Performance	See chart
National Benchmark	See narrative
National Target	2 of 4 reported programmes has uptakes meeting target
National Target Achievement	See charts
Benchmark	See charts





NOTE: Within cervical screening, the % of eligible population screened within age-appropriate timeframe is now referred to as "coverage". Annual cervical screening statistics for Scotland published - News - Public Health Scotland

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Exec Lead
Jennifer Davies, Director of Public Health

Pre-school vaccination

Key Performance Indicators

Meet the 95% national target for the t ree ren' a nat n

Service Summary & Feedback

There continues to be improvement required in relation to both the uptake and timeliness of pre-school vaccinations.

For most of the vaccinations measured, the WHO 95% vaccination uptake target is not being met.

For all of the vaccines measured at both 12 months and 6 years, the vaccination uptake across A&B HSCP exceeded the Scottish average. However, for 10 of the 12 vaccines measured, the uptake rates for Highland HSCP fall within the three lowest performing HSCPs in Scotland.

Improved performance across a range of metrics is a key aim of the delivery of the hybrid model.

Service Risks

Scottish Government is working with Highland HSCP in level 2 of its performance framework.

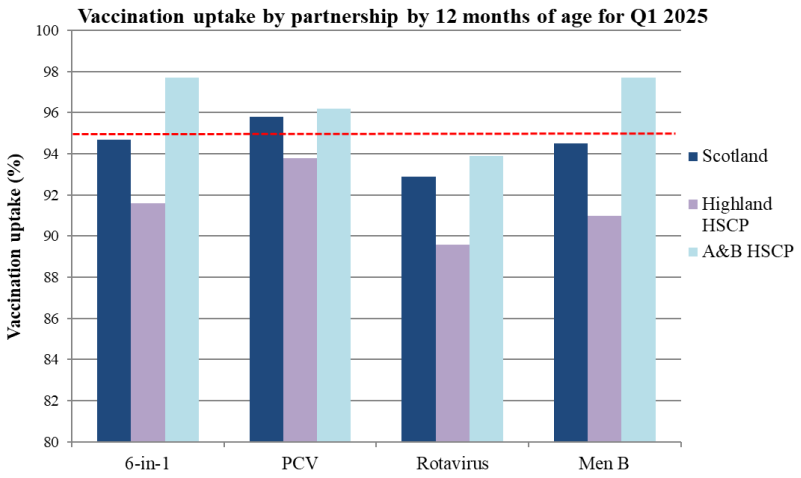
The Vaccination Collaborative Implementation Group has been convened to support the delivery of the collaborative hybrid model across the partnership.

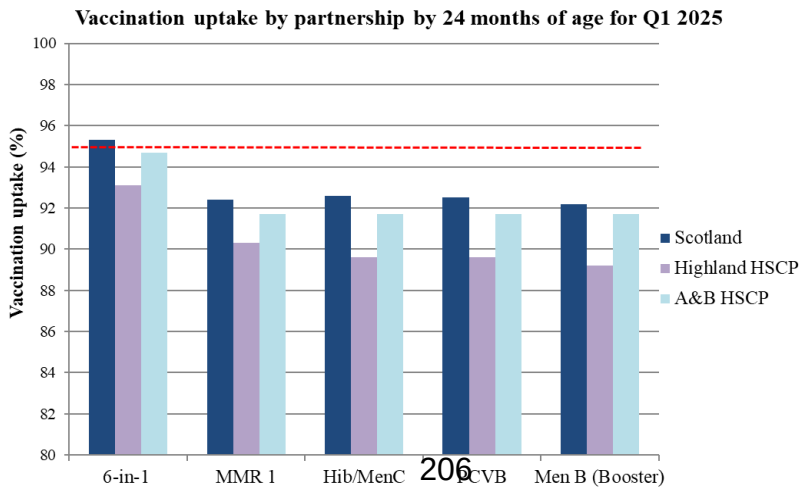
A tripartite advisory group has been convened (SG, PHS, NHSH) to offer external support to Highland HSCP as part of the implementation of the hybrid model of delivery.

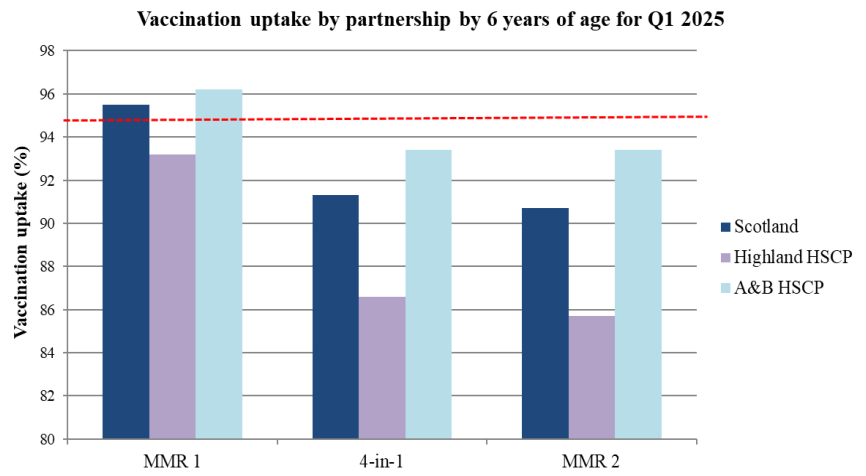
Work is ongoing in Argyll & Bute to maintain uptake rates and to support wider improvement work.

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

Performance Rating	
Latest Performance	95% target vaccination uptake achieved for 3 of the 4 vaccines measured at 12 months in A&B.
National Benchmarking	A&B vaccination uptake rates exceed the national average for all vaccines measured at 12 months and 6 years.
National Target	Vaccine uptake of 95%
National Target Achievement	See charts
Position	See charts







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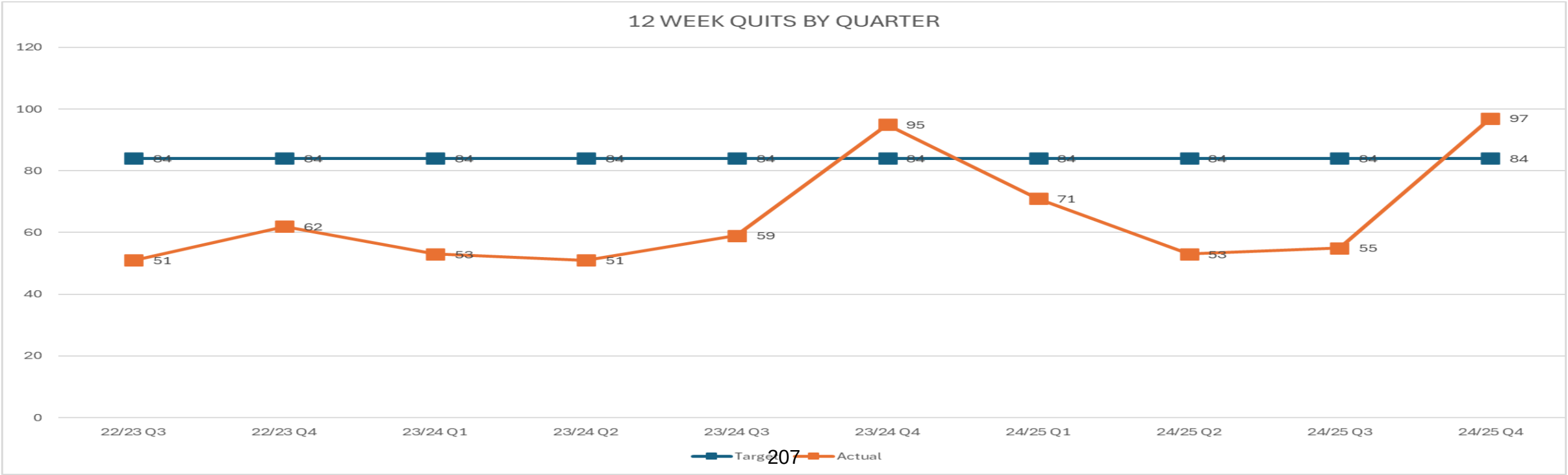
Exec Lead
Jennifer Davies, Director of Public Health

Smoking Cessation

Key Performance Indicators		Service Summary & Feedback	Service Risks
Delivery on national targets for Smoking Cessation interventions (12 week quits)		• 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.	•Missing data from quit dates set from 1st April 2025 currently being reviewed – timeline for outcome will be 3 months •Meeting with Procurement and voucher provider re: financial incentive scheme taken place. Pilot due to start beginning of October. •Early indication of pilot at Raigmore is positive, report to be developed November (6 months from pilot begun)

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Stay Well	
Performance Rating	
Latest Performance	97 (24/25 Q4)
National Benchmarking	
National Target	336 successful quits in 12 weeks in 40 most deprived SIMD areas
National Target Achievement	n/a
Position	



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Exec Lead
Jennifer Davies, Director of Public Health

Alcohol Brief Interventions (ABIs)

Key Performance Indicators	Service Summary & Feedback	Service Risks
Deliver at least 100% of the planned Alcohol Brief Intervention (ABI) activity target by March 2026	Fig 1.:Total no of ABIs delivered in Q1 is 944. This number is 3% above target for NHS Highland as set out in the Scottish Gov Local Delivery Plan (LDP). Fig. 2: Delivery is being met largely by GP Practices in Highland H&SCP (90.5%) with the remainder mainly being delivered in wider settings across NHS Highland.	ABI training sessions set for September- December 2025. In Highland HSCP, bespoke face to face training will be offered to mental health staff at New Craigs to increase ABI recording and delivery. This will begin sept/ October. The ABI e-learning module has been reviewed, and changes are being made to update course material and accessibility.

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Stay Well	
Performance Rating	
Latest Performance	944 Q1
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

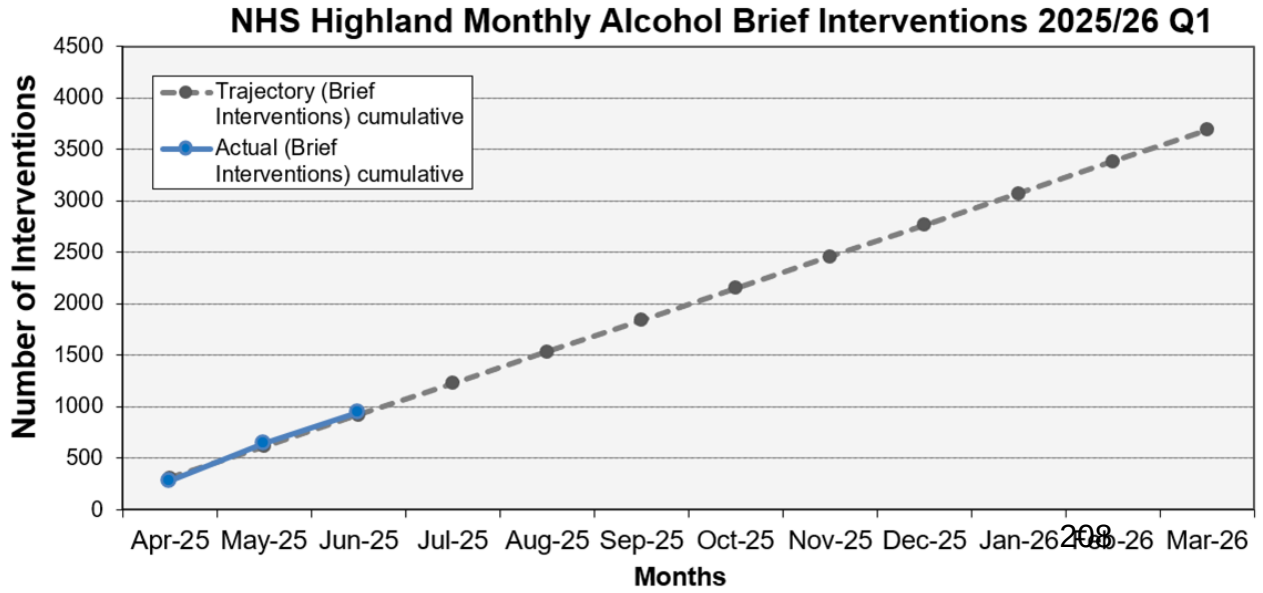

Fig.2

Setting Contribution 25/26 Q1

Primary Care	854	90.5%
Antenatal	4	0.4%
Wider Settings	86	9.1%
TOTAL	**944**	**100%**

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Exec Lead
Jennifer Davies, Director of Public Health

Breastfeeding

Key Performance Indicators

Reduce the attrition of any breastfeeding at 6 –8 weeks by 10% by 2025

Service Summary & Feedback

- National infant feeding statistics published annually in November
- Breastfeeding scorecard distributed to boards in March by PHS providing data down to intermediate zone level to allow for planning and targeted intervention
- Scorecard data demonstrates a need to support our Polish community where attrition rates have increased.
- Unicef BFI Gold award has been achieved by all maternity and community (H.V and F.N.P) services in NHS Highland
- The neonatal unit at Raigmore has achieved full accreditation
- Recruitment in place to increase numbers of infant feeding support workers in North Highland through Whole Family Wellbeing Funding. This includes working in partnership with CALA to provide feeding groups which will commence in September.
- Work with CALA to test the roll out of the National Early Learning Scheme where their nursery provision will become accredited as Breastfeeding Friendly Scotland
- Initial scoping with A and B HSCP re: testing the Local Authority Breastfeeding Friendly Scheme
- Recruitment of breastfeeding keyworkers in existing midwifery, health visiting, children's ward and FNPs services to support audit and specialist support in all areas of NHS Highland.

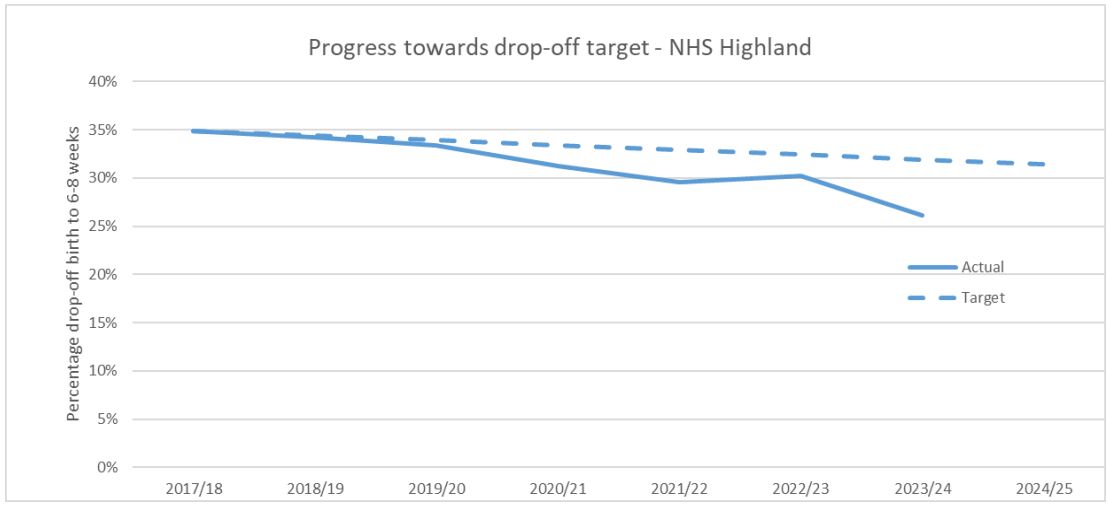
Service Risks

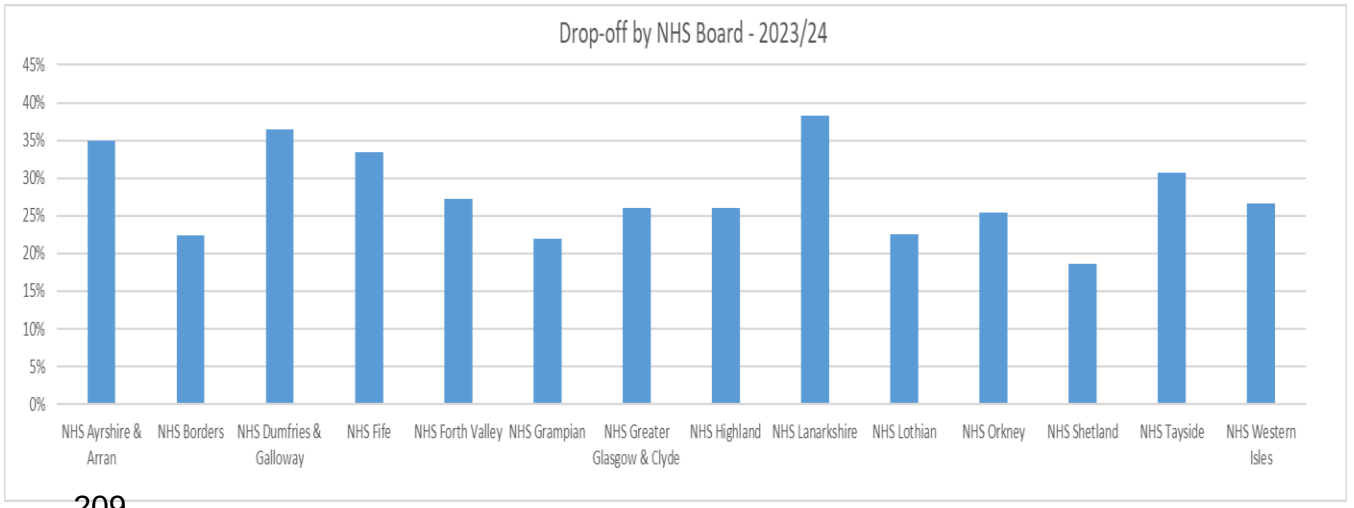
Work continues to drive improvements in all aspects of infant feeding workstreams.

Publication of National Infant feeding strategy will support forward planning Breastfeeding and Infant Feeding Strategic Framework and Delivery Plan

PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Start well

Performance Rating	
Latest Performance	See chart
National Benchmarking	See chart
National Target	See chart
National Target Achievement	See chart
Benchmarking	See chart





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Exec Lead
Arlene Johnstone
Chief Officer, HHSCP

Drug & Alcohol Recovery (DARS)

Key Performance Indicators

Achieve 90% of clients referred to DARS receiving a completed intervention or treatment plan within 3 weeks by March 2026.

Service Summary & Feedback

During 2024/25, DARS implemented waiting lists across multiple regions due to a reduction in staff capacity and a surge in service demand. This n f ant m a te an ' ability to meet its referral-to-treatment targets.
Focused improvement initiatives have been undertaken in our largest population centres and now these areas are providing support to rural communities . This collaborative approach is contributing to a reduction in overall waiting times across the region.
Efforts ongoing to ensure equitable access and timely care for all NHS Highland residents.

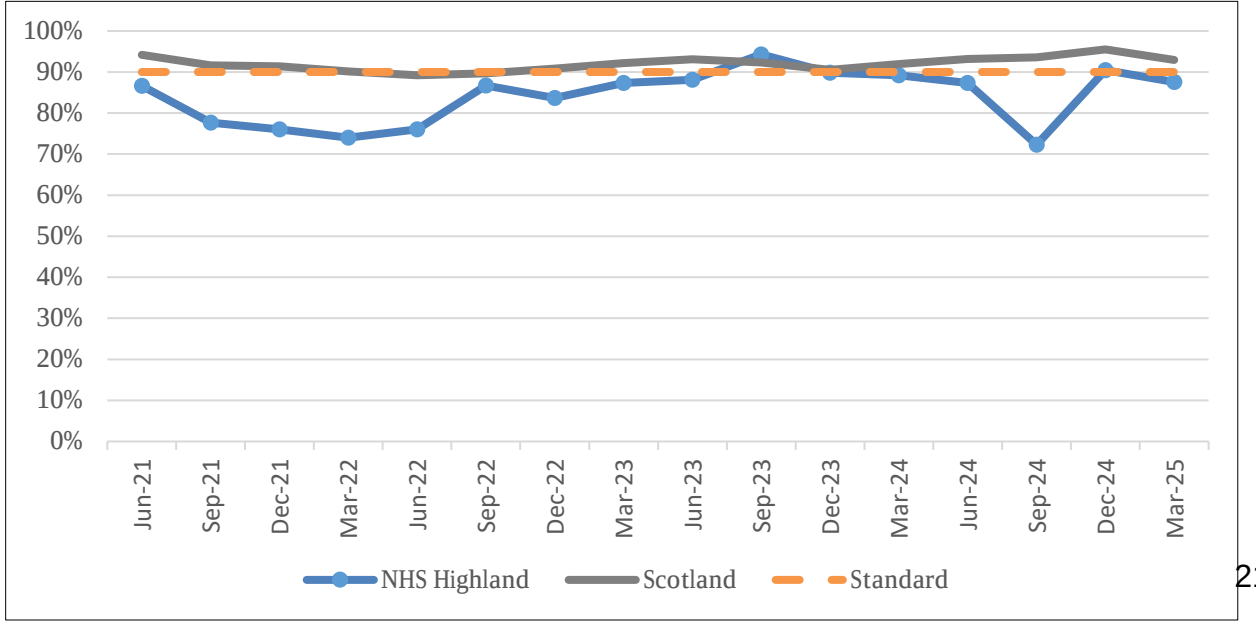
Service Risks

- Capacity Constraints: Limited clinical and administrative resources may impede the ability to meet fluctuating demand, exacerbating service delays.
- Access Inequity: Rural and remote communities may continue to face barriers to timely access.
  Performance Targets: Failure to consistently meet referral-to-treatment timeframes poses a risk to national compliance and could impact future strategic priorities.
- Patient Experience: Prolonged waiting times can contribute to patient dissatisfaction and potential deterioration in clinical outcomes.

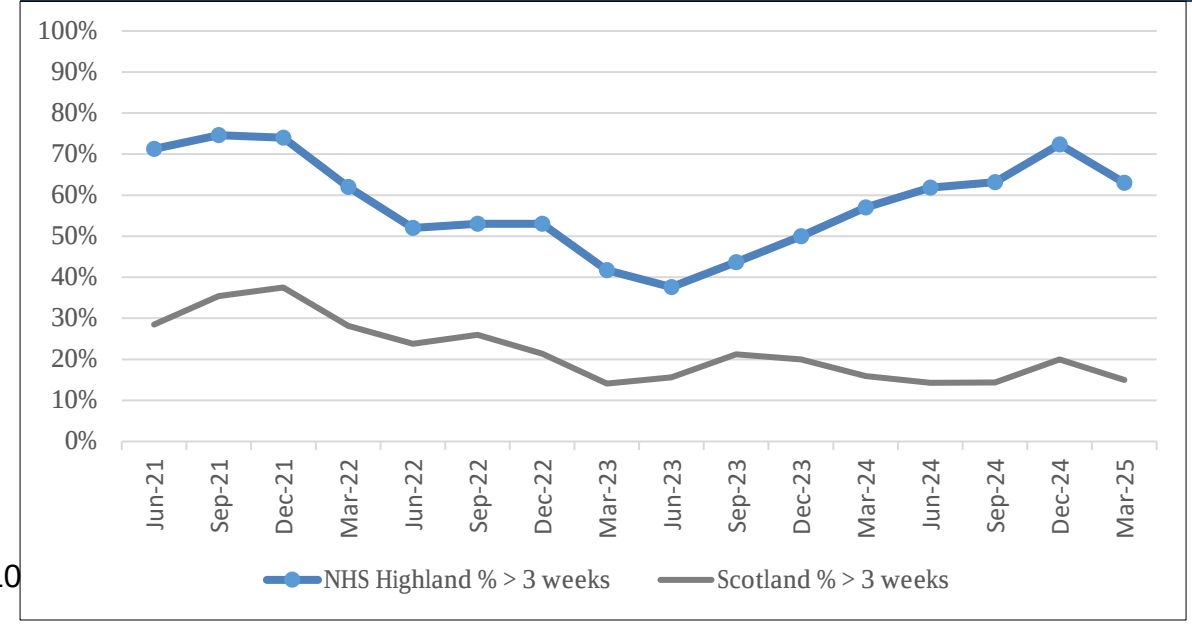
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Stay Well

Performance Rating	
Latest Performance	87.6%
National Benchmarking	92.9%
National Target	90% DARS referrals seen within 3 weeks
National Target Achievement	n/a
Position	n/a

NHS Highland DARS: Performance Against Standard for Completed Waits



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



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Exec Lead
Katherine Sutton
Chief Officer, Acute

OIP

Emergency Department Access

Key Performance Indicators

Achieve at least 95% of patients attending A&E being seen, treated, admitted, or discharged within 4 hours by March 2026.	
Ensure that 99% of A&E patients are admitted, transferred, or discharged within 8 hours of arrival by March 2026, reducing extended waits and improving care quality.	
Reduce the number of patients waiting longer than 12 hours in A&E to zero by March 2026, ensuring no patient experiences excessively prolonged waiting times.	

Service Summary & Feedback

- OPEL for RGHs successfully piloted in Belford during August, with plan to roll out to CGH and L&I in September.
- Follow up action to explore cross partner action card alignment between RGHs and Raigmore towards the end of 2025.
- Lochaber redesign programme developing workforce place with focus on medical models of care, frailty and rehab and place of safety. All workstreams delivery UUC improvements.
- Hospital at Home service expansion into weekends and whole system approach work for community services is underway in L&I.
- Ra m re' m r ement r m n at pace and being supported/monitored through the Acute Urgent & Unscheduled Improvement Programme.

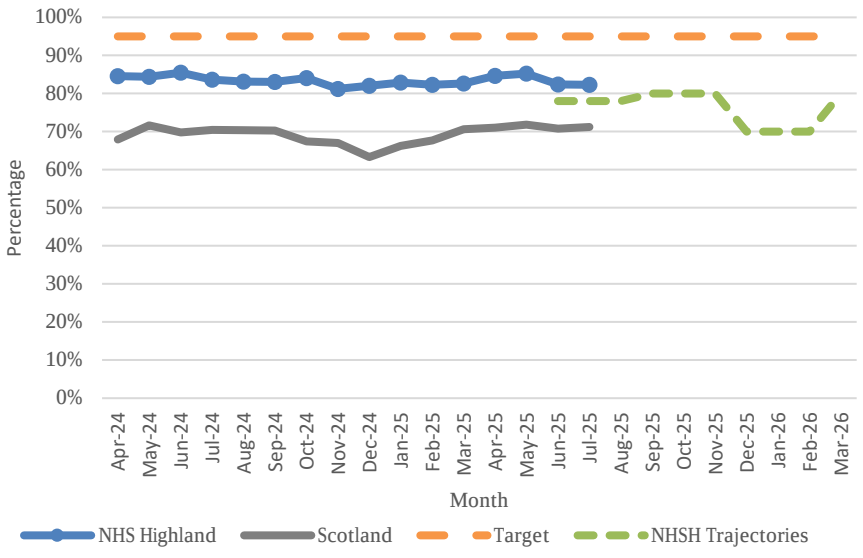
Service Risks

Belford capacity and demand for emergency er e ex ee e artment' a a t t n designated triage room to prioritise patients.
CGH Planned returns continue in ED with an appointment system in place to support Surgical & Medical returns which is working well.
Delayed transfers of care patients in the wards has contributed to increased LOS and breaches in ED
L&I note patient flow is impacted by a number of DDs. Reviews are being undertaken for workforce gaps and MH pathways.
Ra m re' ntent na m r ement r n Flow Groups 1 to 4, with an aim to reduce waits in ED, improve SAS off load time and improve over-all ED performance.

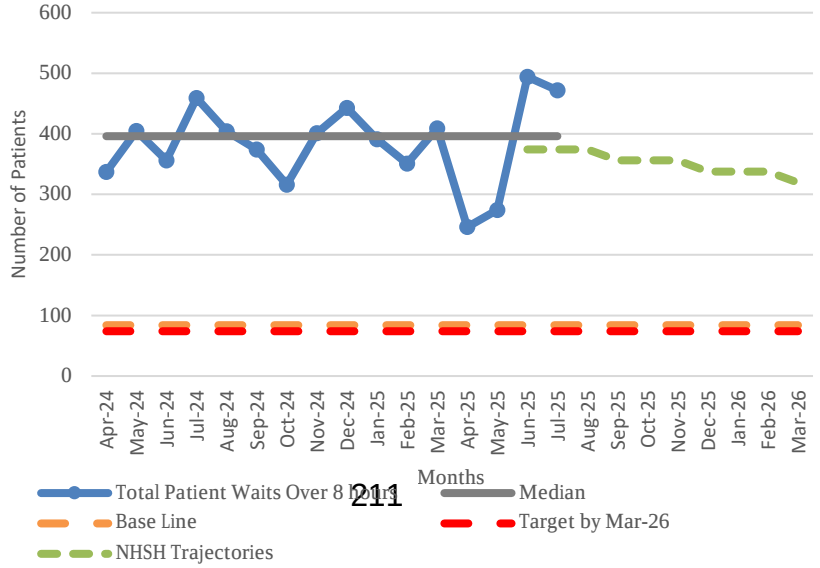
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Respond Well

Performance Rating	
Latest Performance	82.3%
National Benchmarking	71.2%
National Target	95%
National Target Achievement	NHS H as a whole remains above the Scotland average, but off target
Position	5th out of 14 Boards

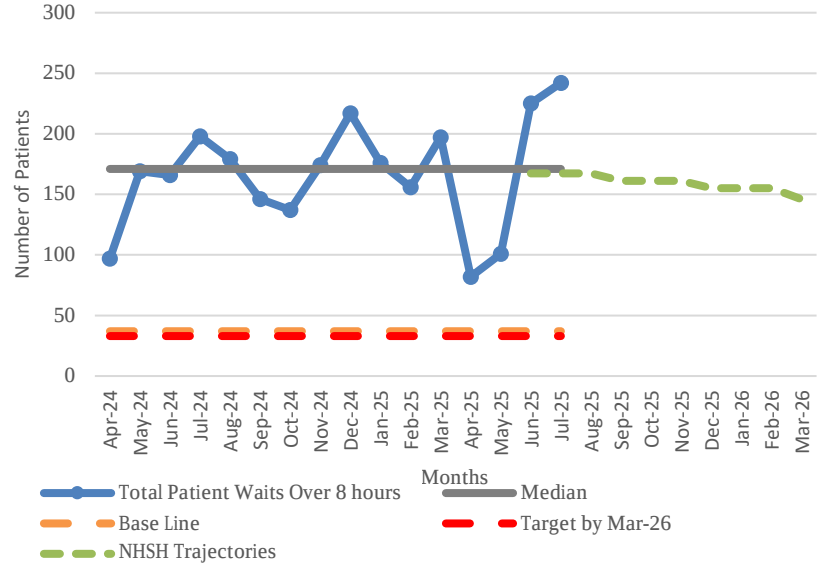
% of people seen in ED within < 4 hours per month



Total Patients waiting > 8 hours in ED per month



Total Patients waiting > 12 hours in ED per month



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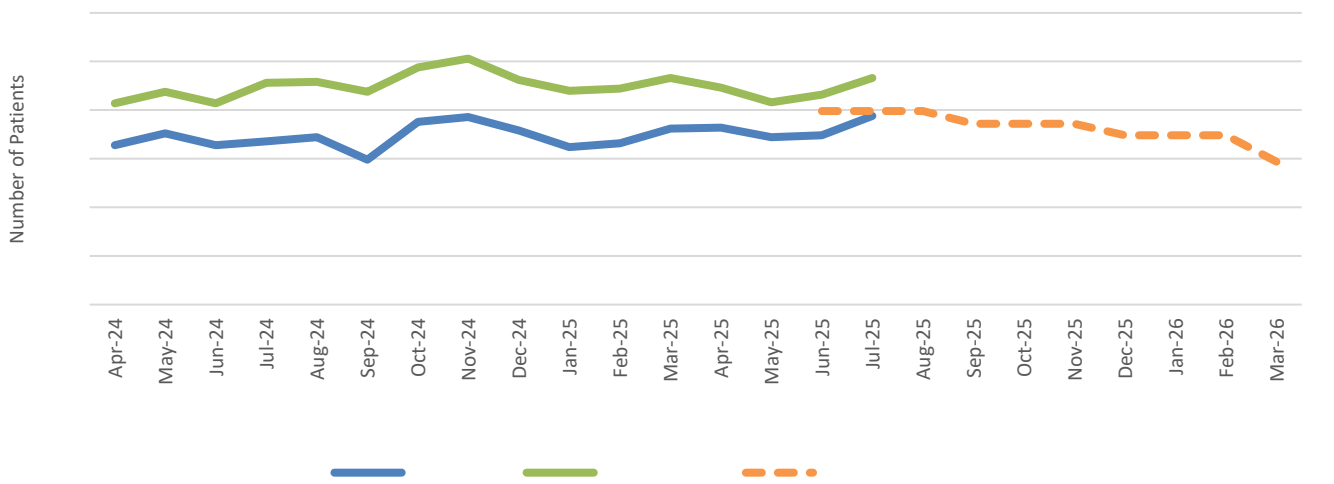

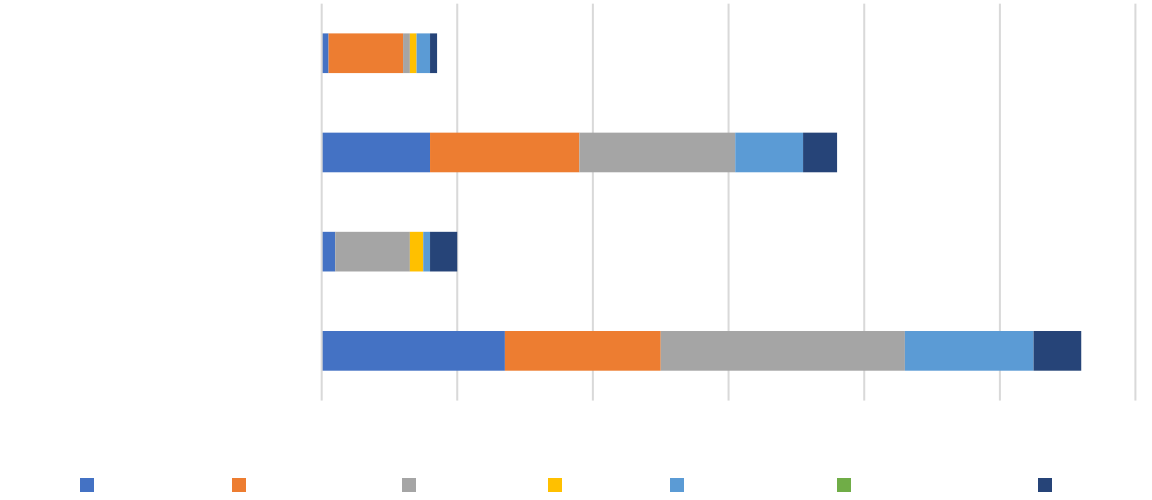

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Chief Officer, Acute

Exec Lead
Arlene Johnstone
Chief Officer, HHSCP

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Delayed Discharges

Key Performance Indicators

Reduce the total number of patients experiencing a standard delay in discharge from hospital across NHS Highland to agreed targets and trajectories.

Please note: These targets and trajectories will be included in future IPQR reporting.

Service Summary & Feedback

HHSCP community risks are a limited ability to provide step up and step down intermediate care and rehabilitation. There is also a whole system risk associated with reduced flow through the system.

- NCH has a total of 98 beds – 18 of which are delayed discharges.
- The average length of delay once fit for discharge awaiting a care home is 158 days.
- The average length of delay once fit for discharge awaiting care at home is 183 days.

A&B continue to focus on early identification, intervention and proactive management of DDs and daily operational flow meetings, MDTs to ensure appropriate allocation of all available resources. A robust review programme ensures those discharged to assess have access to reablement first and that care packages are reviewed and reduced in line with enablement / improvement. Proactive impact assessment for all hospital delays.

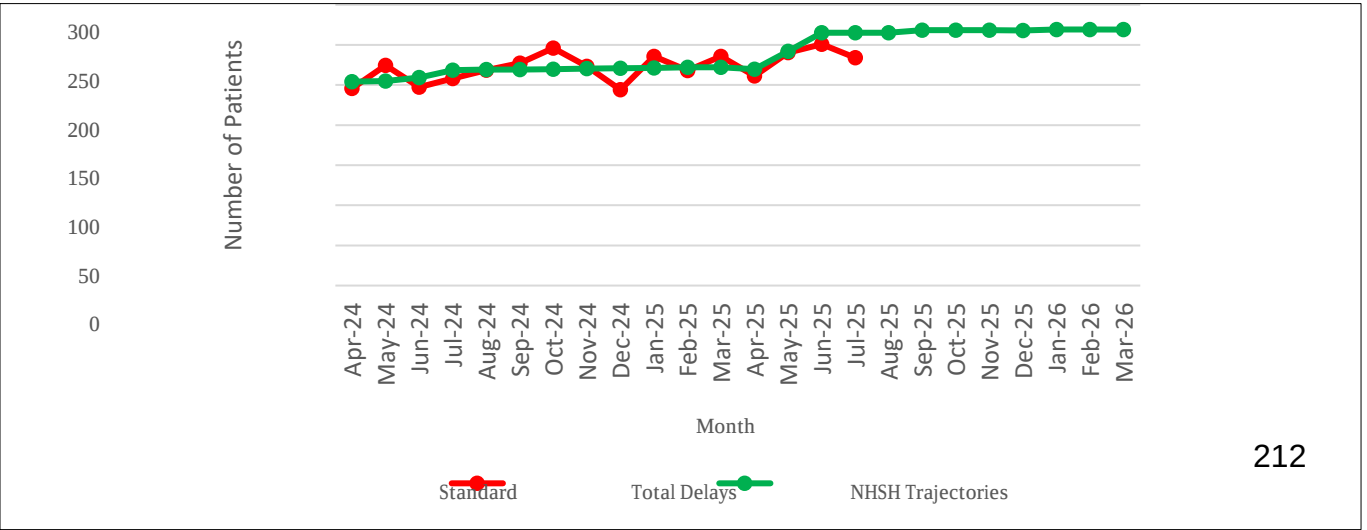
Service Risks

Risks to MHLD Inpatient services include – inability to meet statutory duty under MHA to admit detained patient within 72 hours – difficulty ensuring the whole of a patient's recovery takes place within the appropriate specialist environment – increased risk within community settings when unable to provide an admission bed within a timely manner.
The MHLD Division oversight of delayed discharges includes daily operational site rundown (twice per day), tactical weekly flow and capacity meeting, and strategic monthly oversight from Divisional Senior Leadership Team.
In A&B the situation with lack of homecare across the region, due to both availability of staff and budget, has increased, together with challenges for 24hr care provision, impact of AWIs and court backlogs

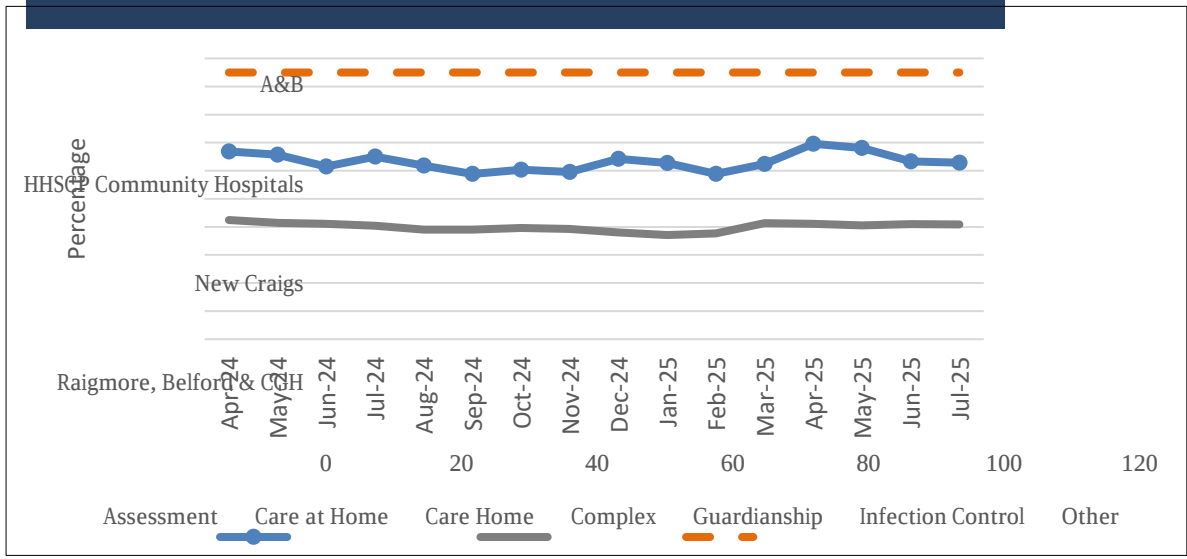
PERFORMANCE OVERVIEW
Strategic Objective: In Partnership
Outcome Area: Respond Well

Performance Rating	
Latest Performance	234 at Census Point
National Benchmarking	Engagement through national CRAG group and CfSD
National Target	Trajectories developed
National Target Achievement	Not Met
Position	14th of 14 Boards

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



Number of people delayed from discharge – Location and C



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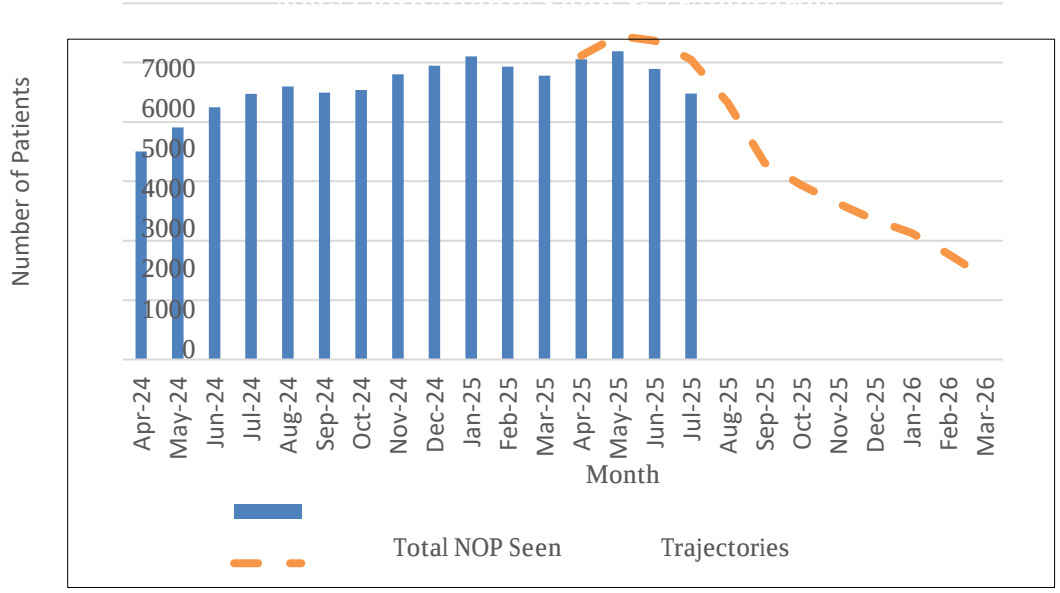
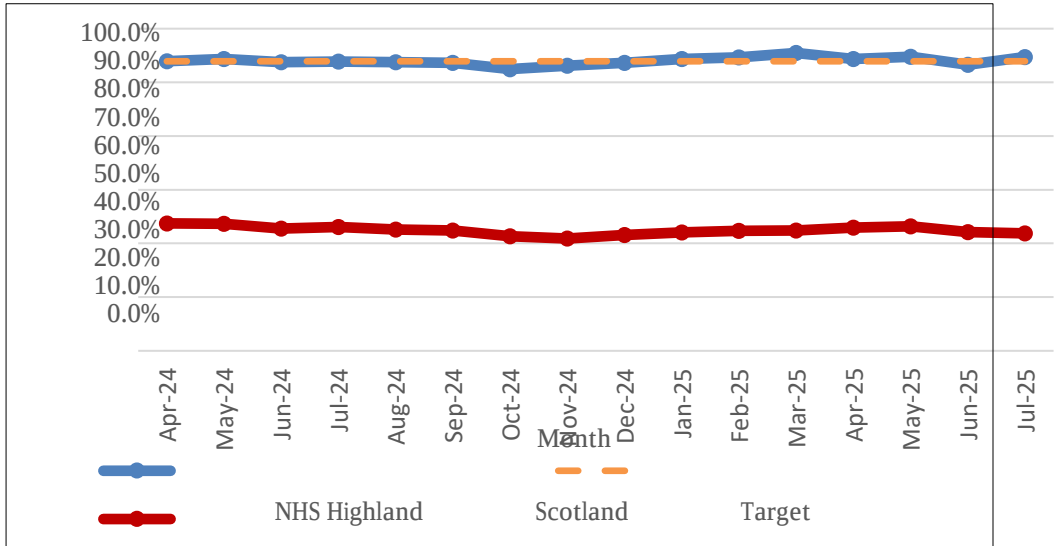
Outpatients (New Outpatients – NOP – seen within 12 week target) – Slide 1 of 2

Key Performance Indicators		Service Summary & Feedback	Service Risks
Increase the percentage of new outpatient referrals seen within 12 weeks of referral equal to or above 95%.		At the end of July, NHS Highland had seen 0.8% (n=595) fewer new outpatients than intended. Speciality performance is monitored weekly and action plans have been developed with those services where activity is lower than anticipated. We continue to focus on booking our longest waiting patients to reduce how long people are waiting for our services. Overall, there is a reduction in the past couple of months in the number of people waiting over 52 weeks for a new appointment. Work is ongoing to establish an access meeting in Argyll & Bute to improve ownership of waiting times and data quality across the hospital sites and direct attention to performance against the planned care planned activity and targets. Patient focused booking and phone call reminders/list validation will be employed to target our longest waiting patients.	an ' ma n r continues to be staffing, particularly in our smaller services where absence/vacancies can have a disproportionate impact on our ability to meet our activity trajectories. In Argyll & Bute the main risk is around the future of the Minor Oral Surgery service and urgent discussions are required to take forward.
Reduce the number of new patients waiting over 52 weeks for a new outpatient appointment to 1393 by March 2026.			
The number of completed new outpatients appointments is equal to or exceeds the monthly target			
The number of completed new outpatients appointments is equal to or exceeds the cumulative target			
Total number of patients currently waiting for return outpatient appointments to be equal to or less than previous year's monthly average			

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

Performance Rating	
Latest Performance	62.8%
National Benchmarking	40.9%
National Target	95%
National Target Achievement	Target not met Below lower control limit
Position	3rd out of 15 Boards





Outpatients (Planned Activity, Long Waits & Return Outpatients) - Slide 2 of 2

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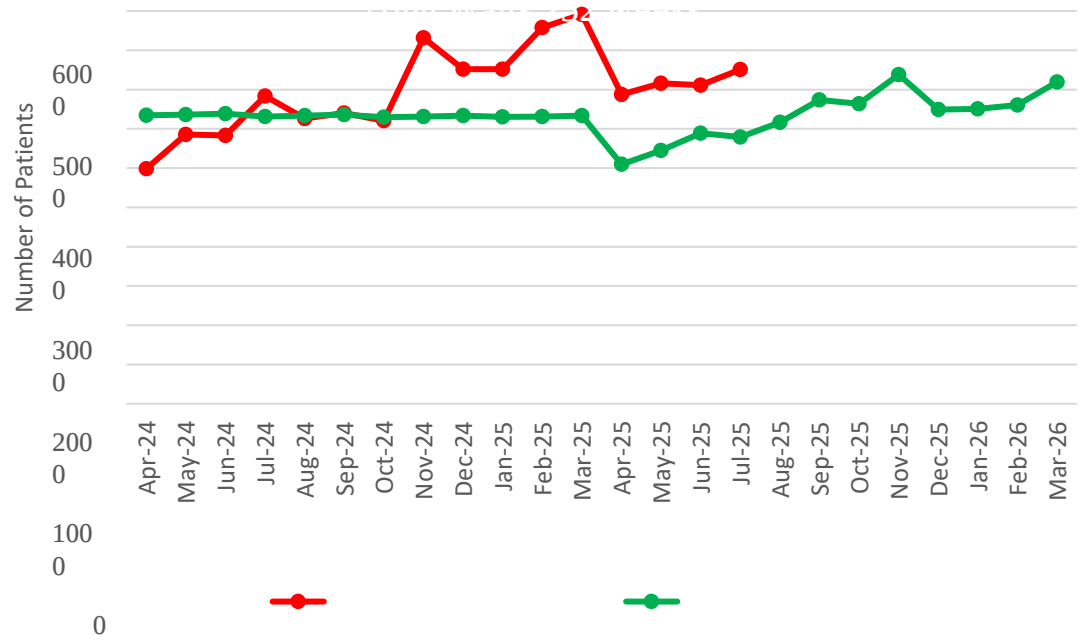
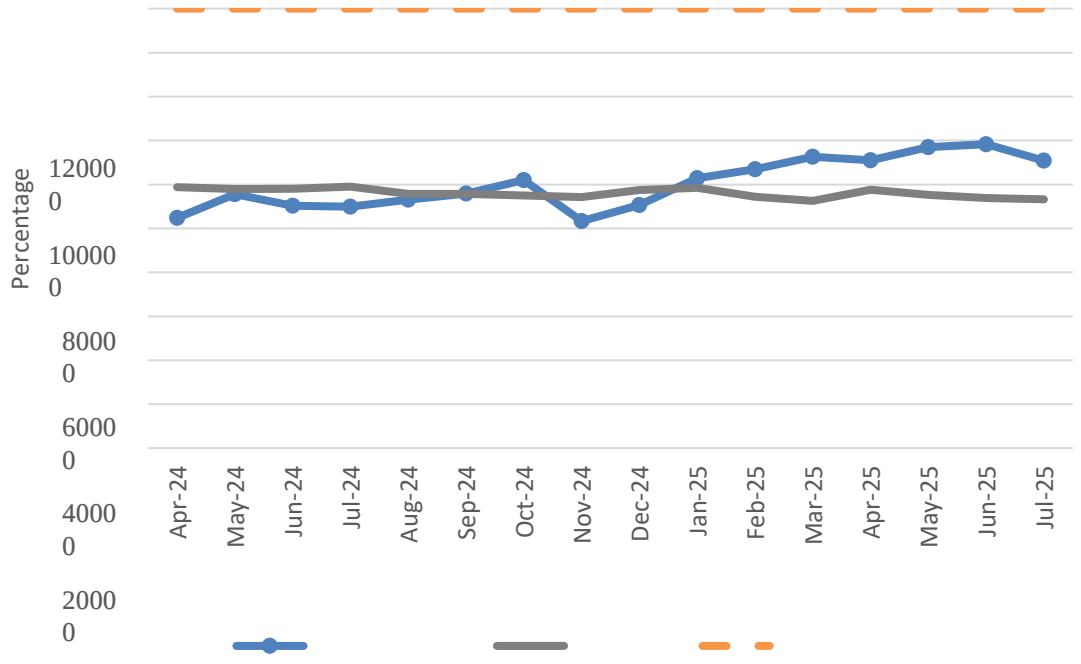
Planned Activity





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tients Wait List | Total | Patients Waiting, Patients Past Recall Date

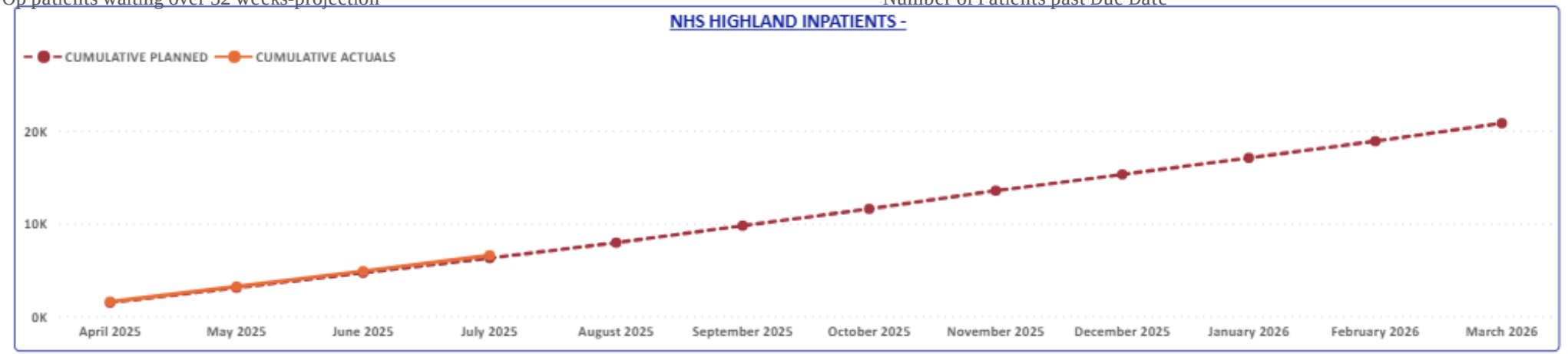
Month

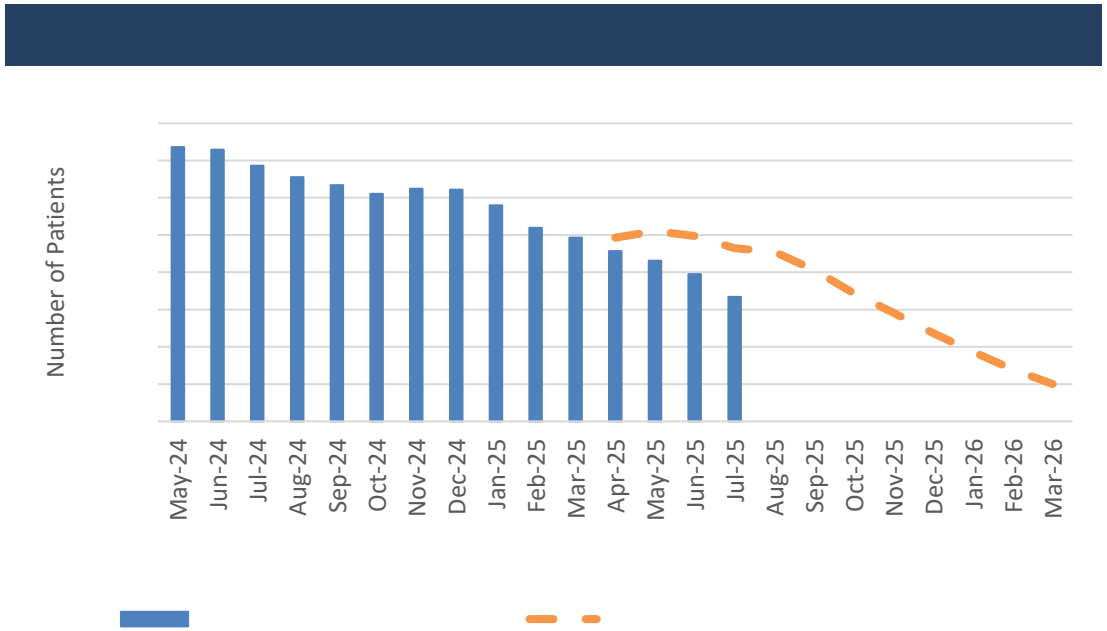
OP Patients Waiting Over 52 Weeks 214

Number of Patients on Return WL 2024/25 Monthly Average

Op patients waiting over 52 weeks-projection

Number of Patients past Due Date





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Treatment Time Guarantee: TTG < 12 week target

Key Performance Indicators

- Percentage of TTG patients seen within 12 weeks of referral equal to or above 95% every month.
- Reduce the number of TTG patients waiting over 52 weeks to 200 by March 2026
- The number of inpatient/day case procedures undertaken is equal to or exceeds the monthly target
- The number of inpatient/day case procedures undertaken is equal to or exceeds the cumulative target

Service Summary & Feedback

At the end of July, NHS Highland had undertaken 7.32% (n=1,287) more procedures than intended. Speciality performance is monitored weekly and action plans have been developed with those services where activity is lower than anticipated. We continue to focus on booking our longest waiting patients to reduce how long people are waiting for our services and waiting times continue to fall more quickly than we had anticipated.

TTG performance in Argyll & Bute continues to be above target and enhanced monitoring as part of access meetings will be established.

Service Risks

Our main risk continues to be staffing, particularly in our smaller services where absence/ vacancies can have a disproportionate impact on our ability to meet our activity trajectories.

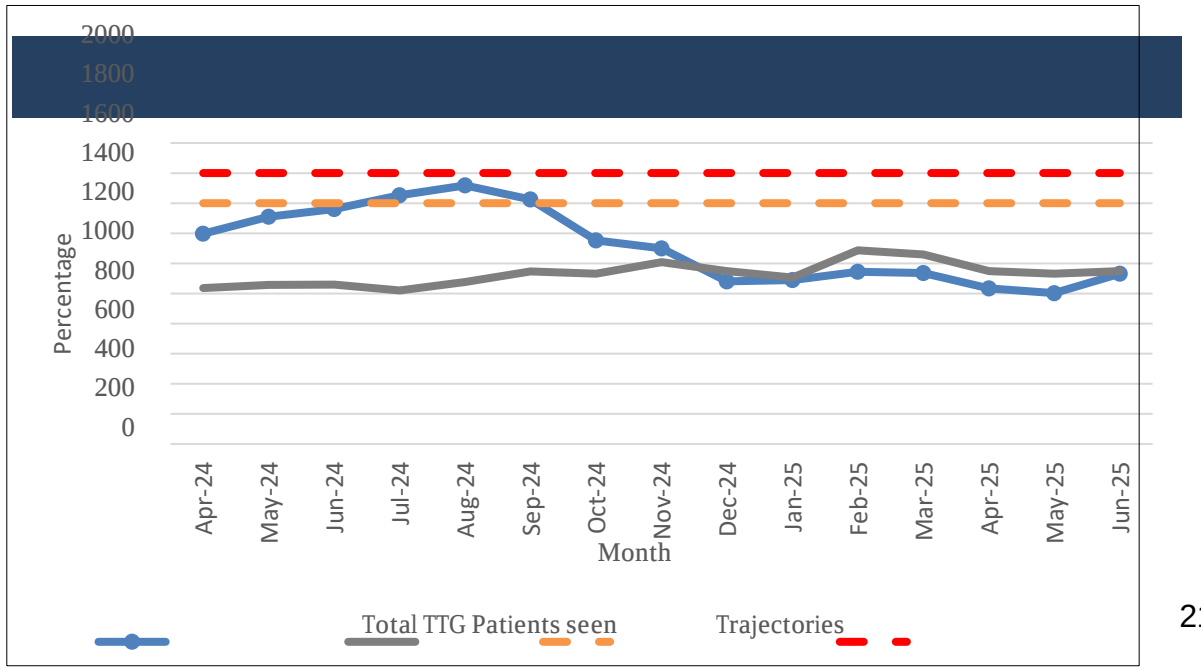
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

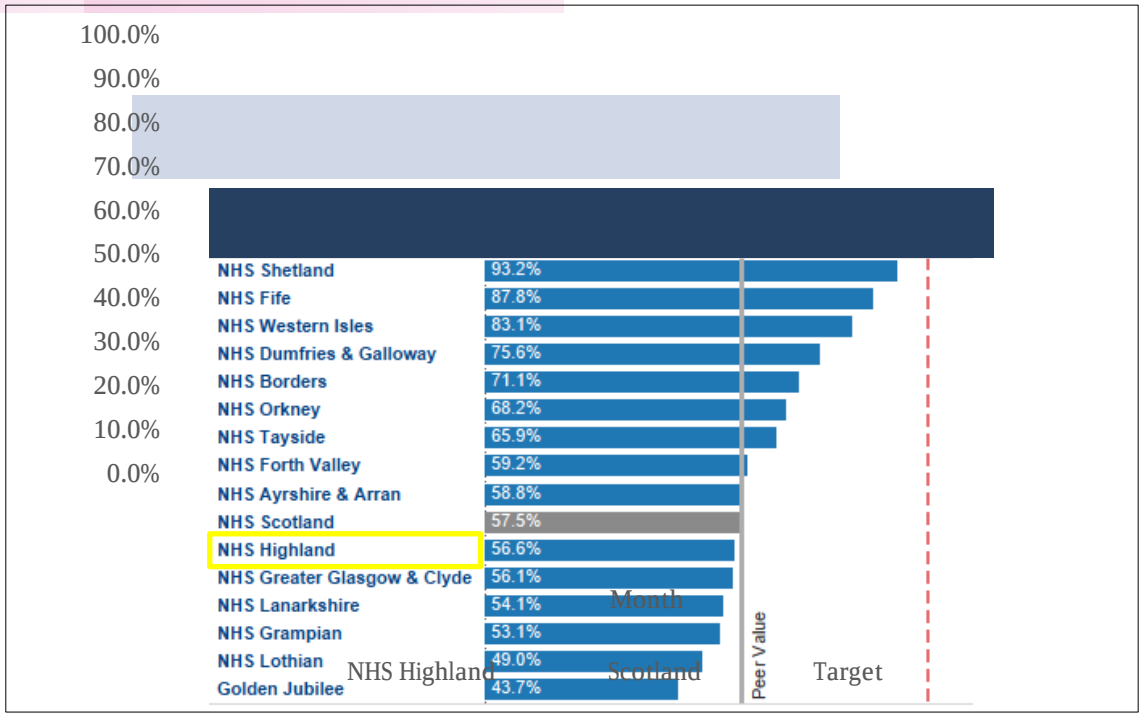
Performance Rating	
Latest Performance	65.4%
National Benchmarking	56.6%
National Target	100%
National Target Achievement	Target Not Met; Above median for 1 month after 2 below
Benchmarking	4th of out 15 Boards

Patients Seen & Trajectori

TTG Seen

Consu





TTG (Planned Activity & Long Waits) - Slide 2 of 2

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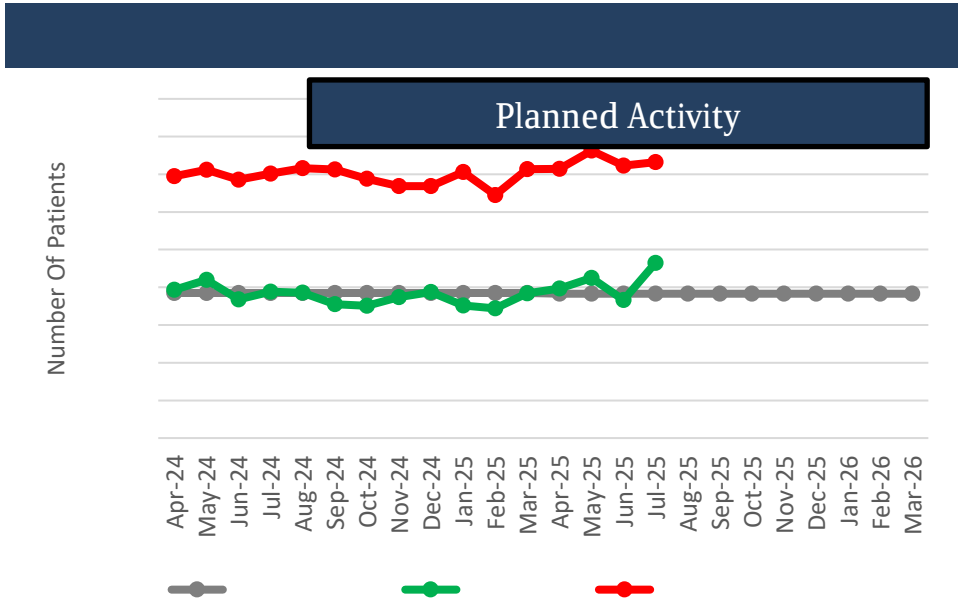

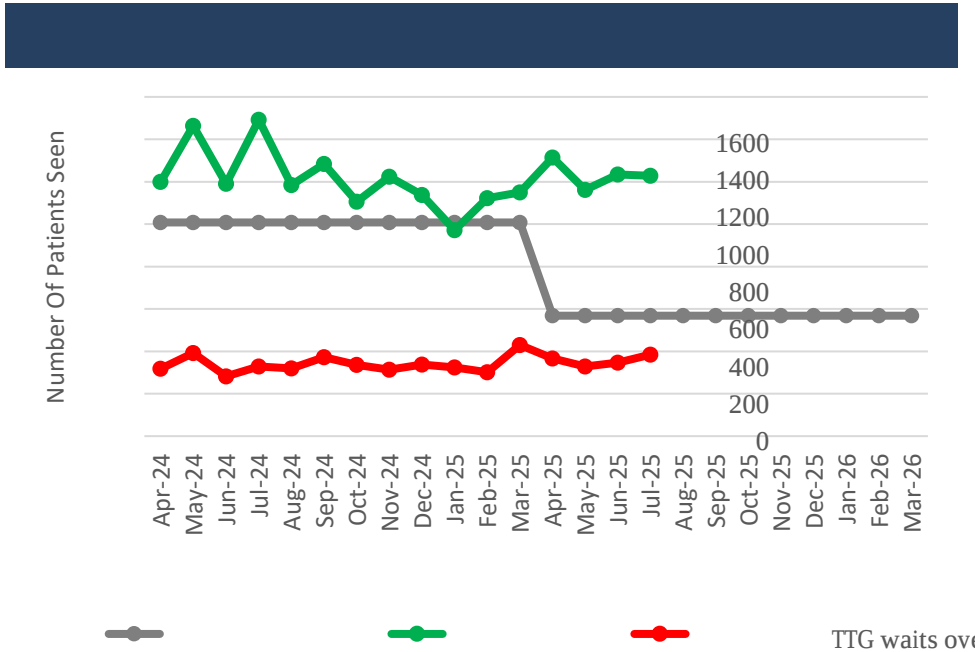

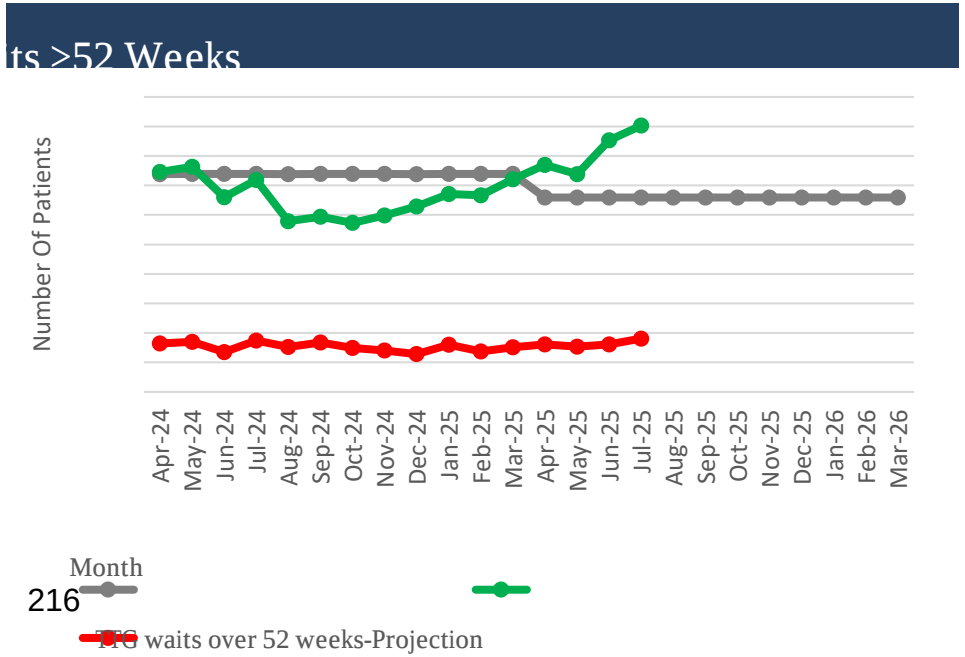

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Diagnostics – Radiology – Slide 1 of 2

Key Performance Indicators

Increase the number of patients receiving a key diagnostic test within 6 weeks from referral, in line with NHS Scotland guidance.	
The number of patients who receive imaging (all) is equal to or exceeds the trajectory every month.	
The number of patients who received a CT scan is equal to or exceeds the number of planned appointments every month	
Patients seen for non-obstetric ultrasound radiology testing is equal to or exceeds trajectory every month	
The number of patients who receive an MRI scan is equal to or exceeds the number of planned appointments every month	

Service Summary & Feedback

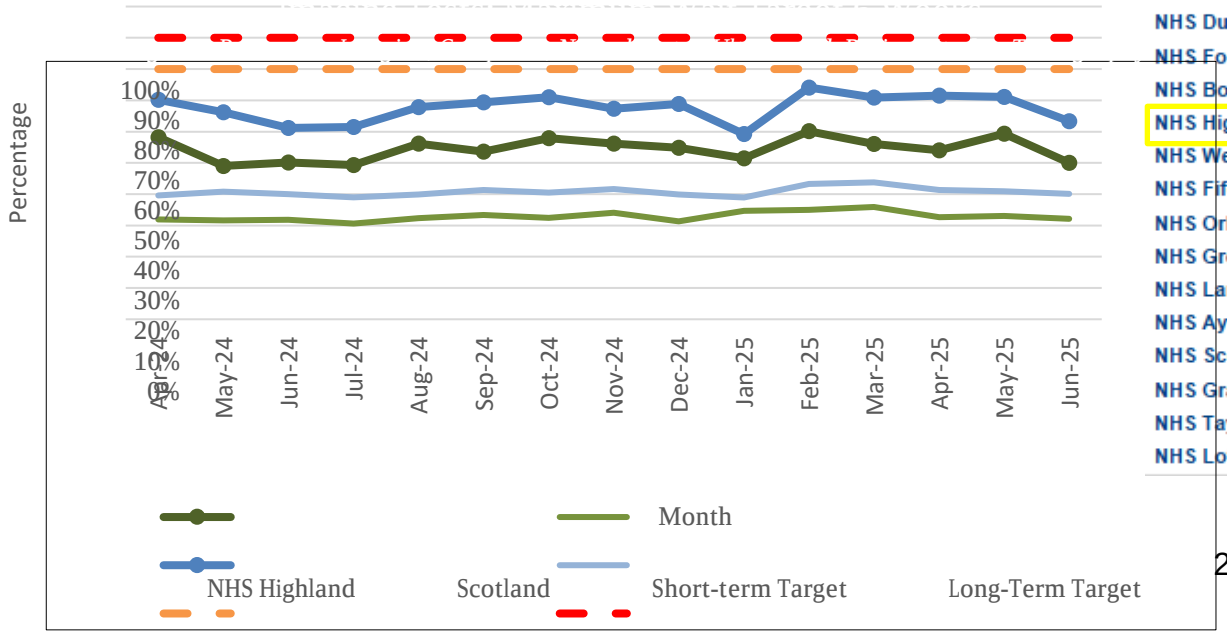
A new radiographer team lead/professional lead has been appointed in L&I and will take up role in November. Axon providing outsourcing service, which is working well. Wait times satisfactory at present but pressure within General Ultrasonography from September onwards due to vacancy.

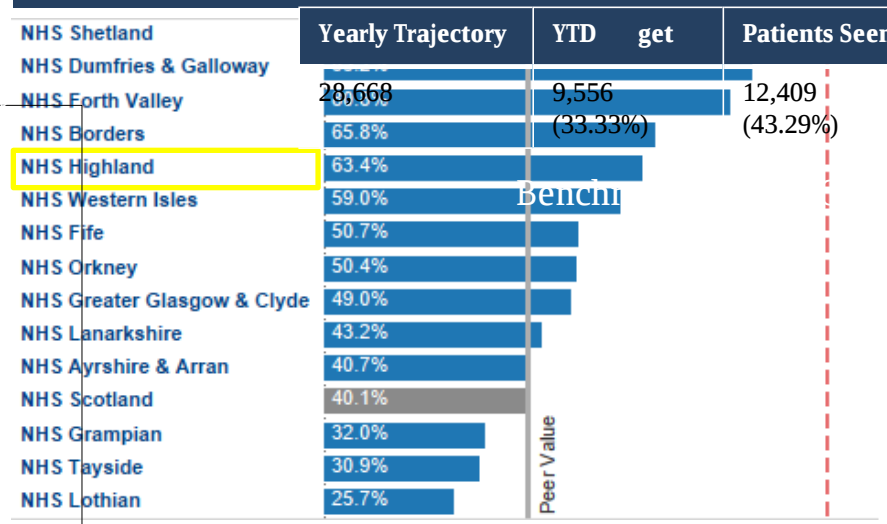
Service Risks

General Ultrasonography capacity due to retirement, the post is currently out for advert. Negations to cover with some locum, short term underway to ensure waiting times maintained.
Lack of F/T Radiographer Team Leader due to vacancy. Interim arrangements in place for post holder, but only on a part time basis is. Recruitment has successfully taken place and new post holder will be available from November on wards.
CTCA – pressure due to availability of clinician.

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

Performance Rating	
Latest Performance	56.6%
National Benchmark	57.5%
National Target	80% (Short-term) 90% (Long-term)
National Target Achievement	National target not met, performance in NHSH is below Scotland average
Benchmarking	10th out of 15 Boards





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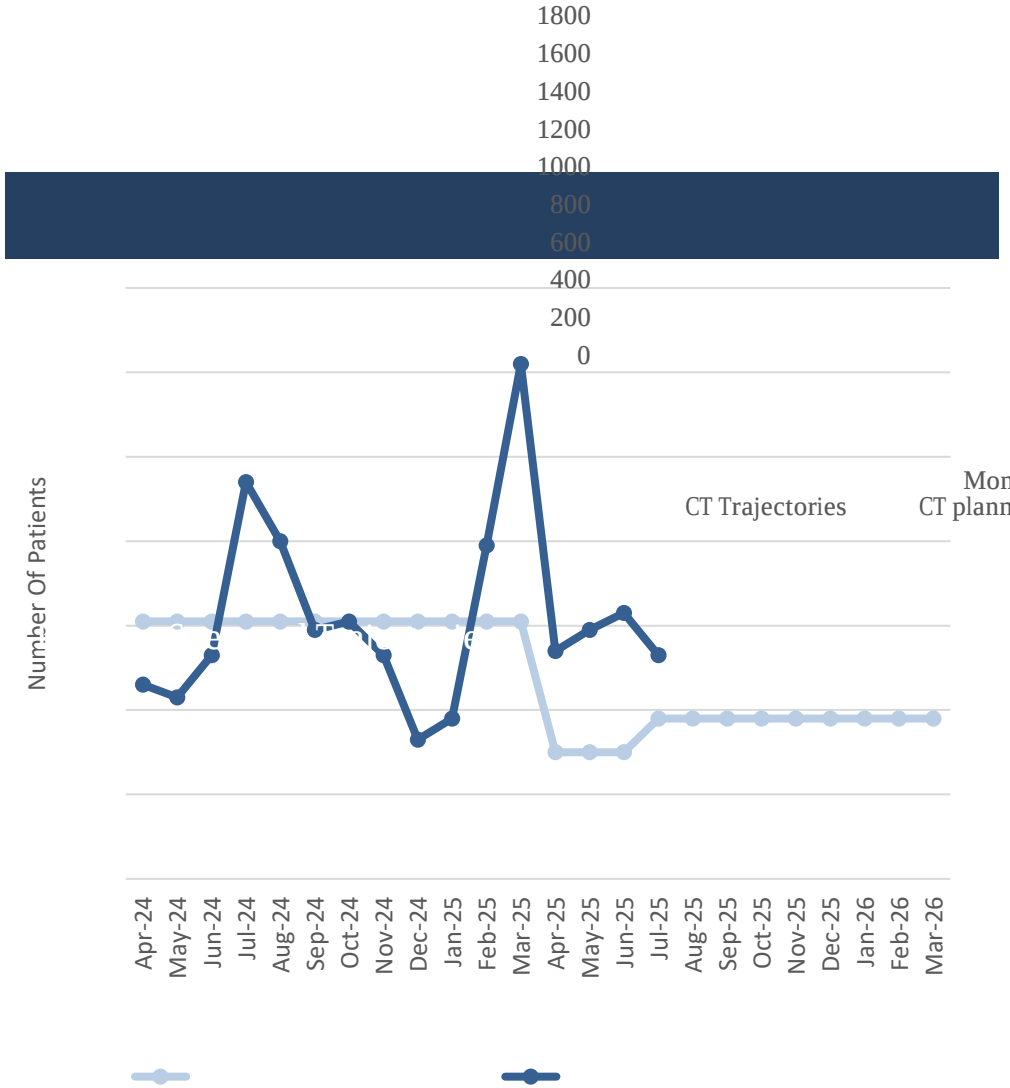

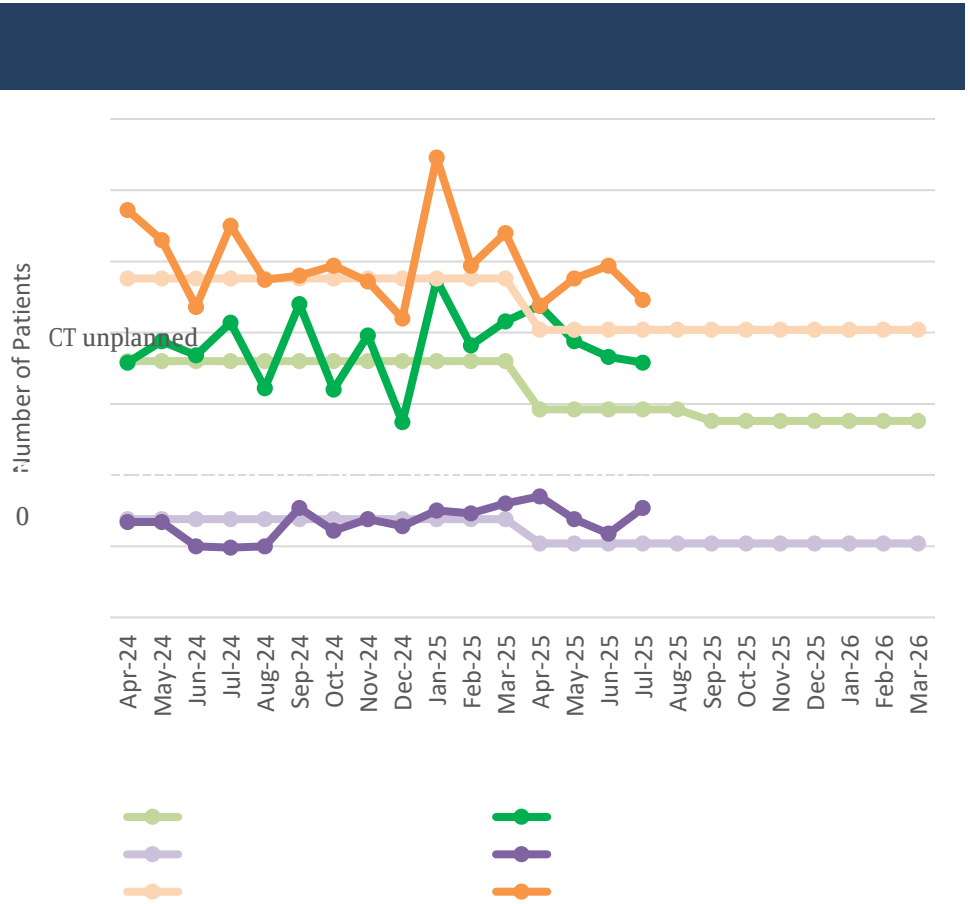

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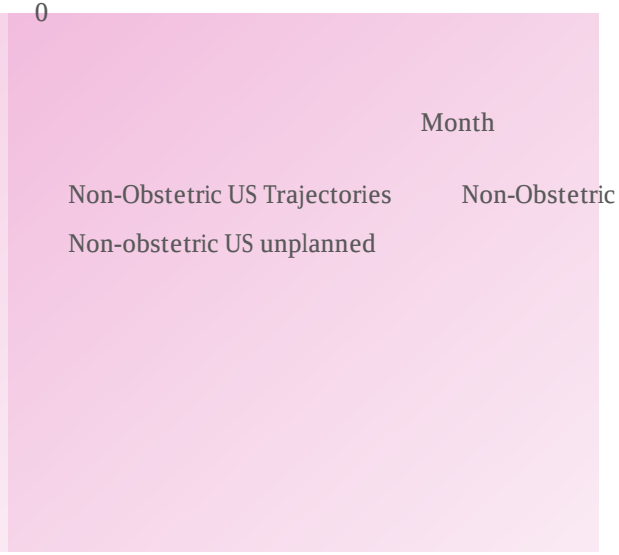

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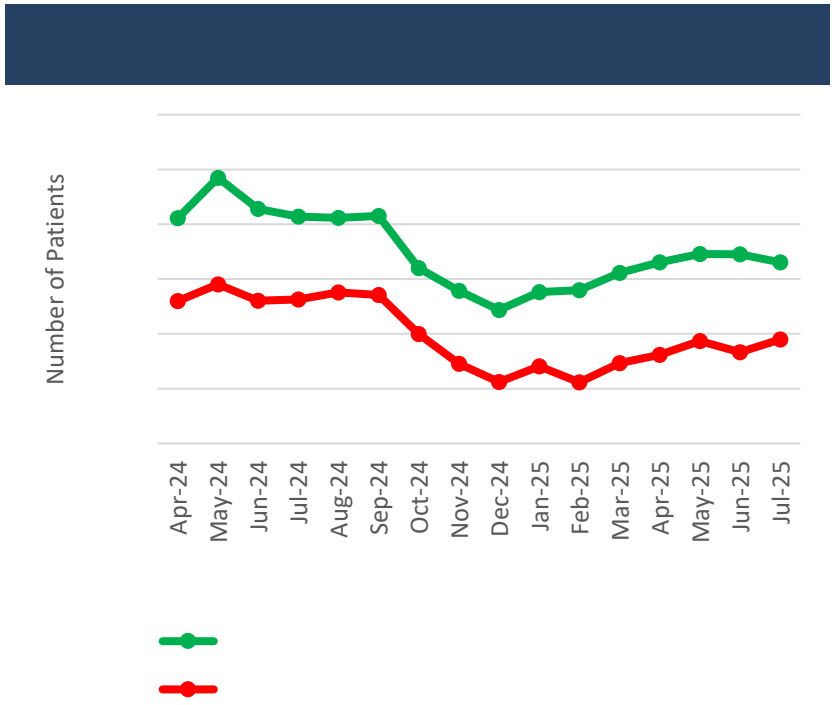

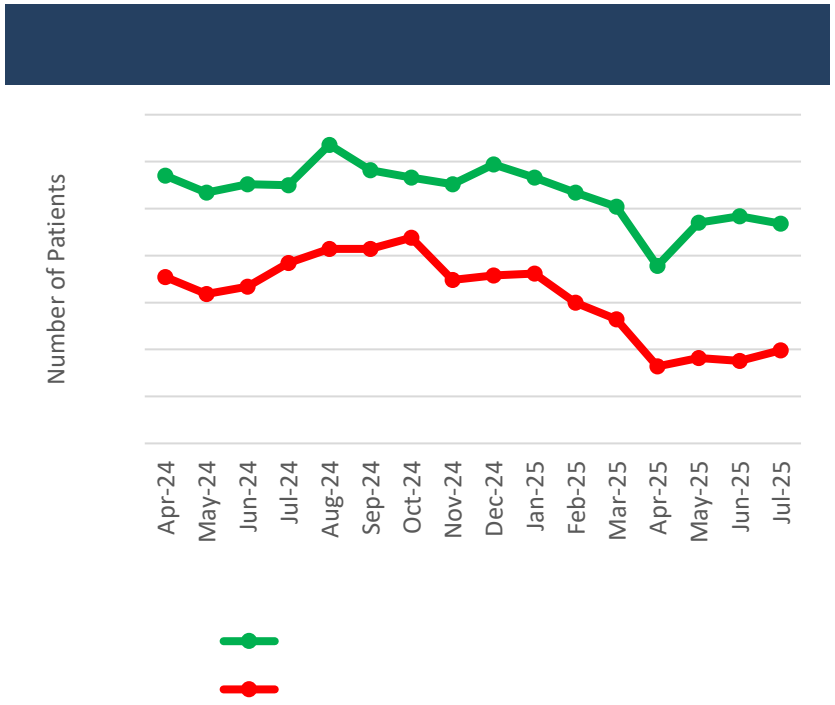

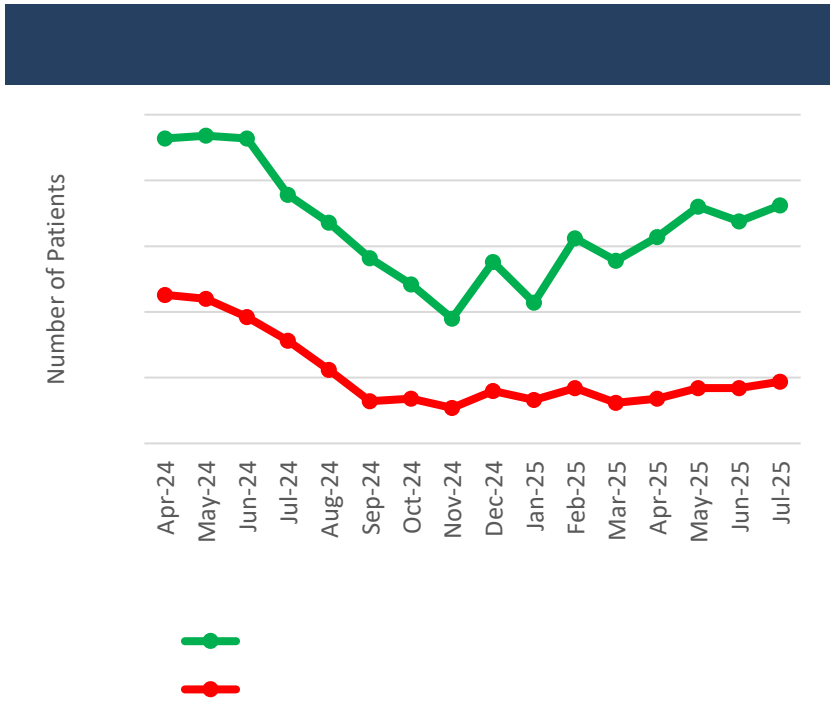

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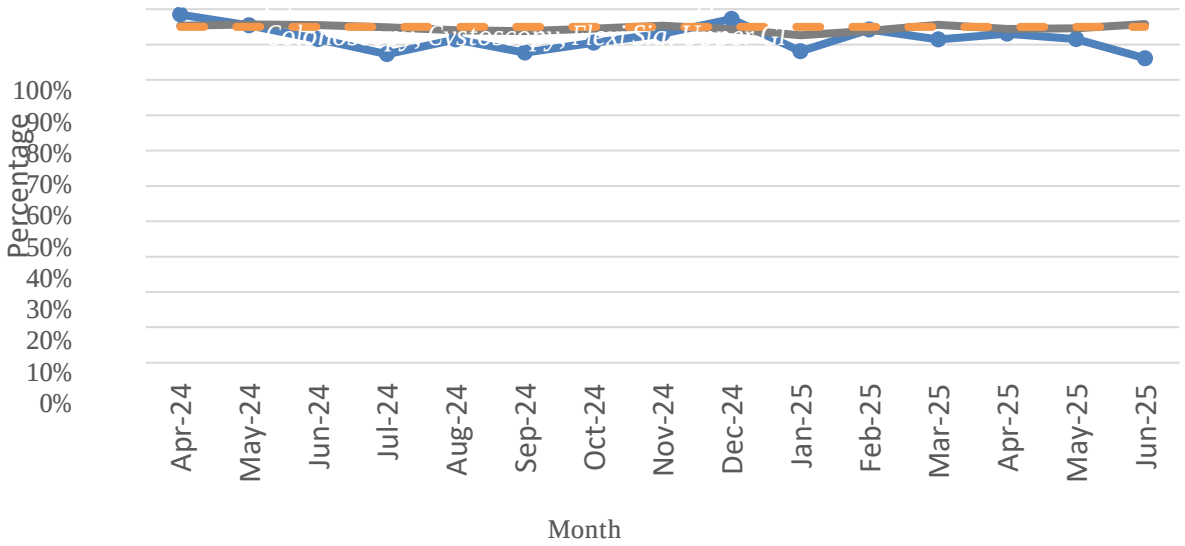
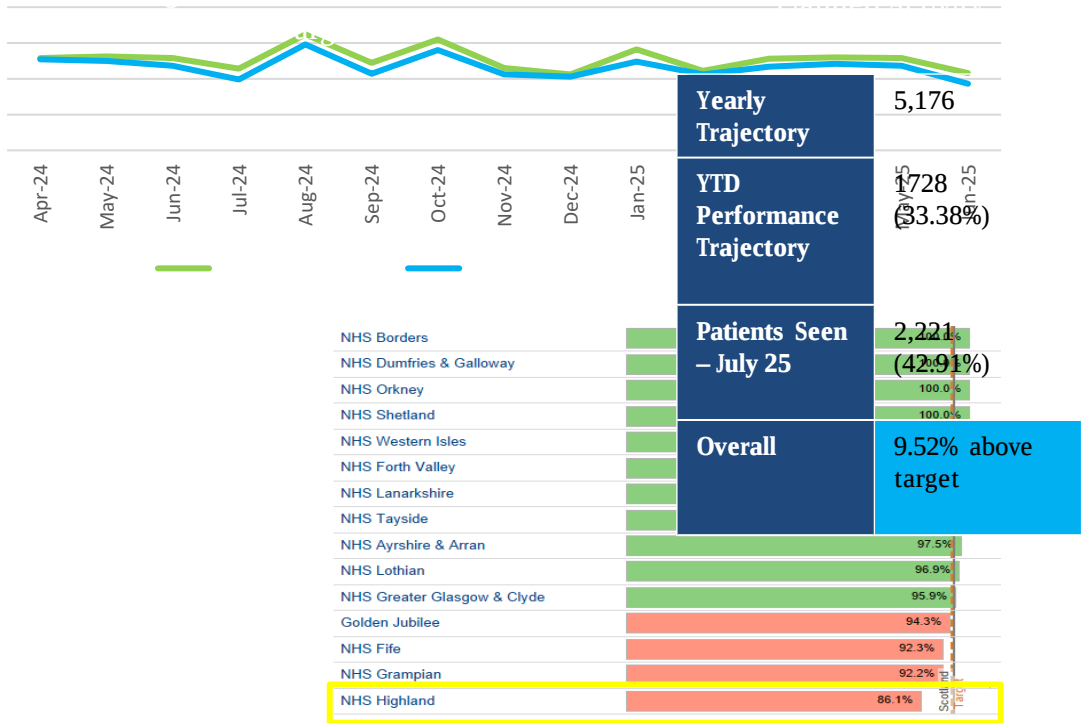
Diagnostics – Endoscopy – Slide 1 of 2

Key Performance Indicators	Service Summary & Feedback	Service Risks
No patients waiting longer than 6 weeks for an endoscopy test (from referral to test) in line with Scottish Waiting Time Targets	Endoscopy – need NHS Highland to update TrakCare PMS to report on 6 week target; currently no clock resets or unavailability will be counted from 28-42days which means are reporting a worse position. GI endoscopy – national diagnostic group to confirm how those patients having upper and lower investigations at same appointment should be recorded. Ehealth support required to finalise the formstream referral form to reduce a 2.8day delay for paper-referral card to arrive with booking team. Cystoscopy – booking will be moving to GI endoscopy team in October 2025. In September, in preparation for booking transfer, 50/week (new patients on non-USC pathway) will be sent a letter to ensure they still wish to proceed.	GI endoscopy – collapse/pause of colon capsule endoscopy – due to UK branch of company has gone into administration. Work is ongoing with procurement to contract this element of service. This also impacts on the small bowel capsule reading service. Cystoscopy – 2 consultant resignations with ongoing pressures around recruitment. Nurse staffing review underway to increase scope sessions.
The number of patients seen for a new endoscopy appointment is equal to or exceeds the trajectory every month.		
The number of patients seen for a new Colonoscopy, Cystoscopy, Flexi Sig and Upper GI is equal to or exceeds the number of planned appointments every month		

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

Performance Rating	
Latest Performance	63.4%
National Benchmark	40.1%
National Target	80% (Short-term) 90% (Long-term)
National Target Achievement	While national target not met, performance in NHSH is ahead of Scotland average
Benchmarking	5th out of 14 Boards





Diagnostics – Endoscopy – Slide 2 of 2

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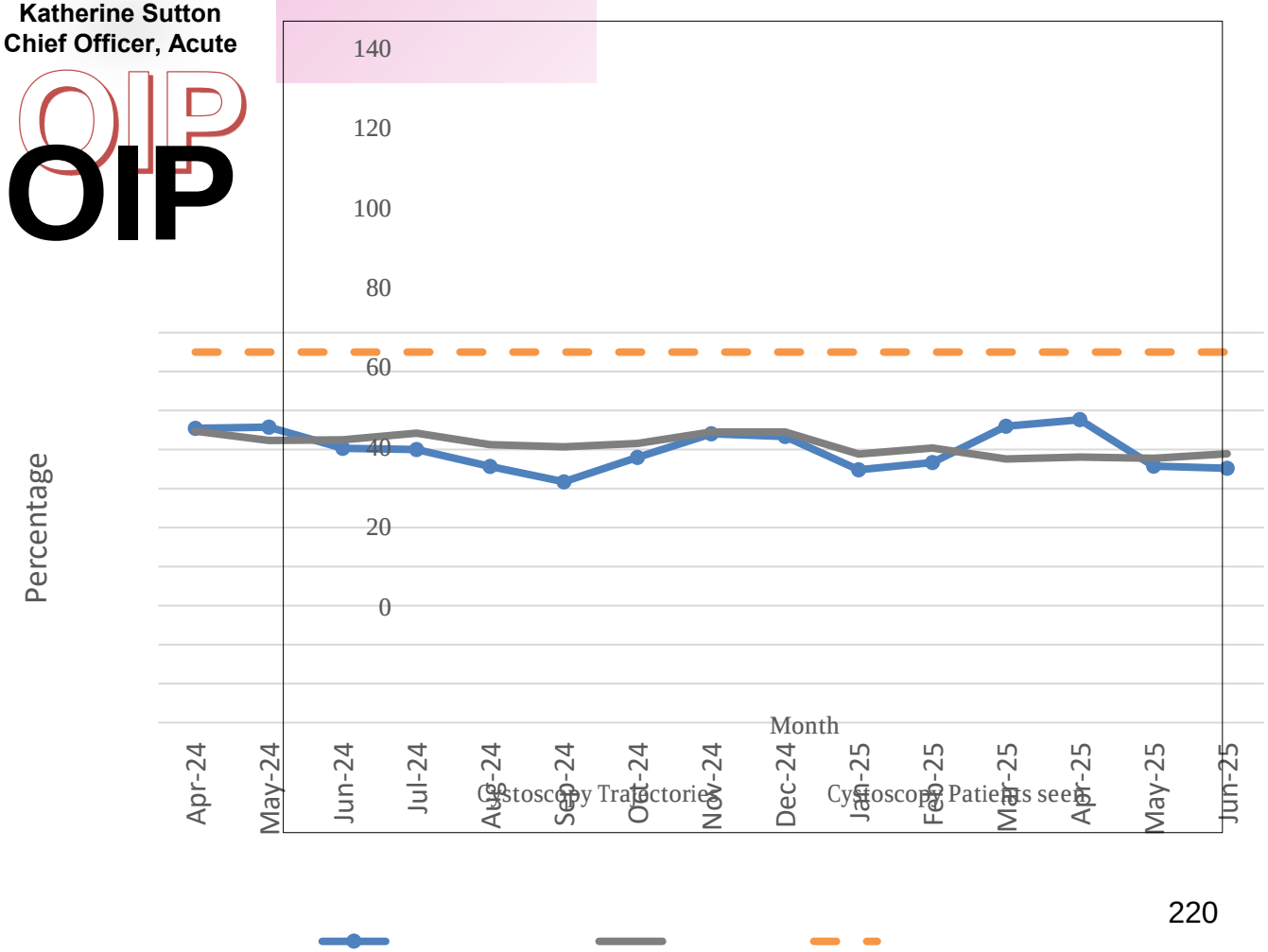

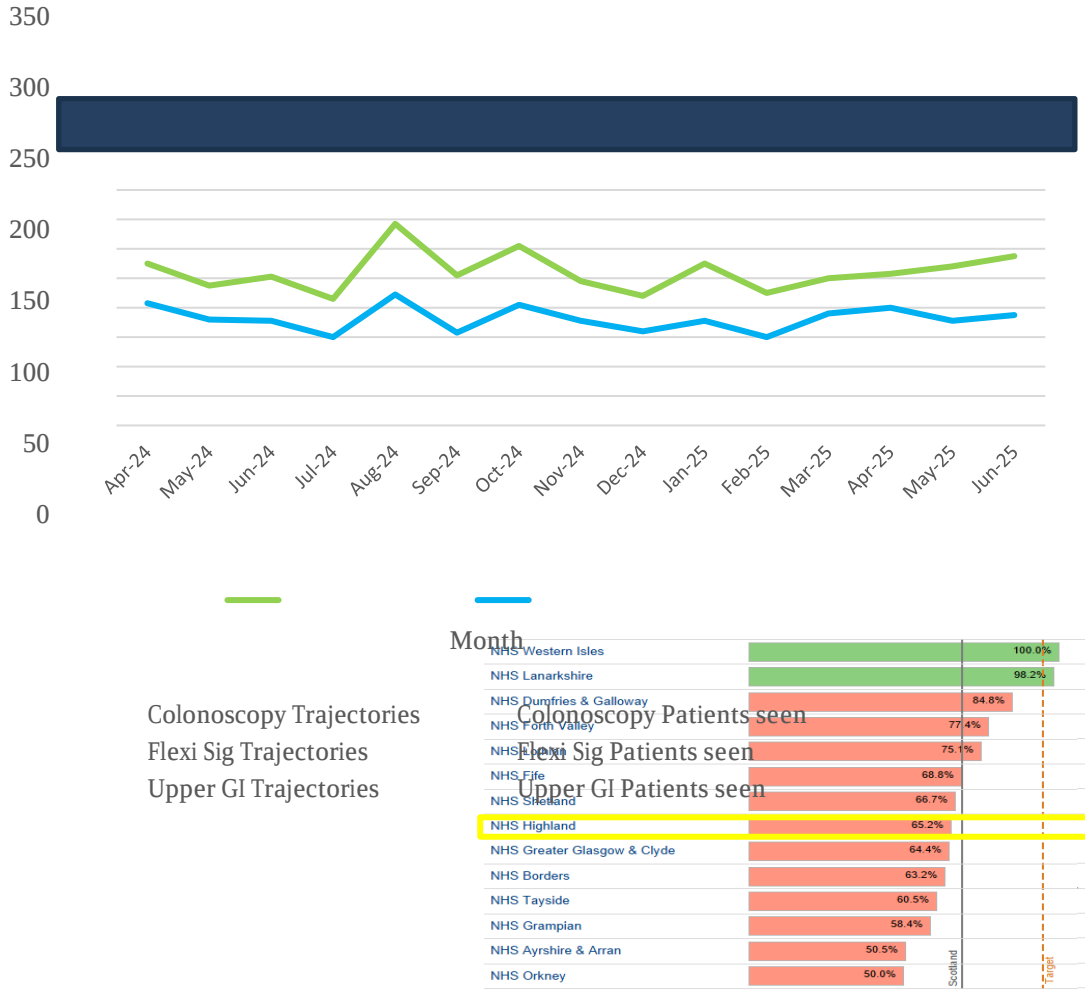

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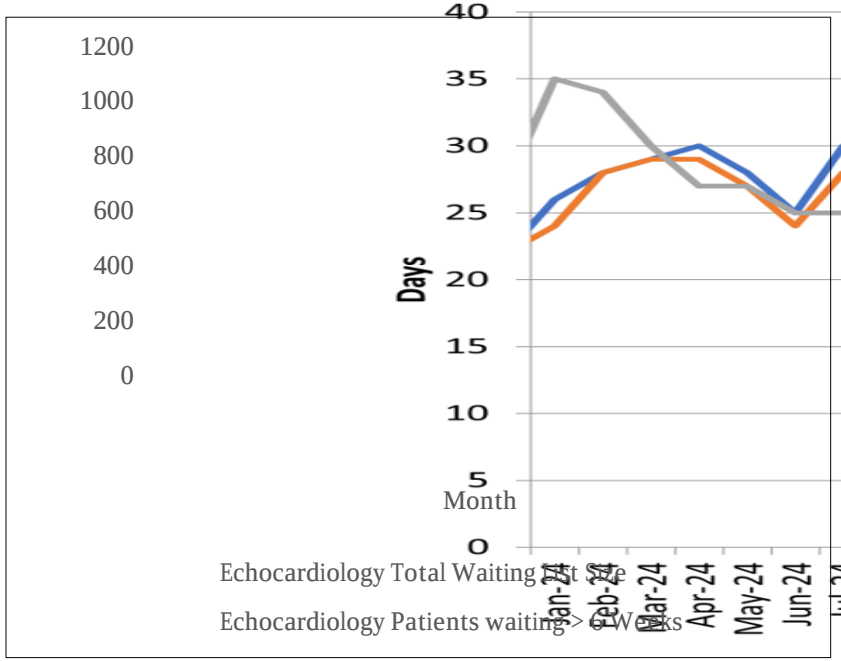
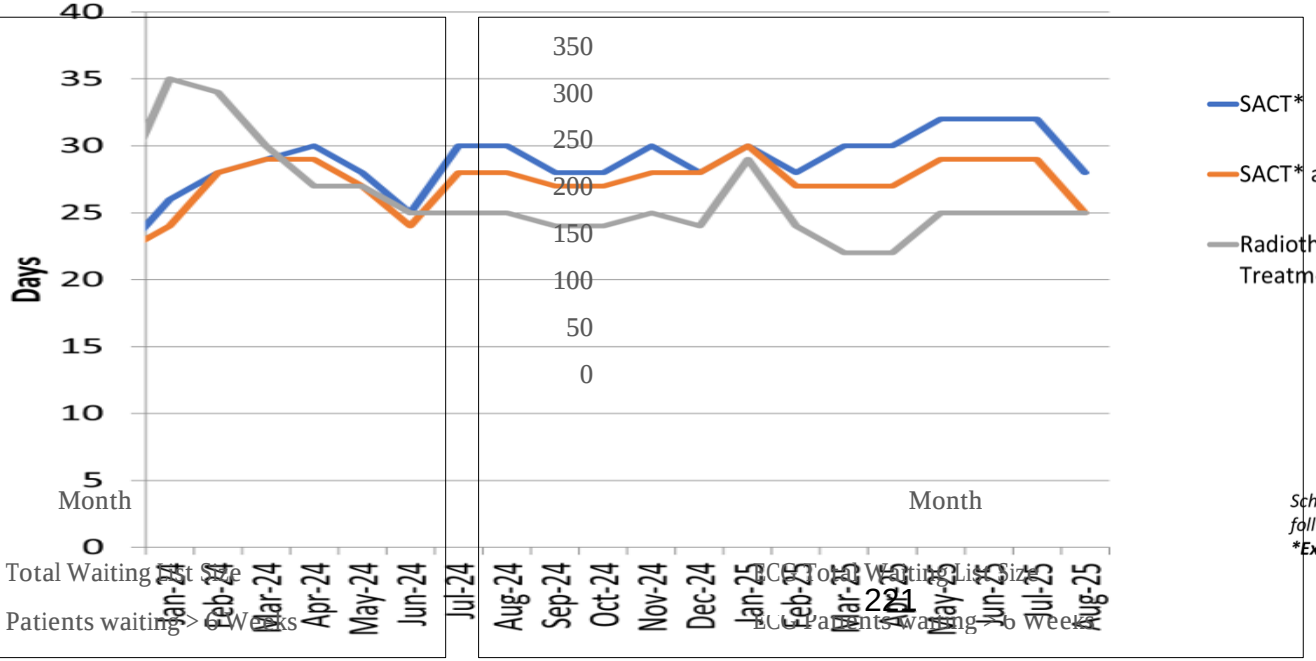
Diagnostics - Wait List Other

Key Performance Indicators	Service Summary & Feedback	Service Risks
Increase the number of patients waiting less than 6 weeks for an ECHO test (from referral to test) in line with Scottish Waiting Time Targets	Wait times in Clinical Physiology services shown have improved over the previous 18 months as a result of focused work and/or staffing.	In Echocardiology, a combination of vacant lead post and approaching likely reduction in staff numbers means some risk of further increase in wait times.
Increase the number of patients waiting less than 6 weeks for an R Test / 24 ECG (from referral to test) in line with Scottish Waiting Time Targets		
Increase the number of patients waiting less than 6 weeks for an spirometry test (from referral to test) in line with Scottish Waiting Time Targets		

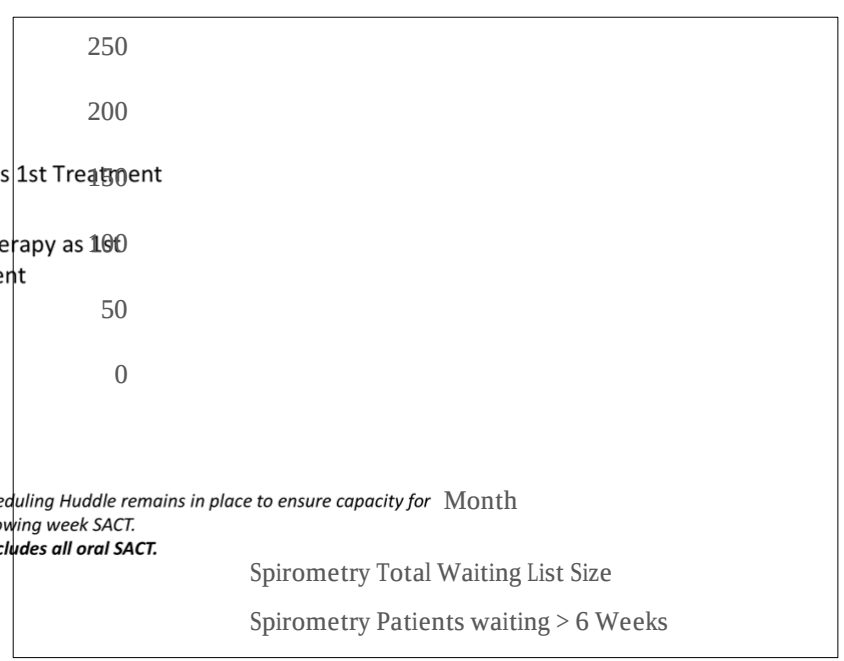
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

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





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



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31 Day Cancer Waiting Times

Key Performance Indicators

95% of patients should begin treatment within 31 days of the decision to treat, regardless of the referral route.

Service Summary & Feedback

Very little cancer treatment is delivered within Argyll & Bute. Treatment will be mostly delivered at NHS GGC locations (or in partnership) with NHS GGC locations.

In Highland this standard which measures the wait from decision to treat to treatment is a challenge in a number of areas: surgery for breast and bladder and also radiotherapy for both Head & Neck and Lung. Future analysis shows performance in July has improved to 93 per cent.

Service Risks

In Highland lack of surgical capacity with 2 out of 6 Consultant Urology posts vacant and the retiral of a Clinical Oncologist from 1 November necessitates a new way of working

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

Performance Rating	
Latest Performance	86.1%
National Benchmarking	95.8%
National Target Achievement	Last met in December 2024
Position	15th out of 15 Boards

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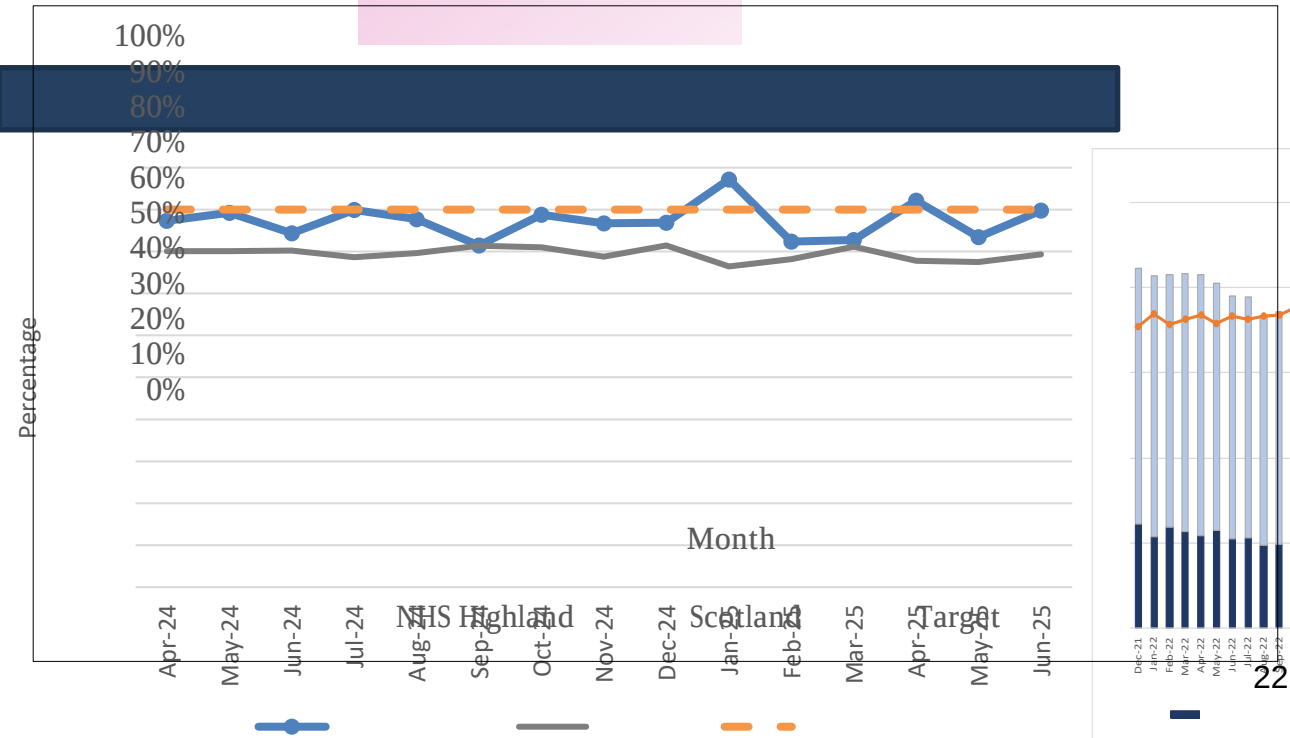
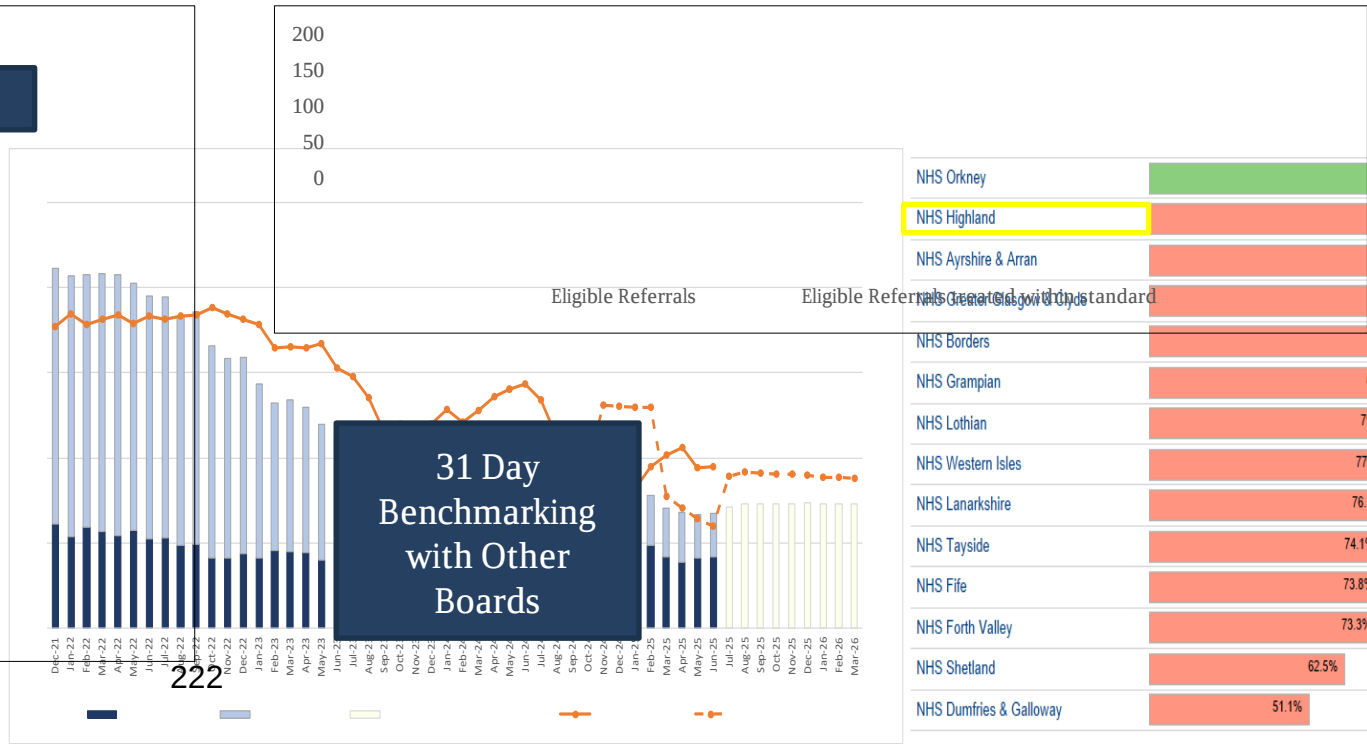
31 Day Cancer Waiting Times



Patients Seen on 31 Day Pathway



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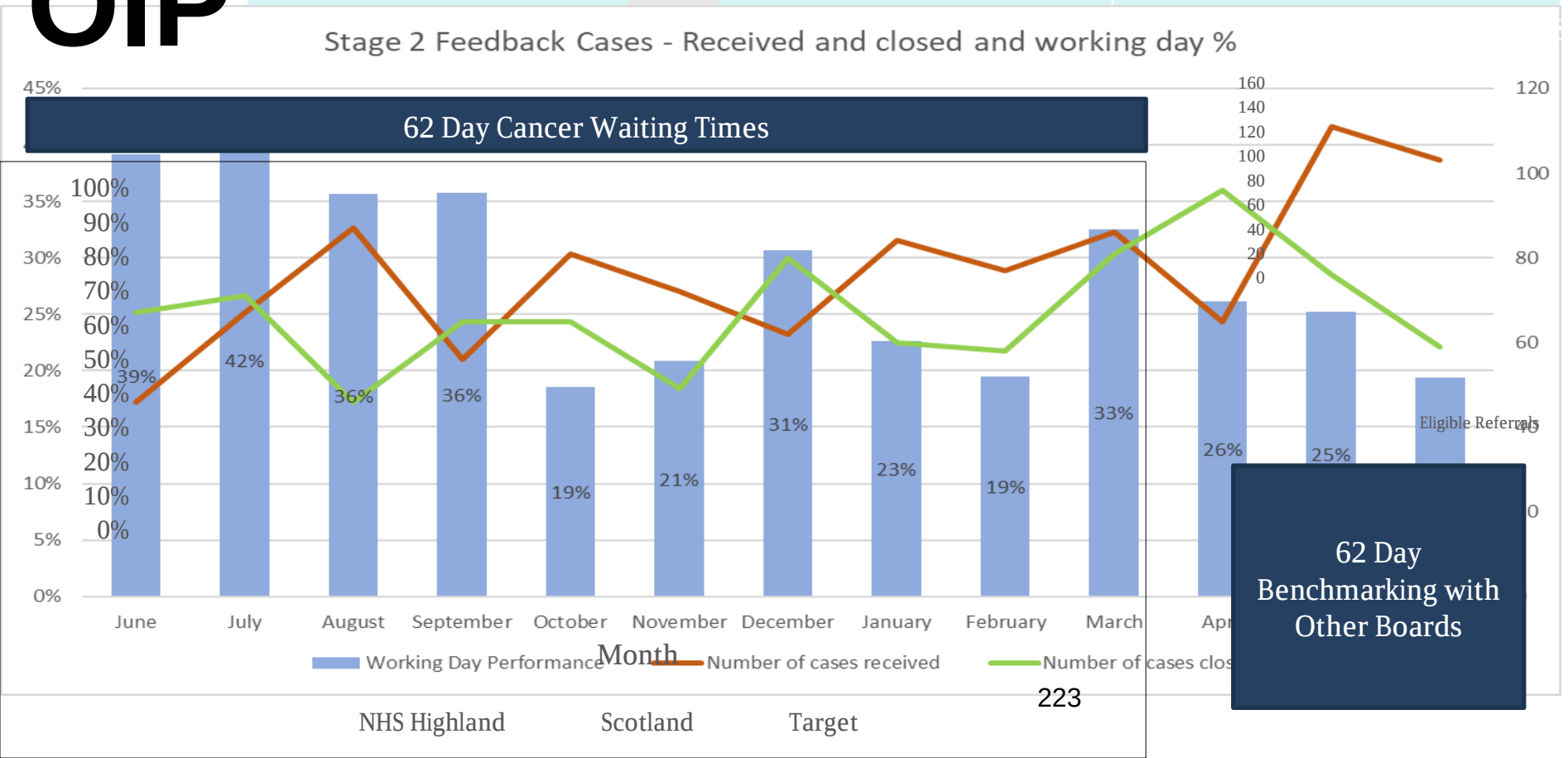
62 Day Cancer Waiting Times

Key Performance Indicators	Service Summary & Feedback	Service Risks
95% of patients referred urgently with a suspicion of cancer (USC) - whether through a GP referral, national screening programme, should be their first cancer treatment within 62 days of receiving the referral.	The focus is upon reducing the backlog of detected cancer patients as quickly as possible and also reducing the number of patients without a diagnosis by day 48 of their referral. This is a particular problem within Urology and Breast.	Lack of assessment, diagnostic and treatment capacity in Urology and Breast.

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

Performance Rating	
Latest Performance	65.2%
National Benchmarking	68.9%
National Target	95%
National Target Achievement	Nationally target not achieved in some time
Position	8th out of 14 Boards

OIP



Eligible Referrals

Eligible Referrals treated within standard

62 Day Benchmarking with Other Boards

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SACT Access and Benchmarking

Key Performance Indicators

The average waiting times for SACT as 1st Treatment, Radiotherapy as First Treatment and ASCT patients overall (new and subsequent) will be no more than 28 days.

Service Summary & Feedback

The Highland waiting times to Oncology treatment have reduced slightly in the last month. The pressures throughout the sites are significant, including the RGHs where the availability of specialist nursing staff is even more acute.

Very little cancer treatment is delivered within Argyll & Bute. Treatment will be mostly delivered at NHS GGC locations (or in partnership) with NHS GGC locations. There is no radiotherapy delivered at Argyll & Bute sites. Some chemotherapy is delivered at LIH and oral and subcutaneous in Lochgilphead.

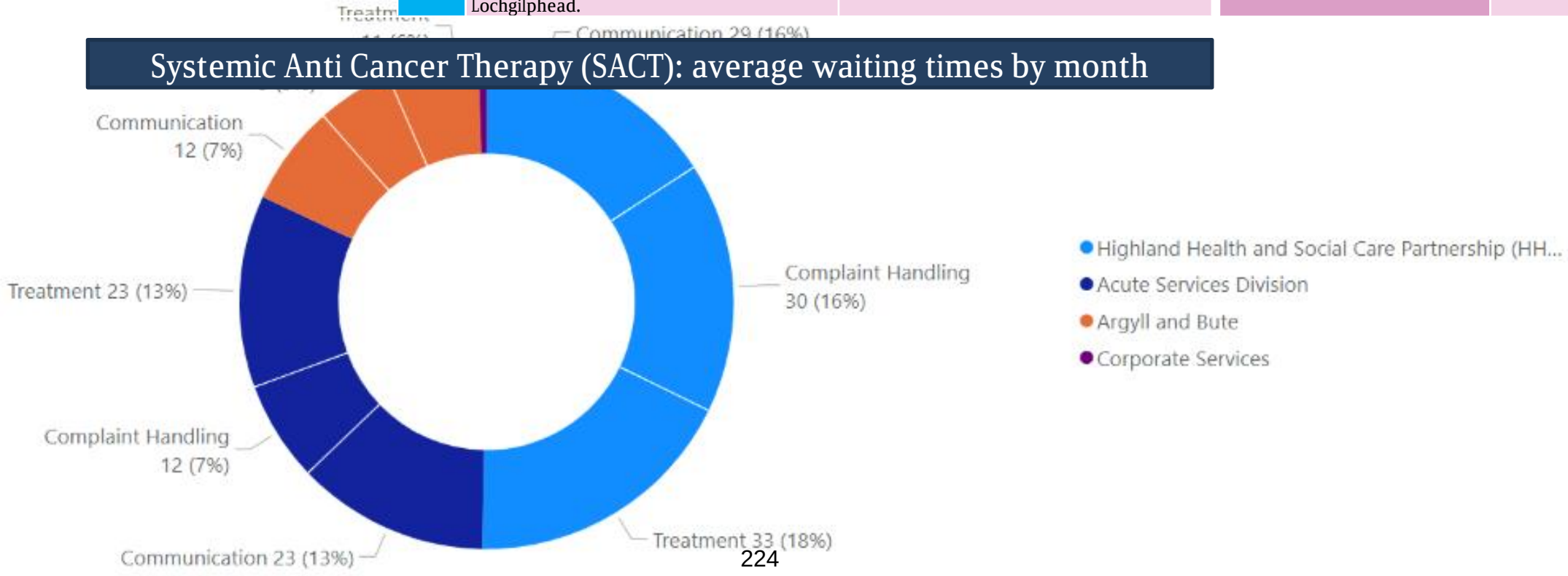
Service Risks

Small teams of specialist staff, an inability to recruit during times of short and long term absence.

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

Performance Rating	
Latest Performance	Average range = 25-28 days to start treatment
National Benchmarking	n/a
National Target	n/a
National Target Achievement	n/a
Position	NHS Highland activity matches national trends

Top Issue Categories | Last 3 Months



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Psychological Therapies Waiting Times

Key Performance Indicators

Ensure that at least 90% of patients referred to Psychological Therapy services are seen for their first appointment within 18 weeks of referral by March 2026. (pan-Highland)

Increase number of completed PT waits (pan-Highland)

Service Summary & Feedback

Psychology Services still continues to make positive improvements in patient referral to treatment times. For the period March 2025 – June 2025, 87.3% of patients referred to the service received treatment within the national performance timescale of 18 weeks, compared to the national average of 78.9% for the same period. Whilst the national target is 90%, NHS Highland was 3rd highest in Scotland and 2nd highest of the mainland boards.

Argyll and Bute have continued to work towards ensuring accurate data, wait well and appropriate trajectories. We have continued to utilise our dovetailed commissioned partner to assist in delivery. Our own Integrated Performance Framework indicator for Q1 highlights that the service has been able to reduce waits.

Service Risks

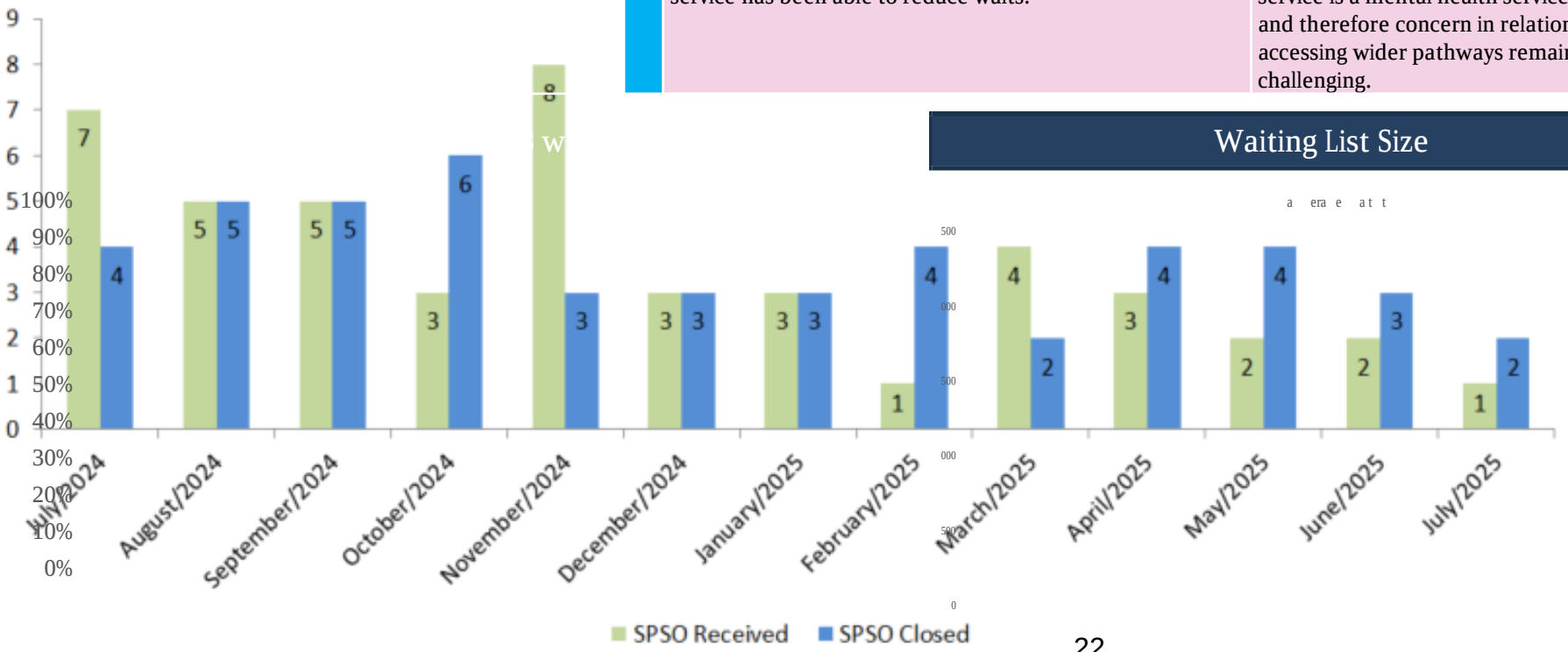
While development to improve quality within the department continues, several projects have now stalled due to our competing eHealth department priorities. This has prevented DCAQ and forecasting projects continuing, work on EPR for psychology, and has negatively impacted on CAPTND and aggregate reporting (e.g. sub-specialties and questionnaire).

Argyll & Bute staffing levels do not offer a critical floor and we are currently impacted by vacancies and leave. The service is a mental health service only and therefore concern in relation to accessing wider pathways remains challenging.

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

Performance Rating	
Latest Performance	89.8%
National Benchmarking	79.3%
National Target	90%
National Target Achievement	Consistent improvements in targets and downward trajectory
Position	2nd out of 14 Boards

Number of S



Waiting List Size

Benchmarking with Other Boards

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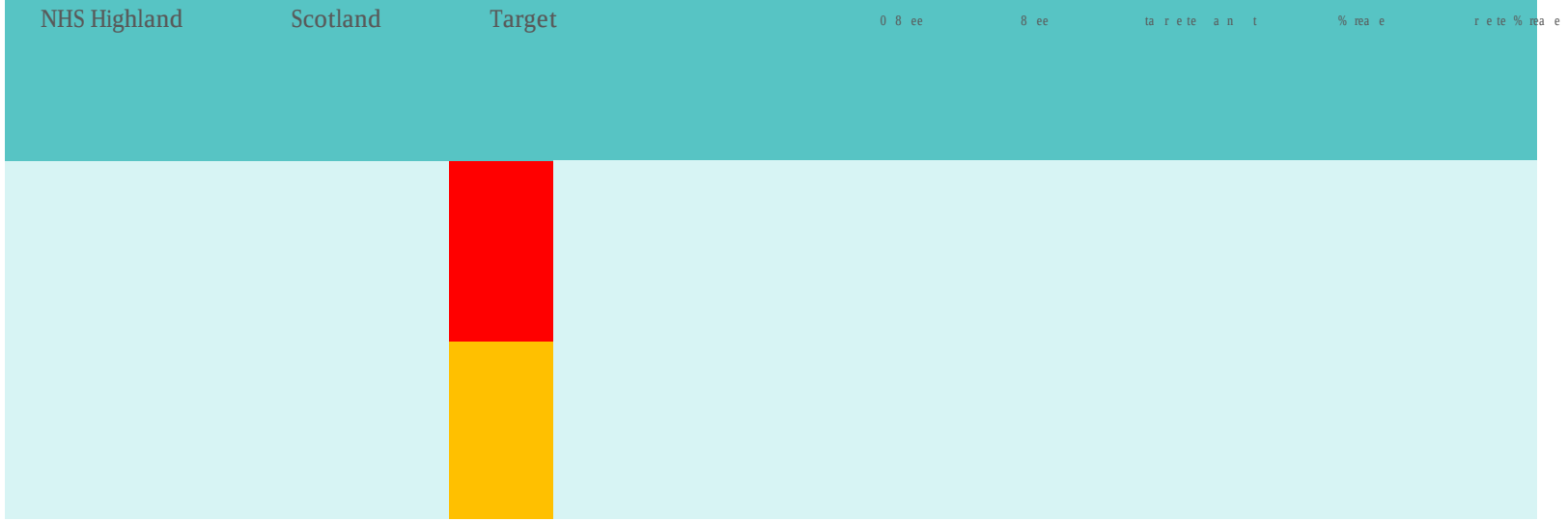
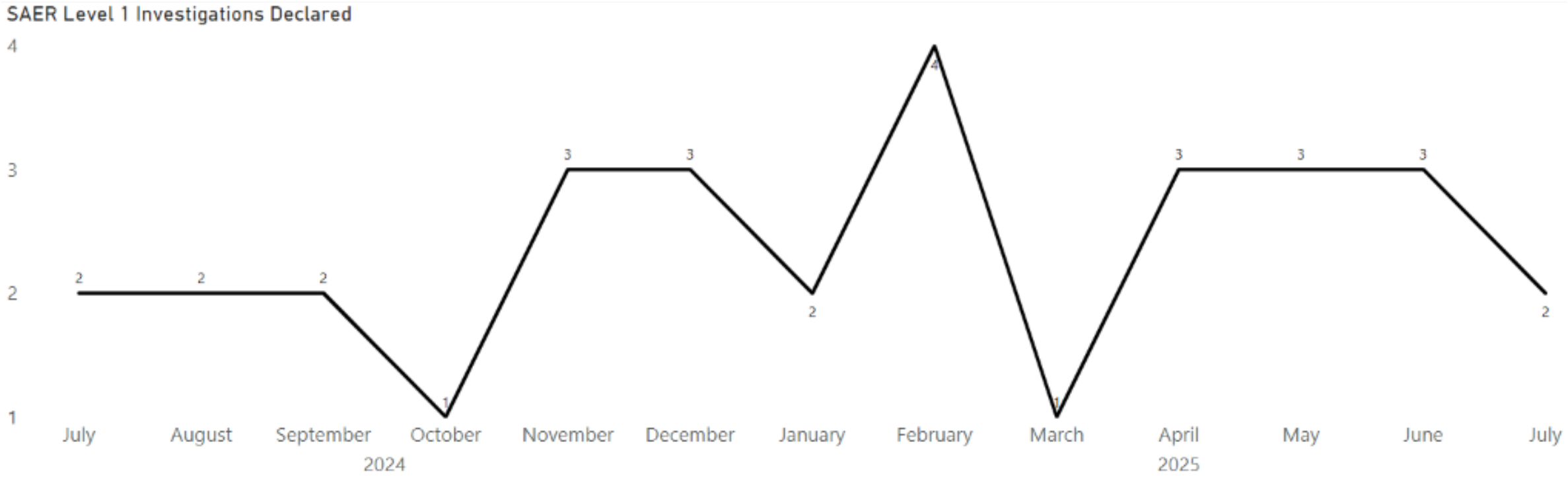
NHS Highland Scotland Target



26	10	31	0.19%
Open Level 1 (L1) Incidents	L1: Active more than 26 weeks	L1: SAER Declared Last 13 Months	Incident | SAER Conversion Last 13 Months



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Stage 2 Complaint Activity (June 2024 – June 2025)

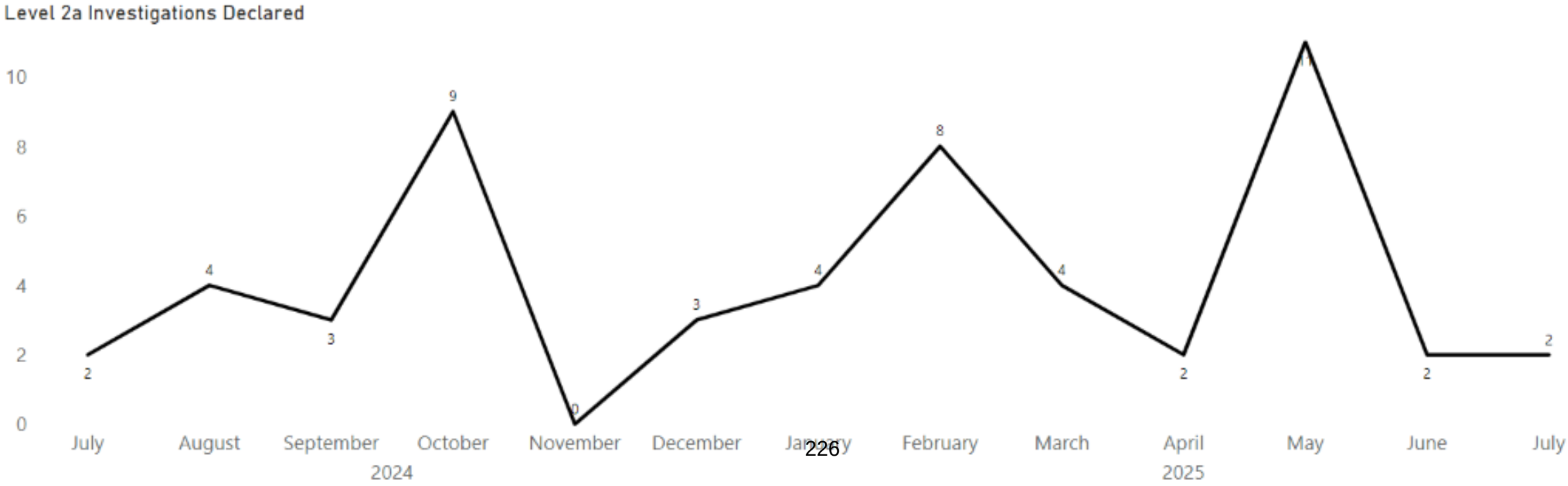
ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations
N/A	Continued poor performance against the 20 day working target with 50.1% increase in Stage 2 complaints receive in May/June 2025 compared to previous 11 months. The Services to receive most complaints over the past 2 months are: General Practice Services Orthopaedics Medical – Emergency Care	Reporting to EDG and escalation to Board Medical Director where required. Update at Partnership Development Day regarding review of complaint and further discussed at Clinical and Care Governance Meeting Case management in place within Feedback Team from May 2025. Meetings are being held with Acute to identify area for improvement

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

Performance Rating	
Latest Performance	19%
National Benchmarking	None
National Target	60%
National Target Achievement	
Position	

52
Open Level 2a (L2) Incidents

41
L2: Active more than 12 weeks



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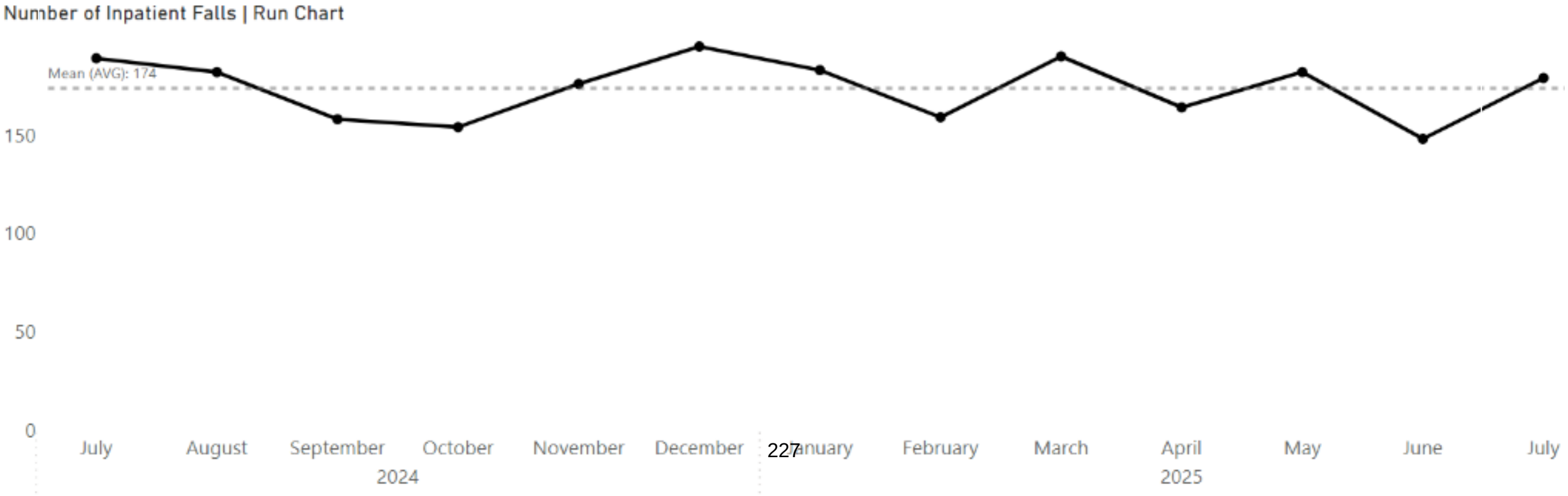
Stage 2 Complaint Issues (April 2025 – June 2025)

ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations
	Recording all overdue complaints through ISD coding as 'Complaint Handling'. All GP/Local Enhanced Services (diabetes) complaints recorded under 'communication' and 'treatment'.	

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



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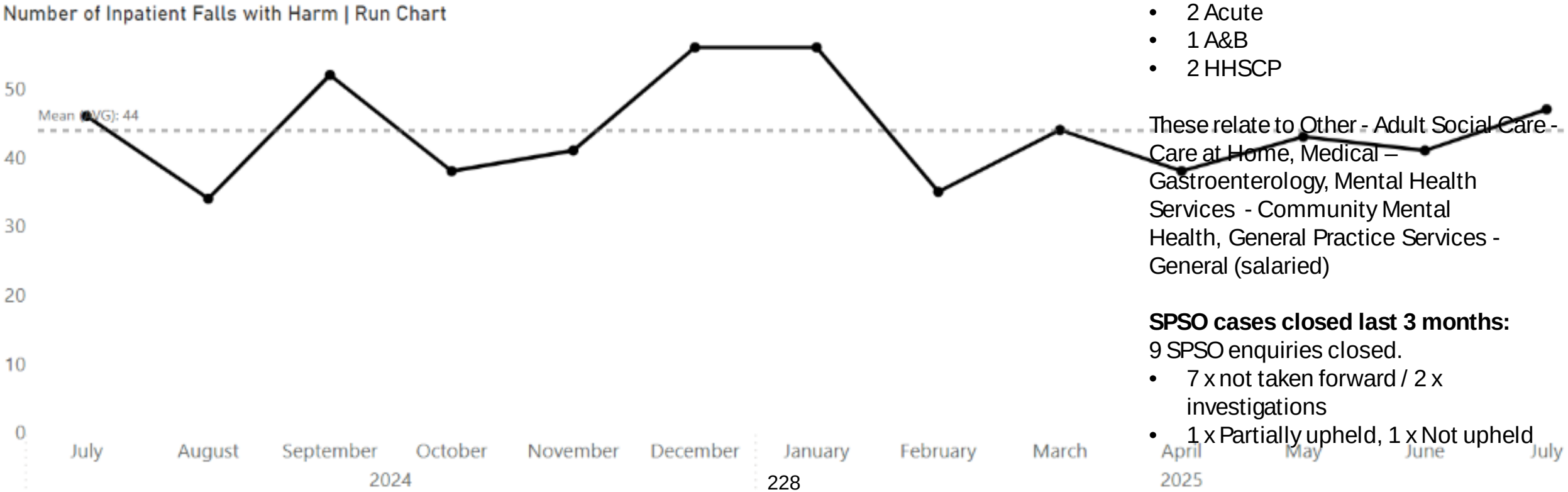
SPSO Activity (July 2024 – July 2025)

ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations
	SPSO activity has remained steady over the last few months. Observed that recent cases have required significant amount of information to be sent. Majority of cases have been not been taken forward.	SPSO cases continue to be monitored via the Quality and Patient Safety structure. A SPSO case features as the complaint case as part of the patient experience paper.

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



SPSO cases received last 3 months:

5 received:

- 2 Acute
- 1 A&B
- 2 HHSCP

These relate to Other - Adult Social Care - Care at Home, Medical – Gastroenterology, Mental Health Services - Community Mental Health, General Practice Services - General (salaried)

SPSO cases closed last 3 months:

9 SPSO enquiries closed.

- 7 x not taken forward / 2 x investigations
- 1 x Partially upheld, 1 x Not upheld

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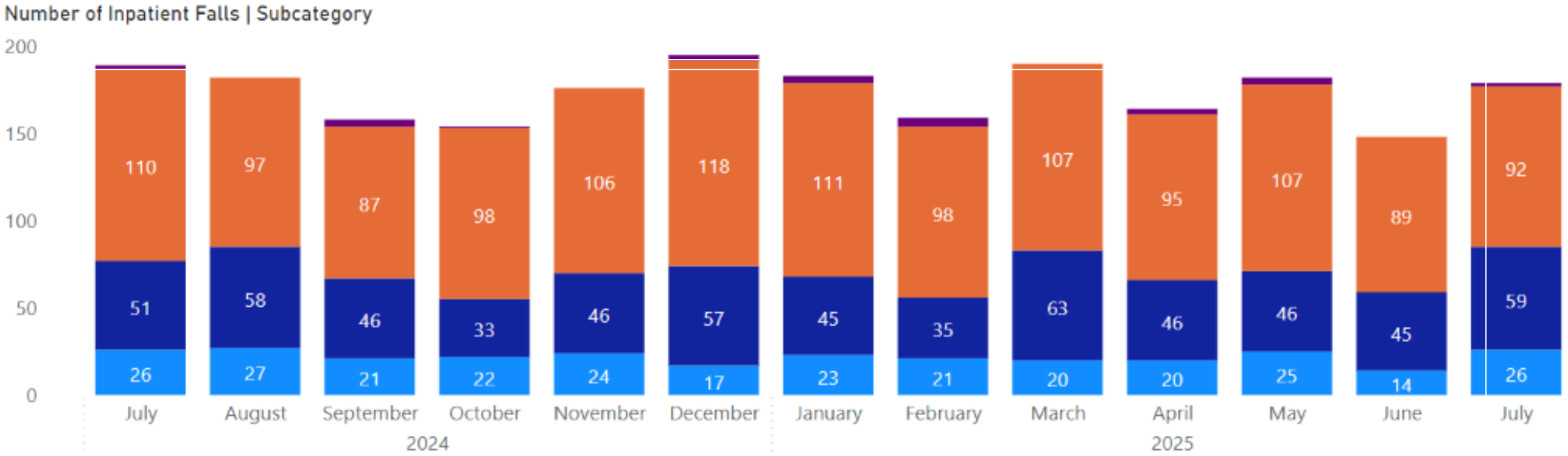
Level 1 SAERs Declared and Status Overview (July 2024 – July 2025)

ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations
	11 SAERs are over the 26 week target. 77 SAER actions are overdue.	All 11 cases have been reviewed. 4 were completed and ready for approval. Review progress is monitored through the Quality and Patient Safety Structure. The adverse event policy and procedures have been updated to reflect the national framework. This is out for consultation and meetings arranged with professional groups.

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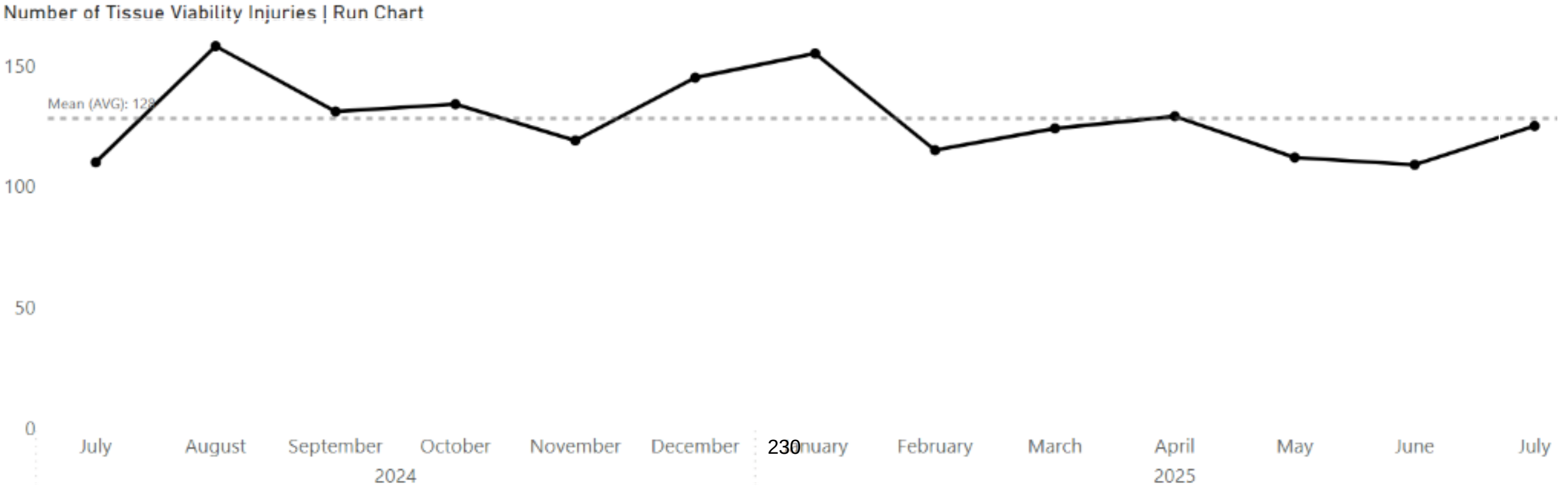
Level 2a Declared and Status Overview (July 2024 – July 2025)

ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations
	20 Level 2a reviews are over the 12 week target. 28 actions are overdue.	All open reviews and open actions are reviewed by the Quality and Safety Groups. Overdue actions are being followed by the CGST.

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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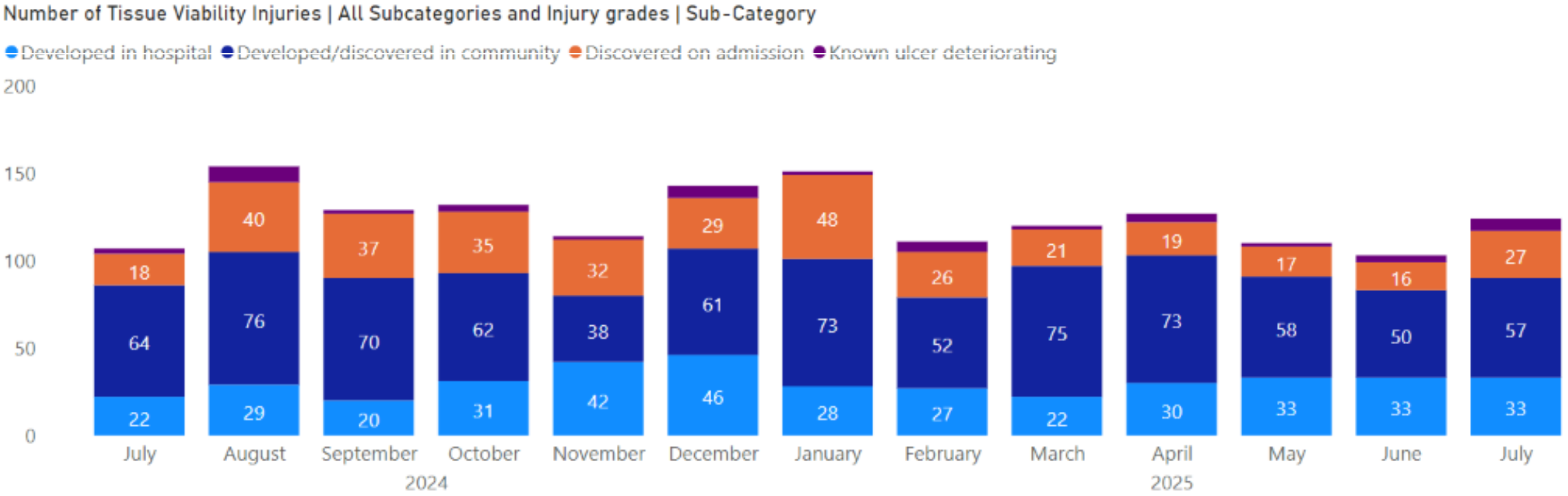
Hospital Inpatient Falls (July 2024 – July 2025)

ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations
	Inpatient falls remain static. A&B 20% reduction in falls over April, May and June	Work continues across the organisation to share learning – poster developed by A&B team to be distributed across NHSH Teams encouraging safe mobilisation for patients and families Completion of DCP and non adherence to policy main reason for RIDDOR reporting

Performance Rating	
Latest Performance	
National Benchmarking	
National Target	20% reduction (falls) 30% reduction (falls with harm)
National Target Achievement	
Position	



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Hospital Inpatient Falls with Harm (July 2024 – July 2025)

ADP Deliverables Progress as at End of Q1 2025/26		Insights to Current Performance	Plans and Mitigations
		Reduction in falls with harm over the last 6 months although total falls remain static	Continue to share learning through monthly falls steering group Falls audit tool determining areas of focus for individual teams

Performance Rating	
Latest Performance	
National Benchmarking	
National Target	20% reduction (falls) 30% reduction (falls with harm)
National Target Achievement	
Position	

Subcategory | Injury

Injury	Developed in hospital	Developed/discovered in community	Discovered on admission	Known ulcer deteriorating	Total
Mucosal Pressure Damage	18	1	13		**32**
Pressure Ulcer - combination lesions	5	9	0	0	**14**
Pressure Ulcer - deep tissue injury	27	83	15	5	**130**
Pressure Ulcer - ungradable	38	110	31	13	**192**
Pressure ulcer (grade not specified)	9	10	8	0	**27**
Pressure ulcer Grade 1	107	135	83	2	**327**
Pressure ulcer Grade 2	175	385	163	8	**731**
Pressure ulcer Grade 3	16	58	37	14	**125**
Pressure ulcer Grade 4	1	18	15	13	**47**
Ulcers	1	3	6	0	**10**
Total	**397**	**812**	**371**	**55**	**1635**

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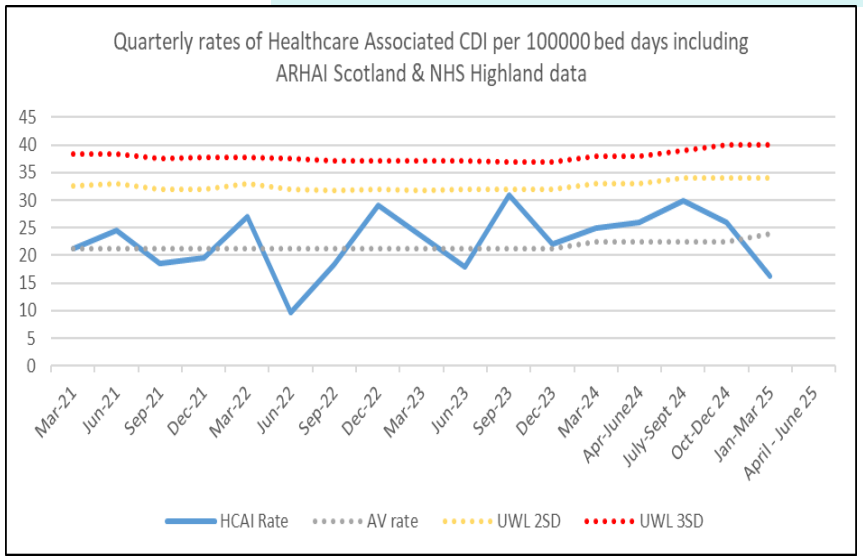
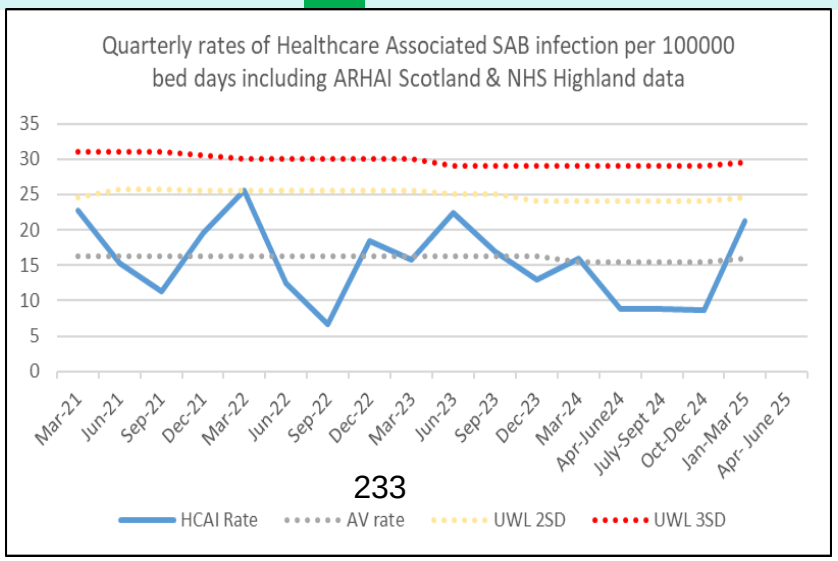
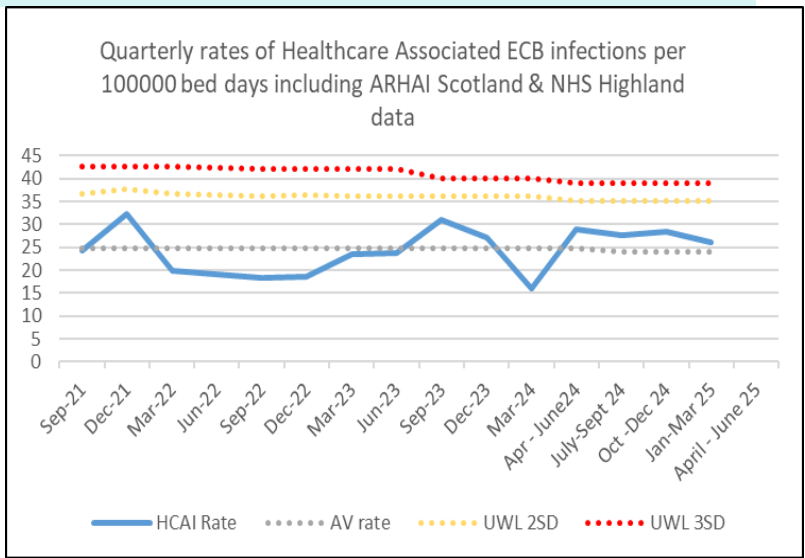
Hospital Inpatient Falls by Subcategory (July 2024 – July 2025)

ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations

Performance Rating	
Latest Performance	
National Benchmarking	
National Target	20% reduction (falls) 30% reduction (falls with harm)
National Target Achievement	
Position	







Organisational Metrics Jul 2025

Exec Lead
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Sickness Absence Rate (%)
6.14

Long Term SA Rate (%)
3.86

Short Term SA Rate (%)
2.27

Recorded Absence Reason (%)
76.98

Vacancy Time to Fill (Days)
102.72

Annual Employee Turnover (%)
7.09

ADP Deliverables
Progress as at End of Q1 2025/26

-Pressure Ulcer Policy under review via NATVNS – almost complete
-Training and support for key at risk areas continue
-Engagement with teams and equipment continues, acute and community
-Audit of interventions to be agreed, on equipment knowledge for acute and community services, as well as grading
-Tissue Viability Link Practitioners contact updated for acute and community services
- SAS discussions ongoing

Insights to Current Performance

- Developed pressure ulcers continue below the median – to consider reducing the median to address common themes etc
- More training needed on Grading Pressure Ulcers and a campaign to raise awareness of pressure ulcer grading is next target
- Moisture Associated Skin Damage Tool updated to include bacterial and fungal infections and for review via NATVNS.

Plans and Mitigations

- -Continue to implement support for high risk areas
- -CPR for Feet on Red Day Tool now and for TVLG
- -CPR Feet documents updated and will be available on PECOS- old stock of Nursing Assx Packs to be used up first
- Seek clarity from this group on moving forward with pressure ulcer benchmarking as HIS will not be doing this for a while
- -Pressure Ulcer training ro be Essential/Mandatory for all clinical Nurses/AHPS and Support Workers

Performance Rating

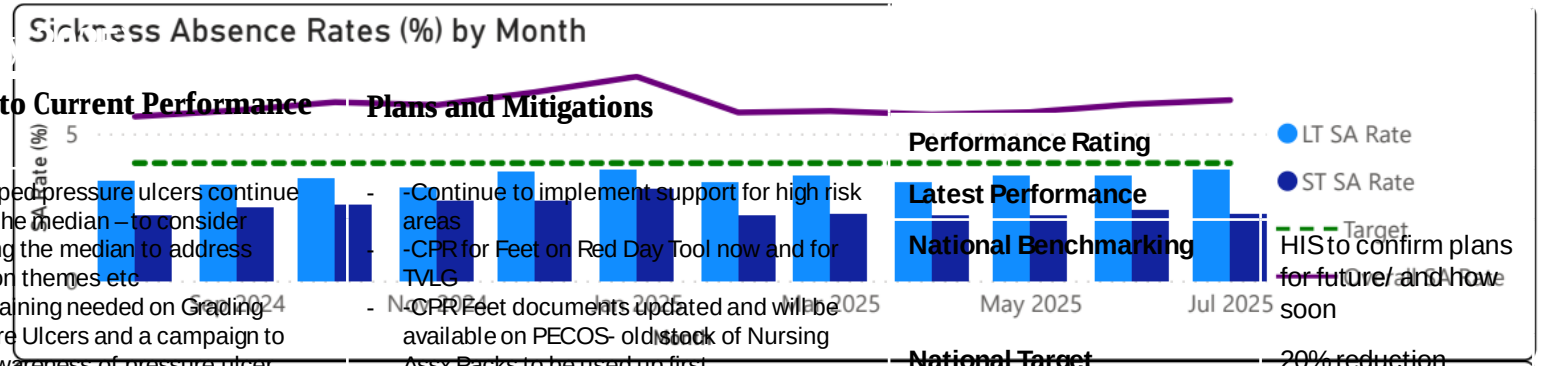
Latest Performance

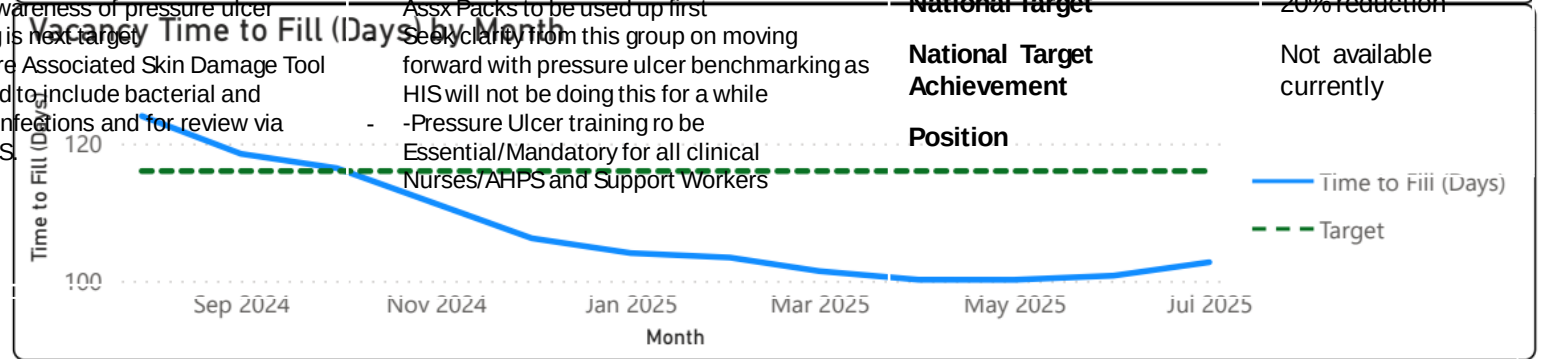
National Benchmarking
HIS to confirm plans for future/ and how soon

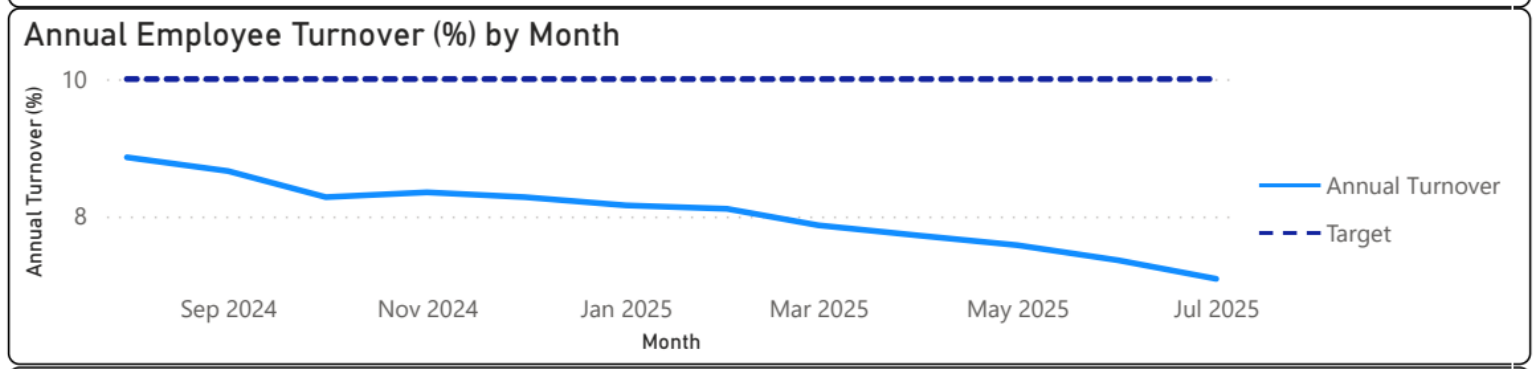
National Target
20% reduction

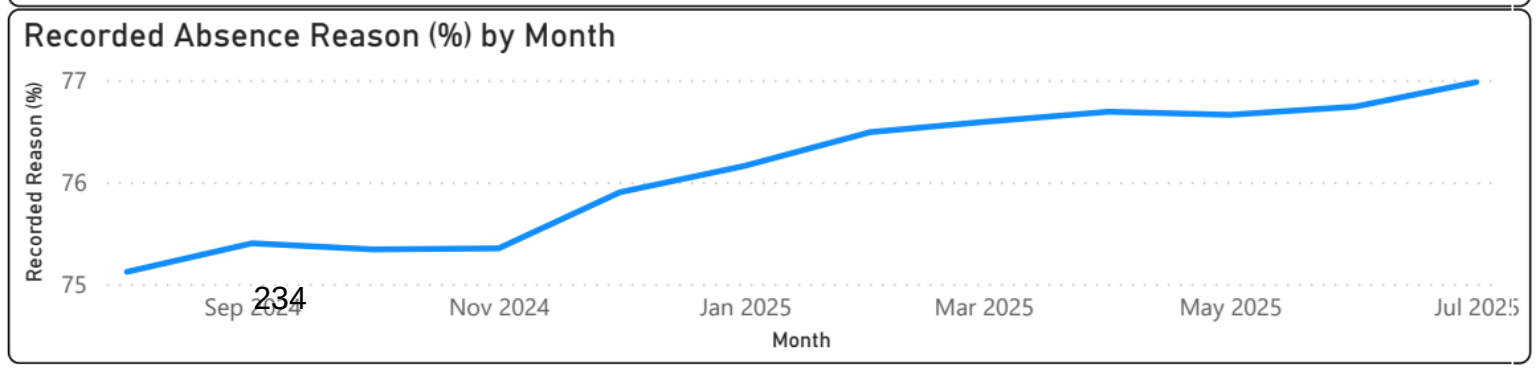
National Target Achievement
Not available currently

Position









Training Metrics Jul 2025

ADP Deliverables

Progress as at End of Q1 2025/26

Insights to Current Performance

Plans and Mitigations

- At risk ward shows improvement with PUs, but now has increase in number of PUs to feet- ongoing support and include roll out of CPR Feet
- Red Day Tool Updated and now includes CPR Feet question- for TVLG
- Await new guidelines for PU Policy
- -Discuss with NATVNS how we can move forward with benchmarking our PU/lincontinence related Datix and who best to support

Performance Rating

Latest Performance

National Benchmarking

HIS to confirm plans for future/ and how soon

National Target

20% reduction

National Target Achievement

Bank eLearning Completion Rate (%)	Substantive eLearning Completion Rate (%)
48.5	78.6

Exec Lead
Louise Bussell

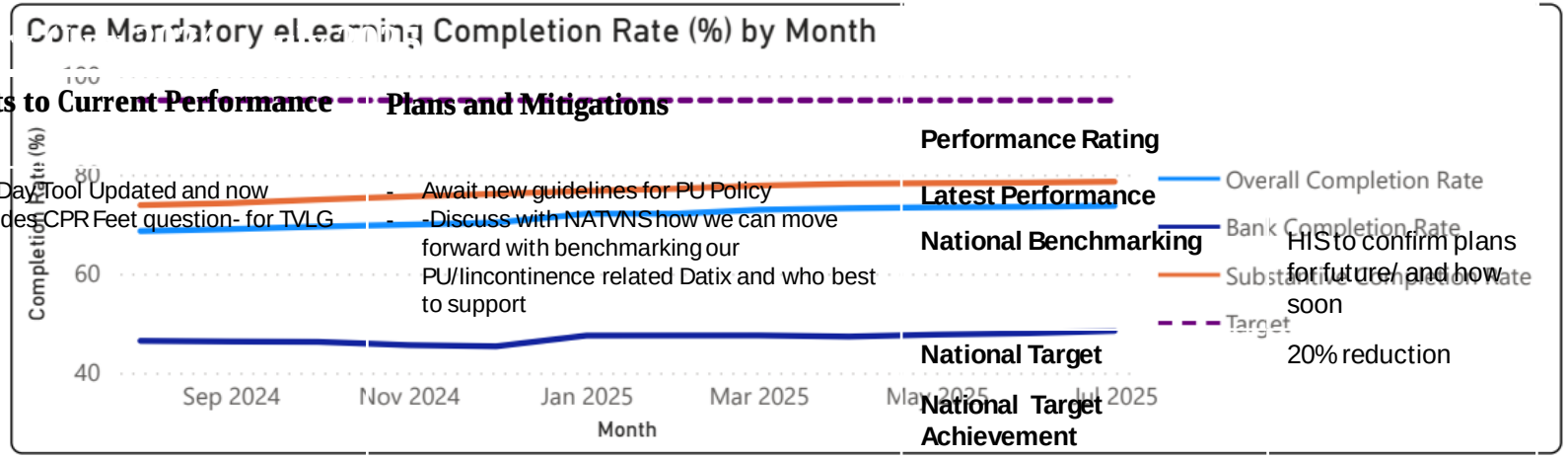
Overall eLearning Completion (%)
73.7

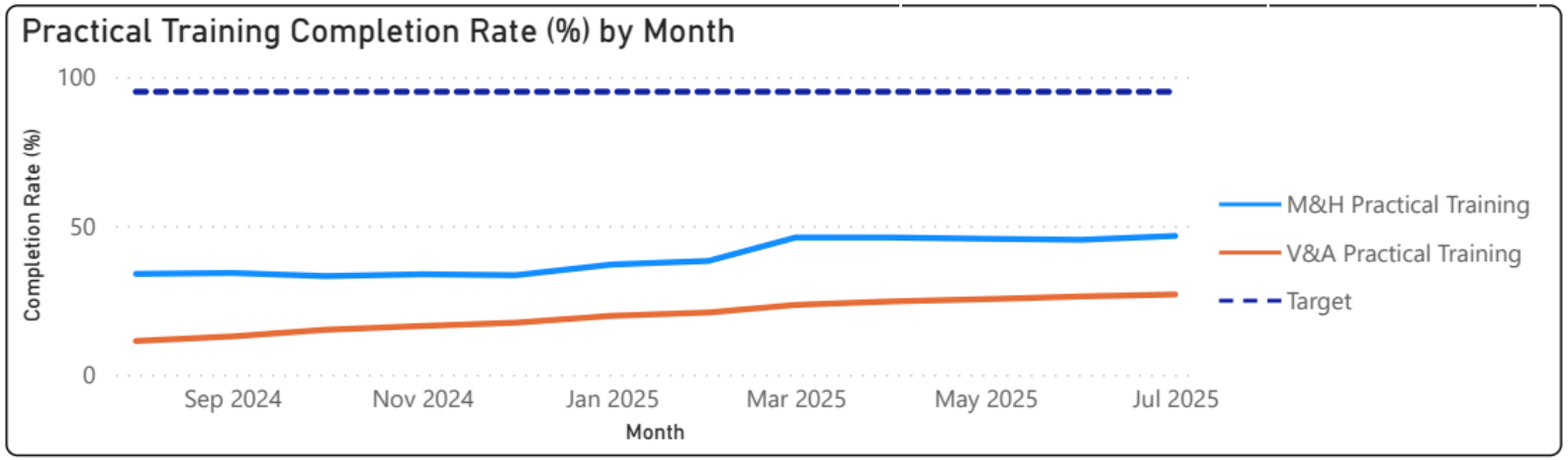
Note that from Jul 2024 V&A e-Learning module has been reintroduced to Mandatory Training compliance figures as a new course was launched in June for all Job Families. V&A Practical figures have dropped due to a new template report which is mirroring the new V&A training pathway requirements.

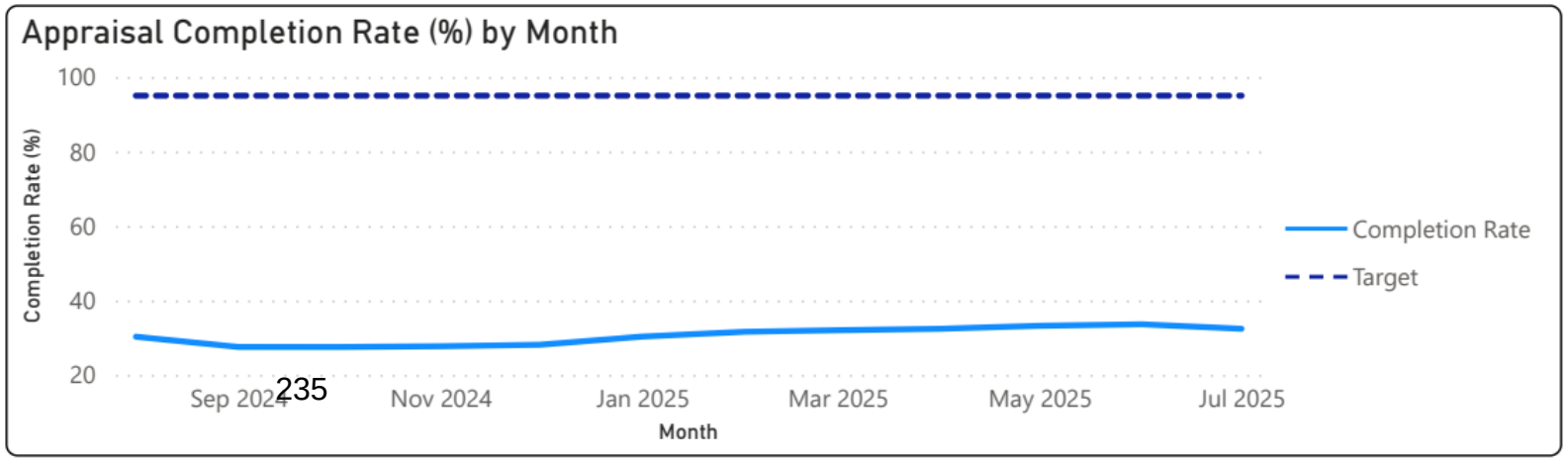
M&H Practical Training Completion Rate (%)	V&A Practical Training Completion Rate (%)
46.6	27.0

Appraisal Completion Rate (%)
32.4

Note that from Sep 2024, new starts are no longer excluded from Appraisal figures.







	ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations		
Exec Lead **Louise Bussell**	- Need to focus on Grade 2 and Grade 1 prevention as these 2 categories still account for the highest incidents of developed PUs.	- TO discuss if Grade 1 can continue to be Datixed, as well as Grade 2- as there is discussion that Grade 1 should not be reported- but it should as it is the start of skin damage	There is a head to toe inspection video that will be used via NATVNS – I have asked TURAS to share and be made accessible to/including non NHS Highland care homes- https://youtu.be/zUs93xdBKxU -Equipment guide being updated as a step up/step down guide for all clinicians across acute and community- for TVLG	**Performance Rating** **Latest Performance** **National Benchmarking** **National Target** **National Target Achievement** **Position**	HIS to confirm plans for future/ and how soon- ongoing 20% reduction

Exec Lead
Louise Bussell

ADP Deliverables: Validated position for 2024/25 and current position for 2025/26

Clostridioides difficile (CDI)
Validated end of year Healthcare Associated infection (HCAI) rate of 24.6 (79 cases) against target of 15.6 (April24-March 25) reported. As predicted, target not met.

2025/2026 reduction aim is 75 HCAI cases. As of 30/06/2025 13 HCAI cases reported

Staphylococcus aureus bacteria (SAB)
Validated end of year Healthcare Associated infection (HCAI) rate of 11.8 (38 cases) against target of 15.3 (April24-March 25) reported. This reduction aim has been met.

2025/26 reduction aim is 53 HCAI cases. As of 30/06/2025 19 HCAI cases reported

Escherichia Coli (ECB)
Validated end of year Healthcare Associated infection (HCAI) rate of 27.7 (89 cases) against target of 17.1 (April24-March 25) reported. As predicted target not met.
2025/2026 reduction aim is 75 HCAI cases. As of 30/06/2025 18 HCAI cases reported

Insights to Current Performance

The RAG rating is calculated on the predicted monthly numbers.

A rise in SAB cases was seen in Jan-March 25, upon investigation no commonalities have been identified. ARHAI Scotland have been approached regarding complexity of cases and to understand if NHSH is an outlier. Awaiting response. Case numbers now reduced.

Plans and Mitigations

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

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

Continue to ensure adherence to national guidance for the management of infections.

- NHS Highland absence remains above the national 4% target and is now 6.14% for July 2025, the previous peak was 6.94% in January 2025. 24.6% of Long-term absences are related to anxiety/stress /depression/other psychiatric illnesses. Short term absences in Cold, Cough, Flu (21.6% of short-term absences) remain high as well as gastro-intestinal problems (16.6% of short-term absences).
- Absences with an unknown cause/not specified remaining high (accounting for around 23.02% 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.
- Attendance Management audit concluded with number of actions to progress to support managers.
- 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. It has improved markedly since its peak of 128.9 days in July 2024 and is now 102.7 days. Work continues to improve on timescales.
- an ’ annual turnover sits at 7.09% for July 2025.
- In July 2025 we continued to see high levels of leavers related to retirement (25.5%) and new NHS employment (23.6%) and we see high levels of leavers t t e rea n re r e a ‘ t er’ a nt f r .5% f r ea er . 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. 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 to support planning and discussions with teams.

Appendix: IPQR Contents

Slide #	Report	Frequency of Update	Last Presented
4	18 Weeks CAMHS Services Treatment	Monthly	August 2025
4	CAMHS Waitlist NHSH	Monthly	August 2025
5	1st New Appointment Only	Monthly	August 2025
5	NDAS Total Awaiting 1st App (incl unvetted)	Monthly	August 2025
5	New + Unvetted Patients Awaiting First Appointment by Wait Band	Monthly	August 2025
6	Screening Programme Uptake KPIs in NHS Highland	Annual	August 2025
6	Inequality in Screening Comparison of NHS Highland and Scotland	Annual	August 2025
7	ren' Va nat n U ta e	Quarterly	August 2025
8	Smoking Cessation	Quarterly	August 2025
9	NHS Highland-Alcohol brief interventions 2023/24 Q2	Quarterly	August 2025
9	Setting Contribution 2024/25	Quarterly	August 2025
10	Breastfeeding	Monthly	NEW
11	.Drug and Alcohol Recovery Performance Against Standard for Completed Waits	Quarterly	August 2025
11	% Ongoing Waits at Quarter End Waiting More than 3 Weeks (Breached Target)	Quarterly	August 2025
12	A&E – 4 Hour Target	Monthly	August 2025
12	Weekly ED Patients Waiting 12-Hour Plus	Monthly	August 2025
12	Weekly Ambulance Handover Results: Under 60 Minutes	Monthly	August 2025
13	Delayed Discharges at Monthly Census Point	Monthly	August 2025
13	Delayed Discharge – Location and Code	Monthly	August 2025

Slide #	Report	Frequency of Update	Last Presented
14	New Outpatients Patients seen and Trajectories	Monthly	August 2025
14	OP Patients Waiting Over 52 Weeks	Monthly	August 2025
15	Return Outpatients Wait List	Monthly	August 2025
15	Outpatient Conversion Rates to TTG	Monthly	August 2025
15	Outpatient Follow Up Ratio	Monthly	August 2025
16	Planned Care Patients Seen and Trajectories	Monthly	August 2025
16	TTG Patients waiting over 52 weeks	Monthly	August 2025
17	Imaging Tests: Maximum Wait Target 6 weeks	Monthly	August 2025
17	Board Comparison % met Waiting time standard	Monthly	August 2025
18	Endoscopy Tests: Maximum Wait Target 6 Weeks	Monthly	August 2025
18	Board Comparison % met Waiting time standard	Monthly	August 2025
19	Cancer 31 Day Waiting Times	Monthly	August 2025
19	Board Comparison % Met waiting time standard	Monthly	August 2025
19	Patients Seen on 31 Day Pathway	Monthly	August 2025
20	Cancer 62 Day Waiting Times	Monthly	August 2025
20	Board Comparison % Met waiting time standard	Monthly	August 2025
20	Patients Seen on 62 Day Pathway	Monthly	August 2025

Slide #	Report	Frequency of Update	Last Presented
21	Systemic Anti Cancer Therapy – Waiting Times	Monthly	August 2025
22	18 Weeks All Ages Psychological Therapy Treatment	Monthly	August 2025
22	Board Comparison % Met waiting time standard	Monthly	August 2025
22	Psychological Therapies Waitlist NHSH	Monthly	August 2025
23	Highland Wide Stage 2 Complaint Volumes Received and % Performance Achieved	Monthly	August 2025
24	SPSO Feedback Cases	Monthly	August 2025
25	SAER & Level 1 Volumes: Declared Last 13 Months	Monthly	August 2025
26	Level 2a Investigations Declared	Monthly	August 2025
27	Active SAERs Level 1	Monthly	August 2025
28	Number of Hospital Inpatient Falls 2024/25	Monthly	August 2025
29	Number of Hospital Inpatient Falls with Harm 2024/25	Monthly	August 2025
30	Number of Hospiital Inpatient Falls by Subcategory	Monthly	August 2025
31	Number of Tissue Viability Injuries | Run Chart	Monthly	August 2025
32	Number of Tissue Viability Injuries | All Subcategories and Injury Grades | Sub-Category	Monthly	August 2025
33	Number of Tissue Viability Injuries | Subcategory by Injury Grade	Monthly	August 2025

Slide #	Report	Frequency of Update	Last Presented
34	Quarterly Rate of Healthcare Associated CDI per 100,000 Bed Days	Quarterly	August 2025
34	Quarterly Rate of Healthcare Associated ECB per 100,000 Bed Days	Quarterly	August 2025
34	Quarterly Rate of Healthcare Associated SAB per 100,000 Bed Days	Quarterly	August 2025
35	Organisational Workforce Metrics	Bi-monthly	August 2025
36	Workforce Training Metrics	Bi-monthly	August 2025
37	Workforce IPQR Narrative	Bi-monthly	August 2025

Agenda Item 6

NHS Highland

Meeting:	**NHS Highland Board Committee**
Meeting date:	**30 September 2025**
Title:	**Operational Improvement Plan update**
Responsible Executive/Non-Executive:	**Kristin Gillies, Interim Head of Strategy & Transformation**
Report Author:	**Bryan McKellar, Whole System Transformation Manager**

Report Recommendation:

The Board are asked to **note** the content of the report and take **Substantial Assurance** on the interface between NHS Highland's Annual Delivery Plan and the deliverables set out within the Scottish Government Operational Improvement Plan (OIP).

1 Purpose

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

NHS Highland has approved its Annual Delivery Plan (ADP) for 25/26; this has subsequently been approved by Scottish Government.

The requirements of Scottish Government's Operational Improvement Plan (OIP) are included within the Board's ADP across the four areas of focus. FRPC were previously assured that reporting of OIP would be delivered through the existing ADP and Integrated Performance and Quality Reporting (IPQR) mechanisms.

The purpose of this paper is to provide NHS Highland Board with a further update on the progress with the Operational Improvement Plan.

2.2 Background

On 27th January 2025, the First Minister described plans to renew the health service and deliver the renewal of the NHS. The First Minister set out the Government's ambition for renewal to deliver more accessible, more person-centred care, trying to reduce immediate pressures across the NHS, shift the balance of care from acute services to the community, and use digital and technological innovation to improve access to care.

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.

Boards submitted their Annual Delivery plans to the Scottish Government in March 2025 which is still the main delivery plan for NHS Boards. The specific commitments outlined in January in the OIP are anticipated to be delivered and build on health boards' own delivery planning.

2.3 Assessment

Scottish Government's OIP is described as the first component of 3 "products", the second product will be the population health framework and the third a 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.

The development of the OIP followed the substantial development of the board's ADP, which represents a far wider set of objectives for all the services provided by NHS Highland. The OIP focusses on key policy directions which are fundamental to our key transformation and service improvement plans.

A matching exercise has been undertaken to link the deliverables of the OIP with NHS Highland's ADP. This is included in Appendix 1 and is broken down into 4 sections:

- Improving access to treatment
- Shifting the balance of care
- Improving access to health and social care services through digital and technological innovation
- Prevention – working with people to prevent illness and more proactively meet their needs.

There has been significant progress updates in each area described below:

Improving access to treatment

Planned Care and Cancer services have received additional investment in 2025/26 to provide additional new outpatient and treatment slots and in particular to reduce the number of patients waiting over 52 weeks for treatment.

NHS Highland was made aware of the results of bidding process in June 2025 and since that time work has focused on moving forward with the required additionality and standing-up of reporting arrangements.

A Planned Care dashboard has been created which allows interrogation of planned activity vs. actual activity at speciality level. Weekly meetings with services have been arranged where data is interrogated and mitigations and actions put in place to ensure the activity is delivered.

There a weekly escalation meeting with the Chief Executive and other members of the Executive Team, with a focus on ensuring there are measures in place for any patients tripping over to a >104 week wait.

There is a weekly data submission to Scottish Government on all planned care activity.

These actions link into national attention through the Board Chief Executives group who interrogate national data on a weekly basis. This has recently extended to both Cancer and Diagnostics activity reporting.

For Cancer services, NHS Highland is reviewing the framework for delivery of the Cancer Waiting Times 31 and 62-day targets. Current improvement activity is focussed on Urology and Breast pathways which result in a failure to meet the 31 and 62-day pathways.

A weekly huddle has been instigated with all services involved in delivery of cancer pathways, and there is a bi-monthly Cancer Performance and Delivery Group for escalation of any issues relating to cancer service delivery.

Cancer is now a standing item on the weekly Chief Executive Assurance Meeting alongside planned care.

Both these areas are subject to interrogation through quarterly Acute Performance Reviews, and for assurance data is provided as part of the Integrated Performance and Quality Report, the latest version is provided to FRPC on 12 September.

Shifting the Balance of Care

Urgent & Unscheduled Care

The focus of work in this space is within our Urgent & Unscheduled Care portfolio where the priorities for strategic transformation of services has been identified.

This work includes commitments such as a frailty assessment area within Raigmore Hospital, and the development of Hospital at Home services as per the commitments in the Operational Improvement Plan. Further detail of these are included in Appendix 2

NHS Highland has recently agreed its plan for 25/26 in relation to the OIP commitments and the targeted spending of additional funding made available by

Scottish Government. Performance trajectories have been set in liaison with Centre for Sustainable Delivery.

These trajectories are incorporated in reporting to the Urgent * Unscheduled Care Portfolio Board and data reporting that supports all groups. These are focussed on the key measures outlined by CfSD (CfSD) including Emergency Department performance (4/8/12 hour waits), Delayed Hospital Discharges, Hospital Occupancy and Length of Stay. This is provided at the board-level, but can also be provided in individual site level due to the work ongoing in both Highland and Argyll & Bute.

A quarterly data submission will be required for CfSD, while the development of a dashboard for within NHS Highland is in progress, to support actions within the portfolio.

Emergency Department Access and Delayed Discharges are part of the IPQR provided routinely to FRPC. Furthermore, LoS and other measures are currently being considered for reporting in the Highland HSCP IPQR that is provided to Highland Health and Social Care Committee.

U&USC measures will be key to reporting at the Acute, Highland and A&B Performance Reviews.

A further programme under this area is Community Glaucoma. NHS Highland is committed to the implementation of the national digital solution (OpenEyes) within 2025/26 which will include delivery of additional optometric activity within the community. A clinically-led project team has been established to move this work forward.

Improving access via Digital

Key focus areas that have a digital element are also key to the Operational Improvement Plan. Since the last update, there has been a review of these areas and updates as to current progress are underway.

A key area is the delivery of an Operating Theatre Scheduling Tool. This is being expanded across General Surgery and has linkages to other digital initiatives. Work to consider the impact and benefits of this implementation has commenced with a focus on how the digital scheduling tool increases efficiency of the use of theatres in Raigmore.

NHS Highland is also engaging with national groups on the readiness of the Digital Front Door project which is to be trialled in NHS Lanarkshire.

Furthermore, NHS Highland is moving into phase 2 of its Digital Dermatology programme which is looking to maximise the use of the system through engagement across the health and care system.

Preparation for the Digital Type 2 Diabetes remission digital solution is underway in NHS Highland, and development work will be sequenced with the national project team delivering this programme across Scotland.

NHS Highland does not deliver genetic testing on sight but is working very closely with services in the East of Scotland Regional Genetics team as a customer of these pathways.

Prevention

Opportunities for prevention are being captured through our Population Health programme board. The programme is currently COLLATING all current activity with a view to then moving into the CURATE stage working with services and other programmes to identify opportunities as part of our strategic planning and development of a population-health needs based NHS Highland strategy to move on from Together We Care.

The governance, timescales and programme plan for development of this refreshed board-wide strategy is in development.

Core to the delivery of NHS Highland's Urgent and Unscheduled Care programme is work regarding Frailty, with specific elements relating to primary prevention and sign-posting to non-NHS services is a core part of the programme being led through the Highland HSCP Primary Care Medical Director.

Reporting

Now that all elements of the Operational Improvement Plan have been agreed, reporting on the quarterly ADP deliverables will commence. Progress on the deliverables to 30 September 2025 will be reported to EDG in October 2025, and thereafter FRPC.

Performance monitoring will continue at the operational and portfolio levels with the weekly CE assurance call and interface nationally.

In order to ensure timely reporting on both the deliverables of the OIP and the related performance indicators, as well as keeping updates on the board's wider commitments in the ADP, the following schedule of updates to FRPC is proposed to align with reporting requirements to NHS Highland board:

FRPC Meeting Date	Items
3 October 2025	
14 November 2025	IPQR OIP Deliverables Report ADP End of Q2 25/26 Report
5 December 2025	
9 January 2026	IPQR OIP Deliverables Report
6 February 2026	
13 March 2026	IPQR OIP Deliverables Report
10 April 2026	
8 May 2026	
5 June 2026	ADP End of Q4 25/26 Report

2.4 Proposed level of Assurance

Substantial	X	Moderate	
Limited		None	

Comment on the level of assurance

NHS Highland Board are asked to take substantial reporting on the progress of the Operational Improvement Plan, reporting of the deliverables will be through existing ADP 25/26 quarterly reporting and bi-monthly IPQR reporting for performance metrics.

Furthermore it is proposed to provide regular updates on both progress of the Operational Improvement Plan and Planned Care deep dive on alternate months to the IPQR reporting.

3 Impact Analysis

3.1 Quality/ Patient Care

The strategic transformation of services across NHS Highland is required to support the delivery of sustainable services that meets the strategic outcomes of Together We Care.

3.2 Workforce

An easy read version of the ADP 25/26 is being made available. The OIP has been shared in board-wide communications on plans.

3.3 Financial

Financial resource has been assigned to each STAG ABC programme to help scope the benefits of each programme. Benefits realisation remains a key area to deliver in this ABC programme framework, in particular in relation to areas with Urgent & Unscheduled Care.

3.4 Risk Assessment/Management

Each programme will maintain a risk register. There are two Level 1 Corporate Risks relating to the delivery of our Annual Delivery Plan and Together We Care. This relates to resource and capacity to meet all the objectives required.

3.5 Data Protection

Each programme will require to consider Data Protection considerations accordingly.

3.6 Equality and Diversity, including health inequalities

Each programme will undergo an EQIA screening assessment to consider the impact to people with protected characteristics, and plan any mitigations / actions require

3.7 Other impacts

N/a

3.8 Communication, involvement, engagement and consultation

3.9 Route to the Meeting

EDG – Monday 28th July
FRPC – Friday 1st August
EDG – Monday 27th August
FRPC- Friday 12th September

4.1 List of appendices

The following appendices are included with this report:

Appendix 1, OIP Dashboard Update as at 03/09/2025

OIP	TWC Outcome	Area	Description	Executive Lead	Update	BRAG at 03/09/25
Improving Access to Treatment	Treat Well	Planned Care	Delivery of additional Planned Care activity (TTG and NOP) to reduce the longest waiting patients (target 0 >52 weeks by March 2026) across all specialities (or to target levels agreed with SG if 0 not possible)	Katherine Sutton	System of escalation and weekly performance monitoring in place. Planned Care activity is reported as part of the FRPC IPQR	Some areas under plan, but monitoring in place and recovery plans being made.
Improving Access to Treatment	Treat Well	Diagnostics	Drawing from the additional £100 million investment we will deliver additional MRI, CT, ultrasound and endoscopy procedures to target the backlogs. This will support delivery of 95% of referrals to radiology being seen within six weeks by March 2026.	Katherine Sutton	System of escalation and weekly performance monitoring in place. Diagnostics activity reported as part of the FRPC IPQR.	
Improving Access to Treatment	Journey Well	Cancer	Improving performance against the 31 and 62-day Cancer Waiting Times performance, improving access to cancer diagnosis and treatment	Katherine Sutton	System of escalation and weekly performance monitoring in place. Trajectories for performance improvement submitted to PHS. Cancer 31 and 62-day performance reported as part of FRPC IPQR	Performance improvement required to meet trajectories.
Improving Access to Treatment	Live Well	CAMHS	Continue to improve access to CAMHS services and meet the CAMHS waiting times standard of 90% starting treatment within 18 weeks of referral.	Katherine Sutton	Service improvement plan moving into BAU.	
Shifting the Balance of Care	Respond Well	Unscheduled Care	Expanding Same Day Emergency Care (SDEC) at Raigmore so more patients can be assessed, treated, and discharged on the same day – avoiding unnecessary overnight stays	Katherine Sutton	Programme plan in place and trajectories agreed with SG and agreed KPIs reported through FRPC IPQR.	
Shifting the Balance of Care	Respond Well	Unscheduled Care	An AHP service, including physiotherapists and occupational therapists, will be based at Raigmore ED and medical receiving units to assess older and more frail patients as early as possible	Katherine Sutton	Programme plan in place and trajectories agreed with SG and agreed KPIs reported through FRPC IPQR.	
Shifting the Balance of Care	Respond Well	Unscheduled Care	A safe and consistent Discharge to Assess model – to be trialled in East Ross before rolling out across all districts – will enable patients to return home as soon as they are medically ready, with care needs assessed in the comfort of their own surroundings.	Katherine Sutton	Programme plan in place and trajectories agreed with SG and agreed KPIs reported through FRPC IPQR.	
Shifting the Balance of Care	Respond Well	Unscheduled Care	Hospital at Home services will be progressed, starting with Inverness in FY 25/26 with a view to implementing across other districts across the Highland area allowing more patients to receive hospital-level care in the comfort of their own home.	Katherine Sutton	Programme plan in place and trajectories agreed with SG and agreed KPIs reported through FRPC IPQR.	

Shifting the Balance of Care	Respond Well	Unscheduled Care	A dedicated Acute Frailty Assessment Area in Raigmore will give people identified as frail faster, specialist treatment, reducing the time they need to spend in hospital.	Katherine Sutton	Programme plan in place and trajectories agreed with SG and agreed KPIs reported through FRPC IPQR.	
Shifting the Balance of Care	Respond Well	Unscheduled Care	There is additional planning work progressing to support developing a sustainable Flow Navigation Centre (FNC) and Out-Of-Hours (OOH) model that is integrated across primary and secondary care services and supporting patients to access care through more streamlined pathways.	Katherine Sutton	Programme plan in place and trajectories agreed with SG and agreed KPIs reported through FRPC IPQR.	
Shifting the Balance of Care	Respond Well	Unscheduled Care	In Argyll & Bute, plans are progressing on redesigning and expanding its Extended Community Care Team (ECCT) to prevent deterioration, respond rapidly in the community, and deliver Discharge to Assess with a strong reablement focus. This enhanced service will see a significant rise in frailty screening and early clinical assessments, helping more people return home quickly with tailored support.	Evan Beswick	Programme plan in place and trajectories agreed with SG and agreed KPIs reported through FRPC IPQR.	
Shifting the Balance of Care	Care Well	Primary Care Optometry	Expand the Community Glaucoma service in line with delivery of the national system Open Eyes, currently being led through NTC-Highland	Katherine Sutton	Position statement submitted to SG and operational plan agreed.	
Digital and Technological Innovation	Digital Delivery Plan	Digital Front Door	Digital Front Door' app by the end of 2025 to improve access to health and social care services, starting with a pilot in Lanarkshire and expanding nationwide over five years, supported by integrated data sharing through the Community Health Index.	David Park	Working with national team on setting up the local readiness workshop (this workshop will involve a range of staff who have knowledge and skills that will be required to support the DfD programme).	Engagement with national team underway.
Digital and Technological Innovation	Digital Delivery Plan	Digital Dermatology	A new Digital Dermatology Pathway, enabling GPs to attach skin images to referrals, is being rolled out across Scotland by spring 2025 to streamline diagnoses, reduce unnecessary consultant visits, and fast-track urgent cases, with impact tracked through usage and triage outcomes.	Katherine Sutton	Phase 2 commenced: - Application Live from 1st May 2025, NHS Highland. - Next steps ensure uptake and implementation of primary care practice's in NHS Highland. - Data reporting - development of dashboard (currently reporting to CSfD - internal reporting route to be confirmed - National funding for next FY to be confirmed	
Digital and Technological Innovation	Digital Delivery Plan	Type 2 Diabetes Remission Programme	New national digital intensive weight management programme will support 3,000 newly diagnosed type 2 diabetes patients over three years from January 2026, aiming for significant weight loss and remission in up to 40% of participants, with outcomes tracked by recruitment, remission rates, and health improvements.	Katherine Sutton	This ANIA programme is being supported nationally by NHS Highland with our Interface Lead helping the national teams design the final technical solution. Their will be work required by Board but this work is now known as yet and is not required for some months. To be scheduled nearer the required time	

Digital and Technological Innovation	Digital Delivery Plan	Genetic Testing	Introducing new genetic testing for stroke patients newborn babies with bacterial infections, and new stroke patients	Katherine Sutton	Genetic testing is delivered for NHS Highland by the East of Scotland service. Labs service working closely with service provided on the introduction of these pathways.	Services not delivered in NHSH – engagement underway with service provided.
Digital and Technological Innovation	Digital Delivery Plan	Theatre Scheduling	A theatre scheduling tool that boosts operating theatre productivity by up to 20% is being rolled out across all Scottish health boards by June 2025 to optimise theatre use, prioritise patients more effectively, and reduce treatment wait times.	Katherine Sutton	Continued rollout rollout if Infix across general surgery. Further implementation of OPCS-4 coding to ensure Scan4Safety and Infix projects successful. Intention to work with services where Infix has been implemented to understand impact on administration time. Increased efficiency potentially result in fewer theatres running, whilst maintaining throughput of current numbers of patients.	
Prevention	All Well Themes	Proactive Prevention	Preventative action at any stage of a person's health can significantly improve outcomes, with new investments in 2025–26 supporting proactive interventions for cardiovascular disease and frailty, including enhanced services and dedicated leads in general practice.	Jennifer Davies	Opportunities for prevention are being captured through our Population Health programme board. The programme is currently COLLATING all current activity with a view to then moving into the CURATE stage working with services and other programmes to identify opportunities as part of our strategic planning and development of a population-health needs based NHS Highland strategy to move on from Together We Care. The governance, timescales and programme plan for development of this refreshed board-wide strategy is in development.	
Prevention	Care Well-Primary Care	Cardiovascular Disease (CVD)	A new General Practice enhanced service launching in spring 2025 will target key cardiovascular disease (CVD) risk factors—like high blood pressure and cholesterol—by identifying those at highest risk and enabling early interventions to significantly reduce long-term health impacts.	Arlene Johnstone / Evan Beswick	Feedback is awaited from both Highland and Argyll & Bute on plans for this new GP enhanced service.	Update pending.
Prevention	Care Well-Primary Care	Frailty	A new Frailty Enhanced Service launching in April 2025 will support earlier identification and management of frailty in General Practice, with each practice appointing a Frailty Lead to improve care through training, data use, and collaboration.	Arlene Johnstone / Evan Beswick	The specific Primary Care and prevention elements of this frailty programme are being taken forward in tandem with work to embed processes for the identification and management of frailty.	

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**30 September 2025**
Title:	**Winter Preparedness/Surge Planning Update**
Responsible Executive/Non-Executive:	**Katherine Sutton, Chief Officer – Acute; Arlene Johnstone, Chief Officer – HHSCP; Evan Beswick, Chief Officer – A&B**
Report Author:	**Grace Barron, Senior Programme Manager – Strategy & Transformation; Karl McLeish – A&B Urgent & Unscheduled Care Lead**

Report Recommendation:

The Board is asked to **note** the content of the report and take **moderate assurance** regarding NHS Highland's 25/26 winter preparedness.

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	X	Live Well		Respond Well	X	Treat Well	X
Journey Well		Age Well		End Well		Value Well	
Perform Well		Progress Well		All Well Themes			

2 Report summary

NHS Highland has undertaken a comprehensive winter preparedness assessment aligned with the Scottish Government's resilience checklist. The review covers acute, primary care, social care, mental health, workforce capacity and seasonal outbreak planning.

The assessment confirms that contingency arrangements are in place across most domains, with strengthened escalation protocols, enhanced vaccination uptake campaigns and cross-sectoral coordination mechanisms embedded through the Health and Social Care Partnership.

Key risks remain around sustained workforce pressures, variable resilience in remote and rural services, and capacity constraints within community and social care provision that impact timely hospital discharge. Winter vaccination uptake will require continued focus, and resilience planning for concurrent outbreaks (COVID-19, influenza, norovirus) remains critical.

Overall, NHS Highland enters winter 2025/26 with a resilience framework, sustained monitoring, rapid escalation pathways, and targeted support in identified pressure areas will be essential to maintain system stability and ensure safe, effective care delivery.

2.1 Situation

NHS Highland is entering the 2025/26 winter period facing sustained system pressures across acute, primary, community, and social care. A comprehensive winter preparedness plan has been completed in line with Scottish Government guidance, operational challenges are anticipated due to continuing workforce shortages, rising demand for unscheduled care, and increased acuity within an ageing population.

The system is expected to experience peaks in emergency attendances, delayed discharges, and potential seasonal outbreaks of influenza, COVID-19, and norovirus. Resilience in remote and rural services, where capacity to flex or escalate is limited will require agile and responsive leadership.

2.2 Background

Each year, all NHS Boards in Scotland are required to provide assurance to the Scottish Government on winter preparedness, supported by a standard checklist covering resilience across health and social care. Much of this work reflects established "business as usual" activity within NHS Highland, including surge

planning, vaccination delivery, escalation procedures, and cross-system coordination through the Health and Social Care Partnership.

For winter 2025/26, NHS Highland has reviewed and updated its arrangements across acute, primary care, social care, mental health, and public health domains. The Board continues to operate within a challenging environment of workforce shortages, system pressures and variable resilience in remote and rural areas. However, strong collaborative working with local authority partners and independent/third-sector providers supports a coordinated approach to seasonal resilience planning.

2.3 Assessment

An assessment of each resilience focus area is found below. Each area has been reviewed against the Scottish Government winter preparedness checklist to identify what is in place, what is partially in place, and any ongoing risks. Cross-cutting issues such as workforce pressures, out-of-hours support, and integration between health and social care have been considered throughout and areas that require strengthening are being mitigated at operational level with oversight through the Operational Senior Leadership Teams supported through the Urgent Unscheduled Care Portfolio board.

Acute – HHSCP (Raigmore, CGH, Belford)

Acute services have partial assurance across most winter preparedness domains. The Flow Navigation Centre provides cover 0800–0000 further application of these pathways to support Rural General Hospitals (RGHs) is being considered. Safety huddles and discharge processes are established. Consistent approaches to Home First and step-down pathways are being progressed where appropriate.

Flow Co-ordinator roles are in place at Raigmore Hospital and have been recently introduced to Caithness General Hospital and Belford Hospital. Alternatives to admission, including Outpatient Antibiotic Therapy (OPAT) and Respiratory Rapid Response, are available, while Hospital at Home and frailty pathways remain under development.

Planned care resilience is strong, Emergency and urgent care patient pathways are being strengthened in the key areas of; zero-day length of stay (LOS) pathways, frailty pathways, and extended Same Day Emergency Care (SDEC) provision.

Acute – A&B (Community Hospitals and Lorn and Isles RGH)

Acute Services across Argyll and Bute continue to experience significant pressures in the approach to winter. The Flow Navigation Centre provides cover 0800–0000 and local patient pathways are being reviewed to ensure a greater uptake across Argyll and Bute populations. GP OOH arrangements are in place during out of hours periods, across all locality areas, and will continue to focus on community MDT working to avoid attendance and admission where

appropriate. Local communications will continue to ramp up campaigns such are Right Care and Pharmacy First.

A&E departments will continue to operate in response to urgent care needs 24/7 across 6 non-bypass community hospitals and 1 RGH (LIH). Hospital at Home is operational across LIH. Limited contingency bed planning is available within some sites. Bed management meetings are in place to remain agile and responsive to changing pressures in system flow.

Focussed Impact Assessment work has been undertaken to assess and manage the impacts of increased front door traffic, admission and delayed discharge. A clear action plan has been generated as a result, and this will be driven forwards by the system pressures steering group.

Primary Care – HHSCP

Primary care services have strong winter preparedness arrangements. General Practice has established escalation processes for service disruption, with Board-level oversight and an Out of Hours (OOH) winter plan aligned to Flow Navigation Centre development (FNC), Scottish Ambulance Service (SAS), and NHS 24 pathways. Dental services have escalation protocols and NHS 24 liaison in place to ensure resilience.

Consideration of strengthening links with Primary Care will be progressed through appropriate governance processes, with Anticipatory Care Planning already established within care home settings.

Primary Care – A&B

Plans are in place to support the continued delivery of General Medical Services over the winter period. This includes the development and use of clear escalation policies/practices to support any sites that have difficulty in opening/ operating due to adverse impacts. Any events of this nature would be supported with the use of Highland Health and Social Care Partnership (HSCP) communications team to inform patients of difficulties and alternative arrangements. Buddy system/arrangements/mutual aid protocols from COVID remain in place. Multi-Disciplinary Team (MDT) arrangements are expected to continue per business-as-usual arrangements.

In terms of OOH GP care, the majority of out of hours care is delivered from community GPs under SLA/B2B arrangements and rotas are in place. Access to dentistry services can be challenging.

Additional levels of MDT working have been intimated within the current round of B2B contract negotiations although an ongoing programme of works is required to map the delivery of this across OOH services in A&B.

Contingency is in place to enable remote / Near Me consultation for Islands as required in the event of service disruption. Neighbouring area contingencies are in place as normal where applicable.

The necessity to deliver care home visits has been included within this year's contract negotiations for OOH contractors although negotiations have not yet firmly concluded. All GP providers are being reminded of the importance of ensuring anticipatory care plans (ACPs) are in place in the winter briefing letter.

Responder services are in place and are linked to telecare providing the pathway for uninjured falls and de-escalation of non-emergency care. ACP is in place in care homes, and consideration of strengthening links with Primary Care will be progressed through appropriate processes.

Mental Health – HHSCP

Mental health services have comprehensive winter readiness plans in place. The Mental Health Assessment Unit at New Craigs provides 24/7 crisis response and professional-to-professional support, accessible across health, social care, SAS and Police Scotland.

The Mental Health Learning and Disability Division has embedded real-time staffing and risk mitigation processes to maintain safe delivery of care, including for forensic patients and prison healthcare. Discharge planning and continuity of care for those with complex needs, dementia, or learning disabilities is supported through strong MDT working and partnerships with the third sector. Daily monitoring of demand and capacity enables responsive escalation.

Mental Health – A&B

Plans are in place to manage waiting lists and escalations during winter months, by utilising existing resource to maximum capacity. Escalation routes are clearly defined.

Mental health crisis teams are in place 24/7 and winter planning takes full account of the needs of patients and carers with a mental health diagnosis. This includes a clear focus on anticipatory/future care planning and carer support planning.

Discharge planning considers the needs of patients with a mental health need/ additional need and implements adjustments to discharge/care planning where appropriate.

Inpatient Quality and Safety forums remain in place to identify and mitigate risks in real time.

There is a clear HSCP focus on place of safety arrangements across the region. OPEL has recently been introduced to Succoth Mental Health ward, and we expect that this approach to demand and capacity/risk management to allow greater capabilities in managing surge capacity as a part of a whole system approach.

Workforce – HHSCP & A&B

NHS Highland continues to take proactive steps to support recruitment and retention across the system, including permanent, bank, and flexible contracts, as well as student engagement for holiday cover. Retire-and-return, partial retirement, and flexible working arrangements are embedded to bolster workforce capacity.

Winter staffing plans are in place across acute, primary, mental health, and social care services, with contingency arrangements for holiday periods and crisis response. Challenges remain with ongoing vacancies and hard-to-fill posts, particularly in social care, which may affect timely discharges and service resilience.

Volunteer deployment is partially planned, with acute-based volunteers available for escalation if required. Staff wellbeing resources are accessible year-round and integrated into winter communications, while business continuity plans account for potential adverse weather or staff disruption.

Seasonal Outbreaks – HHSCP

NHS Highland has comprehensive plans in place to manage seasonal outbreaks, including COVID-19, influenza, RSV, and norovirus. Staff vaccination programmes are widely accessible, including drop-in clinics, peer-to-peer vaccination, and workplace delivery, supported by awareness campaigns, education, and leadership engagement. Despite strong systems, staff flu uptake remains a focus for improvement.

Surge management is embedded across acute, primary, mental health, and social care, with Operational Pressures Escalation Levels (OPEL) meetings and business continuity plans ensuring timely response to staffing pressures and service impacts. Closed settings, such as care homes, receive targeted Infection Prevention and Control (IPC) support and 24/7 outbreak management via the Health Protection team. Debriefs following outbreaks inform continuous learning and system adaptation.

Routine monitoring of epidemiological data through PHS publications and Whole System Winter outputs provides early warnings of rising infection levels. Staff have access to, and adhere to, national guidance on infection prevention, including norovirus management in care settings.

Seasonal Outbreaks – A&B

Staff vaccination clinics are widely accessible and available in across Argyll & Bute community settings. There are also local community clinics accessible to all staff including those who are non-hospital based. The model is delivered via a mix of scheduled appointments, drop-ins and peer vaccinations. Robust communication plans are in place to raise awareness, promote the campaign and signpost to resources.

From a staffing and resources capacity perspective, surges in infection which impact capacity would be anticipated, monitored and managed via the system escalation huddles and system pressures oversight groups.

Updates regarding surges in infection/means of early detection are reviewed as part of weekly huddle and weekly system pressures calls. These frameworks would routinely include both Infection Prevention Control advice and Public Health advice supported by local intelligence, gathered by way of escalation from area teams.

Social Care (Cross Cutting)
Social care is considered a cross-cutting theme because it interacts with all other areas of winter readiness. Its delivery directly impacts acute care through discharge pathways, influences primary care via out-of-hours support, and contributes to mental health outcomes through co-ordinated care for vulnerable individuals.

HHSCP

Challenges within social care can create system-wide pressures, making effective integration essential for overall winter resilience. In Highland, assurance arrangements are in place for Care at Home and care home services, supported by governance boards that monitor risk and maintain capacity across child and adult protection, as well as Multi-Agency Public Protection Arrangements (MAPPA). Targeted support for older adults with complex needs is provided through community access beds, daycare services, and the Care Home Collaboration team.

Resilience across all areas remains variable, with differences in service availability and coverage contributing to inconsistent experiences. For example, while Care at Home services typically operate until 10pm, regional variation in care home support may affect the ability to respond to urgent needs, particularly during out-of-hours periods. These inconsistencies can delay discharges and increase pressure on acute services. Workforce challenges, including persistent vacancies and hard-to-fill posts, continue to pose a significant risk to service continuity.

Cross-system planning is in place to support seasonal outbreaks and surge management, incorporating infection prevention and control (IPC) training, vaccination programmes, and on-call crisis response teams. However, these resources may be limited during periods of high demand, particularly in remote and rural areas.

Social Care – A&B

Operational Care at Home and Care Home Assurance functions continue to function on a regularly scheduled timetable consisting of a multi-disciplinary team with clear escalations and management of risk. All meetings are recorded/ noted with action points to be addressed within agreed timescales.

Higher level care governance meetings also take place which focusses on strategic and policy directions for these services. These meetings give opportunity for discussion and ratification of policy and guidance documents to be used ensuring a clear and consistent methodology.

The care at home service is subject to a system wide review of its vision, structure and delivery at the present time. In the fullness of time this will provide us with assurance about the effectiveness and efficiency of this essential service.

All protection functions are in place and are reviewed through forums such as the Adult Protection Committee. The COGPP is in place for escalations. Assessment of the adult protection referrals is conducted as and when received and assured through the Care Home and Care at Home Assurance meeting which meets fortnightly.

Urgent & Unscheduled Care Priorities for FY 25/26 – HHSCP & A&B

To strengthen NHS Highland's winter resilience, a series of urgent and unscheduled care improvement initiatives are being delivered in 2025/26. Supported by Scottish Government funding, these programmes focus on building community and acute capacity, improving patient flow, and easing pressure on hospital services. Together, they align with the Operational Improvement Plan (2025–2026) and are designed to deliver measurable benefits for patients and the wider system. A summary of programme scope and the outcomes to be achieved by March 2026 is set out below.

- **Same Day Emergency Care (SDEC and Ambulatory Care)**
  The SDEC service is being expanded in Raigmore, creating new pathways that allow patients to be assessed, treated, and discharged on the same day where appropriate. This will help reduce admissions, avoid overnight stays where clinically safe, and improve A&E flow; key to easing winter pressures and supporting 4-hour performance standards.

  Argyll and Bute plans to deliver an Ambulatory Emergency Care Unit Pilot at Cowal Community Hospital. This initiative responds to the 0 Day LoS target and is to be fully implemented by March 2026. It is anticipated that this approach will support clear focuses on alternatives to admission for high volume pathways, where an ambulatory approach is appropriate, with a drive on same day treatment and discharge. It is anticipated that this approach will align with primary care referral pathways, OOH pathways as well as supporting triage and streaming through ED. Planned impacts include reduced unplanned attendance, alternatives to admission, improved ED and escalation flow and reduction in delayed discharge/ delayed transfers of care.

- **AHP at the Front Door (Raigmore Emergency Department)**
  A new Allied Health Professional (AHP) front door model has gone live in Raigmore Emergency Department (ED) this year, ensuring people with identified frailty and mobility needs are assessed early by occupational

therapists and physiotherapists. This aims to reduce length of stay, enable safe discharge, and support flow through the hospital, directly contributing to winter resilience.

- **Frailty Assessment Area**
  A new frailty assessment area within Ward GA will enhance support for older patients during the critical “golden 72 hours” of their hospital journey. By expanding into a dedicated multi-disciplinary team, the service will deliver earlier comprehensive geriatric assessment, closer to the front door, helping prevent deterioration and avoid unnecessary admissions.

  Argyll and Bute plans to focus on intensive community frailty response models within two key localities (Cowal and Oban). Additionality is being implemented to support the operationalisation of whole system frailty MDT response, spanning across primary and secondary care. The additional service provision will have clear links with enhanced Extended Community Care Team (ECCT - urgent community response) and community prevention (Living Well). AHP and Frailty and the Front Door response will continue to be delivered as part of core service provision and will be enhanced across these localities by way of clear interface working with Hospital at Home (Oban) and Ambulatory Emergency Care (Cowal) services. There will be a clear focus on identification, assessment and care management, including future care planning. It is anticipated that this approach will support the prevention of deterioration and avoid unnecessary admissions.

- **Hospital at Home (Inverness model & Oban Model)**
  NHS Highland is investing in expanding the Hospital at Home model in Inverness during 2025/26, with a planned phased increase to 15 beds by March 2026. This will enable more patients to be treated safely at home rather than admitted to hospital, supporting patient recovery, improving outcomes, and reducing pressure on acute wards during periods of peak demand, particularly over winter, with a planned 8 beds live by December 2025.

  The Oban Model has a clear plan to deliver 16 virtual beds by March 2026. 14 of these are to be delivered within the Oban locality, with a further 4 planned across the wider system, by way of a ‘hub and spoke’ approach, as part of the expansion. Plans are underway to develop an Island Pilot. Additionality is being implemented to expand the reach of the service over 7 days to ensure maximum impact. Expansion plans include specific scoping, identification and facilitation of clinical training to better enhance and integrate community models of care.

- **Flow Navigation Centre (FNC) / Out of Hours (OOH) Integration**
  Work will continue to strengthen the Flow Navigation Centre and Out of Hours response model, ensuring patients are directed to the right care at the right time. By improving access to advice and alternatives to hospital attendance, this initiative will aim to reduce A&E demand and ambulance conveyances, improving whole-system resilience.

- **Discharge to Assess (East Ross pilot and ECCT Scale A&B)**
  A consistent Discharge to Assess model will be implemented in East Ross during 2025/26, with plans to expand to other districts following a pilot period. This approach supports patients to leave hospital as soon as they are medically fit, with their care needs assessed at home. The model will aim to reduce delayed discharges and improve reablement outcomes.

  Argyll and Bute HSCP plan to support additionality and increased 'Home First' capacity across two localities with significant pressures (Oban and Cowal). Additionality is planned to support increased urgent community response and early supported discharge within an intensive reablement approach. This additionality seeks to provide alternatives to hospital attendance/admission and facilitate early supported discharge in line with criteria led discharge pathways. The aim is to reduce unplanned attendance, unplanned admission, overall LoS and bed days lost from delayed discharges.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	X
Limited		None	

Proposed level of assurance is Moderate - Many elements are partially implemented due to a combination of resource, workforce, and geographic challenges. In acute and primary care, some pathways such as frailty assessment, Hospital at Home, and anticipatory care are under development and will be implemented over winter. Workforce pressures, including vacancies and hard-to-fill posts, constrain the full delivery of some services. Additionally, some initiatives, such as staff vaccination uptake, are in place but require further engagement to achieve optimal coverage.

3 Impact Analysis

3.1 Quality/ Patient Care

Safety and quality processes are maintained, and timely care and patient experience will continue to be monitored from ward to Board throughout the winter period.

3.2 Workforce

Ongoing vacancies, hard-to-fill posts and seasonal pressures risk workforce resilience across health and social care.

3.3 Financial

Additional resources may be required to support extended OOH care, surge capacity, and recruitment initiatives, potentially impacting budget allocation.

3.4 Risk Assessment/Management

Risks actively managed by services during winter peaks as business-as-usual.

3.5 Data Protection

No significant impact identified; existing systems for patient data and escalation processes remain compliant.

3.6 Equality and Diversity, including health inequalities

Access to services during times of peak pressure may disproportionately affect vulnerable or isolated populations, requiring targeted mitigation.

3.7 Other impacts

No relevant impacts.

3.8 Communication, involvement, engagement and consultation

Heads of service were consulted as part of the audit against 25/26 winter preparation.

3.9 Route to the Meeting

Through UUC Portfolio Board

4 List of appendices

N/A

Agenda Item 8

NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**30th September 2025**
Title:	**Tobacco and Vaping Strategy 2025-2030**
Responsible Executive/Non-Executive:	**Jennifer Davies, Director of Public Health**
Report Author:	**Susan Birse, Health Improvement Principal**

Report Recommendation: The Board is asked:

- **Consider** and **Agree** the actions for delivery in 2025 – 2030 and take **Substantial Assurance**.

It is recommended that NHS Highland:

- **Endorse and Implement** the Tobacco and Vaping Strategy 2025 – 2030 as a key public health initiative.
- **Prioritise actions** that reduce health inequalities, particularly in SIMD 1 and 2 areas, among vulnerable groups such as pregnant women and those with mental health conditions.
- **Support workforce development** through ongoing training and capacity building across services.
- **Strengthen data systems** to improve monitoring, evaluation, and service improvement.
- **Ensure sustained engagement** with communities, partners, and stakeholders to promote smoke-free environments and cessation support.
- **Monitor progress** against national targets and adapts the strategy in response to emerging evidence and policy changes.

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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	X	Thrive Well		Stay Well	X	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			

2 Report summary

2.1 Situation

Tobacco use remains the leading preventable cause of death in Scotland, with significant health inequalities persisting across socioeconomic groups. NHS Highland has developed a comprehensive Tobacco and Vaping Strategy for 2025–2030 to address these challenges and support the national ambition of achieving a tobacco-free generation by 2034.

2.2 Background

Smoking rates have declined overall, but disparities remain, particularly in the most deprived communities. The strategy builds on previous work (2018–2021) and aligns with the Scottish Government's 2023 Tobacco and Vaping Framework. It introduces a flexible, evidence-based action plan focused on three strategic themes: **People**, **Place**, and **Product**.

Key drivers for the strategy include:

- Findings from a 2023 NHS Highland deep dive into smoking cessation services.
- National review by Public Health Scotland identifying service improvement themes.
- Rising use of vapes and nicotine pouches, especially among young people.

2.3 Assessment

The strategy outlines targeted actions across nine priority areas:

People

- **Information**: Standardised training and resources for schools and professionals.
- **Engagement**: Participation in national campaigns and local outreach.
- **Cessation**: Enhanced service delivery models (Specialist Adviser, Community Pharmacy, Shared Care), with a focus on deprived areas and underrepresented groups.
- **Pregnancy**: Dedicated midwife support, CO monitoring, financial incentives, and stigma reduction.

Place

- Promotion of smoke-free hospital grounds and public spaces.
- Development of smoke-free policies in schools, sports clubs, and homes.

Product

- Monitoring and support for vaping cessation.
- Collaboration with Trading Standards to address underage and illicit sales.
- Advocacy for regulation of emerging nicotine products.

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 strategy is comprehensive, evidence-based, and aligned with national priorities. It demonstrates a clear commitment to reducing tobacco-related harm and health inequalities across NHS Highland.

3 Impact Analysis

3.1 Quality/ Patient Care

- The strategy supports improved patient outcomes through targeted smoking cessation services, especially for vulnerable groups including pregnant women, patients in our acute hospital, those with mental health conditions, and people in deprived areas.
- Promotes evidence-based interventions and continuity of care across hospital and community settings.

3.2 Workforce

- Enhances staff capability through training on tobacco, vaping, and nicotine products.
- Supports multidisciplinary collaboration, including midwives, GPs, pharmacists, and mental health practitioners.
- May increase demand on staff time for training and service delivery, requiring resource planning

3.3 Financial

- Smoking-related harm costs NHS Highland an estimated £19–30 million annually.
- Investment in cessation services may reduce long-term healthcare costs.
- Financial incentive schemes (e.g. for pregnant women) require budget allocation and monitoring

3.4 Risk Assessment/Management

- Addresses risks of service inconsistency, data gaps, and underperformance against national targets.
- Introduces SOPs and referral pathways to mitigate operational risks and improve service quality

3.5 Data Protection

- No identifiable personal data is used in the strategy document.
- Data collection for service evaluation (e.g. CO monitoring, quit rates) is anonymised and compliant with NHS data governance standards.

3.6 Equality and Diversity, including health inequalities

- Strong focus on reducing health inequalities by prioritising support for SIMD 1 and 2 areas.
- Inclusive approach targeting LGBTQ+ communities, people with mental health conditions, and pregnant women.
- Stigma reduction embedded in service language and delivery.

3.7 Other impacts

- Supports national public health goals and contributes to the Scottish Government's 2034 tobacco-free ambition.
- Aligns with NHS Highland's strategic outcomes across prevention, care, and community wellbeing.

3.8 Communication, involvement, engagement and consultation

- Developed collaboratively with NHS Highland Health Improvement Team and external partners.

- Ongoing engagement through campaigns, training, and community outreach.
- Feedback mechanisms in place to inform service improvement.

3.9 Route to the Meeting

The Tobacco and Vaping Strategy went to the Public Health Leadership Group on 10th September and Population Health Programme Board on 24th September.

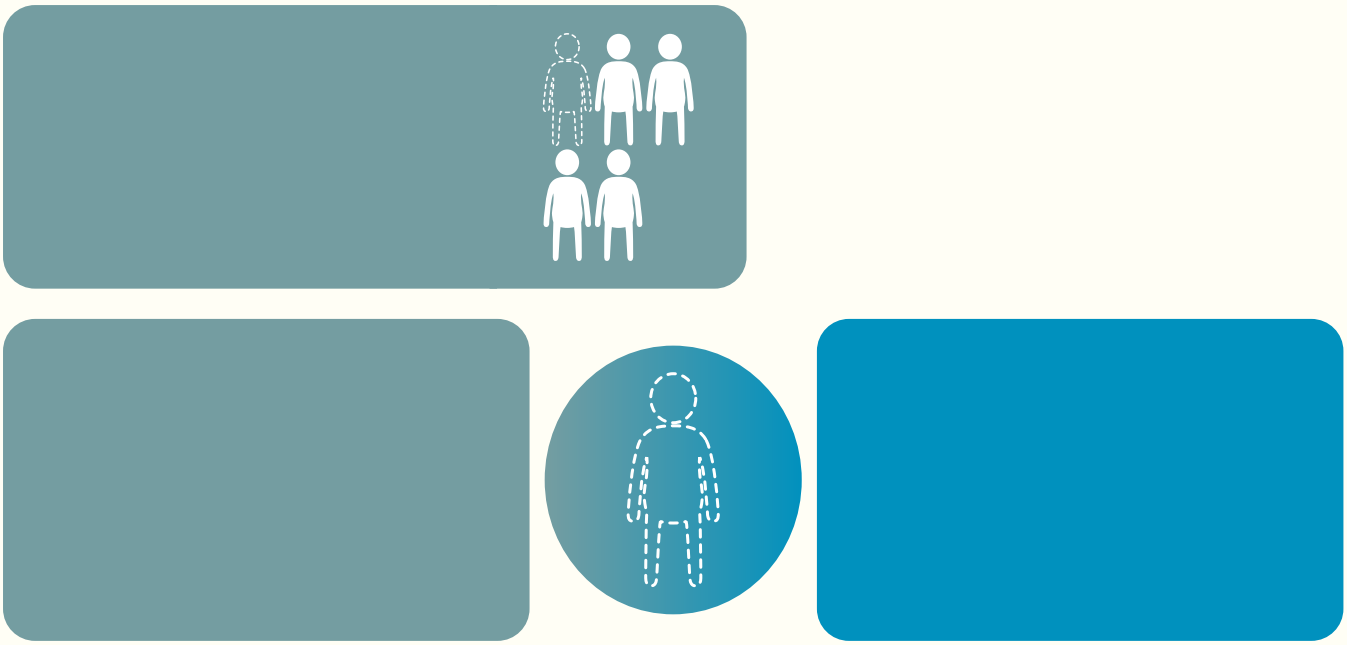
4.1 List of appendices

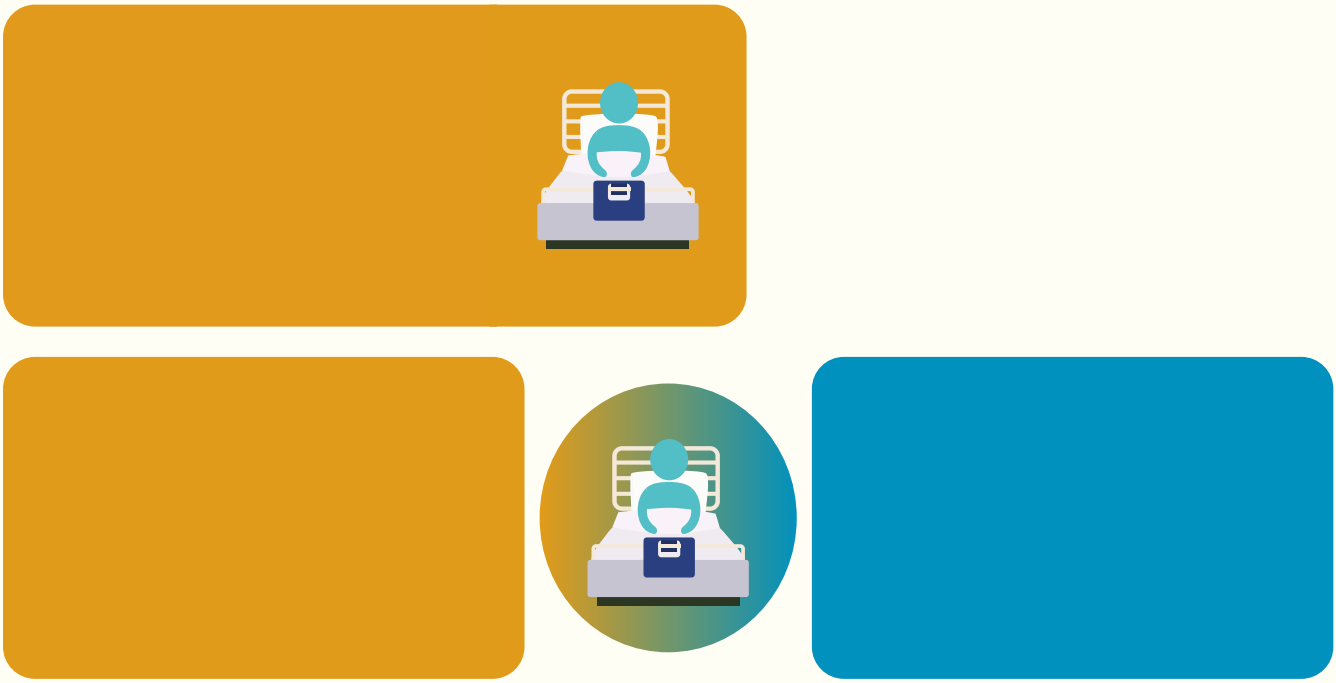
The following appendices are included with this report:

Appendix one – NHS Highland Tobacco and Vaping Strategy 2025 - 2030

Appendix two – Equality Impact Assessment and UNCR Impact Assessment

NHS Highland
Tobacco and Vaping Strategy
2025-2030





Acknowledgements

Thanks to the NHS Highland Health Improvement Team colleagues who co-developed the strategy.

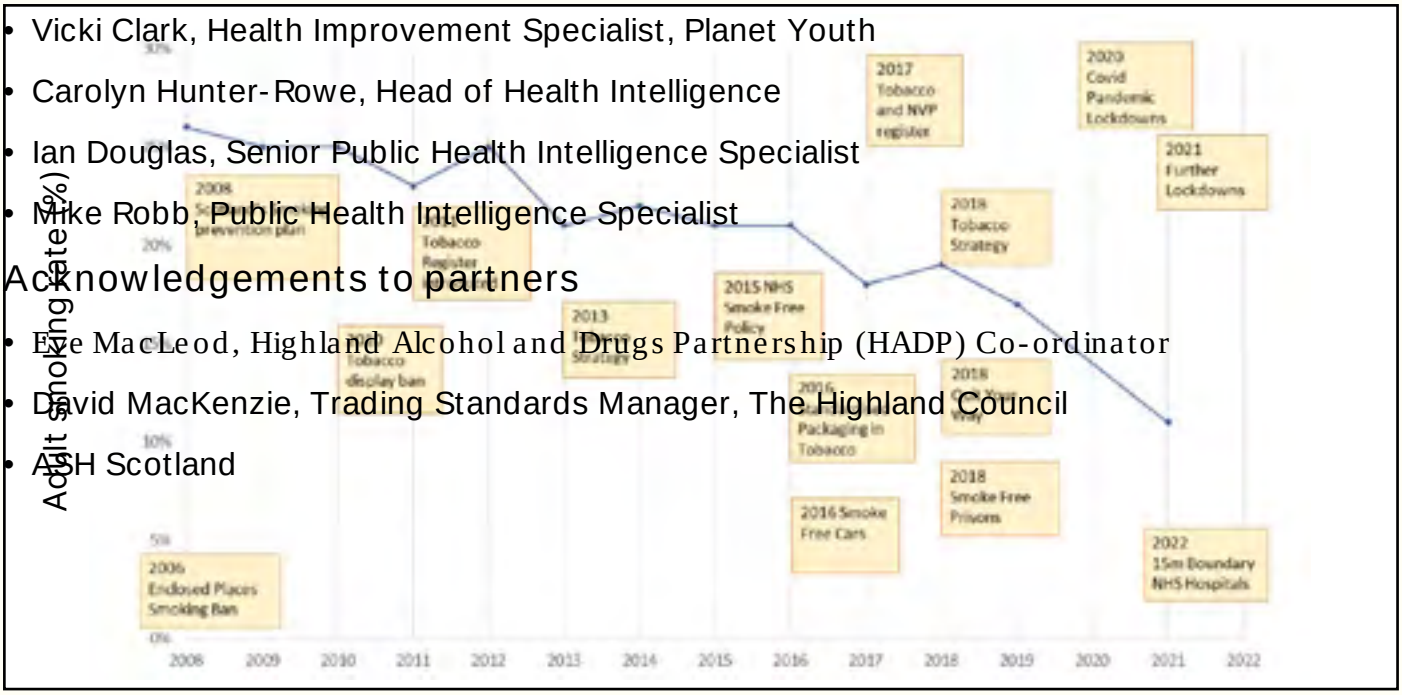
- Susan Birse, Health Improvement Principle
- Katy Allanson, Health Improvement Specialist
- Andrew Kyle, Health Improvement Specialist
- Louise Benson, Health Improvement Adviser
- Catherine Clark, Smoking Cessation Midwife
- Lorna Mackenzie, Smoking Cessation Midwife

Acknowledgements for contributions to the strategy

- Jennifer Davies, Director of Public Health (2025 - present)
- Tim Allison, Director of Public Health (2020 - 2025)
- Cathy Steer, Head of Health Improvement
- The NHS Highland Smoke Free Highland Service
- Barry Collard, Health Improvement Specialist (Web and Graphic Design)
- Vicki Clark, Health Improvement Specialist, Planet Youth
- Carolyn Hunter-Rowe, Head of Health Intelligence
- Ian Douglas, Senior Public Health Intelligence Specialist
- Mike Robb, Public Health Intelligence Specialist

Acknowledgements to partners

- Eve MacLeod, Highland Alcohol and Drugs Partnership (HADP) Co-ordinator
- David MacKenzie, Trading Standards Manager, The Highland Council
- ASH Scotland

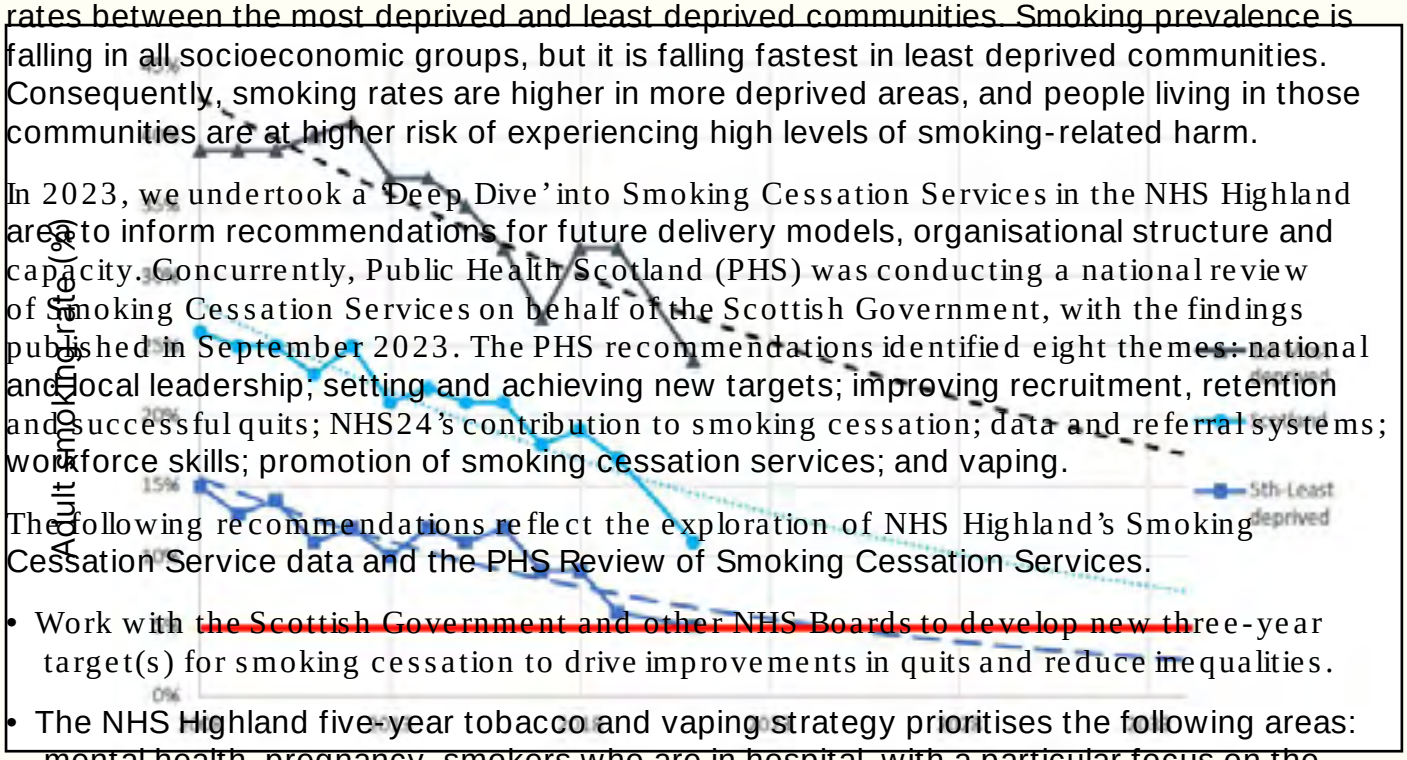


Contents

Acknowledgements 3
Foreword 5
Introduction 6
Tobacco and Vaping in Scotland. 7
Tobacco control and smoking in Scotland 7
Deprivation, smoking prevalence and health harms 8
Vaping and other nicotine products prevalence in Scotland 10
Tobacco and vaping in NHS Highland 11
Smoke-Free Highland delivery, quit attempts and quit rates 11
NHS Highland Tobacco and Vaping Strategy Aims and Actions 14
NHS Highland Tobacco and Vaping Strategic Action Plan 16
1. PEOPLE 17
1.1 Priority: Information 17
1.2 Priority: Engagement and Promotion 18
1.3 Priority: Cessation 19
1.4 Priority: Pregnancy 22
2. PLACE 27
2.1 Priority: Smoke-free Spaces 27
3. PRODUCT 29
3.1 Priority: Appeal 29
3.2 Priority: Regulation 30
Endnotes 32
Appendices 34

Foreword

Tobacco smoking remains a significant driver of inequalities and health. Although smoking rates have been falling since 2003, these reductions hide a widening difference in smoking rates between the most deprived and least deprived communities. Smoking prevalence is falling in all socioeconomic groups, but it is falling fastest in least deprived communities. Consequently, smoking rates are higher in more deprived areas, and people living in those communities are at higher risk of experiencing high levels of smoking-related harm.



In 2023, we undertook a 'Deep Dive' into Smoking Cessation Services in the NHS Highland area to inform recommendations for future delivery models, organisational structure and capacity. Concurrently, Public Health Scotland (PHS) was conducting a national review of Smoking Cessation Services on behalf of the Scottish Government, with the findings published in September 2023. The PHS recommendations identified eight themes: national and local leadership; setting and achieving new targets; improving recruitment, retention and successful quits; NHS24's contribution to smoking cessation; data and referral systems; workforce skills; promotion of smoking cessation services; and vaping.

The following recommendations reflect the exploration of NHS Highland's Smoking Cessation Service data and the PHS Review of Smoking Cessation Services.

- Work with the Scottish Government and other NHS Boards to develop new three-year target(s) for smoking cessation to drive improvements in quits and reduce inequalities.
- The NHS Highland five-year tobacco and vaping strategy prioritises the following areas: mental health, pregnancy, smokers who are in hospital, with a particular focus on the acute care setting, and people living in the 40% most deprived areas within the Board identified by the Scottish Index of Multiple Deprivation (SIMD).
- Work in collaboration with Community Pharmacy colleagues to improve the quality of follow-up data at four weeks and twelve weeks by rolling out standard operating procedures.
- Assign Specialist Advisers to Community Pharmacies and GP practices in defined areas to build and maintain strong, supportive relationships within a Shared Care model and provide smoking cessation training to staff in Community Pharmacies.
- Continue to promote the service to support those most affected by smoking harms, targeting our most deprived communities.
- Expand the Smoking Cessation Service in Raigmore Hospital and embed good practices in helping patients who smoke from admission to discharge.

I want to thank all those who have contributed to developing this Strategy and, more importantly, the work towards progressing to a Smoke-Free Generation by 2034. I am confident that their commitment to this crucial public health issue will lead to continued progress in our joint efforts as a Board to reduce tobacco-related harm in NHS Highland.

Jennifer Davies, Director of Public Health

Introduction

Smoking attributable deaths

Smoking tobacco remains the single largest preventable cause of death with 8,942 smoking attributable deaths a year in Scotland (ages 35+)[1].

In 2022...

21% of deaths in Scotland annually are attributed to smoking[1].

Between 2020 and 2021...

270 per 100,000 deaths are attributable to smoking in Scotland[2].

Between 2020 and 2021...

235.8 per 100,000 deaths are attributable to smoking in NHS Highland[2].

Smoking attributable hospital admissions

There were 44,573 smoking attributable admissions to hospitals in Scotland accounting for 29% of all admissions for conditions that can be caused by smoking in the population (ages 35+)[3].

In 2022...

29% of hospital admissions in Scotland are attributable to smoking[3].

Between 2020 and 2021...

1263.9 per 100,000 hospitalisations attributable to smoking in Scotland[3].

Between 2020 and 2021...

1118.8 per 100,000 hospitalisations attributable to smoking in NHS Highland[3].

The harms caused by smoking are vast:

Productivity losses due to associated absenteeism, smoking breaks and lost output through premature death are estimated to cost the country £692 million annually. Overall, the societal costs of tobacco use in Scotland amount to around £1.1 billion annually[6].

Tobacco and Vaping in Scotland.

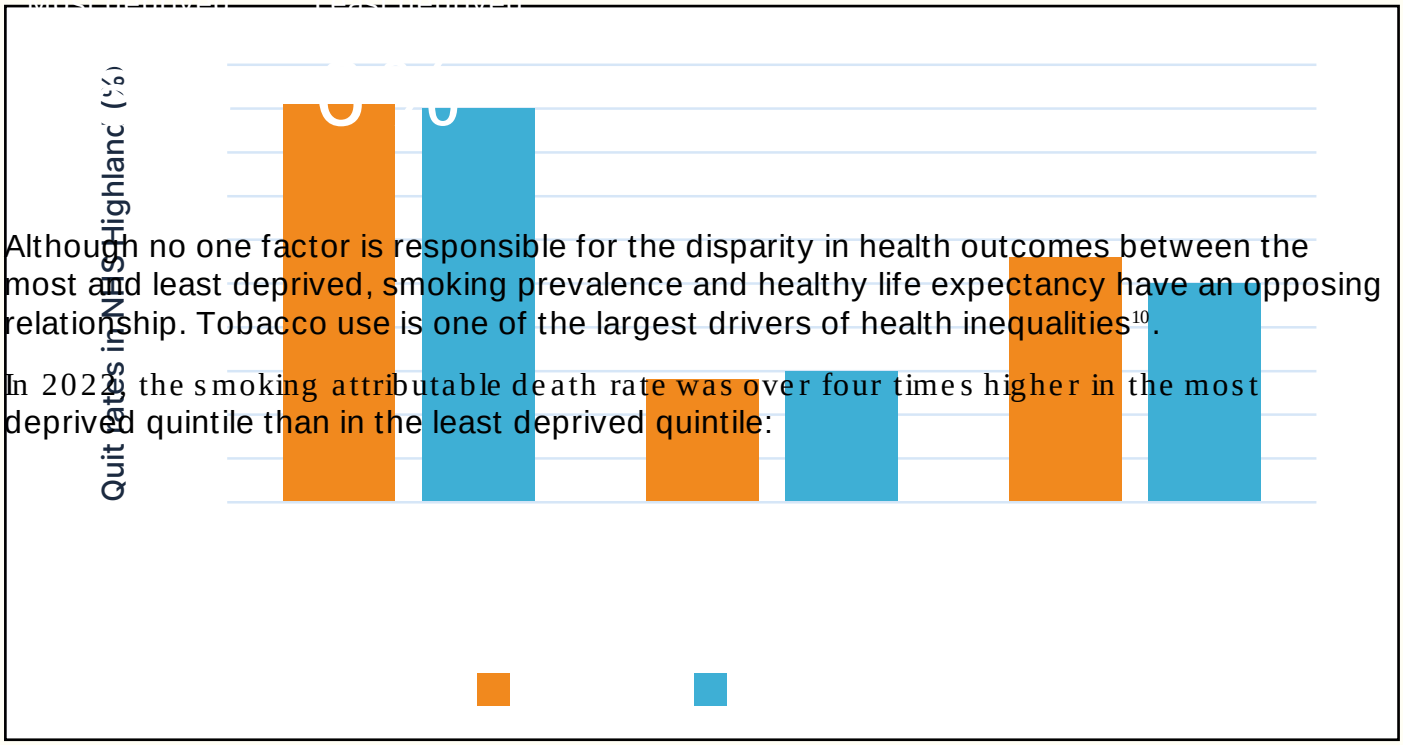
Tobacco control and smoking in Scotland

Scotland is a world leader in tobacco control, implementing legislation, effective policies, strategies and shifting cultural attitudes about smoking. Over ten years ago the Scottish Government launched the 'Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland' which set an ambitious target to create a Tobacco-Free Scotland, lowering smoking rates to 5% or less by 2034[7]. Figure 1 below shows the wide range of policy interventions and strategies in Scotland alongside adult Scottish smoking rates.

Figure 1. Changes in adult smoking rates in the Scottish Health Survey with key policy interventions in Scotland[8]

Deprivation, smoking prevalence and health harms

Smoking rates continue to fall, with 14% of adults currently smoking in 2023, however, this reduction hides a widening difference in smoking rates between the most deprived and least deprived communities[9]. Tobacco use affects the most deprived sections of our communities the most:



Although no one factor is responsible for the disparity in health outcomes between the most and least deprived, smoking prevalence and healthy life expectancy have an opposing relationship. Tobacco use is one of the largest drivers of health inequalities[10].

In 2022, the smoking attributable death rate was over four times higher in the most deprived quintile than in the least deprived quintile:

Figure 2 suggests that Scotland, at a population level, is generally on course to achieve the goal of 5% of the adult population smoking by 2034. However, the inequality gap in prevalence remains significant, with more work being required to support the most deprived communities to prevent smoking initiation and to help those wanting to stop.

Figure 2. Prevalence trends across Scotland by deprivation[8].

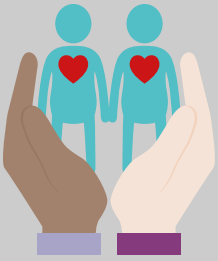
Smoking also drives further inequalities in other groups of society, with some of the highest smoking rates seen among people with mental health conditions and LGBTQ+ communities. Active tobacco dependency in pregnancy is the single most significant preventable risk of harm to pregnant women and their babies.

LGBTQ+ Communities

24.9%

of Lesbian, Gay and Bisexual people smoke in Scotland[11]

Mental Health



30%

of people with a long-term mental health condition smoke in Scotland[12]

Pregnancy

11%

of women in Scotland reported to be current smokers at their booking appointment[13]

Vaping and other nicotine products prevalence in Scotland

The use of e-cigarettes (vapes) has increased in Scotland, with the percentage of the adult population who currently vape more than doubling from 5% to 12% between 2014 and 2023[9]. It is concerning that in 2023 use was most prevalent in younger adults aged 16-24, with 22% reporting that they currently use e-cigarettes, an increase of seven percentage points since 2022 (15%)[9].

22%
of people aged 16-24
reported that they currently used vapes[9].

Other nicotine products, such as nicotine pouches, have also seen a rapid increase in use both among adults and young people in the UK. Nicotine pouches are small teabag-like pouches that are placed under the top lip, filled with a fibrous white powder infused with nicotine and other ingredients such as sweeteners and flavourings. Nicotine pouches do not contain tobacco.

The number of UK adults who have tried nicotine pouches doubled from 2.7% in 2020 to 5.4% in 2024[14]. A 2023 survey among young people aged 16-19 in England found that 6% had ever used nicotine pouches and 2% had used in the past 30 days, an increase of 1% and 0.3%, respectively, from 2022[15].

In Scotland and the UK, nicotine pouches are not covered by tobacco or e-cigarette regulations and thus are not required to adhere to the same controls on advertising and retail displays as tobacco or age of sale restrictions which are in place for cigarettes and nicotine containing vapes.

Therefore, within any tobacco control strategy it is important to take stock of the current situation relating to vapes and the rise of other nicotine products to ensure that we protect children and non-smokers, while also following the evidence base in relation to vaping being a potential route towards stopping smoking for adults who smoke.

Tobacco and vaping in NHS Highland

Smoke-Free Highland delivery, quit attempts and quit rates

13%
of people aged 16+ smoke in NHS Highland[2].

12.2%
of pregnant women reported as current smokers at their booking in NHS Highland[13].

Specialist Advisers and Community Pharmacies provide smoking cessation services across the NHS Highland area. Three service delivery models operate in NHS Highland and are described as:

- Specialist Adviser (Smoking Cessation Adviser)
- Community Pharmacy
- Shared Care (Specialist Adviser and Community Pharmacy)

Specialist smoking cessation services can provide behavioural support in person as one-to-one contacts or to groups, with the availability of pharmacotherapy (nicotine replacement therapy (NRT), Varenicline and Bupropion) delivered by specially trained staff either in person or remotely. Contacts can be in NHS or non-NHS settings.

Community Pharmacy Cessation Services can advise those seeking to stop smoking and provide NRT over twelve weeks.

Shared Care represents cessation pathways that start with a referral to a Specialist Adviser who will contact the client and triage. The client will then either be referred to a Community Pharmacy or remain with the Specialist Adviser to commence a Shared Care or, in some circumstances, a Specialist Adviser journey. During a shared care journey, the Specialist Adviser provides one-to-one behavioural support, and the Community Pharmacy will provide Nicotine Replacement Therapy (NRT) if required.

The current smoking cessation target set by the Scottish Government focuses on successful twelve-week quits for those who live in the 40% most deprived areas. However, cessation support is offered to anyone who wishes to stop smoking. There is also a focus on pregnant women and their partners, mental health and a new focus on patients in hospitals.

Quit rates in NHS Highland are variable between delivery models, as seen in Figure 3. In 2023/2024, the quit rate delivered by community pharmacy was 14.3%. The quit rate delivered by Specialist Advisers was 45.5%, and the quit rate delivered through Shared Care (support shared between a Specialist Adviser and Community Pharmacy) was 28.7%.

Quit rates are similar for those in the 40% most deprived areas compared to the rest of the population in NHS Highland (Figure 3). However, more quit dates are set in the 40% most deprived areas. This is also seen in national data across Scotland[16].

Across Scotland, Community Pharmacies consistently have a lower success rate for quit attempts than Specialist Services. In 2023/24, the percentage of quit attempts that were successful at twelve weeks was 22.0% in Community Pharmacies compared to 46.1% in Specialist Services[16].

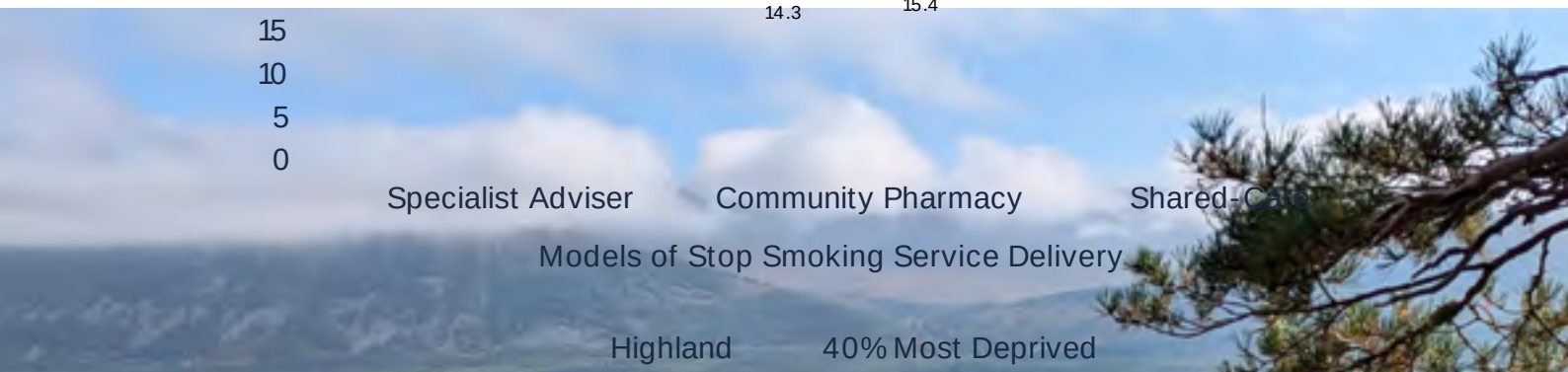


Figure 3. Smoking cessation service quit rates in NHS Highland by service delivery model, 2023/24[16].

In 2023/24, the quit rates of pregnant women were higher in NHS Highland than in Scotland, with an overall quit rate of 52.9% at 12 weeks compared to 40.6% in Scotland. In the 40% most deprived areas in NHS Highland, the quit rate for pregnant women was 45.2% compared to 37.4% in Scotland[16].

The deep dive of smoking cessation services in NHS Highland in 2023 highlighted that many follow-ups were not carried out, and quit rates may consequently be higher. In 2022/23, there were 664 successful quits at 4 weeks. However, 469 quit attempts had no data to indicate any further contact. The national review of smoking cessation services also saw similar missing data across Scotland and highlighted the importance of data to ensure Boards are achieving targets and able to identify priorities for service improvement[17]. This issue is reflected in this NHS Highland Strategic Actions.

For many years, the service has been promoted as 'e-cigarette friendly', and Specialist Advisers have offered tailored support to anyone who wishes to stop vaping or using any nicotine-containing products. These quits are recorded via a separate database and do not contribute towards the current Scottish Government target.

NHS Highland have a well established network of Health Improvement Advisers specialising in stopping smoking covering all geographies.

A health inequalities focused service. Focusing on the most deprived communities and people with mental health conditions.

Smoking Cessation

Over 3,200 people have stopped smoking with help from our service since 2018.

Pregnancy

NHS Highland's 'Smoke-Free Highland' service has two dedicated smoking cessation midwives. Supporting pregnant women and their families to become smoke-free.

Local Pharmacies

Over 80 Community Pharmacies deliver smoking cessation support.

Shared Care

A streamlined shared service between community pharmacy and NHS Highland to provide the best support to anyone stopping smoking.

Vape Quits

Over 150 people have come to the service to stop vaping since 2022.

Smoke Free Grounds

All hospitals grounds including mental health hospitals are smoke free.

HM Prison Inverness is smoke-free.

NHS Highland Tobacco and Vaping Strategy Aims and Actions

The prevous 2018 – 2021 NHS Highland Tobacco Strategy, set out a three-year action plan for tobacco control in NHS Highland, delivering a range of work around the three focused themes of prevention, protection and cessation. During this time, the service adapted to changing circumstances, including continuing and maintaining the service during the COVID pandemic by moving most aspects of the service online and restarting key aspects such as face-to-face clinics, training and engagement work as soon as it was safe.

The new NHS Highland Tobacco and Vaping Strategic Action Plan continue to build on our previous work. It aligns with the latest 2023 Scottish Government's National Framework on Tobacco and Vaping[8] and aims to provide a flexible and responsive plan.

The strategy has well-defined, measurable actions targeted and specific to the needs of people in Highland and Argyll and Bute. The plans include actions that benefit the whole population and specifically help those living in the 40% most deprived areas to achieve the national ambition of 5% smoking prevalence by 2034.

The strategy and action plan have been developed to adapt to the changing evidence base and policy implications of tobacco harms, vapes and other nicotine products. Current evidence indicates that vapes are significantly less harmful than tobacco. Vape products can be used as one of many stop-smoking tools for smokers to quit. The long-term harm of vapes remains unknown. Moreover, there is also limited research on the health effects of using nicotine pouches nor is there sufficient research to assess how effective nicotine pouches are as a cessation product[18].This strategy looks to reduce the number of young people using vapes as it is recommended that vapes and other nicotine products should not be used by young people or adult non-smokers. Reducing the appeal of these products through education is an essential goal.

To align with the National 2023 Scottish Government Tobacco and Vaping Framework, our strategy focuses on three overarching themes: People, Product and Place. In addition to the priorities within the national framework, pregnancy has been added under the theme of people.

People: To help prevent uptake, support people in stopping smoking, and educate them on the risks of tobacco harm.

Product: To support the restriction and limitation of tobacco-containing products and ensure vapes are used appropriately for cessation, deterring use when not.

Place: To limit where tobacco and vape products are sold and can be used.

Raising Scotland's tobacco-free generation - 2034 target

People	Product	Place
Information	Appeal	Smoke-free spaces
Engagement	Regulation	Tobacco and Nicotine Vapour Products Register
Cessation		
Pregnancy		

NHS Highland
Tobacco and Vaping Strategic Action Plan

1. PEOPLE

1.1 Priority: Information

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
1.1.1 Improve the consistency and advice given about tobacco, nicotine products and vapes to young people in NHS Highland.	Scope and develop standard training and resources for schools and organisations around vaping and young people. Partner with Planet Youth for this work to ensure it is evidence based.	Increase referrals and signposting to the smoke-free services for support to stop using a vape		Records of community groups and schools who have received training	Spring 2026
	Deliver and promote the newly updated Discussing Drugs and Alcohol Training to staff (NHS Staff, Third Sector, The Highland Council).	Numbers of staff attending training	Train the Trainers Date set for 7th March 2024	• Records of staff trained • Number of training sessions delivered	Ongoing
	Continue to develop, implement and evaluate Smoke-Free programme in Argyll and Bute Primary Schools.	Evaluation data from NHS Highland (Health Improvement Team) and Argyll and Bute Council Education Authority			Ongoing
	Review the smoking and vaping related material on the Highland Substance Awareness Toolkit (www.h-sat.co.uk)	Feedback and google analytic data from H-SAT website			Spring 2025
1.1.2 Deliver and promote training available to staff around tobacco, vaping and nicotine. (See section 1.2.1)	IMPACT training; increase the uptake of IMPACT training to practitioners working in mental health as well as pharmacies, nurses, GPS.	• 6 monthly reports submitted to ASH Scotland and the bespoke training available • Numbers of those attending training / the number of training sessions delivered.		• Submitted reports • Records of training attendance	Ongoing

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
	• Cost of Smoking training; increase the uptake of the Cost of Smoking training. • Scope delivering training to: Welfare teams/ Money Advisers / citizens advice.	Numbers of those attending training / the number of training sessions delivered.		Records of training attendance	Ongoing
	Continue to offer bespoke training (Raising the topic of smoking training with elements of vaping and other nicotine products awareness and health inequalities) to groups, such students via UHI and NHS services (See section 1.2.1)	Numbers of those attending training / the number of training sessions delivered.		Records of bespoke training delivered.	Ongoing

1. PEOPLE

1.2 Priority: Engagement and Promotion

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
1.2.1 Raise awareness and increase the number of people being signposted to the NHS Highland Smoke-Free Service	• Take part in national prevention events and other tobacco related campaigns i.e.: – No Smoking Day, – Quit Your Way, – STOPTOBER • Regular NHS Highland social media posts • Develop local resources to support the national materials.	• Number of people engaged with at events (evaluation sheet with key points) • Number of referrals from events • Social media metrics • Number of resources given out		Brief write up and pictures	Ongoing
	• Continue to promote and engage with professionals and the public at local events with information stands i.e. UHI (capture this work in newsletters, Facebook posts, freshers fair) • Continue to work with Health Improvement Lead on Gypsy/Traveler health to support any upcoming Gypsy Traveler Health days and other areas of work.	Records of information stands and possible referrals			Ongoing

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
	Promotion and engagement of the Highland Smoke-Free Service in all NHS Highland hospitals and through various NHS services such as Sexual Health, GPs, Pharmacy (see section 1.3.5), Mental Health: – Advisers working with assigned GP practices – Establishing/ Revisiting referral pathways (TAMs) (see section 1.3.3) – Signposting and contacting services with up-to-date information i.e. posters & leaflets (see actions above) – Offer training available (see section 1.1.2)	• Amount of NRT prescribed through hospital pharmacies • Monitor which Department hospital referrals come from • Distribution of information on referral pathways • Numbers of staff attending training			Ongoing

1. PEOPLE

1.3 Priority: Cessation

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
1.3.2 Capture the range of work health improvement advisers are delivering	• Capture the range of work health improvement advisers are delivering as part of their core role. • Scope, develop and maintain good working relationships and links with voluntary sector organisations and community groups that target under – represented groups or in the target SIMD quintiles.	• Number of people completing training via Turas • Numbers of ABIs • Number of screening conversations • Number of advisers trained in delivering training	Examples of specific groups i.e. Prison, Inverness food stuff, Drug and Alcohol services.	• List of organisations • Records which are kept.	Ongoing

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
1.3.3 Increase and ensure appropriate NRT prescribing in acute and community hospitals.	• Run pilot in Raigmore wards • NRT protocol • Referral pathways • Develop SOPS and staff guidelines • Include vaping – establish nicotine intake and appropriate NRT • Awareness amongst staff on how to manage this • Scope full roll out of standard NRT provision throughout NHS Highland Hospital Estate.	• Project evaluation report • NRT prescribed in Hospitals • Monitor referrals from hospitals • Number of staff trained		Number of quits from pilot wards or increased NRT use in wards	Winter 2025 for initial pilot
1.3.4 Producing NHS Highland Guidance that supports the work of the NHS Smoke-Free Highland Service and Public Health Team	• Standardising practices and guidance within the service across NHS Highland • Produce NHS Highland guidance on the use of vapes as a stop smoking tool. Ensure that health and social care professionals have access to this guidance and are confident to give advice about them and signpost accordingly.	Practice and Guidance documents		• i.e. Adviser guidelines, SOPS, shared care and directory of services • Guidance produced and reach/distribution	Ongoing
1.3.5 Increase number of quit attempts from SIMD 1 and 2 areas, and under-represented groups, to help achieve LDP target and reduces inequalities	• Utilise local data to prioritise working with those who live in SIMD 1 and 2 areas. • Work in partnership with GP practices and Community Pharmacies to ensure as many people as possible living in deprived areas can access support to stop smoking regardless of rurality.	Data of quit attempts from stop smoking team, GP practices and community pharmacies			Ongoing
	Work in partnership with Scottish Ambulance Service (SAS) to establish a referral pathway from SAS into NHS Highland Smoke Free Service via their central pathway HUB.	Data of quit attempts and referrals from stop smoking team and feedback from local SAS partners.	Pathway launched March 2025. Webinar with SAS staff May 2025	Webinar slides, posters, referrals via pathway.	Summer 2025

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
	Continue to link with the Highland Drug and Alcohol Partnership (HAPD) to scope work and utilise local data to increase referrals and quit attempts for those who attend drug and alcohol services.	• Data of quit attempts and referrals from stop smoking team and DAIS database. • Training delivered to staff.		Smoking included in the HADP strategy (include link). The HADP will promote the completion of 'Smoking and Problematic Substance Use' (include link) e-learning developed by ASH Scotland to further address inequalities	Ongoing

1. PEOPLE

1.4 Priority: Pregnancy

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
1.4.1 Reduce harm to women, children and families from tobacco dependency in pregnancy.	Provide evidence-based, effective treatment options: – Scope CBT as treatment option – Financial incentive scheme pilot – Optimise CO monitoring in pregnancy	• Data on participation and outcomes. • Data on compliance with CO monitoring.	Exploring CBT training options.		Ongoing
	• Provide up to date, accessible resources for women and families e.g. NHSH website, Badgernet leaflets, collaboration with HIRS, patient information videos. • Provision of resources in digital and paper format as appropriate.	Website analytic data, Badgernet leaflet access data			Ongoing
	• Gather feedback from service users to inform service • Explore digital feedback mechanisms to gather service users' experiences in a standardised way.	Number of responses, content of responses			Ongoing
	Ensure flexible service provision: – NRT at point of consultation (in Inverness) – Local support – Face to face or telephone support	• Data collection (ISD) on service use (face to face or telephone). • Data collection on number of clients that we have successful engagement with.			Ongoing
	Explore group support options: – Scope closed Facebook group		Consult with breastfeeding service to assess feasibility and suitability.		Ongoing

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
	Regular data collection and analysis to inform service: – Create SOP for monthly collection of CO monitoring data.	CO monitoring compliance.	SOP created December 2024. Monthly data collection re. CO monitoring at booking ongoing. To commence data collection on 36 week CO monitoring.		Ongoing
	Embed clear care pathways for cannabis use during pregnancy (including resources).	Data collection on number of women using cannabis during pregnancy.	• Leaflet update in progress. • Training for NHS Highland Smoking Cessation service by NHS Lanarkshire completed December 2024.		Ongoing
	Reduce harm from second-hand smoke: – Inclusion of significant others in treatment.	Number of referrals for partners.			Ongoing

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
	Reduce health inequalities: – Financial incentive scheme pilot. – Links with Family Nurse Partnership.	• Uptake of incentive scheme for eligible women. • Outcomes for women who participate in incentive scheme.	• Awaiting process for voucher purchase. • Awareness raising with staff completed. • Supplementary resources for service users and staff created.		Ongoing
	Reduce stigma experienced by women and families: – Focus on treatment for health condition rather than lifestyle choice. – Language use - “Tobacco dependency treatment” rather than “smoking cessation”. – Embed optimal CO monitoring and opt-out referrals as normal practice.	Data collection on CO monitoring and referral numbers.	Stigma reducing approach embedded in staff training.		Ongoing

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
1.4.2 Increase skills, confidence and motivation of all healthcare staff to support women and families to access treatment for tobacco dependency during pregnancy.	Improve communication with maternity multidisciplinary team: – Bi-annual newsletter. – Teams channel. – Infographics. – Feedback forms from Smoking Cessation Advisers.	Number of newsletter viewings. Interaction with Teams channel.	• Established format for newsletter – published January and July. • Regular teams channel updates with CO monitoring data and other relevant information and updates. • Plan for monthly infographics. • Established system for feedback forms from smoking cessation advisers.		Ongoing
	Regular training for maternity multidisciplinary team: – Monthly midwifery update days. – Obstetric colleagues, neonatal colleagues.	• Number of midwives attending training. • Feedback from training sessions.	Awaiting dates for monthly update days. Explore training opportunities with medical and neonatal colleagues.		Ongoing

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
	Regular pregnancy updates for smoking cessation advisers.	Number of sessions or updates given to whole team.	• Arrange to deliver a pregnancy specific session to whole team. • Regular teams channel updates and resources.		Ongoing

2. PLACE

2.1 Priority: Smoke-free Spaces

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
2.1.1 Support smoke-free hospital grounds legislation and increase awareness amongst staff at all NHS Highland hospitals, including awareness of Smoke-Free Service and how to access. Further reduce exposure to second hand smoke on NHS Hospital grounds. Ensure NHS Highland set, advocate and lead in a being a smoke-free environment.	Increased compliance with the revised NHS Highland Tobacco Policy to ensure NHS grounds are smoke-free / Ensure NHS Highland Tobacco policy is fully adopted and managed well in Mental Health services including use of the NRT Protocol: – See section 1.3.3: Increase support in Raigmore to manage patients unable to be smoke-free whilst in hospital. – Continue the joint working and coordinated efforts with Environmental Health and focus on including Highland Smoke-Free Service details on the Environmental Health website and environmental health fixed penalty notices. – Scope the smoke-free sites training and where it could sit in mandatory staff training / Scope including vaping into this to ensure staff are aware of vaping being including in the NHS Highland Tobacco Policy. – Scope Smoke-Free Champions in hospitals to improve support available to patients who smoke (see section 1.3.3 for pilot).	Improved staff knowledge and awareness of NHS Highland Tobacco Policy procedures and supporting NRT protocols.		Updated NHS Highland Tobacco Policy.	Ongoing

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
2.1.2 Promote and develop Smoke-Free Policies and Guidance across varying organisations in Highland to limit where Tobacco and Nicotine Vapour Products can be used to deter use and reduce harm from second hand smoke.	• Scope, redesign and relaunch Smoke-Free Sports to include other sports. • Work in partnership with Highlife Highland on Smoke-Free Sports. • Scope to include vaping.	Number of clubs / teams signed up.		New resources for Smoke-Free Sports.	Ongoing
	In conjunction with young people, develop a schools, colleges and universities Smoke-Free Policy including vapes and recycling and promote with all sites to encourage sign up.	Number of sites signed up.			Winter 2026
	Encourage local authorities and communities to consider adopting smoke-free policies in children's services and spaces.	Number of policies reviewed / put in place.			
	Relaunch Smoke-Free homes: – promotion work see section 1.2.1. – scope work with Animal Rescue Centres and Veterinary Practices.	Number of leaflets and packs sent out.		New Smoke-free homes materials.	Winter 2026

3. PRODUCT

3.1 Priority: Appeal

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
3.1.1 Scope service users who wish to stop vaping or using nicotine containing products through the NHS Smoke-Free Highland service.	• Promote that support is available through the NHS Highland Smoke-Free Service. • Data recording of vape and other nicotine product quits on a separate database out with national smoking database. • Work with national colleagues and pharmacy colleagues to continue to gauge support available to people wishing to stop vaping. • Monitor the rise in use of new nicotine products. For example, smokeless tobacco products.	Data collected on vaping quits through the NHS Highland Smoke-Free Service.			Ongoing

3. PRODUCT

3.2 Priority: Regulation

Outcomes	Actions	Evaluation/ Measurement	Progress	Evidence	Status/ deadline
3.2.1 Ensure vapes are used appropriately to support cessation but deter take up where not used for quitting tobacco (prevention).	• Work with local vaping shops/retailers to scope how the NHS Smoke-Free Service could more closely align with retailers to ensure evidence-based support is available to anyone wishing to stop smoking. • Continue work with Trading Standards to have a coordinated approach on challenges such as illicit and underage sales. • See section 1.1.1, improve consistency and advice given to young people about tobacco, nicotine products and vapes in Highland, to reduce uptake.	Details of joint working.	Vaping Cessation information and resources shared with Trading Standards to support their work.	Trading Standards recent press release on test purchasing	Ongoing
	Scope work around a reduction/ limit in selling vapes at festivals (at bars and pop-up shops) and information stands for the Smoke-Free Highland service.	Information stands held at any events and outcomes of these.	Explore with wellbeing community for Belladrum and other festivals.		Ongoing

Notes

Endnotes

1 Scottish Public Health Observatory (ScotPHO). (2024) Tobacco use: smoking attributable deaths [online].

Available from: Scottish Public Health Observatory website [Jun 2025]

2 Scottish Public Health Observatory (ScotPHO). (2023) Profile: Tobacco [online].

Available from ScotPHO Profiles website [Jun 2025]

3 Scottish Public Health Observatory (ScotPHO). (2022) Tobacco use: smoking attributable admissions [online].

Available from: Scottish Public Health Observatory website [Jan 2025]

4 Scottish Government. (2019) NHS Scotland performance against LDP standards [online].

Available from: Scottish Government website [Feb 2025]

5 Scottish Public Health Observatory (ScotPHO). (2012) Smoking ready reckoner – 2011 Edition [online].

Available from Scottish Public Health Observatory website [Jan 2025]

6 ASH Scotland. (2024) Tobacco and vaping statistics factsheet [online].

Available from ASH Scotland website [Jun 2025]

7 Scottish Government. (2013) Tobacco Control Strategy - Creating a Tobacco-Free Generation [online].

Available from Scottish Government website [June 2025]

8 Scottish Government. (2023) Tobacco and Vaping Framework [online].

Available from: Scottish Government website [September 2024]

9 Scottish Government. (2024) The Scottish Health Survey. 2023 [online]

Available from: Scottish Government website [Jun 2025]

9 ASH Scotland. (2019) Health Inequalities and Smoking [online].

Available from: ASH Scotland website [Jan 2025]

11 Scottish Government. (2021) Scottish Survey Core Questions 2019 [online].

Available from: Scottish Government website [Jan 2025]

12 ASH Scotland. (2019) Smoking and Mental Health [online].

Available from: ASH Scotland website [Jan 2025]

13 Public Health Scotland. (2023) Antenatal Booking in Scotland [online].

Available from: Public Health Scotland website. [Jan 2025]

14 ASH Scotland. (2023) Use of vapes (e-cigarettes) among adults in Great Britain [online].

Available from: ASH Scotland website [Jan 2025]

15 Hammond, D et al. (2024) Trends in the use of nicotine products among youth in Canada, England, & the US between 2017 and 2023 findings from the ITC youth tobacco & vaping survey. International Tobacco Control Policy Evaluation Project (ITC). [online].

Available from: David Hammond PHD website [Jan 2025]

16 Public Health Scotland. (2023) NHS Stop Smoking Services Scotland [online].

Available from: Public Health Scotland website [Jan 2025]

17 Public Health Scotland. (2023) Review of Smoking Cessation Services in Scotland [online].

Available from Public Health Scotland website [Jan 2025]

18 ASH Scotland. (2025) Nicotine pouches and snus [online].

Available from: ASH Scotland website [June 2025]

Appendices

Infographic references

Page 6

1st row infographic (% smoking related deaths Scotland):

Source: ScotPHO 2024, Attributable deaths/Observed deaths in Calendar Year 2022.

'Observed deaths' counts the total number of deaths in Scotland where the main cause of death is recorded as cancer or any circulatory, digestive or respiratory condition.

'Attributable deaths' are those deaths that have been attributed to smoking using the methods described.

2nd row left infographic (rate deaths attributable to smoking Scotland):

Source: ScotPHO 2023, Age-sex standardised rate per 100,000: 2020 to 2021 calendar years; 2-year aggregates

2nd row right infographic (rate deaths attributable to smoking NHS Highland):

Source: ScotPHO 2023, Age-sex standardised rate per 100,000: 2020 to 2021 calendar years; 2-year aggregates

3rd row right infographic (% hospital admissions attributable to smoking Scotland):

Source: ScotPHO 2024, Attributable admissions/Observed admissions in Calendar Year 2022.

'Observed admissions' counts the total number of hospital admissions in Scotland where the main diagnosis is recorded as any cancer or any circulatory, digestive , respiratory or other condition that can be caused by smoking.

'Attributable admissions' are those admissions that have been attributed to smoking using the methods described.

4th row left infographic (rate hospitalisations attributable to smoking Scotland)

Source: ScotPHO 2023, Age-sex standardised rate per 100,000: 2020 to 2021 calendar years; 2-year aggregates.

4th row right infographic (rate hospitalisations attributable to smoking NHS Highland)

Source: ScotPHO 2023, Age-sex standardised rate per 100,000: 2020 to 2021 calendar years; 2-year aggregates.

Page 7

Left infographic (Smoking costs Scotland):

Source: Scottish Government. (2019) NHS Scotland performance against LDP standards.

Right infographic (Smoking costs NHS Highland):

Source: Scottish Public Health Observatory (ScotPHO). (2012) Smoking ready reckoner – 2011 Edition

Page 8

1st row infographic (Most and least deprived smoking prevalence)

Source: Scottish Government 2024. Scottish Household Survey 2023 smoking prevalence estimates based on a sample survey with 'current smoker' category excluding those who reported only smoking cigars or pipes and expressed as a percentage of those sampled who are 'current smokers' The Scottish Index of Multiple Deprivation 2020 (SIMD2020) was used in the 2023 report.

2nd row infographic (Most and least deprived smoking attributable death rate)

Source: ScotPHO 2024a. Estimated numbers and age-sex standardised rates (per 100,000 population) of deaths attributable to smoking, in people aged 35 and over, in Scotland, by deprivation grouping.

Page 10

Top infographic (vaping prevalence amongst 16-24 year olds)

Source: Scottish Government 2024. Scottish Household Survey 2023 E-cigarette or vaping device use in the 16-24 age group expressed as a percentage of those sampled 'currently using'.

Produced by NHS Highland Public Health

August 2025

Equality Impact Assessment Template: Please complete alongside the guidance document

Title of work: **Highland Tobacco & Vaping Strategy 2025 - 2030**	**Date of completion:** **February 2025**	**Completed by:** **Susan Birse, Katy Allanson, Andrew Kyle and Louise Benson**

Description of work:

The Highland Tobacco & Vaping Strategy has been created in partnership with Highland and Argyll and Bute NHS boards is line with the Scottish Governments national strategy 'Creating a tobacco-free generation: A Tobacco Control Strategy for Scotland'. It contained the ambitious aim of making Scotland tobacco-free (population smoking prevalence of 5% or less) by 2034. Since then, further national actions places have been launched with the most recent being the 2023 Tobacco Action Plan '**Tobacco and vaping framework: roadmap to 2034'** which covers the implementation and monitoring of the 2022 new sections 4A to 4D of the Smoking, Health and Social Care (Scotland) Act 2005, creating new offences of smoking and permitting other to smoke in the no-smoking area outside hospital buildings.

The strategy takes a focus on being responsive to the rapidly changing landscape around tobacco control, especially around the rise in popularity of vapes.

The Highland Tobacco Strategy will be overseen by Susan Birse.

Outcome of work:

The Highland Tobacco & Vaping Strategy will focus efforts to reduce the number of people beginning to smoke protect more people from second hand smoke and increase the number of people stopping smoking. There will be direct and indirect benefits to the health and wellbeing of the population. Aswell as taking a bigger focus on tackling the rising use of vaping across the population, especially amongst young people and those who have never smoked and supporting those who wish to stop smoking using a vape or stop vaping only. The 5-year action plan will be ongoing and flexible with progress updates on actions to react to an ever-evolving policy area, and ongoing tobacco, nicotine and vaping product development. Actions will ultimately support the Scottish Government aim of a tobacco-free Scotland by 2034.

There are three overarching themes of the strategy are:

- People – What we can do to prevent uptake and what support we can provide to help people stop smoking, and to educate them on the risks
- Product – What restrictions and limitations can be placed on tobacco containing products to further reduce use and ensure nicotine vapes are used appropriately to support cessation but deter take up where not used for quitting tobacco; and
- Place – What restrictions and limitations can be placed on how and where tobacco and vaping products are sold to deter use of the former and ensure appropriate use of the latter.

The main aims and outcomes of NHS Highland Smoke free policy is to:

- ***help reduce the use of tobacco and nicotine vapes across the population;***
- ***target groups of pregnancy, deprived areas, those in hospital***
- ***to support people to in their efforts to stop smoking and vaping***
- ***prevent or reduce exposure to second-hand smoke***
- ***to ensure the NHS in Scotland is exemplar in the promotion of good public health.***
- ***support the de-normalisation of smoking***

Who:

Stakeholders: (who will this work affect?)

- People who smoke
- People who vape or use nicotine containing products
- Pregnant mums and their families
- Families & friends of above
- NHS Highland staff, patients, visitors on NHS grounds
- Highland Council
- Smoking cessation services and service users
- Wider communities
- Schools and youth organisation

How do you know:
How will you know what impact this will have - please detail what work you have done to find this out? Remember to consider the way in which you use language matters.

The guidance has been widely consulted on with stakeholders during the review process for example HADP, NHS Public Health, ASH Scotland, and be ratified by the NHS Highland Board

What will the impact of this work be? (see appendix 1 for list of protected characteristics and other groups that you may wish to identify)

Groups with protected characteristics and other potentially disadvantaged groups were considered, as follows.

Age - A number of strategy actions focus on children and young people. This focus exists due to almost 9 in 10 people who smoke in the UK, start before the age of 21 (Health Survey for England, 2020). A number of actions have a prevention and protection focus whilst ensuring cessation support is available to anyone over the age of 12. Further, the strategy has a number of actions looking at reducing vape use and uptake in young people. This is due to vape use being the highest among those aged 16 to 24 years in the UK, the percentage of people in this age group who were daily or occasional vapers in 2022 has increased to 15.5% compared with 11.1% in 2021 (Office for National Statistics 2023). Although those 65 years and over continue to have the lowest proportion of current smokers (8.3%, around 1 million people), these needs are also met within the strategy, with access to smoking cessation support provided in homes for those who are housebound, and smoke free policies are in place in nursing homes (Office for National Statistics 2023).

Gender – statistics suggest that significantly more men (18%) than women (13%) reported that they were currently smokers. However, no negative impacts resulting from the strategy are anticipated to widen this difference in smoking prevalence and only to reduce overall smoking level in both genders.
Information regarding gender is gathered using the ISD client record sheets, and from this database it reports that in the year 2023/24 more men in various age groups had more successful 12-week smoking quits, with 161 successful quits in men aged 35 – 64 compared to 143 women, moreover 53 men aged 65+ were successful at weeks compared to 46 women. More women in the 16-34 age group were successful with 46 successful 12 week quit compared to 26 men.

It is acknowledged that the ISD system only records male and female, and there isn't currently the option to record as transgender via this system. Whilst there is a lack of robust research on smoking among transgender people, surveys do show transgender people are more likely to smoke (Rooney E. 2012. All Partied Out?: Substance Use in Northern Ireland's Lesbian, Gay, Bisexual and Transgender Community. Rainbow Project; 2012.) When official statistics become available, we will respond accordingly. It is likely that the specific needs from the transgender community may not be being best met from within a generic service and any opportunities to better this is acknowledged within the actions of the strategy.

Sexual orientation - A higher prevalence of smoking rates exists among the LGBTI+ community (Scottish Government, 2013c) and there are justifiable actions associated with this. Office for National Statistics in 2019 states that LGB people are approximately 1/3 more likely to smoke than heterosexual people. 20.5% of lesbian and gay people and 20.1% of bisexual people were current smokers, compared to 14.9% of heterosexual people. Young LGB people are also more likely to smoke, start smoking at a younger age and smoke more heavily (Corliss et al, 2013). Actions are associated with this within the strategy. All staff working in the smoking cessation service are supported to undertake the NHS Scotland Pride badge pledge which promotes inclusion for LGBTQ+ people and makes a statement that there's no place for discrimination or harassment of any kind in NHS Scotland. As an NHS staff member who wears the badge, they are pledging to:

- be aware of and responsive to issues faced by LGBTQ+ people accessing care
- be a friendly, listening ally who colleagues and service users can safely approach
- use inclusive language and respect identity

Disability – In Scotland, 19% of people living with long-term limiting health conditions smoke, compared with 13% of people with no limiting condition (The Scottish Health Survey, 2022). There is also an increased smoking prevalence amongst people will mental ill health, 31% of people with a long-term mental health problem smoke compared to 16% without (Scottish Health Survey, 2019). There are associated actions within these strategies to target these groups.
As regards learning disabilities, there is no good information about smoking prevalence in this group. However, we are available to support and encourage the use of appropriate materials when relevant. For example, resources are also produced in line with accessibility regulations for people with dyslexia or have limited to no vision and might be using a screen reader.

Race / ethnicity - Access to interpreters and materials in other languages are available when required. A wide range of tobacco products, including chewing tobacco and shisha, are recorded via ISD. Support is provided for gypsy / travellers who wish to access support to stop smoking. All Health improvement advisers are supported to complete an online module; Raising awareness of Gypsy Traveller communities | Turas | Learn (nhs.scot) that develops awareness of the culture and circumstances

of Gypsy/Traveller communities in Scotland. It explores barriers to inclusion and good health, and ways to make services more accessible and responsive to the needs of Gypsy/Travellers.

Religion or no religion - Potentially during festivals or religious fasting, using smoking cessation pharmacotherapy may not be culturally appropriate but other support options can be discussed in these circumstances.

Pregnancy and maternity - There are multiple actions focusing upon this targeted group. This is justifiable as the smoking in pregnancy rate is higher in Highland than in Scotland overall, this is seen from 12.2% current smokers at antenatal booking, compared to 11% in Scotland overall (Public Health Scotland 2023)

Marriage and civil partnership - No negative impact identified.

Carers – There is no available information on smoking prevalence within this group. If information was to be published this would be taken into consideration and steps to mitigate any negative impact would be applied. Smoking cessation support is accessible for people who aren't able to attend in person, including telephone support, video call via NHS Near Me, text/email and online information.

Remote and Rural – As highlighted above, smoking cessation support is accessible, this includes for those living in remote and rural locations. Telephone support, video call via NHS Near Me, text/email and online information. Health Improvement Advisers are located to cover the geography well and support is available via community pharmacies too, these options are discussed with new referrals to decide the best option for them. We recognise the limits of broadband in some areas and will aim to offer in person support if required.

People living in poverty – The strategy recognises that there is large health inequality of smoking rates amongst adults living in poverty in Scotland. 25% of adults in the most deprived quintile (SIMD1) smoke compared to 7% in the least deprived quintile (SIMD5) (The Scottish Health Survey, 2022) There are multiple actions focused on areas of deprivation and focusing on reducing this health inequality. For example, Smoking Cessation Services & actions targeting deprived areas, prescriptions are free, and clinics are accessible, and in areas of deprivation the service may be delivered within a pharmacy by a Health Improvement Adviser.

Homeless people – Support is provided to homeless people who want to stop smoking. At times, lack of an address can be problematic. This is dealt with on a case by case.

Prisoners – Since the smoking ban in prisons there is stop smoking support to all prisoners.

We provide an inequalities sensitive service, and all Health Improvement Advisers provide a person centred approach. Advisers will also support their clients with other issues in order to improve health and wellbeing, and quality of life. The Strategy includes numerous targeted actions in order to improve health inequalities.

Given all of the above what actions, if any, do you plan to take?

Health Improvement Advisers to complete statutory and mandatory 'Equality and Diversity' training through LearnPro. To further this learning, we will support advisers to 'Equal Opportunities and Diversity' training, and / or 'Health Inequalities: Why bother?'. We also support advisers to attend training with a focus on health inequalities and the determinants of health to ensure every contact matters with clients:

- Money worries
- Suicide Intervention and Prevention
- Introduction to mental health
- Alcohol brief interventions
- Discussing drugs and alcohol with young people
- Screening brief interventions

The Smoking Cessation Midwifes trains community midwife teams and Health Improvement Advisers to ensure best practice is applied when working with pregnant women who smoke.

With a rise in the use and popularity of vapes, the health improvement advisers can provide up-to-date information on vaping for people who want to stop smoking and use a vape, however, we cannot prescribe or promote specific vapes, but we encourage safe purchasing to reduce the likeness of exposure to elicit vapes where possible. We also support people who wish to stop using vapes or any other nicotine contain product.

To conclude on the above, we will endeavour to provide a person-centred service and ensure that all groups are considered within our work. In order to achieve this we will:

- continue to train other staff, and our team to ensure best practice
- provide appropriate information to support people to stop smoking
- continue to monitor emerging statistics and prevalence information, and if any negative impacts are identified, steps would be taken to mitigate against this

What is the impact of this policy/service development on infants, children and young people? (The United Nations Convention on the Rights of the Child places a compatibility duty on public authorities including NHS Highland to ensure the rights of children are protected and promoted in all areas of their life).

What impact will your policy/service change have on Children's Rights? Will the impact of your policy/service development on Children's Rights be Negative/Positive/Neutral? What articles of the UNCRC does the policy/service development impact on? Will there be different impacts on different groups of children and young people e.g. preschool children; children in hospital; children with additional support needs; care experienced children; children living in poverty?

Article 17 (access to information from the media) Every child has the right to reliable information from a variety of sources, and governments should encourage the media to provide information that children can understand. Governments must help protect children from materials that could harm them

The Highland Tobacco Strategy will have a positive impact on article 17 as we are looking to improve the resources on smoking & vapes directly for young people and for those who work with young people. These resources will also highlight the impact social media, peers and the tobacco industry can have on young people. By improving the consistence of resources, it is hoped that we will have a more equitable approach across Highland. This can be done through lesson plans for schools and training for staff.

Article 24 (health and health services) Every child has the right to the best possible health. Governments must provide good quality health care, clean water, nutritious food, and a clean environment and education on health and well-being so that children can stay healthy. Richer countries must help poorer countries achieve this

The Strategy has a positive effect on article 24 as the actions include support for smoke free spaces which young people can benefit from. Specifically for children this includes support for schools to develop smoke & vape free policies.

Article 27 (adequate standard of living) Every child has the right to a standard of living that is good enough to meet their physical and social needs and support their development. Governments must help families who cannot afford to provide this

There is also a positive impact on article 27 as the policy looks to relaunch and promote smoke free homes thus reducing the number of children harmed by second hand smoke.

Article 31 (leisure, play and culture) Every child has the right to relax, play and take part in a wide range of cultural and artistic activities

The strategy benefits article 31 as it looks to relaunch Smoke free sports, with the aim of more children being able to take part in sports without having people smoking at the side and creating a healthier environment to enjoy sport.

Article 33 (drug abuse) Governments must protect children from the illegal use of drugs and from being involved in the production or distribution of drugs.

There is a positive effect on article 33 as the policy looks to work in partnership with trading standards and reduce the number of children able to purchase nicotine products. Two thirds of adult smokers say they started before they were 18 years old. Improved resources for young people about the risk of smoking & vaping will likely reduce the number of young people that start using nicotine products.

If a **negative impact is assessed** for any area of rights or any group of children and young people, can you explain why this is necessary and proportionate? What options have you considered to modify the proposal, or mitigate the impact?

Young children under the age of 12 are potentially negatively by this policy due to NRT is only available for children over 12 years old. Data on children under the age of 12 smoking is limited in Highland, however, we know 12% of 13-year-olds have tried smoking (SALSUS 2018). Of these 2% are occasional smokers (sometimes smoke but less than one per week) and 2% are

regular smokers (one or more cigarettes per week) (SALSUS 2018). Support can be provided to those under 12 with consent from their parents. The work of the smoking cessation midwives who work with the whole families can mitigate this.

In what ways have you taken the views of children and young people in to consideration in the development of this policy/service change? What evidence have you used or gathered on children's views? How will you monitor the impact of the policy / service change and communicate this to children?

Evidence:

Work in schools & Youth clubs

During the development of the Highland Tobacco & Vaping Strategy several sessions on smoking and vapes took place. These sessions were led by stop smoking advisors and health improvement specialist. Most of these sessions were specifically for young people and a few sessions looked to include parents and the whole family. Young people expressed a range of views on the policy and on the tobacco & vapes in general. Feedback included an awareness that sometimes vape products are targeted at young people there they should be able to access services to help stop smoking / vaping. Young people viewed both tobacco and vapes as a product which can both harm their physical and mental health, therefore, they often supported policy and actions which reduce the likelihood of other young people using tobacco & vapes. Young people who were reaching the end of their time at secondary school (S5-S6) often felt it was those who are younger than them (S1-S4) that used vapes more often, and they would benefit the most from policies which reduce the number of people who start smoking / vaping. A range of partners help us host these sessions, in particular we would like to thank to Dingwall Academy, Highland Youth Parliament and Aviemore Youth Club for their feedback and supporting this work. Continued work with young people will look to include how the policy is being implemented and how it may potentially impact their rights.

Planet youth

Data from Planet Youth in Highland highlights the importance of this work for young people. The local data shows 25% of young people (S4 pupils) have tried smoking and 39% have tried vapes. The data from Planet Youth shows links between substance use and other risk-taking behaviour. Thank you to the Planet Youth Team for their continued support.

How will the policy / service change give better or further effect to the implementation of Children's Rights in NHS Highland?
This is the first time the NHS Highland Tobacco & Vaping Strategy has examined its impact on young people and fully consider how its implementation impacts Children's Rights. As many of the actions from this strategy benefit young people's health and link with their rights, this should better implement the rights of the child within NHS Highland and its stop smoking service.
Approved by: **Susan Birse**

EQIA Children's Rights – Guidance Notes

EQIA Children's Rights – Flowchart

Screening Sheet

General description of the policy/service development and its aims, supplemented by an initial assessment of the applicability of the policy/ service development to children and young people in NHS Highland.

Asks you to consider:

- What aspects will affect children and young people up to 18
- What the likely impact will be
- Which groups of children and young people will be most affected
- Will this require completion of the EQIA Children's Rights questions

Completion of EQIA Children's Rights Questions **NOT Required.**
Explain your reasons.

Sign the EQIA Children's Rights Screening Sheet and return to:

Completion of the EQIA Children's Rights Questions **IS Required**
Sign the EQIA Children's Rights Screening Sheet and return to:

Continue to next stage.

EQIA Children's Rights Questions – Completion

Asks you to set out:

What impact will your policy/service change have on Children's Rights? Will there be different impacts on different groups of children and young people e.g. preschool children; children in hospital; children with additional support needs; care experienced children; children living in poverty?

If a **negative impact is assessed** for any area of rights or any group of children and young people, can you explain why this is necessary and proportionate? What options have you considered to modify the proposal, or mitigate the impact?

In what ways have you taken the views of children and young people in to consideration in the development of this policy/service change? What evidence have you used or gathered on children's views? How will you monitor the impact of the policy / service change and communicate this to children?

How will the policy / service change give better or further effect to the implementation of Children's Rights in NHS Highland?

EQIA Children's Rights – Screening Sheet

The United Nations Convention on the Rights of the Child places a compatibility duty on NHS Highland to ensure the rights of children are protected and promoted in all areas of their life. Completing this Screening Sheet will indicate if completing the **EQIA Children's Rights Questions** is required.

Please note that the actions, or inactions, of public authorities such as NHS Highland can impact children more strongly than any other group in society and every area of policy/service development affects children to some degree, whether directly or indirectly.

For information or support contact: NHSH Child Health Commissioner: deborah.stewart2@nhs.scot

Overview

Completing the Children's Rights Screening Sheet is a preliminary check on the proposed policy/service development to help determine whether completing the Children's Rights questions in the EQIA is required, and provide a record of that decision.

The Children's Rights screening questions below; ask basic information about the policy/service development and how it will affect children and young people specifically.

Decisions about whether or not to complete the Children's Rights Screening questions as part of the EQIA should take place as early as possible in the formation of the policy/service development.

This is the best way of ensuring that children's rights and wellbeing influence the way in which the policy develops, and that NHS Highland duties to act in a manner compatible with the UNCRC (Incorporation) (Scotland) Act 2024 are met.

Who takes part in the Screening exercise depends on the complexity and potential reach of the policy/service development under consideration.

1. What aspects of the policy/service development will affect children and young people up to the age of 18?
The Articles of the UNCRC apply to all children and young people up to the age of 18, including non-citizen and undocumented children and young people.

2. What likely impact – direct or indirect – will the policy/service development have on children and young people?
'Direct' impact refers to policies/service developments where children and young people are directly affected by the proposed changes, e.g. in early years, education, child protection or looked after children (children in care). 'Indirect' impact refers to policies/service developments that are not directly aimed at children but will have an impact on them. Examples include: hospital visiting policy, treatment/support to parents, staff parental leave, access to play areas, transport schemes.

3. Which groups of children and young people will be affected?
Under the UNCRC, 'children' can refer to: individual children, groups of children, or children in general. Some groups of children will relate to the groups with protected characteristics under the Equality Act 2010: disability, race, religion or belief, sex, sexual orientation. 'Groups' can also refer to children by age band or setting, or those who are eligible for special protection or assistance: e.g. preschool children, children in hospital, care experienced children and young people, children in rural areas, young people who offend, victims of abuse or exploitation, child migrants, or children living in poverty.

4. Is completion of the EQIA Children's Rights Questions required?
Please state if completion of the Children's Rights Questions in the EQIA template will be carried out or not. Please explain your reasons.

5. Sign, Date and Authorise

Person Leading the Policy/Service Development: Katy Allanson
Email: katy.allanson@nhs.scot

Signature & Date of Sign Off: **K.allanson**

04/03/25
Line Manager: Susan Birse

Email: susan.birse2@nhs.scot
Signature & Date of Sign Off: Susan M Birse
04/03/25

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Agenda Item 11

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**30 September 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:

- **Note** the ongoing collaborative working that has been undertaken by local partners in respect of developing potential options for a SAM in Argyll and Bute and take **substantial assurance**.
- **Accept** the recommended views of the SLWG that options 4 and 5 are reported to the Scottish Government by end September as the preferred models at this point in time subject to further investigation to support the development of detailed proposals;
- **Agree** that authority is delegated to the Chief Executive and Executive Director with responsibility for Legal and Regulatory Support, in consultation with the Leader of the Council and the Policy Lead for Care Services, to utilise the Invest to Save Fund in accordance with the spend conditions set out by the Scottish Government.

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	

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Journey Well		Age Well		End Well		Value Well	
Perform well	X	Progress well	X				

2 Report summary

2.1 Situation

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.

Officers have been working in partnership with colleagues from Argyll and Bute HSCP, NHS Highland, the Scottish Government (SG), COSLA, and other local authorities, such as Western Isles and Orkney, over a period of time to explore the potential benefits and opportunities of alternative governance arrangements, such as a Single Authority Model (SAM).

Following on from previous update reports, with the latest of these to Council in June 2025 and NHS Highland in July 2025, this paper provides a further update on the development work that has been undertaken in respect of exploring options for a SAM and makes recommendations in terms of proposed next steps.

2.2 Background

Argyll and Bute is made up of a rich mix of remote, rural and island communities, which present a number of challenges in terms of service delivery. In recognition of the unique demographics and geography, and the numerous strands of public sector reform that the SG has committed to, we recognise that a shift in public sector structures may be required to fulfil the ambition laid out in policy. Building on the current collaborative/joint working arrangements and the relative success of fully integrated health and social care services, a whole system approach is required.

Public sector service sustainability in Argyll and Bute requires a multi-agency integrated model. Greater integration, collaboration and coordination through joined up strategic planning and delivery of public sector services could deliver better outcomes for the population of Argyll and Bute.

The exploration of SAMs forms part of a wider package of public sector reform being driven at a national level including:-

a) The Local Governance Review was launched jointly by COSLA and the SG in December 2017 with the aim of exploring how power, responsibilities and resources might by shared between local and national government, and with communities. A key element of this work relates to Democracy Matters, which has involved two rounds of consultation by the SG. The latest, phase 2, findings were published in

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September 2024 and the SG have established a steering group to develop potential models/options for streamlining the community empowerment landscape.

b) 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 SG:

i. Community Empowerment through a new relationship with public services where communities have greater control over decisions.
ii. Functional Empowerment of public sector partners to better share resources and work together.
iii. Fiscal Empowerment of democratic decision-makers to deliver locally identified priorities.

c) Programme for Government

i. 2024-25 Programme 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 includes developing single authority models (SAMs) with local government and health partners to strengthen and streamline local decision making, and support a shift towards more preventative public services.

ii. 2025-2026 Programme states that by the end of the Parliament the SG will 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."***

d) The 'Public Sector Reform Strategy' was published in June 2025. Within Workstream 3 – Empowering People, Places and Communities – there is a commitment to ***"Empower local government and health partners to strengthen and streamline local decision-making through the development of Single Authority Models in three rural and island local areas, resulting in improved service delivery, better outcomes for communities and a shift towards more preventative public services. We will promote and share learning to inform local governance reform in other geographies."***

e) Health and Social Care Service Renewal Framework was also published in June 2025 and reinforces the importance of whole-system planning and governance, and that all planning must demonstrate partnership working across the public sector. SAMs are cited as being an opportunity to explore the role of alternative local governance arrangements in delivering service renewal, with a particular focus on health and social care, and to develop local decision-making arrangements which can best respond to the unique challenges faced by communities.

f) Scotland's Population Health Framework sets out the SG and COSLA's long term collective approach to improving Scotland's health and reducing health inequalities for the next decade. The conclusion of the Local Governance Review and the establishment of Single Authority Models in rural and island areas such as Argyll and Bute, Western Isles and Orkney, will provide key learning and insights into new place-based approaches for Scotland. Work led by Democracy Matters will also provide blueprints for innovative, democratic community-level decision-making models.

Any proposals developed for a SAM for Argyll and Bute will require to have regard to the outcomes and principles set out in the above publications. The SG have also provided guidance on additional national reform parameters which we should work within when exploring potential models. These are summarised below, with further detail provided in section 4.3.5 below and in appendix 1:-

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- Health bodies and integration authorities will retain their respective responsibilities for clinical governance
- No detriment to terms and conditions, pay or pensions
- No loss of skills or expertise
- Protection of employment in line with the public sector pay policy
- Some health law was not devolved to the Scottish Parliament. Matters such as professional regulation are addressed at UK level. Anything that falls within this category is out of scope for SAMs.
- Scottish Government will retain responsibility for development of current and future national policy and strategy relating to Primary Care
- As Scottish Ministers will retain overall responsibility for health service provision, suitable lines of accountability to Scottish Ministers must remain in place.
- As above, consideration should be given to existing arrangements and frameworks when developing proposals, however partners do not need to be limited by the current legislative context where this would stand in the way of delivering an optimal model.
- Financial governance - the Director-General Health & Social Care/ Chief Executive of NHS Scotland and all accountable officers will be expected to continue to carry out their responsibilities when evaluating any proposals for a SAM.
- Health Boards - any proposals should recognise that there must be a health board in place to carry out the various legal responsibilities (of a health board) for the geographical area that the SAM will cover. This could include agreements with health boards in other geographies, as already happens for some functions. The development of any proposals for SAMs should recognise the importance of health boards collaborating with each other to optimise patient outcomes, address inequalities, and improve efficiency across the system.
- Public Bodies (Joint Working) (Scotland) Act 2014 - when developing proposals for SAMs, local partners should consider whether the aims can be achieved using the existing mechanisms in the 2014 Act. If any proposals would require changes to existing integration schemes and the integration functions, then the constituent authorities would have to follow the processes within the 2014 Act. If there are obstacles in the 2014 Act, or its associated regulations, removal of those can be considered.

The SG are facilitating quarterly Ministerial Meetings to drive forward this strand of reform. The first of these meetings took place in December 2024 and are chaired by Ivan McKee – Minister for Public Finance, and Neil Gray – Cabinet Secretary for Health and Social Care, bringing together SG officials, local partners (Health Board Chairs, Council Leaders and Council Officers from Argyll and Bute, Western Isles, and Orkey), and other relevant interests to explore the possibility of SAMs. In addition, monthly meetings are held at a local level between SG officials and local authority/health board officers.

A national workplan and timeline have also been developed, with the following key milestones in place:-

- September 2025 - local partners should aim to share first draft preferred models with the Scottish Government in September 2025. This should be accompanied by detailed plans mapping out next steps for inclusive policy development, including through extensive engagement with communities and relevant workforces. Draft preferred models should take into account the parameters guidance. In addition, they should make reference to the anticipated impact of reforms on progress against current, or refreshed, Joint Strategic Needs Assessments.

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- December 2025 - In line with previous indicative milestones that have been shared, to support Ministerial and COSLA consideration, local partners should submit detailed models to Scottish Government in December 2025.

The Scottish Government will be providing further information on the type and level of detail that local partners should submit in December 2025. The development of implementation plans will be heavily dependent on the preferred models identified, including what legislative change might be required to enable full implementation. This will be an iterative conversation between SG officials and local partners.

2.3 Assessment

SAM SLWG

Given the increasing frequency of meetings held at a national level and the ongoing pace of development with regard to the development of a SAM, there was a need to put in place arrangements to allow officers to effectively engage and contribute to these meetings on an agile and flexible basis and to facilitate ongoing dialogue with elected members outwith the formal committee structure.

To this end, the Council agreed at their meeting held on 24th April 2025, to establish a SAM SLWG to act as a sounding board and take forward the development of alternative governance models for Argyll and Bute, including the identification of a preferred model, which can be used as the basis for further consultation.

Terms of reference were also agreed as follows:-

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).

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

Meetings and Reporting

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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

The SAM SLWG, as established in April, has met on two occasions – 16th May and 3rd June 2025. Following the SLWG held on 16th May, Officers met with colleagues from the HSCP and NHS Highland to continue a collaborative approach to this work and to update on the discussions/decisions taken at the SLWG. This included agreement to extend an invitation to appropriate NHS Highland non-executive Board members to future meetings of the SLWG.

A joint meeting of the SLWG was held on 1st September 2025. The main item of business was for local partners to consider the development work undertaken to date, including an appraisal of the models identified, with the aim of coming to an agreed position on a preferred model(s) for Argyll and Bute which can be reported to the SG by end September deadline. Further details on these discussions and the options is provided in sections 4.3 and 4.4 below.

An Officer led working group has also been established to drive forward this work and to facilitate the multi agency approach being adopted for this project. The core membership of this group includes senior officer representation from across the Council, HSCP and NHS Highland.

Assessment of SAM Model Options:

The Senior Officer Working Group and joint SLWG have worked together to consider a range of information in order to make a recommendation to the full Council and NHS board on options that could be considered further to develop a SAM.

This includes:

- Success to date of the current model of health and social care integration
- The case for change
- Potential benefits of moving to a SAM
- Principles and parameters to be considered in relation to assessing options for a SAM
- SAM options
- Assessment of the options proposed for a SAM for Argyll and Bute

A key document that has informed these discussions is included at appendix 2 – A Single Authority Model For Argyll and Bute – Overview of Key Principles and Models.

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Successful Strategic Joint Working in Argyll and Bute

It has been acknowledged by both partners that health and social integration has delivered notable success through fostering good working relationships that enable collaboration and joined up strategic planning including:

i. Comprehensive Delegation: One of only two partnerships in Scotland to delegate all health and social care functions permitted by legislation, fostering close collaboration between Council and NHS Highland.
ii. Innovative Strategies for Older Adults: Development of targeted strategies for older people, promoting longer, healthier, and more independent lives.
iii. Effective Co-location of Services: Multiagency teams sharing premises in all localities, enabling daily collaboration, better care planning, and smoother hospital discharges.
iv. Flexible, Localised Care Models: Home care services tailored to the needs of different communities and closely connected with hospital pathways for the best outcomes.
v. Integrated Palliative and End-of-Life Care: Consistent, high-quality support delivered jointly by social care, district nursing, and community hospitals.
vi. Successful Joint Decision-Making: Examples such as the Kintyre Care Centre purchase demonstrate the positive impact of joint leadership and strategic working.
vii. Embracing Technology: Technology Enabled Care and digital strategies help deliver innovative solutions suited to the local geography.
viii. Community-Focused Planning: Place-based, co-productive assessments and planning ensure services reflect community needs and priorities.
ix. Prevention and Early Intervention: Long-term focus on tackling inequalities and promoting public health, particularly in the wake of the pandemic.
x. Integrated Children's Services: Fully joined-up approach from pre-conception through education, addressing child poverty and delivering on children’s rights.

Case for Change

A SAM offers the opportunity to consider wider and deeper integration across public sector organisations to improve outcomes for the people of Argyll and Bute. This includes considering integration of services and functions beyond health and social care as well as opportunities for improved sustainability of existing health and social integration including workforce and financial sustainability. Key points in relation to the case for change include:

i. Successes of Integrated Working: The Argyll and Bute HSCP has achieved positive outcomes across a wide range of regulated services, credited to fully integrated service delivery under the Public Bodies (Joint Working) (Scotland) Act 2014.
ii. Potential for a Whole System Approach: Expanding beyond clinical and care services to a whole system approach could build on current successes and support more comprehensive, place-based planning tailored to community needs.

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iii. Strengthening National Policy Delivery: Enhanced arrangements would consolidate resources and capacity, enabling more effective influence and delivery of national policy, especially through a rural-focused lens.
iv. Workforce Attraction and Retention: All public sector organisations are committed to collaborating to attract and retain skilled workers, ensuring families have opportunities to grow, learn, work, and thrive locally.
v. Benefits of Full Integration: The full integration of permissible functions has already delivered many benefits, as outlined in previous successes, and provides a strong foundation for further improvement.

Benefits of a SAM

The potential benefits of a SAM are described in the paper included in Appendix 2 and can be grouped as follows:

Place based decision making and joined up strategic planning

- Tailored, Place-Based Reform: Adapts governance and decision-making to fit the unique needs of Argyll and Bute, avoiding 'one size fits all' models often imposed on rural or island areas.
- Enhanced Local Accountability and Democracy: Empowers locally accountable decision-makers with better knowledge of community needs and enables citizens to actively influence and participate in local democracy, fostering greater legitimacy and transparency.
- Expanded Democratic Participation: Increases opportunities for communities to scrutinise, analyse, and participate in public decision-making processes, enhancing the vibrancy of local democracy and accountability of service providers.

Improved service delivery and efficiency

- Improved Public Service Delivery: Aims to improve or at least maintain the quality of services despite financial constraints, aligning resources and priorities for more effective, joined-up service delivery tailored to community priorities.
- Efficient Use of Resources: Reduces duplication in management and supporting structures (e.g., multiple Chief Executives and corporate teams), enabling more efficient use of declining budgets while safeguarding vital public sector jobs and redistributing opportunities across the area.

Improving outcomes through wider integration

- Greater Integration Across Sectors: Facilitates joined-up working not just in health and social care, but also in housing, education, and other public services, supporting comprehensive approaches to longstanding challenges such as depopulation, workforce retention, and the housing emergency.
- Potential for Improved Educational Outcomes: Opens possibilities for closer collaboration between schools and further/higher education (such as UHI Argyll), potentially improving learner outcomes and resource coordination.

These categories align well and could be summarised as: - more effective joined up strategic planning across a wider range of public sector services combined

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with improved efficiency, productivity and effectiveness to improve outcomes for people.

Principles and Parameters

The following principles were developed between the two partners to guide discussions on SAM options:

i. Brand identity and professional status are key considerations for the SAM, requiring the continued prominence and protection of the NHS brand while establishing a clear identity for the new partnership.
ii. Professional roles and their associated status must also be safeguarded, with transparent plans for workforce models and engagement with professional bodies at all levels.
iii. Governance structures, including clinical and care governance, would need to ensure professional accountability across partner organisations, whether through existing models or new organisational frameworks.
iv. Any move towards a single employer model would necessitate significant legislative changes, especially regarding staff terms and conditions, which would likely remain unchanged unless beneficial alternatives are provided.

In addition, the parameters developed by Scottish Government officials (set out at section 4.1.4 above and appendix 1) to ensure SAM options were compatible with the current legislative and policy context were taken into consideration, alongside the suite of public sector reform publications set out at section 4.1.3 above.

SAM Options / Assessment

The options for a SAM are set out within appendix 2. Detailed below is an overview of each option, together with an assessment of each one. Discussions to date have focussed on narrowing down the options for further exploration through considering:

- Alignment with the benefits of the concept SAM
- Compatibility with principles and parameters
- Risks and challenges

Option 1 - Status Quo

This option would be a continuation of the current structures with the retention of the Health and Social Care Partnership with governance through the Integrated Joint Board.

This option provides continuity, but offers limited options for shared services/ efficiency savings, and doesn't offer any change from the challenges currently experienced by partners.

Benefits
It was noted that Argyll and Bute Health and Social Care Partnership has maximised the scope of delegation within the current legislative context and delivered notable successes. This option could continue to deliver effectively for the people of Argyll and Bute and there may be opportunities to further improve placed based approaches to strategic planning joined up working with other agencies to improve service delivery.

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There may be limited opportunities for improved service efficiency beyond the efficiency, productivity and effectiveness initiatives identified and progressed either jointly or within each partner organisation.

Principles and Parameters
This option would appear to be compatible with the principles and parameters.

Risks and challenges
This option minimises risks associated with disruption and significant structural change but potentially risks limiting the opportunity for realising the benefits envisaged for public sector reform and the SAM concept.

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 on the provisions of the ***Community Empowerment (Scotland) Act*** 2015.

Benefits
This option does provide the opportunity for more efficient use of resources through pooling budgets and sharing resources along with aligned strategic planning which could improve service delivery and outcomes for people.
There may be limited opportunities for wider integration within this model.

Principles and parameters
This option would appear to be compatible with the principles and parameters.

Risks and challenges
This option would retain independent organisations and governance structures with strategic planning undertaken and agreements to share resources made within the context of existing community planning powers. This could present a risk procedural disputes arising, meaning that developments could be delayed if one or more partners were not on board with a proposal.

Option 3 - A New Integrated Authority

This model would establish a new elected single legal entity which would have fully integrated service budgets, providing the opportunity for resource efficiencies and more shared services, and would be empowered by 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 the staff from other partner organisations falling under the umbrella) would need to be moved over to the employment of the new Integrated Authority. This could lead to concerns about loss of identity, particularly for NHS staff.

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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 enable implementation.

Benefits

This option would involve significant structural change and would require extensive consultation to agree the design, operating parameters and legislative arrangements including considering governance and accountability arrangements for delegated functions to both councillors and Scottish Government ministers.

In that context it is possible this model would deliver benefits across the categories: Place based decision making and joined up strategic planning; Improved service delivery and efficiency; Improving outcomes through wider integration.

However, there are many uncertainties associated with this model that would need to be explored more fully to understand the specifics of the model and the associated benefits. This includes understanding whether wider integration beyond the current scope of health and social care integration and other agencies/functions is envisaged.

Principles and Parameters

This option does not appear to be compatible with the parameters that have been defined to guide development of the SAM model.

Risks and challenges

There are significant risks and challenges associated with this option including:

- Requirement for primary legislation to enact this model including accommodating NHS accountability to Scottish Ministers
- Timescales associated with fully designing, defining and agreeng this model including staff and community engagement
- Risks of significant disruption to existing health and social care integration which are noted to have achieved several successes
- Consideration of protection of arrangements for negotiating NHS terms and conditions which are currently agreed at national level in partnership with trade unions

Option 4 - A Fully Empowered Local Board

The starting point for this model would be strengthening the IJB and the functions delegated to it by partners (Council and NHS Highland). It could initially build on the existing synergies and effective partnership working demonstrated to date.

However, in an Argyll and Bute context, the maximum functions permissible under the 2014 Act have already been delegated to the IJB. As such, in order to build on existing successes of integration and go any further, the 2014 Act would need to be amended, or new primary legislation required, to expand the functions that could be delegated beyond health and social care (but with similar governance structures to the HSCP/ IJB).

For example, a statutory housing partnership, further/higher education partnership, enterprise partnership etc… However, if new statutory partnerships were created for all

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those service areas it is appreciated this might result in a complex landscape of partnerships/boards, making it difficult for the public sector and public to navigate.

Benefits

This option would require amendments to the 2014 act but would offer the benefits associated with wider integration across the public sector to improve outcomes. It would maintain the current benefits of place based approaches and joint strategic planning within the IJB model and placed based but offer opportunities to enhance these benefits.

There is potential for improved service delivery through wider integration and potential for further efficiencies by working together as independent organisations within the IJB model.

Principles and Parameters

This option appears compatible with the principles and parameters.

Risks and challenges

There are risks and challenges within this option including:

- Further complexity of governance of more than two entities within the IJB model
- Limited opportunities for service efficiencies due to maintaining existing organisational structures

Option 5 - Single Authority Partnership

This model could be considered as a variant of the traditional Lead Agency arrangement (in place within Highland) 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).

There are two sub-options within this option: the council as the lead agency and the NHS board as the lead agency. Only the former has been considered as it is considered that the latter would not satisfy the requirements for local democratic accountability.

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.

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In practice, a Health and Social Care Board or Committee could become the engine room for health and social care delivery, with a membership similar to the IJB if this was desirable - local Elected Members, NHS Non-Executive Directors, professional leads, carers, third sector, etc.

Benefits

This option could include the benefits of option 4 by including wider integration in the scope of the single authority partnership.

It does potentially offer benefits for greater efficiencies and productivity through redesign or consolidation of support functions that are not related to staff.

In addition there may be some advantages to the alternative governance arrangements that would replace the IJB as a legal entity and house the joint strategic planning and decision making structures, mechanisms and governance within the council.

Principles and Parameters

It is possible that this option could be compatible with the principles and parameters. However, further exploration would be required to understand the roles of the Chief Executive of the council and the Chief Executive of the NHS board in relation to accountability. Currently the chief officer of the HSCP is jointly accountable to both CEOs in line with the current legislation.

Other accountable officers including the NHS Board's Director of Finance, Director of Nursing, Midwifery and Allied Health Professionals, Director of Public Health and Medical Director also have a role in the current accountability and governance framework.

Any proposed changes to this accountability framework would need to be explored further to understand the implications on the parameters.

Risks

There are risks and challenges within this option including:

- Potentially complex arrangements for governance and accountability in relation to accountable officer roles
- Further complexity of governance if more than two entities are considered in order to extend the scope of integration of public bodies.

Preferred Options

The Joint Short Life Working Group supported by the senior officers group explored the options and the outcome of the discussion is summarised above in terms of relative advantages and disadvantages of each option. This has resulted in a recommendation from the SLWG that "***options 4 and 5 are reported to the Scottish Government by end September as the preferred models at this point in time subject to further investigation***".

This is on the basis that:

- There were potential benefits that could be achieved through both options
- Both options are potentially compatible with the principles and parameters agreed to guide the SAM work
- There are less risks and challenges associated with both options

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- Further exploration would be required to determine the details of each option and further assess these options for the benefits, alignment with principles and parameters and assessment of the risks and challenges

Option 3 was discounted on the basis that:

- It is not compatible with the principles and parameters as currently defined
- the significant risks and challenges associated with this option

Option 2 was discounted on the basis that it appears to offer limited benefits and presents some level of risk and challenge.

OTHER CONSIDERATIONS/IMPLICATIONS

The Joint Short Life Working Group supported by the senior officers group also discussed other factors that should be considered as part of the further exploration of the options for a SAM. This includes:

Resource requirements

Additional resource may be required as an enabler and the capacity to support change and implement new models of integration needs to be evaluated and assessed against the risks and benefits.

Future governance and role of NHS Highland

It was noted that the two other areas considering a SAM have co-terminous councils and health board areas (Western Isles and Orkney). NHS Highland has a governance and accountability role across two council areas and consideration of the compatibility of a SAM for Argyll and Bute alongside the future model for Highland council is needed.

Interface with other health boards

It was considered that many services are provided by another health board, NHS Greater Glasgow and Clyde. In addition, the future relationship between NHS boards in the context of regional collaboration for NHS services involved in relationships between NHS Highland, NHS GGC, Western Isles and Orkney. These interfaces also should be considered in the context of a SAM for Argyll and Bute as we move forward.

PUBLIC SECTOR REFORM - INVEST TO SAVE FUND

As previously reported to the Council in April 2025, as part of the Cabinet Secretary for Finance's budget statement in December 2024 a £30m Invest to Save fund was launched. This initiative is aimed at funding reforms, driving efficiencies and improving productivity within public services. A bid for funding was submitted jointly by the Society of Local Authority Chief Executives (SOLACE) on behalf of a number of Councils who are currently exploring integrated authority models, including; Argyll and Bute, Eilean Siar, Orkney, North/East/South Ayrshire, Falkirk and Clackmannanshire Councils.

Following the submission of the bid in March, it has been confirmed that Argyll and Bute, Eilean Siar, and Orkney Councils have jointly received funding of up to

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£900K (£300K each), payable over financial year 2025/26, to support the development of SAMs within our respective areas.

NHS Highland and Argyll and Bute council have been working together to identify potential areas of spend for the allocated £300k from the Invest to Save Fund. One of the key next steps in this process, should the recommendations of this report be agreed, is to develop an appropriate programme of consultation and engagement with all relevant stakeholders to obtain views on the proposals. On this basis it is proposed that an element of the Invest to Save Fund is utilised to undertake a joint commissioning exercise to secure external professional support to assist with this large scale engagement process. It is recommended, from a Council perspective, that authority is delegated to the Chief Executive and Executive Director with responsibility for Legal and Regulatory Support, in consultation with the Leader of the Council and the Policy Lead for Care Services, to utilise the Invest to Save Fund in accordance with the spend conditions set out by the Scottish Government. NHS Highland will work with council colleagues to progress this proposal through the joint. senior officers group

Local partners will also continue to work in collaboration with the other two Councils to ensure the most efficient utilisation of the funds, particularly where there are common areas of support required to progress the development of a SAM.

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

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

exploration of a SAM will consider any financial implications arising. £300K has been allocated from the Invest to Save fund to support the project.

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

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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 IJB

4 List of appendices

The following appendices are included with this report:

Appendix 1: Paramaters

Appendix 2: A Single Authority Model for Argyll and Bute - Overview of Key Principles and Models

Appendix 3: Theory of Change – Impact and Outcomes

NHSScotland Chief Operating Officer

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Christine McLaughlin
Chief Operating Officer of NHS Scotland

Mary McAllan
Director of Public Service Reform

The Scottish Government
St. Andrew's House
Regent Road Edinburgh
EH1 3DG

Date: 18 July 2025

Dear colleagues,

SINGLE AUTHORITY MODELS

Thank you for the time and effort that you continue to invest in the ongoing work at local level to develop place-specific Single Authority Models. You will be aware that Ministers' commitment to this work is restated in the current Programme for Government, which describes joint work between local government and health partners to agree detailed plans and timelines for implementation by the end of this Parliament. There are clear opportunities in this work to improve outcomes, unlock prevention and better meet local needs.

The Cabinet Secretary for Health and Social Care and Minister for Public Finance have agreed the enclosed Single Authority Models Information Note 2/2025. This responds to partners' request for further information on the reform parameters which they should work within when developing models. The note also sets out existing law and Ministerial policy, which should be considered throughout this process. This should be seen as a shared starting point for local dialogue on the ambitious reforms to strengthen local decision-making which Ministers want to support.

We recognise the importance of a locally-led approach which involves all relevant partners. We also want to ensure that you have the right input at the right stages from the Scottish Government, as part of an iterative process of policy development. We hope our commitment to working closely with you in this way will help to identify and agree the optimal local governance arrangements for the communities you serve.

You will be aware that the Scottish Government recently published the Population Health Framework, the Service Renewal Framework and the Public Service Reform Strategy – each of which specifically references Single Authority Models. We are confident that enhanced local governance arrangements can align with the wider renewal and reform programme.

As partners have recognised, extensive local engagement will be needed to ensure the voices of local communities and expertise of staff are fully harnessed. This will be key to developing and implementing robust proposals with the greatest potential to improve outcomes.

The next phase of this work will require locally-led policy development to form detailed proposals for Ministerial and COSLA approval. The Scottish Government stands ready to provide further national policy input as more detailed, locally agreed preferred models emerge. Officials will also work with national representatives to support their engagement in discussions on proposals across all geographies. We recognise that there will be both commonalities and variation across emerging models and this will have implications for how key interests will wish to engage.

To support this approach, it would be beneficial if local partners could aim to share first draft preferred models with the Scottish Government in September 2025, accompanied by detailed plans mapping out next steps for inclusive policy development, including through extensive engagement with communities and relevant workforces. These first drafts should take into account the enclosed information note, and current or refreshed Joint Strategic Needs Assessments.

In line with previous indicative milestones that have been shared, to support Ministerial and COSLA consideration, local partners should submit detailed models to Scottish Government in December 2025. We are happy to discuss these timescales and recognise that there may be a requirement for variation across geographies.

The announcement of up to £0.9 million for local model development through the Public Service Reform “Invest to Save” fund provides the opportunity to obtain additional capacity and expertise as appropriate. We encourage local government and health partners to work jointly to identify opportunities for this spend to be used to help accelerate model development.

We are grateful for your continued leadership in progressing this important work to realise transformational change for your communities.

Yours sincerely,

Christine McLaughlin
Chief Operating Officer NHS Scotland

Mary McAllan
Director of Public Service Reform

SINGLE AUTHORITY MODELS – INFORMATION NOTE 2/2025

1. Purpose

The development of proposals for Single Authority Models (SAMs) is a locally-led process, to ensure proposals are most suitable for the unique circumstances and priorities of each geographical area. However, it is recognised that some key considerations, particularly regarding the NHS, are common to all areas. In setting these out, we aim to support development and discussion of preferred models at the local level.

This information note sets out national parameters for the development of models, and key considerations arising from NHS renewal plans and the current legal and financial frameworks, which will be relevant as local partners are developing their joint proposals. Potential models do not need to be limited by the current legislative context, but any need for legislative change would need to be factored into timelines for implementation.

The Scottish Government will work with local partners to consider jointly-developed emerging options which demonstrate the greatest potential to address local priorities and improve outcomes for people. This will involve helping to ensure that new arrangements help to find the optimum balance between place-based and population-based planning and delivery of services. Partners should reference local Joint Strategic Needs Assessments when setting out the potential benefits of preferred models.

This will be an iterative process of policy development. Partners will wish to consider shared local governance arrangements to oversee locally-led model development to help ensure proposals reflect the views of all organisations. Final agreed detailed proposals should have a sound evidence-base and the support of relevant staff groups and the communities they serve.

2. Reform Parameters – Health

2.1 Clinical Governance

Health bodies and integration authorities will retain their respective responsibilities for clinical governance.

2.2 Staff Governance

Our staff are key to the delivery of high quality public services and to the development and implementation of public service reform. The process of developing local proposals must consider health boards' responsibilities as employers, notably in relation to staff governance and partnership working. There will need to be full and meaningful discussions with trade unions on any new model.

Any proposal for a SAM should ensure there is:

- no detriment to terms and conditions, pay or pensions of staff currently employed in the NHS;
- no loss of skills or expertise and continued access to appropriate professional development and training; and
- protection of employment in line with the public sector pay policy.

2.3 Health matters that are not devolved to Scotland, or subject to UK-level regulation or agreement

Some health law was not devolved to the Scottish Parliament. Matters such as professional regulation are addressed at UK level. Anything that falls within this category is out of scope for single authority models.

2.4 Primary Care: Independent Contractors

Scottish Government will retain responsibility for development of current and future national policy and strategy relating to Primary Care to ensure universal coverage while fostering local population needs assessments to shape aspects of local delivery. This includes overarching responsibility for value for money, accountability for primary care policy, expenditure and cost control.

2.5 Accountability to Scottish Ministers

As Scottish Ministers will retain overall responsibility for health service provision, suitable lines of accountability to Scottish Ministers must remain in place.

3. Key Considerations – NHS Renewal

The Scottish Government's plans for NHS renewal include a focus on prevention, sustainability, shifting the balance of care toward delivery in primary and community settings, improved outcomes and reduced health inequalities.

The Scottish Government published the NHS Scotland Operational Improvement Plan in March 2025. The Population Health Framework and Service Renewal Framework, published in June 2025, focus on key reforms to make service delivery models more preventative.

The Population Health Framework focuses on creating and maintaining good health, supporting the people and communities who need it most, changing systems and environments to support people to stay healthy, and delivering a whole-system approach.

The Service Renewal Framework sets out a long-term strategic intent to renew health and social care services. This renewal will implement more person-led health and care, strengthened primary and community healthcare capacity, a wider suite of treatment and services being provided in the community or at home rather than in hospitals, and a redefined hospital model of care.

The Cabinet Secretary for Health and Social Care has also stated that the priorities for this work are primarily to optimise service delivery, with a resultant improvement in outcomes for patients, and secondarily to drive efficiencies, reducing duplication and demand to alleviate resource pressures on public services.

Accordingly, any proposals for SAMs must fully reflect the outcomes and principles that are set out in the above publications.

4. Key Considerations – Existing Legal and Financial Frameworks

As outlined above, consideration should be given to existing arrangements and frameworks when developing proposals, however partners do not need to be limited by the current legislative context where this would stand in the way of delivering an optimal model.

4.1 Financial Governance

As public bodies, health boards, special health boards, NHS National Services Scotland, and Healthcare Improvement Scotland are subject to the Public Finance & Accountability (Scotland) Act 2000. They must comply with the Scottish Public Finance Manual, which includes a section on "Accountability", which assigns personal responsibilities to "accountable officers".

The Director-General Health & Social Care / Chief Executive of NHS Scotland is the "Portfolio Accountable Officer", and the chief executives of health bodies are the "accountable officers" for their organisations.

Health bodies also are required to operate within their resources under the terms of the National Health Service (Scotland) Act 1978.

The Director-General Health & Social Care/ Chief Executive of NHS Scotland and all accountable officers will be expected to continue to carry out their responsibilities when evaluating any proposals for a SAM. The "Accountability" section of the Scottish Public Finance Manual explains that accountable officers should approve in advance all significant initiatives, policies, programmes and initiatives. They must conduct an Accountable Officer assessment against four standards, summarised below:

- **Regularity**: the proposal is compliant with relevant legislation (including the annual Budget Act), delegated authority and relevant guidance issued by the Scottish Ministers i.e., the SPFM and is compatible with the agreed spending budgets.
- **Propriety**: the proposal meets the high standards of public conduct and relevant Parliamentary control procedures and expectations.
- **Value for money (i.e., Economy, Efficiency & Effectiveness)**: the proposal must demonstrate good value for money for the use of public funds. In comparison to alternative proposals or doing nothing, the proposal should be systematically evaluated and assessed to provide confidence about suitability, effectiveness, prudence, quality, value and avoidance of error and other waste, judged for the public sector as a whole.
- **Feasibility**: the proposal is feasible, can be implemented accurately, sustainably, and to the intended timetable ensuring it is demonstrating economy, efficiency, effectiveness, considers the equal opportunities requirements, and contributes to the achievement of sustainable development judged for the public sector as a whole."

Any proposals for a SAM will need to work within these arrangements. The arrangements for the commission, submission and agreement of financial plans and financial reports, following the same schedule as the rest of the NHS, would need to remain in place.

4.2 Health bodies established under the National Health Service (Scotland) Act 1978

Section 2 of the Act requires Scottish Ministers to establish health boards, however it does not stipulate how many there must be. Any proposals should recognise that there must be a health board in place to carry out the various legal responsibilities (of a health board) for the geographical area that the SAM will cover. This could include agreements with health boards in other geographies, as already happens for some functions.

Health boards are responsible for the governance of services to the population they serve. However health boards operate as part of a National Health Service, and use nationally agreed terms & conditions for staff, national procurement arrangements, and draw from services that are managed on a national basis (e.g. screening programmes, blood transfusion, healthcare facilities management).

Health boards also enter into arrangements where some clinical services may be planned and delivered on a national basis, or perhaps on a model that services several health board areas. The Director-General Health & Social Care / Chief Executive NHS Scotland wrote to all NHS Board Chairs and Chief Executives on 7 February 2025 (see Appendix), emphasising the importance of health boards collaborating with each other to optimise patient outcomes, address inequalities, and improve efficiency across the system. The letter summarised the developments that had been put in place to strengthen collaboration across the system, and encouraged health boards to review their arrangements for cross-boundary collaboration.

The Act also provides the legal basis for the establishment of special health boards, Healthcare Improvement Scotland, and NHS National Services Scotland. All of these health bodies have been established to carry out functions and services on a national basis.

The development of any proposals for single authority models should recognise this context, and the potential opportunities that it offers a single authority arrangement.

4.3 Public Bodies (Joint Working) (Scotland) Act 2014

This Act requires constituent authorities (the relevant health board and local authorities) to jointly prepare integration schemes. Under this Act, both bodies are required to delegate certain functions (and budgets) under an integration scheme, and may choose to delegate others.

The Act does offer a variety of integration models, including where a health board can enter into an integration scheme with more than one local authority in its area, and constituent authorities can make choices regarding what functions they delegate to the "integration authority". Where a local authority and a Health Board are preparing an integration scheme they must have regard to the integration planning principles (which include having regard to the well-being of service-users) and to the national health and wellbeing outcomes.

The Act also allows Scottish Ministers to use secondary legislation to implement the Act, including specifying in regulations what functions must and may be delegated, and making provision about the operation of integration joint boards.

The functions of Health Boards that require to be delegated are set out in the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014. The functions which must be delegated in terms of the Regulations include certain functions under the National Health Service (Scotland) Act 1978, the Community Care and Health (Scotland) Act 2002 and the Mental Health (Care and Treatment)(Scotland) Act 2003.

The functions of local authorities that require to be delegated are set out in the Public Bodies (Prescribed Local Authority Functions etc.) (Scotland) Regulations 2014. The functions that require to be delegated include certain functions under the Social Work (Scotland) Act 1968, the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007.

Only those local authority functions conferred by the legislation listed in the schedule of the 2014 Act, and only those health board functions prescribed by the Scottish Ministers in regulations, may be delegated.

When developing proposals for SAMs, local partners should consider whether the aims can be achieved using the existing mechanisms in the 2014 Act. If any proposals would require changes to existing integration schemes and the integration functions, then the constituent authorities would have to follow the processes within the 2014 Act. If there are obstacles in the 2014 Act, or its associated regulations, removal of those can be considered.

It should be noted in this context that the creation of new public bodies, or changes to existing public bodies, are subject to a Ministerial Control Framework and all other delivery mechanisms should be exhausted first.

Appendix – Letter of 7 February 2025 to all NHS Chairs and NHS Chief Executives

Director-General Health & Social Care and
Chief Executive NHS Scotland
Caroline Lamb

E: dghsc@gov.scot

All NHS Chairs and NHS Chief Executives

7 February 2025

Dear Colleagues

Following the First Minister's recent keynote speech on improving public services, I am writing to seek your support in taking forward the programme of reform and renewal for our NHS. The NHS Chairs meetings and the advent of the NHS Scotland Executive Group has meant a fundamental shift in the way we come together and lead the NHS, but we need to increase the pace at which we are implementing the range of improvements across our system, in order to maximise the effectiveness and efficiency of services.

In taking forward the range of system reform and improvement work, it is important that we fully utilise the opportunities provided by working across boundaries – giving life to the statutory duties placed upon all NHS Boards to work collaboratively in delivering healthcare services. This duty is set out in Section 12J of the National Health Service (Scotland) Act 1978 and provides the foundation for ensuring equitable and effective healthcare delivery across Scotland.

As system leaders, you are required to ensure that your Boards actively engage in collaborative arrangements with other Health Boards. This includes sharing resources, expertise and services, where appropriate, to optimise patient outcomes and improve efficiency across the system. Such co-operation is critical to achieving the best possible care for our population, especially given the complex challenges we face in addressing health inequalities and meeting the demands on services.

Over the last year we have strengthened our approach to collaboration and co-operation with you, beginning with the publication of the Model Framework Document for NHS Boards in April 2024. This document outlines how we collaborate and co-operate and provides a structured approach for Boards, detailing our respective roles, responsibilities, and the nature of how Boards interact with the Scottish Government. It aimed to provide greater clarity on governance and accountability and sets out our commitment to fostering effective partnerships to deliver high-quality healthcare services across Scotland.

Our commitment to working together has been further strengthened with the establishment of the NHS Scotland Executive Group, which first met in October 2024. Its primary aim is to support the effective governance, planning and delivery of healthcare services across Scotland. The NHS Scotland Executive Group plays a central role in supporting national and

regional planning initiatives, such as those outlined in the NHS Scotland Planning Framework.

The recent publication of the NHS Scotland Planning Director's Letter, in November 2024, provides additional guidance on population-based planning, once again highlighting the need for strengthened national and regional coordination. The DL emphasised the establishment of a Single Planning Framework to ensure coherence and alignment in service delivery, infrastructure investment, and workforce planning at national level. The NHS Scotland Planning and Delivery Board (NHSSPDB) will oversee and govern these efforts, ensuring that resources are deployed efficiently and equitably across all Health Boards.

At the regional level, the letter outlines the importance of collaboration between neighbouring Health Boards to develop strategies that address the specific needs of local populations. Regional planning groups are expected to drive innovation and adaptability, responding to the unique health dynamics within their areas whilst aligning with the broader NHS Scotland priorities. These planning efforts are integral to achieving the vision set out in the 2016 National Clinical Strategy and the Public Bodies (Joint Working) (Scotland) Act, which prioritise integration and partnership working across sectors.

I believe we have all of the foundations now in place to allow you to fulfil your roles, as NHS leaders, but also in how we come together as an NHS Scotland to meet the needs of patients and the expectations of our communities.

Moving forward, I intend to work with employers to enhance the Executive Management Appraisal System so that we can properly assess and record the impact of working across board and wider system boundaries. This will be incorporated into the guidance for the 2024/25 performance review and 2025/26 objective setting process, which the Chief People Officer will issue in late February / early March. Similarly, the appraisals of NHS Chairs will encompass how they are facilitating and supporting the level of cross boundary working that we all see as essential.

For now, I encourage you all to review your current arrangements for cross-boundary collaboration and identify any areas requiring improvement. Please also ensure that staff within your Boards are familiar with the statutory requirements of the Model Framework.

In the meantime, should you require clarification or support, please do not hesitate to contact my office.

Thank you for your continued leadership and dedication to delivering high-quality, patient-centred care for the people of Scotland.

Yours sincerely,

Caroline Lamb

Director General Health and Social Care and Chief Executive NHS Scotland

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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.

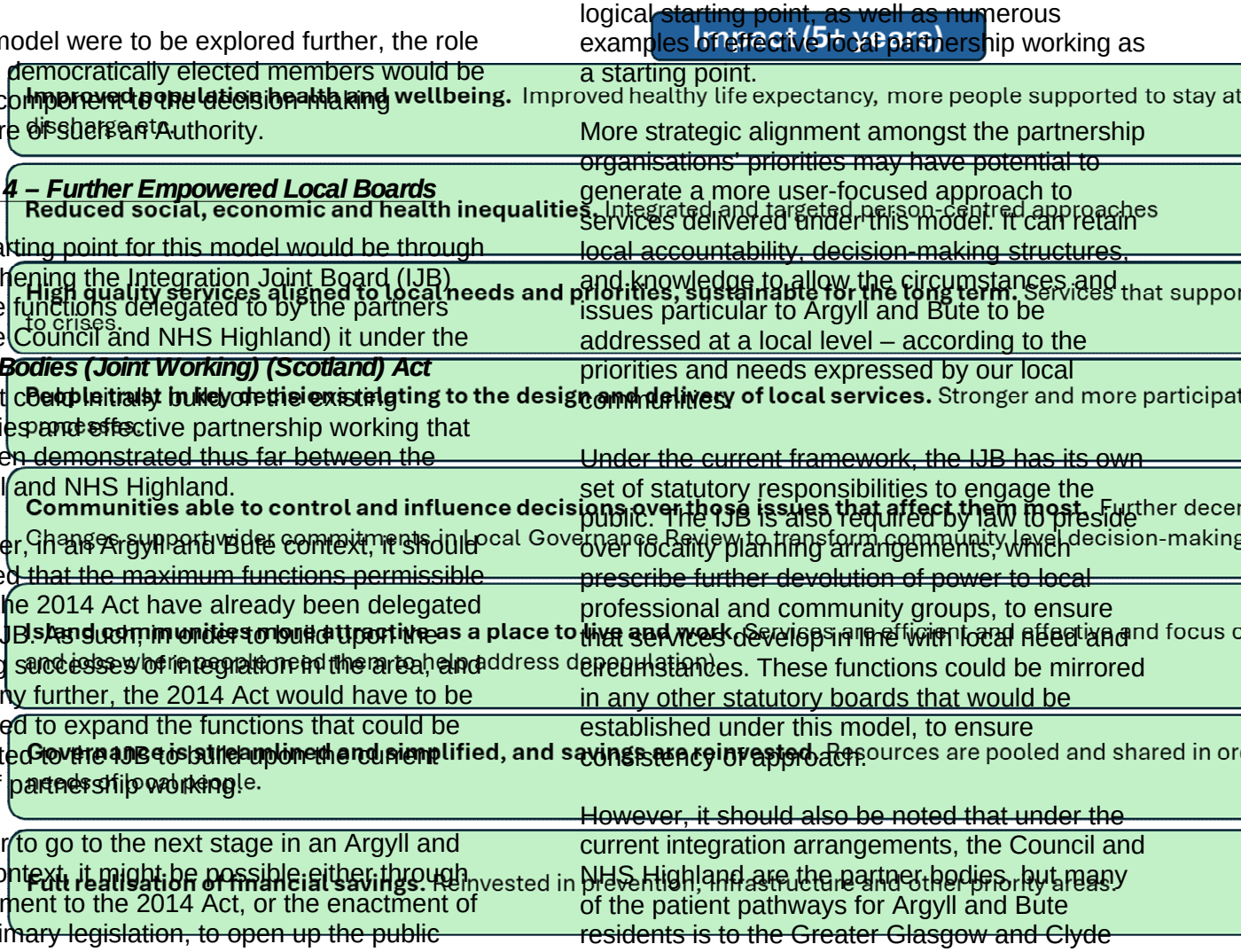
In order to go to the next stage in an Argyll and Bute context, it might be possible either through amendment to the 2014 Act, or the enactment of new primary legislation, to open up the public bodies and public functions that can be integrated wider than just health and social care (but with similar 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 remain a 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:

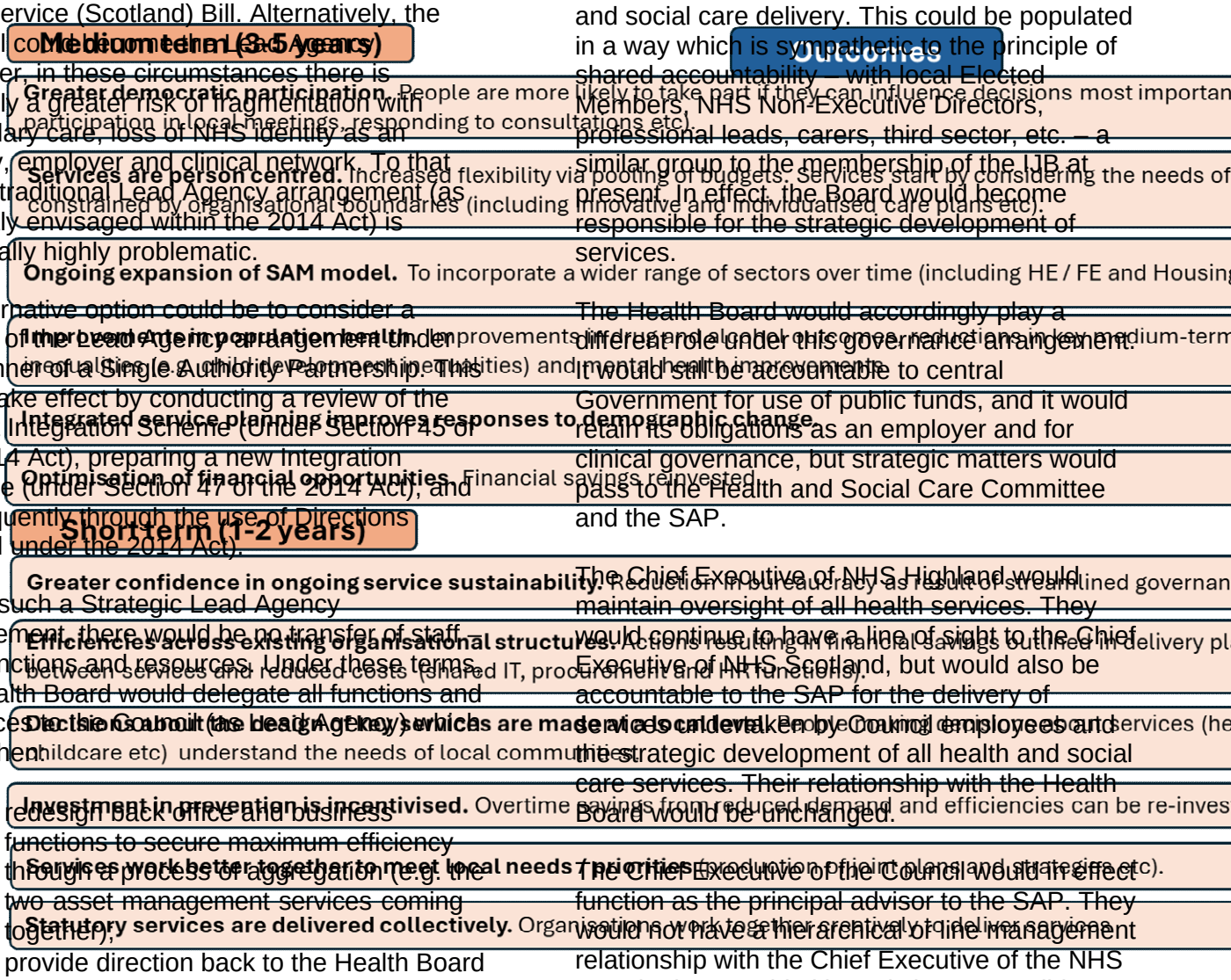
- redesign back office and business functions to secure maximum efficiency through a process of aggregation (e.g. the two asset management services coming together);
- provide direction back to the Health Board to deliver its functions in accordance with a Strategic Plan conceived to deliver maximum 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

Appendix 3 – Theory of Change – Impact and Outcomes

Agenda Item 12

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**30 September 2025**
Title:	**Quarter 1 Whistleblowing Report**
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** the content of the report.
- Take **Moderate Assurance** that the content of the report provides confidence of compliance with legislation, policy and Board objectives **noting** challenges with timescales due to the complexity of cases and investigations.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal Requirement

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

This report is for Quarter 1 covering the period 1st April – 30th June 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 1 covering the period 1st April – 30th June 2025:

- No new cases received
- 1 case remains open
- 1 case has been closed
- INWO closed one case review and there are no current case reviews.

One concern 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 would most likely be managed under our policy conduct.

INWO requested information on a case that is closed and had upheld some aspects of the concerns and partially upheld other aspects of the concerns. INWO determined that further investigation by them is not required following further clarification.

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

N/A

4.1 List of appendices

The following appendices are included with this report:

- Appendix 1 – Case recommendations and Governance Summary report

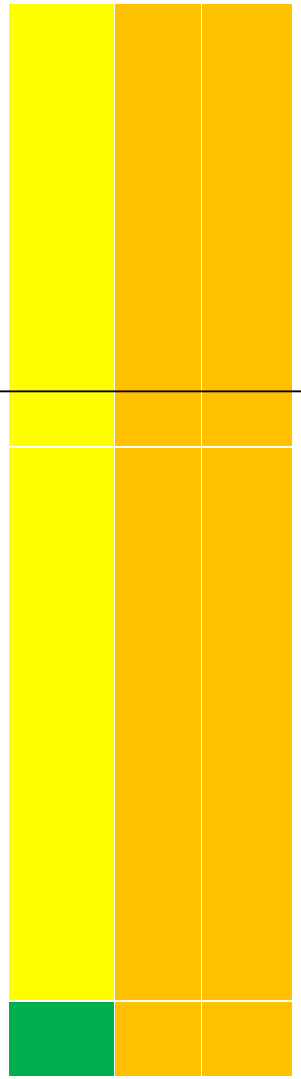
1 2 3 4 5

Likelihood

Appendix 1 – Case Recommendations and Governance Summary

Case ID	Summary	Recommendations	Actions	Governance Arrangements	Review date	Update
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	• Action plan developed and underway • Updates to be provided to whistleblower every 2 months
WB14 2024-25	Concerns raised in relation to: • Medical Staffing • Quality of care • Sustainability of service provision	• Develop and deliver new hub and spoke model of service provision to ensure sustainable future service model • Increase locum medical cover • Implement and embed revised standard operating procedures for managing the service in context of mutual support from other health boards.	• Implement recommendations through senior management team with support from executive team • Continue to work with Scottish Government and other health boards to agree a new national 'operating model' to deliver this service	• Clinical Governance	• December 2025	N/A

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	• Formal report provided to clinical governance • Case closed



Agenda Item 10

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**30 September 2025**
Title:	**Corporate Risk Register**
Responsible Executive/Non-Executive:	**David Park, Deputy Chief Executive Officer**
Report Author:	**Grace Barron, Senior Programme Manager – Strategy & Transformation**

Report Recommendation: The Board is asked to **note** the updates to the appropriate actions and take **substantial assurance** that the content of the 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.

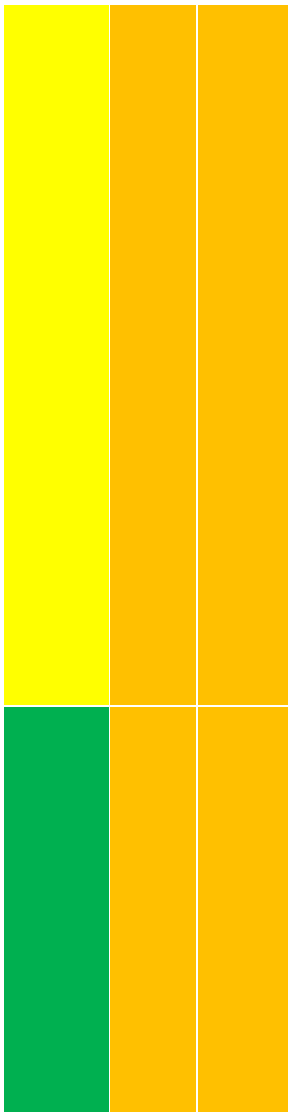
For this meeting, this summary paper presents a summary of the risks identified as belonging to the NHS Highland strategic risk register and recorded on Datix.

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 an overview of the risks contained within the NHS Highland Board Risk Register.



Risk ID	CTTEE	Title	Risk Description	Target	July 25	Sept 25	Executive Lead	Opened	Review Date	Trend	Strategic Objective
632	SGC	Culture across NHS Highland	There is a risk of a poor culture in some areas within NHS Highland due to inadequate leadership and management practice and inappropriate workplace behaviours, resulting in poor organisational performance including colleague and patient experience, staff retention, staff wellbeing and quality of care.	9	16	16	Gareth Adkins	Oct 19	Sept 25	Stable	Listen Well Nurture Well Plan Well
706	SGC	Workforce availability	There is a risk of insufficient workforce to deliver our strategic objectives due to a shortage of available workforce and failure to attract and retain staff, resulting in failure to deliver new 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.	9	20	20	Gareth Adkins	Aug 20	Sept 25	Stable	Plan Well
1056	SGC	Statutory Mandatory	There is a risk of poor practice across cyber-	8	15	15	Gareth Adkins	Mar 25	Sept 25	Stable	Nurture Well Perform Well

		Training Compliance	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.								
1375	FRPC	25/26 Financial Risk	There is a risk that NHS Highland will not deliver its planned financial position for 2025/26 and that the maximum deficit of £40m agreed with SG will not be achieved. There is currently no brokerage confirmed for 2025/26 therefore there is a risk of a section 22 report may be issued.	12	16	16	Heledd Cooper	Jul 25	Oct 25	Stable	Perform Well
666	FRPC	Cyber Security	There is a risk that: NHS Highland could experience a cyber incident that results in loss of access to all or part of the digital infrastructure, devices, systems or data that makes up its digital estate. Such an incident could occur	15	16	16	David Park	Oct 19	Sept 25	Stable	Progress Well

			at a board, regional or national level.								
1097	FRPC	Strategic Transformation	NHS Highland will need to redesign to systematically and robustly respond to challenges faced. If transformation is not achieved this may limit the Board's options in the future regarding what it can and cannot do for our population. The ability to achieve financial balance and the focus on the current operational challenges may leave insufficient capacity for the long-term 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.	6	16	16	David Park	May 23	Oct 25	Stable	Perform Well
1376	FRPC	Adult Social Care Financial Risk 25/26	There is a risk that NHS Highland will not deliver its planned position of financial balance within the Adult	12	16	16	Arlene Johnstone, Heledd Cooper	Jul 25	Oct 25	Stable	Perform Well Care Well

			Social Care delegated budget for 2025/26.								
1352	FRPC	Timely Care and Access to Treatment	Timely Care: There is a risk that access to timely and appropriate investigations, care or treatment as required in the ADP will not be achieved or fully available in a timely fashion. Access to Treatment: There is a significant risk that NHS Highland will fail to achieve all waiting time standards for community and hospital services. This will lead to delay in diagnosis and potential progression of disease/symptoms and hence poorer experience and outcomes for our population.	12	16	16	Dr. Boyd Peters	Jul 25	Sept 25	Stable	Treat Well
1388	FRPC	ADP 25/26 Delivery	There is a risk that the Annual Delivery Plan for 2025/2026 will fail to deliver the outcomes of improving patient quality, care delivery and efficiency due to fragility of services and reliance on additional/ unfounded resource to cope with current levels of demand activity resulting in lack of	8	16	16	David Park	Jul 25	Oct 25	Stable	All Well Themes

			compliance with Scottish Government Objectives.								
714	FRPC	Backlog Maintenance	There is a risk that the amount of funding available to invest in current backlog maintenance will not reduce the overall backlog figure. Continuing to work with SG where able when extra capital funding is provided to remove all high-risk backlog maintenance.	8	12	12	Richard MacDonald	Nov 23	Sept 25	Stable	Perform Well
1182	FRPC	New Craigs PFI Transfer	There is a risk that the transfer of New Craig site does not progress to timescale or concluded effectively due to the tight timescale. This could result in reputational/ service risk is the transaction is not completed or financial impact - through either financial penalties or inability to maximise the estate for future service delivery and estate rationalisation.	6	6	6	Richard MacDonald	Nov 23	Sept 25	Stable	Perform Well
1353	CCGC	Sustainability	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	12	16	16	Dr. Boyd Peters	Jul 25	Sept 25	Stable	Treat Well Care Well Respond Well

			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.								
959	CCGC	COVID and Influenza Vaccines	Uptake rates for vaccination across NHS Highland for the winter COVID and influenza programmes have been reasonable with overall uptake in line with the national average. Staff uptake has tended to be slightly higher 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	6	12	12	Jennifer Davies	Dec 21	Nov 25	Stable	Stay Well

			review, vaccination improvement group and plans for a new model of delivery.								

Assessment – NHS Highland Risk Management Framework

NHS Highland currently faces several key risks in relation to its risk management arrangements, primarily arising from the absence of a designated department, team or manager with formal responsibility for risk management. This has led to vulnerabilities in compliance, oversight, engagement, and systems use, as outlined below.

1. **Ownership and Accountability**
   Without a designated risk management function, there is a risk of poorly managed or unidentified risks, leaving the organisation exposed to non-compliance with the Orange Book requirements. While Strategy & Transformation Project Management has supported risk owners and champions by embedding risk processes within operational divisions, a dedicated risk manager is required to provide consistent leadership, accountability, and compliance assurance.
2. **Staff Engagement and Capability**
   Risk management may be undermined by limited staff engagement, as those required to manage risks often lack the necessary skills, tools or support. Although learning materials and resources have been developed and shared via the Risk Champions Teams channel, these are interim measures. Sustainable improvement requires a central function to coordinate training, build capability, and maintain consistent standards across the organisation.
3. **Oversight and Integration**
   The lack of central oversight across corporate, divisional, and operational risks has created duplication, additional workload, and missed opportunities to align risks across levels. Interim support has been provided by Strategy & Transformation Project Management and risk champions, but formalised oversight must be built into NHS Highland's corporate governance framework to ensure risks are consistently captured, escalated, and monitored.
4. **Link Between Risks and Adverse Events**
   Opportunities to proactively identify risks and reduce adverse events are currently constrained, as risk and adverse event management are managed separately in a closed-loop process. Limited oversight restricts the ability to identify themes and learning across both domains. Incorporating regular review of adverse events into the risk governance system will strengthen proactive risk reduction and patient safety outcomes.
5. **Systems and Technology**
   Sub-optimal use of risk management applications (Datix) and delays in implementing a new software (InPhase) are significant risks.

Overall, the assessment highlights a pressing need for NHS Highland to establish a dedicated risk management function, supported by a commissioned and organisation-owned Risk Improvement Plan. Interim measures have maintained progress, but the recommended actions set out above are essential to embed risk management within corporate governance and to strengthen the organisation's ability to manage risks proactively and effectively.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	x	Moderate	
Limited		None	

While the proposed level of assurance is substantial for level 1 risks, the proposed level of assurance is moderate for the Board's Risk Assurance Framework.

3 Impact Analysis

3.1 Quality/ Patient Care

A robust risk management process will enable risks to quality and patient care to be identified and managed. Assurance for clinical risks will be provided by the Clinical and Care Governance Committee.

3.2 Workforce

A robust risk management process will enable risks relating to the workforce to be identified and managed. Assurance for these risks is also provided by the Staff Governance Group and where appropriate to the Staff Governance Committee.

3.3 Financial

A robust risk management process will enable financial and performance risks to be identified and managed. Assurance for these risks will be provided by the Finance, Resources and Performance Committee.

3.4 Risk Assessment/Management

This is outlined in this paper.

3.5 Data Protection

The risk register does not involve personally identifiable information.

3.6 Equality and Diversity, including health inequalities

An impact assessment has not been completed because this is a summary report.

3.7 Other impacts

No relevant impacts.

3.8 Communication, involvement, engagement and consultation

This is a publicly available document. We aim to share this more widely internally and externally to develop understanding of risks within the system in in line with our strategic objectives and outcomes once strategy is approved.

3.9 Route to the Meeting

Through EDG, FRPC, SGC, CGC and Board.

4 List of appendices

N/A

Agenda Item 9

NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**30th September 2025**
Title:	**Highland Child Poverty Action Report 2024/25** **Argyll & Bute Child Poverty Action Report 2024/25**
Responsible Executive/Non-Executive:	**Jennifer Davies, Director of Public Health; Evan Beswick, Chief Officer Argyll & Bute HSCP**
Report Author:	**Lynda Thomson, Senior Health Improvement Specialist; Mandy Sheridan, Service Improvement Officer**

Report Recommendation: The Board is asked:

- **Consider** and **note** the actions carried out in 2024/25.
- **Consider** and **agree** the actions for delivery in 2025/26.
- **Note** the activity to be undertaken during 2025/26 to review the priorities in line with the refresh of the Integrated Children's Services Plan.
- **Note** the content of the Argyll & Bute Child Poverty Report

1 Purpose

This is presented to the Board for:

- Approval

This report relates to a:

- Government policy/directive

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	x	Stay Well		Anchor Well	X
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			

2 Report summary

2.1 Situation

The Child Poverty (Scotland) Act 2017 places a duty on local authorities and Health Boards to produce annual, joint Local Child Poverty Action Reports (LCPARs) which outline progress on identified actions for the previous year and planned actions to tackle child poverty for 25-26.

Reducing Poverty is also a core theme within both our Anchor Strategy and Annual Delivery Plan and links to Highland's Integrated Children's Services Plan and the Highland Community Planning Partnerships Outcome Improvement Plan.
This paper and the attached Highland Child Poverty Action Plan Report provides the requested update. The report covers the Highland area only.

2.2 Background

In line with the legislation, Highland Council and NHS Highland have led a review of 2024/25 actions taken to reduce child poverty and, in discussion with partners at the Highland CPP Reducing Poverty Group, identified the actions required in 2025/26.

Preparation has also begun for the development of the next Child Poverty Action Plan, aligned with the Highland Integrated Children's Plan for 2026 – 2031. This will come to the Board for approval in Summer of 26.

2.3 Assessment

The report provides an update to Board members on:

- Current Data from the Public Health, Health Intelligence team and Public Health Scotland.
- Progress made and outcomes achieved in tackling child poverty in 2024/25
- Proposed actions to be taken in 2025/26 in line with the key themes identified within the Highland's Integrated Children's Service Plan.

The key drivers that influence the experience of child poverty include income from employment, costs of living and income from social security and benefits in kind.
Whilst many children's services remain under the provision of Highland Council, NHS Boards have been asked to focus on four identified priority areas to tackle child poverty. These are:

- leadership and accountability,
- staff training,
- our role as an anchor organisation focusing on parental employment

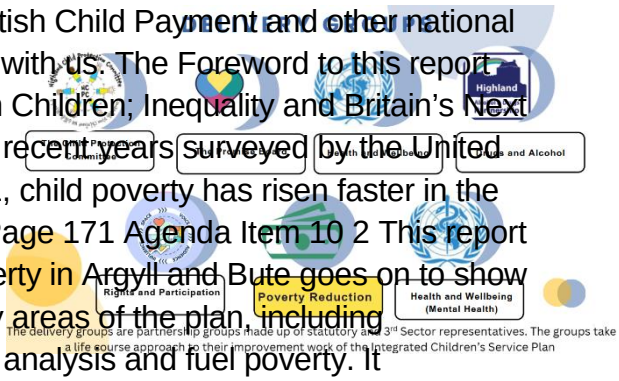
- procurement and income maximisation.

The Highland LCPAR incorporates actions that will support NHS Highland to meet the four identified priority areas outlined above and delivery of NHS Highlands Anchor Strategic Plan.

Argyll & Bute Child Poverty Action Plan:

The Argyll and Bute Child Poverty Action Plan Review 2024-2025 is a review of the Child Poverty Action Plan first published in 2019. It is a requirement under the Child Poverty (Scotland) Act 2017 that local authorities and health boards jointly produce and publish an annual review of their plan, setting out work being undertaken to tackle child poverty in their region. This action is required up until 2030. The Argyll and Bute Child Poverty Action Group, led by Evan Beswick (Chief Officer; Argyll & Bute Health and Social Care Partnership) have produced this year's review, it reflects a children's rights approach children and young people are currently coproducing an updated graphic, plan on a page version of the plan. This will be published with the substantive plan. The review also seeks to reflect the vision that: We want an Argyll and Bute where no-one lives in poverty. Everyone should be able to achieve their potential and feel healthy, happy and valued. We want to be a place where everyone understands that tackling poverty is a shared responsibility. We believe that if we act locally, and in partnership, we can make a difference.

The report notes that although some progress has been made in tackling child poverty in Scotland, because of factors such as the Scottish Child Payment and other national and local actions, child poverty is still very much with us. The Foreword to this report mentions Danny Dorling, who in his Book "Seven Children; Inequality and Britain's Next Generation" 2024, noted that: In the seven most recent years surveyed by the United Nations Children's Fund (UNICEF), 2014 – 2021, child poverty has risen faster in the UK than in any comparable country worldwide. Page 171 Agenda Item 10 2 This report also sets out the challenges of tackling child poverty in Argyll and Bute goes on to show what progress has been made in the various key areas of the plan, including employability, housing, education, benefits, data analysis and fuel poverty. It acknowledges the work of the Council, the Health Board and their partners in continuing to work together to tackle child poverty. 3.1 Other front Sections of the Report are: • Child Friendly Version of the Plan • Integrated Impact Assessments • Data and Child Poverty • Taking Action on Rural Poverty • Child Poverty and Mental Health • The Promise and Whole Family Support The Main Plan This section of the report reviews progress and changes in key areas of the plan and is laid out as always, in the following sections: A. Increasing Income from Employment and Earnings. B. Increasing Income through Benefits C. Cost of Living D. Helping Families in Other Ways E. Other Planned Work



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 attached update reports have taken the level of assurance to Substantial. Planning has already begun for the next update of the Highland Child Poverty Action Plan. This is now closely aligned with the Integrated Children's Service Planning Board and the Highland CPP Reducing Poverty Group have been working closely with the Improvement Service and Public Health Scotland to develop the next plan.

Work is underway on the Argyll & Bute plan.

3 Impact Analysis

3.1 Quality/ Patient Care

Poverty has an impact on the health and wellbeing of communities and specifically for children living in families impacted by poverty. Prioritised and sustained delivery on the identified actions can mitigate some of the worst effects of poverty and reduce the gap in health inequalities for communities who are the most disadvantaged.

3.2 Workforce

A route out of poverty can be through access to good quality jobs and Fair Work. NHS Highland is a major employer and can therefore provide increased opportunities. We seek to not only support our workforce through Fair Work and reasonable pay, but also to offer this opportunity to those furthest from the job market and seeking employment. The new employability strategy seeks to widen access that will be inclusive of people living in poverty.

3.3 Financial

Many of the actions detailed in the plan rely on doing things differently or in partnership rather than requiring specific financial resources. Some actions may require additional workforce commitment or funding going forward, but there are no specific financial risks identified in the delivery of the plan.

3.4 Risk Assessment/Management

There are risks if actions on child poverty are not undertaken. These are primarily long-term risks in relation to poorer health outcomes for children living

in poverty. There are reputational risks if NHS Highland does not deliver on the priority actions identified in the report.

3.5 Data Protection

There are no identified Data Protection issues in delivery of the actions.

3.6 Equality and Diversity, including health inequalities

The actions are targeted to those most in need and living in poverty. A completed Equality Impact Assessment is attached.

3.7 Other impacts

No other impacts to note.

3.8 Communication, involvement, engagement and consultation

This is an update report and so areas of communication, involvement and engagement have formed part of the original report.

3.9 Route to the Meeting

This update report has been considered and supported by the Highland's Integrated Children's Service Planning Board which provides partnership oversight to delivery of the plan and also approved through Highland Councils Communities and Place Committee on the 14th August 25.

4 Appendices

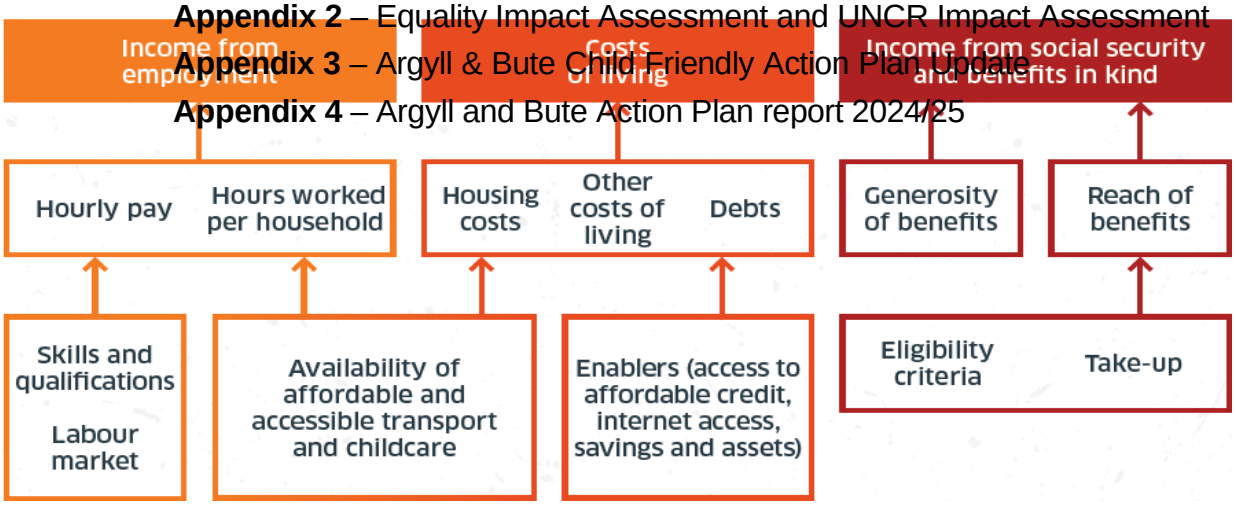
The following appendices are included with this report:

Appendix 1 – Highland Local Child Poverty Action Update Report April 2024 – March 2025.

Appendix 2 – Equality Impact Assessment and UNCR Impact Assessment

Appendix 3 – Argyll & Bute Child Friendly Action Plan Update

Appendix 4 – Argyll and Bute Action Plan report 2024/25



Highland
Local Child Poverty Action Update Report
April 2024 to March 2025

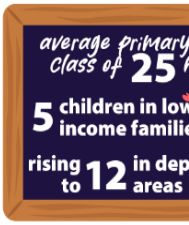
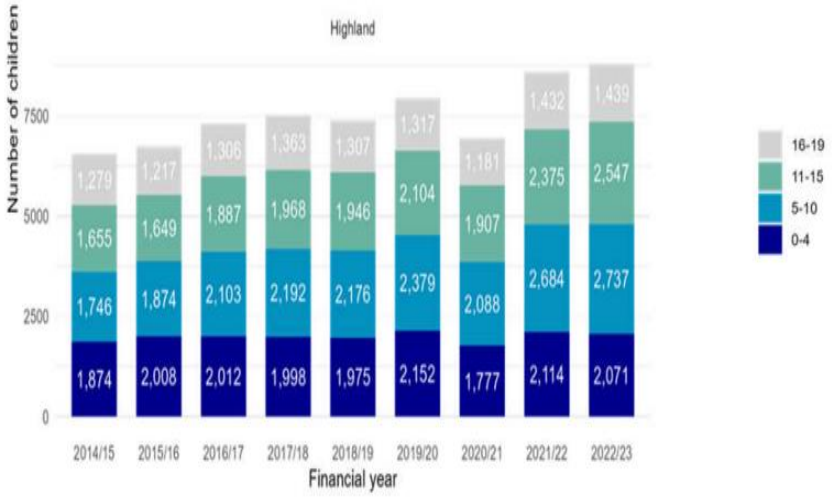
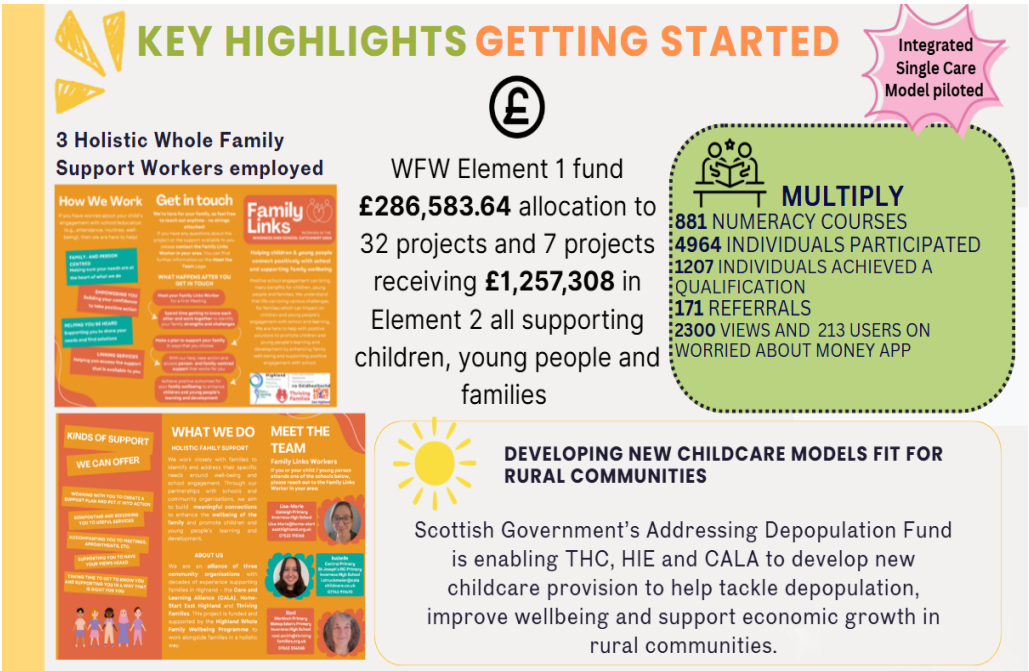


Figure 3: Number of children in low-income families in Highland



Source: DWP/HMRC children in low-income families local measure (Relative poverty before housing costs)

KEY HIGHLIG
Crisis Grant
PADS
100,000 packs of free period products distributed
16,077 products distributed by mail order
149 collection points


KEY HIGHLIGHTS GETTING STARTED
Integrated Single Care Model piloted
3 Holistic Whole Family Support Workers employed
How We Work
Get in touch
Family Links
WFW Element 1 fund £286,583.64 allocation to 32 projects and 7 projects receiving £1,257,308 in Element 2 all supporting children, young people and families
MULTIPLY
881 NUMERACY COURSES
4964 INDIVIDUALS PARTICIPATED
1207 INDIVIDUALS ACHIEVED A QUALIFICATION
171 REFERRALS
2300 VIEWS AND 213 USERS ON WORRIED ABOUT MONEY APP
KINDS OF SUPPORT WE CAN OFFER
WHAT WE DO
MEET THE TEAM
DEVELOPING NEW CHILDCARE MODELS FIT FOR RURAL COMMUNITIES
Scottish Government's Addressing Depopulation Fund is enabling THC, HIE and CALA to develop new childcare provision to help tackle depopulation, improve wellbeing and support economic growth in rural communities.

KEY HIGHLIGHT
Highland Council Employability team supported 266 parents in 24/25
175 were out-of-work parents and were in-work parents
https://www.worklifehighland.co.uk/ launched
2,100 vists to the site
Worrying About Money?
HIGHLAND
Find worrying about money leaflet here

The Approach in Highland

There is a strong commitment in Highland to address poverty and inequality within individual agencies and across the Community Planning Partnership. The vision for the Community Planning Partnership through its Highland Outcome Improvement Plan is:

"Maximise Opportunities and Tackle Inequality to Build a Thriving Highlands for All"

This is underpinned by three high level strategic priorities:

- People – Enable people to live independently, safe and well within their community
- Place – Work in partnership to develop sustainable and resilient local communities
- Prosperity – Creating opportunities for all people and places to prosper and to thrive economically

The Highland Community Planning Partnership brings together public agencies, third sector organisations and other key community groups to work collaboratively with the people of Highland to deliver better outcomes.

The Highland Community Planning Partnership works strategically at a Highland level, through a series of nine geographical local Community Partnerships as well as regional thematic groups. Ultimately these deliver our Local Outcome Improvement Plan.

The Highland Outcome Improvement Plan sets out the vision, purpose and focus for the Highland Community Planning Partnership from 2024-2027. The partnership believes working towards this plan will have a significant impact on reducing inequalities in Highland.

Reducing child poverty is a priority theme within the Highland Integrated Children's Services Plan which sits within a context of the Community Planning Partnership and delivering against the Highland Outcome Improvement Plan.

Our partnership recognises that children's services planning and planning to reduce child poverty is an ongoing process and that central to good planning is to ensure robust connections between all national and local strategic planning. Our child poverty plan connects the partnership strategic planning within a single framework. This framework provides both the tools for planning, self-evaluation, reporting, performance management and assurance.

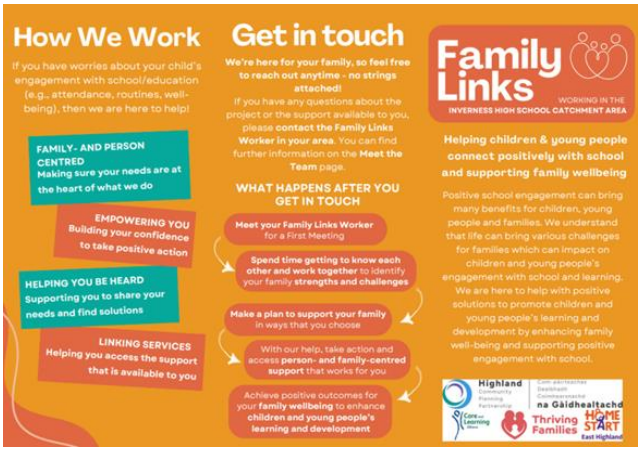
Our child poverty plan articulates how partners work together to provide services which are organised, equipped to deliver high-quality, joined-up, trauma-informed and responsive and preventative support to children, young people and families.

Highland's Integrated Children's Services Board provides oversight to the on-going work of the plan. This group has broad membership, including lead officers from The Highland Council, NHS Highland, Police Scotland, Scottish Fire and Rescue Service and a number of Third Sector organisations. The

Board reports to the Community Planning Partnership Board with additional reporting to Highland Council and NHS Highland Board.

The process to review the Integrated Children's Services Plan (ICSP) began during 2022/23. A Strategic Needs Assessment was undertaken to create the evidence base for the new plan. Child Poverty remains a core priority of the ICSP and the actions developed through that process are reflected in section three as actions for 2023/24 – 2025/6. The Integrated Children's Service Annual Report for 2024-2025 can be found here

A life courses approach has been taken to the plan and actions are structured under three life course stages: **Getting Started** (pre-birth to school), **Growing Up** (primary) and **Moving On** (secondary to young adult).



Section 1: Background and Context

1.1 Child Poverty (Scotland) Act 2017

In 2017, the Scottish Government introduced the Child Poverty (Scotland) Act. This replaced the previous UK Child Poverty Act 2010 and included duties on both the Scottish Government and local partners to address child poverty. It also introduced income targets as a driver for reducing child poverty across Scotland. Child poverty can have negative effects on the health, wellbeing and educational attainment of the children who experience it. It also has a wider cost for society[1]. By introducing a Child Poverty Act, which sets out clear targets for reducing the number of children living in poverty, progress can be monitored on meeting these targets.

The legislation requires:

- The Scottish Government to produce a Child Poverty Delivery Plan every four years highlighting how it intends to meet the child poverty targets laid out in the Act. It must also publish annual progress reports setting out progress towards meeting the child poverty targets. The Scottish Government's second Delivery Plan – Best Start Bright Futures, sets out policies and proposals to help reach the child poverty targets set for 2030.
- Local Authorities and Health Boards to jointly prepare annual Local Child Poverty Action Reports which set out activities that have been undertaken in the Local Authority area during the previous year to reduce child poverty and contribute to the delivery of the national targets and any planned future activities.

Evidence suggests that there are three key drivers which influence the experience of child poverty. These are income from employment, costs of living and income from social security and benefits. These drivers are set out in figure 1 below.

Figure 1: Scottish Government, Local Child Poverty Action Report Guidance 2018

Increasing incomes and reducing costs of living are mechanisms for reducing child poverty but there are many other actions that take place to improve children's quality of life and life chances.

[1] A 2023 study found that child poverty in the UK was costing over £39 billion a year - https://cpag.org.uk/news/cost-child-poverty-2023#:~:text=In%202008%2C%20the%20total%20cost,cost%20could%20be%20substantially%20higher.

1.2 Child Poverty in Highland

There is a large body of evidence that poverty harms children's health, wellbeing and educational opportunities. Rural and island life characteristics are recognised as potential compounders of low earning and higher cost of living.

In 2022/23, 7,355 children under 16 lived in low-income families below the poverty line in Highland

Nationally, six in ten children in poverty live in households where someone is working. In-work poverty remains more common that out-of-work poverty in all areas.

Nearly three-quarters of people experiencing in-work poverty have someone in their family who works in five high-priority industries: hospitality, health and social care, retail, administrative support and manufacturing. Many of these industries are large employers in Highland with a high proportion of part-time workers and seasonal variation.

Full, recent data set on Child Poverty available in Appendix

1.3 Summary of Actions carried out in 2024-2025

The actions to address Child Poverty in 2024/25 are outlined below and reflect those agreed as part of the new Integrated Children's Service's Plan 2023-2026, where one of the core priorities is Child Poverty. Child Poverty has been a core priority of the Integrated Children's Service's Plan since 2021 however the actions identified for the 2024/25 plan reflect the life courses approach taken throughout the whole plan. This reflects a new approach for the child poverty action plan.

The partnership actions to address child poverty are aligned to the Integrated Children's Plan and are reported as part of the Integrated Children's Service Plan monitoring.

Section 2: Action in Highland – What have we done to address Child Poverty in 2024/25

Theme 1: Getting Started - Pre-birth – 5 years

Improvement priority:
We will reduce the financial barriers in order to increase participation, raise aspirations and address the impacts of poverty.

1.1 Develop flexible models of childcare in rural areas

What we said we would do in 2024/25	What we did
➢ Develop and pilot an Integrated Single Care Model (SCM) in one or 2 areas in Highland. ➢ Continue to push for flexibility and a rural childcare approach/policy including childminding ➢ Provide a toolkit of flexible childcare options for rural communities ➢ Develop and deliver the parental employability programme ➢ Plan and develop a pilot for the Caithness area for childcare to support parents who want to undertake work experience. Local employers will be approached to partake in this pilot.	• Funding secured from Scottish Government Addressing Depopulation Action Plan fund enabled Highland Council (THC), Highlands and Islands Enterprise (HIE), and CALA to collaborate with consultants to develop business plans for new childcare models. Models aim to provide flexible and affordable childcare in rural communities, supporting parental employment and addressing underemployment in key sectors. • Business plan submitted to the Scottish Government's ADAP team at the end of April 25. • Evidence report prepared and submitted to Ministers Ms Don-Innes (Children, Young People and the Promise) and Ms Todd (Social Care, Mental Wellbeing and Sport) to support the case for regulatory change. Report has been endorsed by HIREP and its childcare sub-committee and was discussed at CoHI. • Progress continues on the development and piloting of an Integrated Single Care Model (SCM) in Highland. The initiative now transitioning into the development and implementation phase, with two pathway communities identified. Community engagement is planned as part of the next steps. • Positive engagement with regulatory agencies and the Scottish Government, who are supportive of the initiative. However, further legal advice from the Care Inspectorate is still awaited. • CALA presented on the SCM at the CPP Conference and will collaborate with THC and HIE to submit a follow-up report to the next CPP meeting. This report will outline key asks to help address barriers and support the next phase of implementation. • Toolkit developed of flexible childcare options for rural communities

- Parental employability programme – see section 3 for update

1.2 Implement the Whole Family Approach to mitigate the impacts of poverty

Whole Family Wellbeing Programme fund:

- ➢ Allocate Element 1 funding
- ➢ Building Linkages between schools
- ➢ Recruit Holistic Whole Family Support Workers
- ➢ Pilot service to person approaches within Local areas

Whole Family Wellbeing Programme fund: Building Linkages between schools and local food provision

- Partnership formed between CALA, Thriving Families and Home-Start East Highland to provide Holistic Whole Family Support through a Home-School Link model within the Inverness High School ASG area.
- Three Holistic Whole Family Support Workers are now recruited to post, each provider hosting one post across the alliance. This is a significant step forward with the first Programme led, Holistic Whole Family Support worker posts commencing in Highland
- WFW local partnership networks groups established all 9 Community Partnership Areas.

Element 1 Fund (**£286,583.64**), a total of 32 projects funded across Highland tackling poverty and inequalities by providing support and wellbeing activities to reach the six priority family group.

Element 2 Fund (**£1,257,308.00**) has been awarded to the following organisations/partnerships:

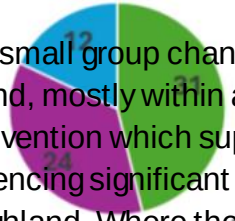
- **Thriving Families**
  - o To make a significant contribution to improving outcomes for children and young people with additional support needs across Highland. This will be achieved by increasing the

holistic, flexible, tailored, one-to-one support available to families and their wider circles of support by expanding the capacity of Thriving Families to deliver this support across Highland.

- **Autism and Neurodiversity North Scotland**
  - Implementation of a leading neurodiverse specific facility in Dingwall, from which newly recruited and trained A-ND staff will deliver specialised neurodiverse specific Outreach Support Services and a Day Care of Children Services, which includes a playscheme and afterschool club for neurodiverse children and young people.
- **Kooth**
  - For the past 12 months Kooth have been funded from the Whole Family Wellbeing Programme fund. As the contract has reached renewal a solution was sought for future funding for the contract. The Change Leadership Group have agreed that the CYP Mental Health and Wellbeing Fund will be utilised to cover the 12-month contract for Kooth for FY 2025/2026. Kooth provides anonymous on-line therapeutic content and activities, peer support which is pre-moderated to ensure safety and professional support through asynchronous messaging and live chat functionality.
- **Contextual Safeguarding Project**
  - The Contextual Safeguarding Project is a partnership between Action for Children, Barnardos, The Anchor Project, Police Scotland and Highland Child Protection Committee. The multi-agency team will be co-located in Rail House, Inverness alongside existing Action for Children and Anchor spaces. This will enable improved collaborative working and a 'four rooms' approach for families in a single setting (this will be replicated in buildings across Highland which have been created using Bairns' Hoose standards). The project will be supported by an Exploitation Steering Group to continue to develop contextual safeguarding approaches for children and young people at risk of community harm.
  - The project has been developed using the Scottish Approach to Service Design methodology using the voices of practitioners and young people, as well as self-evaluation and wider quality assurance work. It was also developed in response to the Inspection of Children's Services for children at risk of harm in 2022 where responses to community harm were highlighted as an area for improvement.

- The funding for this project will come from 3 sources – Alcohol and Drugs Partnership, Bairns' Hoose funding (through Child Protection Committee) and Whole Family Wellbeing Programme. This demonstrates the key elements required to address Exploitation through a Holistic Contextual Safeguarding approach.
- The project aims to bring together and scale up existing programmes to support young people affected by community harm and in particular, those at risk of Exploitation. Community harm can include risks relating to exploitation, youth justice, drugs and alcohol, harmful sexual behaviour and regular missing episodes. To date, the project has established that many young people accessing the services have multiple vulnerabilities within the community, often being on the edge of justice services, whilst being victims of Exploitation.
- Whilst specialist services can provide intensive and direct support to the young person, support for families (and the wider community) to help reduce the risks and vulnerabilities is required to avoid an escalation of harm, and prevent young people being removed from their family and/or Highland for their own safety.
- At present, Side-Step and RISE are offered as two distinct services along with support from Youth Action, HOST and ISS. This project aims to create an overarching Contextual Safeguarding Framework with a joined-up service to enable seamless support for young people and their families. This meets the Bairns' Hoose standards of having a 'four rooms' approach in one space – families should not have to seek out support, the support should be brought to them in a comfortable and safe setting.

- **Seasons for Growth**
  - Seasons for Growth is a small group change, loss and bereavement programme that is delivered across Highland, mostly within a school setting. It is a universal small group, psychoeducational intervention which supports children and young people (and their families) who are experiencing significant change or loss, which ideally would be available to all families across Highland. Where there is capacity and the programme has become embedded, children and young people self-refer to the group due to hearing about it via assemblies, from staff in their school or their peers recommending it to them.



  - A variety of staff from a range of professions have attended two-day training to deliver the CYP Programme and some who have furthered that training and attended a one-day Parent Programme Training, allowing them to deliver small group programmes to Parents

too. There are 237 trained CYP companions, of which 29 have gone on to train in the Parent Programme. These staff are predominantly Highland Council employees, based in our schools and across Health & Social Care. There are a further 20 staff trained in the Third Sector in organisations such as Young Carers and the Ministry of Defence.

- To develop this further, plans exist to enable support for staff from partner agencies to undertake the CYP Programme training and deliver a group so that they can become accredited in the CYP programme which in turn would allow them to train to deliver the Parent Programme. This would create capacity in the system.

- **Infant Feeding Support Worker/ NNU/ Maternity Project**
  - Aims to provide holistic whole family support in both the NNU and children's ward, providing specialist breastfeeding input to every family who needs that support at the right time to fulfil the child's right to optimal nutrition in turn giving the most associated short- and long-term health benefits.
- **Infant Feeding Support Worker/ CALA Project**
  - Is a collaborative project in partnership with NHSH Infant Feeding Support Worker team and CALA. This will ensure that women are supported by NHS Infant feeding support workers to improve breastfeeding outcomes but also ensure that groups are available in all areas of Highland providing continued feeding support but widening this to relationship building, play and nurture.

Employability

➢ Develop and implement a pilot project aimed at progressing unemployed parents in the Wick area into employment, with the SCQF Level 4/5 Employability Award re-designed for adults at its heart and with input from local employers throughout. Childcare, transport, lunch, and all materials will be provided to enable attendance. If successful, the plan would be to roll	Home Start Caithness have started to deliver the initial phase of the project, providing employability support to a group of parents in Wick. The next phase of the project will be to conduct a survey amongst a wider cohort of parents to help determine demand and identified needs. A key ambition for the project is to help parents achieve work readiness and connect them with local employers.

out the programme to other towns across Highland.

Multiply

- ➢ Further delivery of projects across the Highlands and sessions to boost numeracy confidence in everyday life ranging from outdoor family fun days to weekly activities within highlife libraries for families to explore everyday numeracy through games, crafts and play. Introduce additional evening classes to achieve maths qualifications and develop digital tools to support learning

Multiply activity (2023-2025)

- The Multiply interventions delivered support to those over 16, helping improve their functional numeracy skills through free personal tutoring and digital training. The Multiply programme had contracts with 12 providers across Highland to deliver a range of initiatives.
- These providers support a range of individuals, including young people who are at risk of being left behind as a result of their personal challenges, those with disabilities and those facing poverty, homelessness and long-term unemployment.
- Courses delivered included those designed to increase confidence in numbers, encourage people to upskill to access jobs/careers and use numeracy to manage money. There was also targeted support to prisoners or those recently released and their families to enhance numeracy skills and give the best chance for community re-integration.
- As part of The Highland Council's proactive approach to achieving positive outcomes in this area, Highland Multiply projects were offered a 2 month extension to February 2025 which enabled continued delivery. Multiply provider reporting indicates that the outputs delivered significantly exceed the original targets, and these outputs are summarised as follows:-
    - 881 adult numeracy courses were run in Highland through Multiply
    - 4,964 individuals participated in Multiply funded courses
    - 1,207 individuals achieved a qualification
    - 171 individuals were referred from partners onto upskill courses
- To continue the legacy of Multiply, UHI North, West and Hebrides launched a free online resource to help people build confidence with their numeracy skills which the Highland Council actively promoted internally and via social media. The Multiply Highland online resource is a series of interactive [illegible] based on real-life numeracy scenario challenges, such as adding up a bill or reading a pay slip. They are aimed at adults looking to develop number confidence for work, career progression, budgeting, or everyday life.

1.3 Develop financial inclusion pathways

- ➢ Adapt Food Insecurity Pathway for families with infants to access emergency formula milk.
- ➢ Provide Access to emergency funds for families in remote and rural areas and explore cash first approaches.
- ➢ Explore what measures can be put in place to provide assurance on the delivery of the FI Pathway
- ➢ Cash first approaches are difficult in remote and rural areas. Argyll and Bute have newly developed, an emergency voucher scheme which may be able to be adapted for North Highland and provide a solution. Explore other models of good practice in remote and rural areas to support cash first approaches. Update The Highland Information Trail.
- ➢ Provide information on the maternity section of the NHS Highland website. This will enable the information to be reviewed/updated every quarter.

- The Food Insecurity (FI) Pathway in Highland continues to build on the previously funded referral model between the Highland Council's Welfare Support Team and Health Visitors, which has successfully supported families with income maximisation and benefit checks.
- A Steering Group has been established to advance the FI Pathway, currently focusing on gathering data on user experiences and the distribution of formula across Highland. HALO has joined the group and will lead service delivery in the region, with funding to be secured through the Whole Family Wellbeing Programme (WFWP).
- The current Welfare Advice and Health Partnership (WAHP), funded until March 2025, continues to operate in rural GP practices and will remain active based on demand.
- Additionally, the Welfare Support Team has been providing fortnightly support at Dingwall and Invergordon Job Centres throughout 2024, focusing on financial checks, particularly for disability-related claims. Portree and Fort William Job Centres began receiving this support from 4 February 2025.

Develop financial inclusion (FI) pathways

- FI pathways between the HC Welfare Support Team & Health Visitors continue to go from strength to strength with the Welfare Support team assisting families with income maximisation and benefit checks.
- Improvement services pathway – Welfare Advice and Health partnership (WAHP) HC welfare support team are present at various GP practices across rural Highland.
- Job Centre Plus – Welfare support present weekly/fortnightly in Dingwall, Invergordon, Portree and Fort William Job centres assisting families with financial checks, disabilities reviews and appeals.
- New on-line referral route for schools directly into Welfare support to assist with families facing crisis. Being rolled out May/June to Headteacher/guidance teacher team meetings

Theme 2: Growing Up – Primary Years

Improvement priority:
Mitigate the impact of the cost-of-living crisis

2.1 Increase the uptake of sanitary products in schools and other public sector facilities.

What we said we would do in 2024/25	What we did
➢ Ensure free period products are available in Highland to everyone who needs them. ➢ Raise awareness of how to access free period products through community collection, schools or home delivery run by Highland Council or through GP distribution model run by Health Information Service (HIRS) ➢ Increase in product take-up from young people	• Team attended various events across the summer including Belladrum Music Festival, Inverness Highland Games, Pop up shops in Eastgate Centre, Vision 26 at Inverness Leisure Centre with over 100,000 packs of free period products distributed • 16,077 products were distributed by mail order in 2024/25 • 149 collection points have been established around Highland, including GP Surgeries, Community Centres and Highland Council service points. A map of all locations can be found here Map - Pickup Locations • A variety of products can be ordered from the Highland Council Website and delivered by mail for those who are unable to attend at a collection point • There is significant demand in populated areas with existing collection points but a lower uptake in rural areas. • With extra funding received from the Scottish Government every high school pupil was offered a six-month supply of products, helping to address stigma in schools which discourages pupils from taking these products.

2.2 Roll out cost of the school day toolkit

➢ Increase the number of schools using the toolkit	➢ Education Scotland Attainment Officer continues to progress Cost of the School Day programme, including meetings with Head Teachers to share good practice. Further update will be available in 2025/26 report.

Theme 3: Moving On – Secondary and Young Adulthood

Improvement Priority:
We will raise attainment and close the poverty related attainment gap

3.1 Raise awareness of the impact of poverty amongst children and young people

What we said we would do in 2024/25	What we did
➢ Develop and pilot a Money Counts 3 course designed to support teams and services to become more poverty sensitive ➢ Undertake a 3-6 month post evaluation survey for those attending the course ➢ Improve our shared understanding and use of data ➢ Embed Joint Strategic Needs Assessment and Whole Family Wellbeing Strategic Assessment	***Money Counts Training*** This continues to be offered as a means of increasing the number and quality of conversations around money worries. The training highlights the "Worrying About Money?" leaflet and app as tools to support individuals access a range of appropriate support services and organisations. Money Counts Training delivered since April 24: • 5 Brief Conversations (Money Counts 1) courses • 4 Supportive Conversations (Money Counts 2) courses • Poverty Informed Practice (Money Counts 3) course was developed in 24/25 and is designed to support services to be more poverty sensitive. 2 courses run in 24/25 • Positive feedback from evaluation included: "training was useful to think about language"; "when checklist was used within a service it was thought provoking". ***Improve our understanding and use of data*** Data Group has been established as part of PRG. Feedback from the Improvement Service suggests a need to ensure that data is used to identify priorities and actions. Work is underway to explore data requirements regarding health inequalities and the development of a dashboard to monitor progress at

HCPP level. Important to ensure that info is shared and relevant. Potential for a data hub to support work across the CPP priorities.

Embed Joint Strategic Needs Assessment and Whole Family Wellbeing Strategic Assessment
Collection of feedback from families and lived experience to find out what worked, what didn't, how things could be improved. This will support future planning within the Poverty Reduction Delivery Group

3.2 Roll out the Family First approach

- ➢ Reduce the numbers of children in external residential provision
- ➢ Increase the proportion of children in kinship care
- ➢ Increase the number of foster carers
- ➢ Increase community services and supports
- ➢ Implement the Whole Family Wellbeing Programme in Highland.

The most effective protection of children involves early support within the family, before urgent action is needed. In Highland, this relates to the 'Family First' approach and the Whole Family Wellbeing programme. If children do require placement away from home, real protection involves attuned, trauma-informed and sufficiently sustained support towards reunification, or towards an alternative secure home base when this is not possible.

Reduce the numbers of children in external residential provision
The numbers of placements outwith Highland were at the lowest level ever recorded at 9 placements in Oct 2023 but have since increased again to 17, 2 placements above the target. This is a result of several larger families coming into spot purchased residential care and a number of young people with needs and behaviour that required specialist placements outwith Highland. Work is continually targeted through the Home to Highland Programme to reduce the number of children in residential placements outwith Highland.

Increase the proportion of children in kinship care
The lack of increase in overall figures underlies plans to develop a specific Kinship Team to find family members, assess potential carers and offer support thereafter. Proposals have been submitted in respect of this. Whilst the number of children looked after in kinship has not risen in line with the target, there has been an increase of children living in kinship arrangements under a residence order. In June 2024 there were 135 children across 100 households that had residence orders, an increase of 12 from the previous year. These children are cared for by friends & family, but they are not officially classed as looked after children by the Scottish Government in data returns.

Increase the number of foster carers

Family First Strategy is about supporting children to remain at home with their parents, where this is safe to do so, and by providing additional support and scaffolding to families who might need this at different times, to ensure their children's wellbeing and safety is supported. Fostering is an integral part of the Family First strategy and for this to be a success the service needs to retain the current cohort of carers and recruit many more for children and young people of all ages so that we increase the number of local foster placements available for alternative Family-Based Care. Highland Council continues efforts to recruit new Foster careers including supporting Foster Care Fortnight (13-16 May 2024) with a series of online information sessions to encourage new foster carers.

3.3 Identify way to provided targeted support within universal services.

- ➢ Deliver 8 Money Counts courses to 40 people over the course of the year-through NHS Highland Public Health training programme.
- ➢ Distribute around 1500 IFAN Worrying About Money leaflets in 24/25 to those in need of financial support

Worrying About Money leaflets/ WAM app

- **1517 WAM leaflets distributed in 24/25** by the Health Improvement Resource Service (does not include downloads of the online version)
- Figures for the WAM app for 2024 indicate 2.4k views in the year, 218 active users (including 48 new users) and average engagement time of 2 mins 05 sec.
- This provides a helpful baseline for updates of figures in 2025. The annual review of the app has been completed.

Employability

- ➢ Aim to work with 300 parents on their journey towards employment
- ➢ Identify parents that could benefit from offers from employability service.
- ➢ Support private sector take on employability clients in-work progression
- ➢ Launch WorkLifeHighland.co.uk
- ➢ Develop further links between NHSH employability plans and HC to

support young people and parents into employment.	***Aim to work with 300 parents on their journey towards employment*** Highland Council Employability team supported 266 parents in 24/25. 175 were out-of-work parents and 91 were in-work parents seeking to improve their labour market position. ***Identify parents that could benefit from offers from employability service.*** The Employability Child Poverty Co-ordinator (ECPC) continues to engage with Job Centre and CAB staff across Highland to identify parents that could benefit from employability support. ***Support private sector take on employability clients in-work progression*** A full-time Employer Engagement officer has been appointed to the team and is working closely with employer organisations including Chambers of Commerce, FSB, DYW and Business Gateway and individual businesses of varying sizes - to ensure a stronger connection with employability clients. ***Launch WorkLifeHighland.co.uk*** www.worklifehighland.co.uk is now up and running and accompanied by an active social media presence using the WLH brand. To date 3,600 individuals have visited the site since the launch in October 2024. ***Develop further links between NHSH employability plans and HC to support young people and parents into employment.*** NHSH and HC have been working closely over the last few months with members of the Highland Employability Partnership (HEP). A "Fast Track to a New Career in Care" recruitment in Fort William on 9th April was supported by several HEP partners, including HC. The event allowed candidates to discover the range of posts on offer, receive help with completing their application and be interviewed – all on the same day. 20+ candidates inc. young people and parents secured employment because of the event.

Section 3: What are we planning to do to address Child Poverty in 2025/26

In the final year of the current Highland Local Child Poverty Action Plan 2023-26 we will continue to deliver actions to address Child Poverty according to the life courses approach outlined below, reflecting priorities agreed as part of the Integrated Children's Service's Plan 2023-2026, where one of the core priorities is Child Poverty. Further detail is given below.

Getting Started **Pre-birth – 5 years**	**Growing Up** **Primary Years**	**Moving On:** **Secondary/ Young Adulthood**
1.1 Develop flexible models of childcare in rural areas	2.1 Increase the uptake of sanitary products in schools and other public sector facilities.	3.1 Raise awareness of the impact of poverty amongst children and young people
1.2 Implement the Whole Family Approach to mitigate the impacts of poverty	2.2 Roll out cost of the school day toolkit	3.2 Roll out the Family First approach
1.3 Develop financial inclusion pathways		3.3 Identify way to provided targeted support within universal services.

Preparing for the 2026-2031 Highland Local Child Poverty Action Plan

Work has started on developing the next Local Child Poverty Action Plan. With support from the Improvement Service and Public Health Scotland, the Highland Poverty Reduction Delivery Group partners completed a self-assessment survey. The results were collated in a report and examined at a workshop held in May 2025 which resulted in three improvement statements to help the group start to develop the 2026-31 Plan:

- Work with those with Lived Experience, specifically identified priority groups, to help to identify gaps and priorities for improvement and to work together to design solutions.
- Work in partnership with other services and partners to develop a shared understanding of current needs and existing actions to address poverty.
- Be data informed in identifying need and measuring success/progress.

The Poverty Reduction Delivery Group is now focusing on how to deliver these improved approaches to understanding and addressing child poverty in Highland.

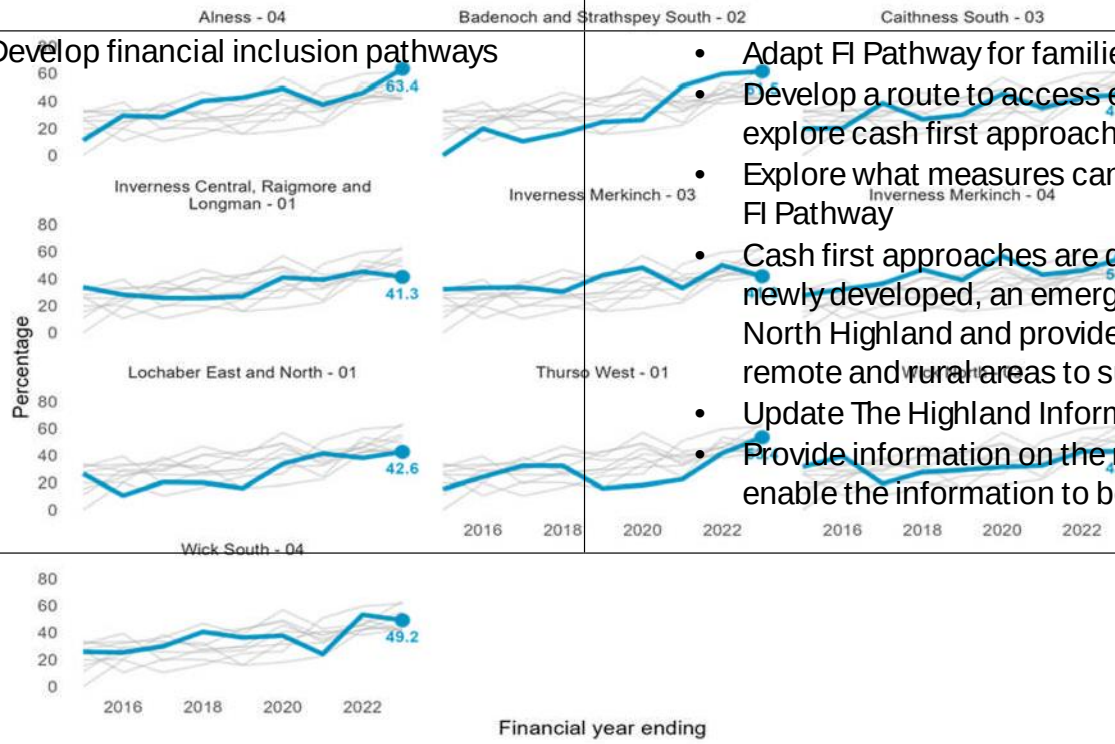
With reference to the 26-31 Plan, while the Scottish Government's child poverty targets, the 6 priority family groups and addressing the drivers of poverty remain central to the approach in Highland, the 2026-31 plan is likely to take a broader view than the current plan, to include a wider range of issues that drive child and family poverty including housing, transport and rurality, and to engage with a wider range of partners across the public, private and third sectors. The broader approach will also allow the Poverty Reduction Delivery Group partners to be more responsive, giving space for those with lived experiences to influence partners' responses to addressing poverty; to better understand what the data is telling us; and to respond to the findings and challenges posed by the recently announced Highland Poverty Commission.

Theme 1: Getting Started Pre-birth – 5 years	
Improvement priority: We will Reduce the Financial Barriers in Order to Increase Participation, Raise Aspirations and Address the Impacts of Poverty.	
Actions	**Priority Actions for 2025/26**
1.1 Develop flexible models of childcare in rural areas	• Develop and pilot an Integrated Single Care Model (SCM) in one or two areas in Highland. • Continue to push for flexibility and a rural childcare approach/policy including childminding • Roll out toolkit of flexible childcare options for rural communities • Continue to develop and deliver the parental employability programme and linking into childcare work experience opportunities where appropriate
1.2 Implement the Whole Family Approach to mitigate the impacts of poverty	**Whole Family Wellbeing Programme** • Continue the WFWP funding strategy through WFWP Locality Coordinators working in 9 local partnership groups across Highland to support services that address the needs of the 6 priority family types. The Tier 1 (£10K) and Tier 2 (2 x £50K per local partnership) funding streams are both open on a rolling programme. • Promote the WFWP self-assessment toolkit as a tool for partners to help improve and align their services and activities with child poverty reduction priorities. The tool will also provide useful intelligence on community activity across Highland • Building on three Inverness High School pilot, develop the Family Links future operation model through schools and/or communities in partnership with the third sector

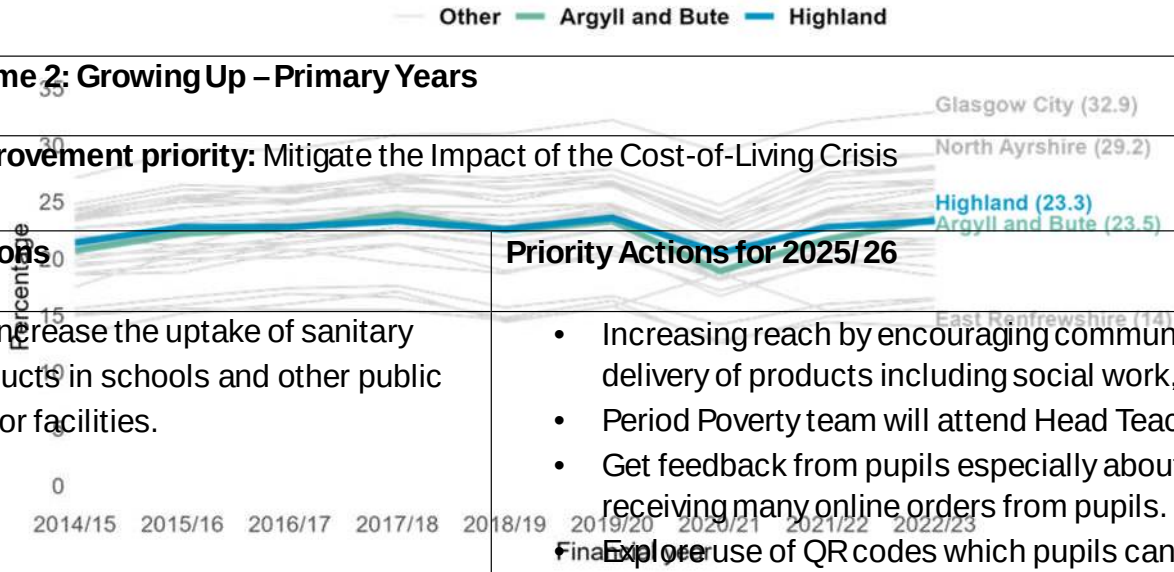
Employability

- HomeStart Caithness have started to deliver the initial phase of the Wick Employability pilot project, providing employability support to a group of parents in Wick. The next phase will be to conduct a survey amongst a wider cohort of parents to help determine demand and identified needs. A key ambition for the project is to help parents achieve work readiness and connect them with local employers.
- The Employability and Whole Family Well-being teams continue to work together on a range of activities. Community engagement activity has progressed in collaboration with the recently appointed HTSI Employability Development Officer. A key part of this work is to promote Work. Life. Highland to groups across the Highland, encourage them to promote the service to potential clients and discuss possible future engagement events.

1.3 Develop financial inclusion pathways

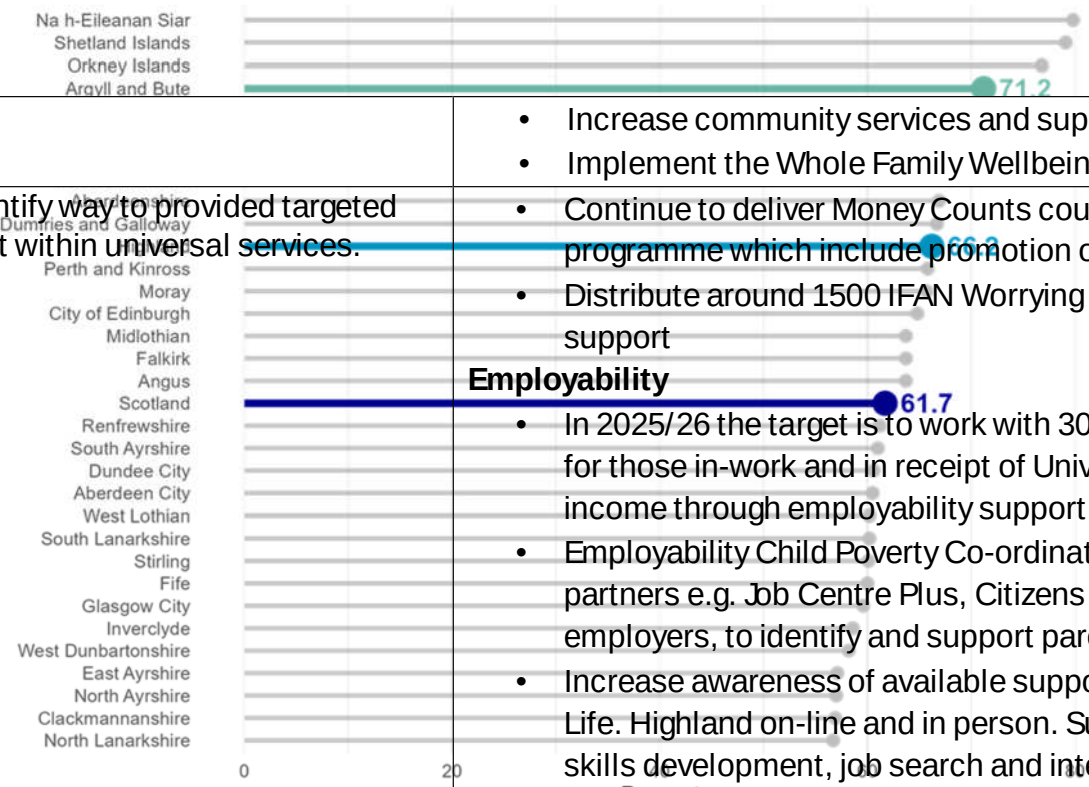


- Adapt FI Pathway for families with infants to access emergency formula milk.
- Develop a route to access emergency funds for families in remote and rural areas and explore cash first approaches.
- Explore what measures can be put in place to provide assurance on the delivery of the FI Pathway
- Cash first approaches are difficult in remote and rural areas. Argyll and Bute have newly developed, an emergency voucher scheme which may be able to be adapted for North Highland and provide a solution. Explore other models of good practice in remote and rural areas to support cash first approaches.
- Update The Highland Information Trail.
- Provide information on the maternity section of the NHS Highland website. This will enable the information to be reviewed/updated every quarter.



Theme 2: Growing Up – Primary Years	
Improvement priority: Mitigate the Impact of the Cost-of-Living Crisis	
Actions	**Priority Actions for 2025/26**
2.1 Increase the uptake of sanitary products in schools and other public sector facilities.	• Increasing reach by encouraging community collection and working with partners to help with delivery of products including social work, homeless teams, Council building receptions • Period Poverty team will attend Head Teachers meeting to gather feedback • Get feedback from pupils especially about reducing stigma/ embarrassment as project still receiving many online orders from pupils. • Explore use of QR codes which pupils can scan and place an order for products which is then sent back to the school in discreet packaging for the pupil to collect.
2.2 Roll out cost of the school day toolkit	• Increase the number of schools using the toolkit

Theme 3: Moving On: Secondary and Young Adulthood	
Improvement priority: We will Raise Attainment and Close the Poverty Related Attainment Gap	
Actions	**Priority Actions for 2025/26**
3.1 Raise awareness of the impact of poverty amongst children and young people	• Improve our shared understanding and use of data • Embed Joint Strategic Needs Assessment and Whole Family Wellbeing Strategic Assessment
3.2 Roll out the Family First approach	• Reduce the numbers of children in external residential provision • Increase the proportion of children in kinship care • Increase the number of foster carers



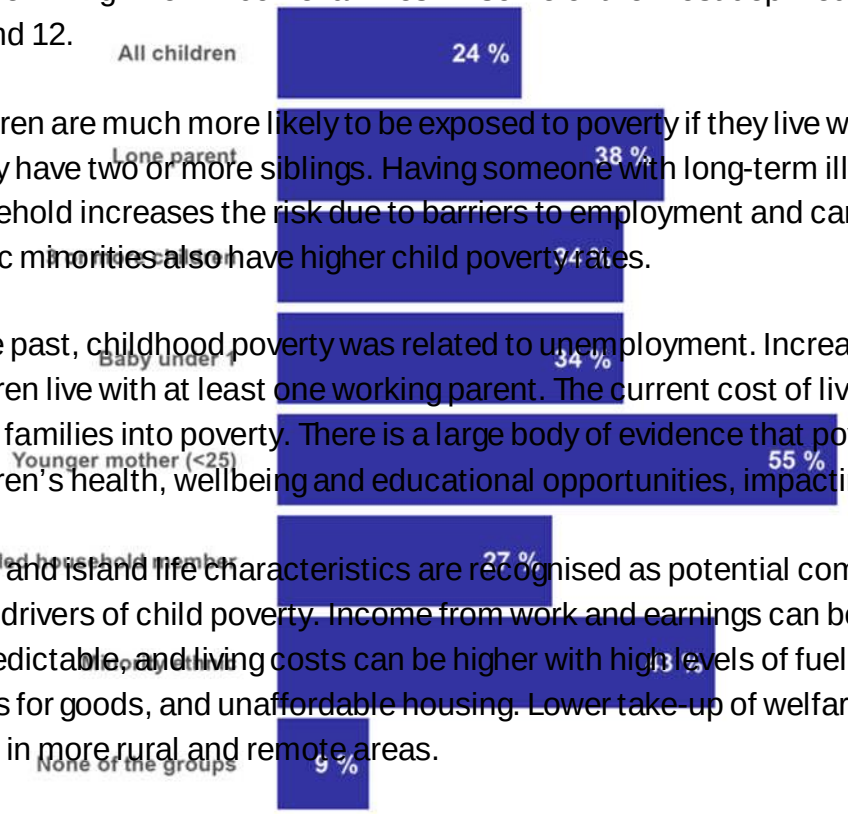
	• Increase community services and supports • Implement the Whole Family Wellbeing Programme in Highland (see 1.2)
3.3 Identify way to provided targeted support within universal services.	• Continue to deliver Money Counts courses through NHS Highland Public Health training programme which include promotion of the WAM leaflet and app. • Distribute around 1500 IFAN Worrying About Money leaflets in 25/26 to those in need of financial support **Employability** • In 2025/26 the target is to work with 300 parents, either on their journey towards employment or for those in-work and in receipt of Universal Credit, to potentially improve their household income through employability support. • Employability Child Poverty Co-ordinator in post and will continue working alongside key partners e.g. Job Centre Plus, Citizens Advice Scotland, community organisations and employers, to identify and support parents that could benefit from our offers. • Increase awareness of available support will continue primarily through the promotion of Work. Life. Highland on-line and in person. Support includes: help with barrier removal, training and skills development, job search and interview skills, volunteering, paid placements in the public and third sectors, self-employment, support for private sector companies to take on employability clients and in-work progression support. • The Work. Life. Highland website was launched in autumn 2024 and is providing a simple point of entry for potential clients and employers to access information about the employability support available across Highland. The clear call to action in the site is to get in touch and to date we have seen a significant number of people contacting the service via this route. • The Highland Council recently added the role of Employer Engagement Co-ordinator to the Employability team. A key part of the role to date has been to promote flexible working options to employers, including options to help parents enter and remain in the workforce **Adult Learning** • Highland Council Adult Learning service will offer training in the following areas in 2025/26 o Core Skills for Work o Money Matters o Personal Finance o Wellbeing Literacy o Family Learning

Appendix – Poverty in Highland

1 Child Poverty[2]

In 2022/23, 13,034 children in NHS Highland (Highland and Argyll and Bute) live in poverty after housing costs. 9,776 of these children live in Highland. This means that they live in a household 60% below the UK median income after deducting housing costs.

The average primary school class of 25 pupils in NHS Highland now has around five children living in low-income families. In some of the most deprived areas, this figure is around 12.



Children are much more likely to be exposed to poverty if they live with a lone parent or if they have two or more siblings. Having someone with long-term illness in the household increases the risk due to barriers to employment and caring demands. Ethnic minorities also have higher child poverty rates.

In the past, childhood poverty was related to unemployment. Increasingly, more poor children live with at least one working parent. The current cost of living crisis is pushing more families into poverty. There is a large body of evidence that poverty harms children's health, wellbeing and educational opportunities, impacting the life course.

Rural and island life characteristics are recognised as potential compounders of the main drivers of child poverty. Income from work and earnings can be seasonal and unpredictable, and living costs can be higher with high levels of fuel poverty, higher prices for goods, and unaffordable housing. Lower take-up of welfare support can be an issue in more rural and remote areas.

Scottish policy measures include support through the benefits system, increased childcare provision, school clothing grants, and free school meals and as part of the Workforce 2030 Vision, transforming the role of school nursing specifically to address the impact of inequalities and child poverty. The Scottish Child Payment was introduced in February 2021. The level has risen to £26.70 a week and was extended to children up to 16 years of age in families receiving means-tested benefits. Families can access means-tested support through Best Start Grants.

Currently, 11,975 children in Highland living in low-income families already receiving qualifying benefits receive the Scottish Child Payment.

[2] Information extracted from a report produced by the Health intelligence team: NHS Highland. "Child Poverty: Children and young people's health and wellbeing profiles: supplementary report" Publication date: 22nd July 2024. Public Health Intelligence, NHS Highland nhsh.publichealthintelligence@nhs.scot

2 Local measures of child poverty

Measure	Argyll and Bute	Highland	Scotland
Households with dependent children[1]	6,900	16,300	582,300
Families with children receiving support from Universal Credit[2]	2,563	7,331	199,583
Lone Parent households[3]	1,839	5,347	149,029
Large families[4]	524	1,425	37,767
Households with dependant children where someone has a disability[5]	708	2,134	58,103
Children under 1[6]	579	1,908	46,959
Ethnic minorities[7]	1,000	1,794	6,624
Ethnic minorities population under 25[7]	773	2,521	171,509

[1] Source: Nomis official census and labour market statistics, Annual population survey 2022.

[2] Source: Stat-Xplore, Households with dependent children receiving support from Universal Credit, Febuaray 2024.

[3] Source: Stat-Xplore, Lone parent households with dependent children receiving support from Universal Credit, Febuaray 2024.

[4] Source: Stat-Xplore, Households with 3 or more dependent children receiving support from Universal Credit, Febuaray 2024.

[5] Source: Stat-Xplore, Households with dependent children receiving support from Universal Credit with Disabled Child Entitlement and/or Limited Capability for Work Entitlement, Febuaray 2024.

[6] Source: National Records of Scotland, Births 2022.

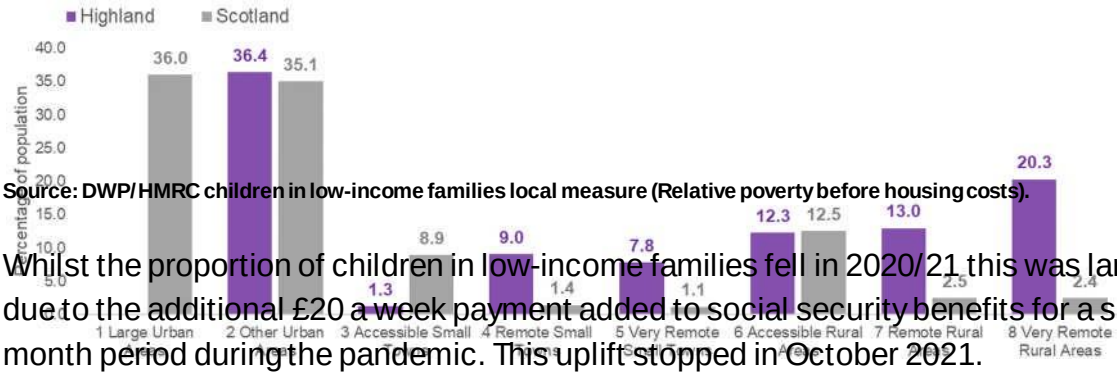
[7] Source: Ethnic group by age, Scotland's Census 2022. Ethnic minorities including:White: Gypsy/ Traveller, Mixed or multiple ethnic group, Asian, Asian Scottish or Asian British: Total, African: Total, Caribbean or Black: Total, Other ethnic groups: Total.

Children in low-income families

The terms low income refers to being below the poverty threshold.

The chart shows the percentage of children under 16 living in families either receiving out-of-work (mean-tested) benefits or tax credits, where their reported income is less than 60 percent of the contemporary UK median income. The Scottish Government recommends this measure of relative poverty to monitor child poverty locally.

Figure 2: Percentage of children in low-income families in Local Authority areas



Source: DWP/ HMRC children in low-income families local measure (Relative poverty before housing costs).

Whilst the proportion of children in low-income families fell in 2020/21 this was largely due to the additional £20 a week payment added to social security benefits for a six-month period during the pandemic. This uplift stopped in October 2021. Subsequently, rates have risen again in Highland and Scotland. Slow economic recovery from COVID-19 and the cost-of-living crisis have resulted in rapid and sustained price increases that disproportionately impact low-income families already at risk from food, fuel and transport costs.

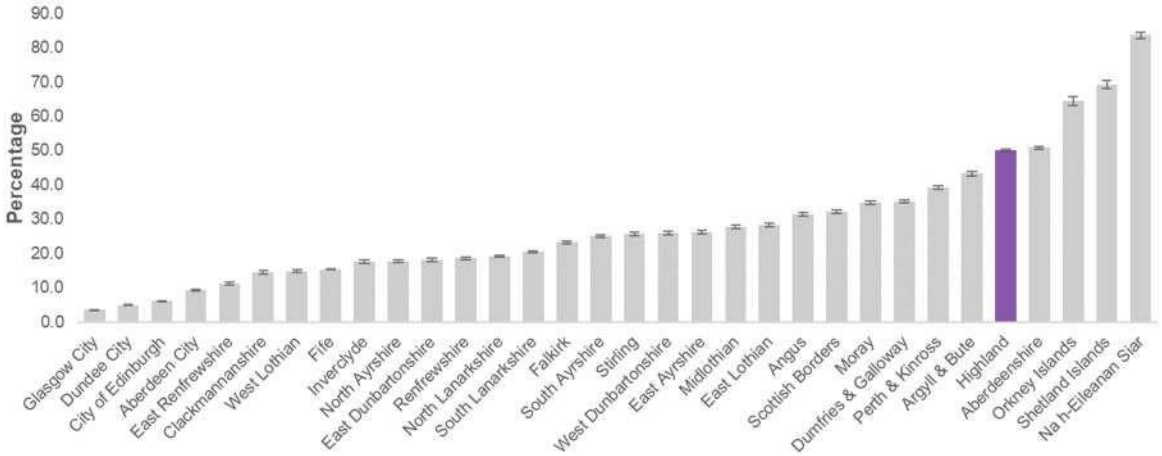
In 2022/23, 7,355 children under 16 lived in low-income families below the poverty line in Highland.

Figure 3: Number of children in low-income families in Highland

Source: DWP/ HMRC children in low-income families local measure (Relative poverty before housing costs)

Figure 4 highlights areas within Highland with high concentrations of children in low-income households. Some caution should be observed when interpreting the data. The focus should be on the overall trend rather than year-on-year change, which is prone to fluctuations in small populations.

Figure 4: Ten small areas in Highland with the highest percentage of children under 16 in low-income households in 2023.



Source: Scottish Index of Multiple Deprivation 2020v2 and National Records of Scotland Small Area Population Estimates 2021

Child poverty estimates after housing costs

Child poverty after housing costs are reported using data from the Centre for Research in Social Policy at Loughborough University. The data extends the children in low-income families data published by the Dept of Work and Pensions by including modelling for housing costs for Local Authority areas and parliamentary constituencies. Housing is the biggest outgoing for most families. Consequently, the availability of affordable accommodation can have a big impact on poverty numbers.

In 2022/23, 9,776 children in Highland live in poverty after housing costs.

Figure 5: Percentage of children living in poverty after housing costs by Local Authority area in Scotland

Source: End Child Poverty Coalition estimates of child poverty rates after housing costs (2024) 1 A child is defined as aged under 15, or aged 16-19 and in full-time education.

Working households

The Department of Work and Pensions data on children in low-income indicates how in-work poverty contributes to overall child poverty in local areas.

Figure 6 shows the percentage of children under 16 in low-income families in a household with at least one adult in work in 2022/23 for the Local Authorities in Scotland. In-work poverty remains more common than out-of-work poverty in all areas.

Six in ten children in poverty live in households where someone is working, and ~~increasingly, only having two~~ parents at work protects against the risk of poverty.

Nearly three-quarters of people experiencing in-work poverty have someone in their family who works in five high-priority industries: hospitality, health and social care, retail, administrative support and manufacturing. Many of these industries are large employers in Highland with a high proportion of part-time workers and seasonal variation in demand.

Figure 6: Percentage of children in poverty before housing costs who are in a household with at least one adult in work by Local Authority area in Scotland in 2022/23.

Source: DWP/HMRC children in low-income families local measure (Relative poverty before housing costs)

Priority Groups – poverty and protected characteristics

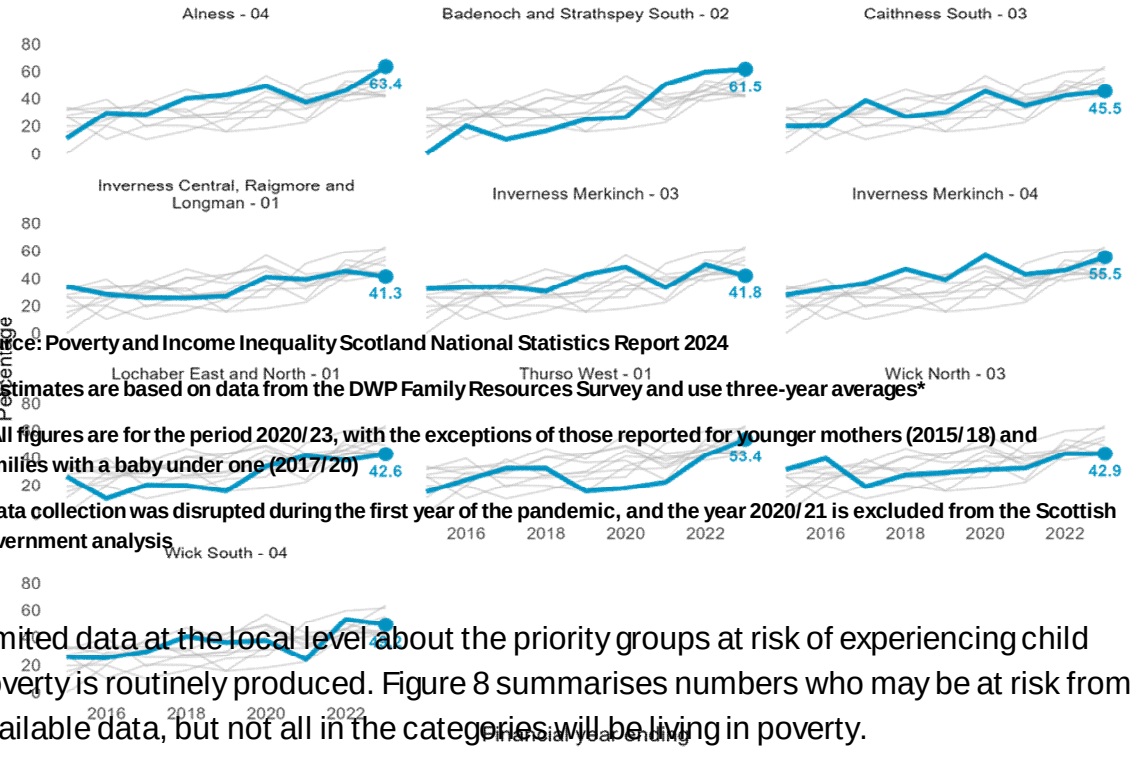
Six groups of priority families are identified as a focus for interventions:

- Lone parent families (majority headed by women)
- Families with a child or adult with a disability
- Larger families with three or more children
- Minority Ethnic families
- Families with a child under one year of age
- Families where the mother is less than 25 years old.

These groupings do not cover all the family types at higher risk of poverty, with nearly one in ten children in poverty living in households with none of these characteristics. There will also be children living in families where these circumstances apply who do not experience poverty.

Figure 7 summarises the estimated proportion of children who live in poverty in these categories in Scotland. Equivalent data for Local Authorities is not available.

Figure 7: Proportion of children in priority groups who are in relative poverty in Scotland



Source: Poverty and Income Inequality Scotland National Statistics Report 2024

1 Estimates are based on data from the DWP Family Resources Survey and use three-year averages*

2 All figures are for the period 2020/23, with the exceptions of those reported for younger mothers (2015/18) and families with a baby under one (2017/20)

*** Data collection was disrupted during the first year of the pandemic, and the year 2020/21 is excluded from the Scottish Government analysis**

Limited data at the local level about the priority groups at risk of experiencing child poverty is routinely produced. Figure 8 summarises numbers who may be at risk from available data, but not all in the categories will be living in poverty.

Figure 8: Priority family groups in Argyll and Bute and Highland

3 Remote and Rural Factors

In Highland, one in three children and young people under 18 years reside in remote rural areas, with one in five living in very remote rural areas. In contrast, one in twenty children lives in remote rural areas in Scotland, with one in forty living in very remote rural areas.

Figure 9: Percentage of the population aged under 18 years of age living in urban and rural areas in Highland and Scotland in 2021

Source: Scottish Government Urban Rural Classification 2020 and NRS Small Area Population Estimates for 2021

Remoteness from services and facilities is an important factor in relation to considering poverty and deprivation in Highland with access challenges compounding

other disadvantages. In remote and rural areas, low incomes of people are exacerbated by additional costs. This includes more expensive food and clothing, more expensive household goods, increased home energy costs and the costs of transport as shown in work on the Minimum Income Standard for Remote Rural Scotland.[3] This highlights that for people living in rural areas of Scotland, a minimum acceptable standard of living typically requires between a tenth and a third more household spending than in urban parts of the UK.

Evidence from the literature highlights that people living in rural areas experience deprivation differently from those living in towns and cities. Particular issues in rural areas include:

- Less accessible key services including health and social care, childcare and high speed digital networks
- Higher consumption of fuel for heating and transport
- 33% of households in Highland experience fuel poverty (average for Scotland is 24%)[4]
- Reduced opportunities to earn adequate income
- Higher cost of living impacted by prices to for basic essential supplies
- Limited frequency and coverage of public transport

50% of children and young people in Highland live in the most deprived access quartile according to SIMD. This is amongst the highest levels in Scotland.

Figure 10: Young people living in the most access deprived quintile, aged 00- 25 years in 2020

Source: ScotPHO Community Profiles – SIMD 2016, Scottish Government and Public Health Scotland

[3] ***Minimum income standard for Remote Rural Scotland – Policy update 2016, Loughborough University*** ***http://www.hie.co.uk/common/handlers/download-document.ashx?id=90d6c2f6-a461-4ff8-9902- 49f073765e39***

[4] https://www.gov.scot/publications/scottish-islands-data-overview-2023/pages/9/

In 2022, the Scottish Government and the Scottish Rural College published ***Improving our understanding of child poverty in rural and island Scotland***.[5] It identified that interventions to tackle child poverty in rural and island locations should:

- recognise higher costs of living and of service delivery in these locations
- ensure early intervention and a long-term approach
- place children and families at the centre of the intervention
- explore digital approaches as a delivery mechanism, where appropriate
- involve schools as key partners
- ensure all interventions are rural and island proofed.

[5] https://www.gov.scot/publications/improving-understanding-child-poverty-rural-island- scotland/

Equality Impact Assessment Template: Please complete alongside the guidance document

Title of work: Highland Local Child Poverty Action Update Report April 2024 – March 2025	**Date of completion:** 19/08/25	**Completed by:** Lynda Thomson Senior Health Improvement Specialist Health Improvement Team

Description of work:

The development of The Highland Child Poverty Action Update report is a duty placed on both Highland Council and NHS Highland to jointly develop annual updates which outline the activity that has taken place in the previous year and the actions proposed to be taken in the following year which will address child poverty.

The Highland update Plan is set around the agreed themes and life stages of children and young people identified by the Integrated Children's Services Plan 2023 – 2026.

Outcome of work:

To address the key drivers of poverty which include Income from employment, costs of living and income from social security and benefits in kind.
The overarching outcomes identified for priority action in 2025/26 include:
We will reduce financial barriers in order to increase participation, raise aspirations and address the impacts of poverty
Mitigate the impact of the cost-of-living crisis
We will raise attainment and close the poverty related attainment gap.

Who will be impacted?
Stakeholders: (who will this work affect?)

This work will impact on children and young people and their families; it is specifically aimed at those children living in poverty and those who are most vulnerable.
This work will also involve partnership working across public sector including NHS Highland and Highland Council, but will also involve actions by third sector and community groups as well as partners represented on the Highland Reducing Poverty Group.

How do you know:

Around 24% of children in Scotland are likely to experience poverty. In Highland this figure is just above 23% after housing costs are included.

Work by the Public Health Intelligence team has identified ten small areas in Highland with the highest percentage of children under 16 in low income households in 2023.

In-work poverty remains more common than out-of-work poverty in all areas. Nearly three-quarters of people experiencing in-work poverty have someone in their family who works in five high-priority industries including hospitality, health and social care, retail, administrative support and manufacturing. Many of these industries are large employers in Highland with a high proportion of part-time workers and seasonal variation in demand.

The Scottish Government identifies 6 priority groups who are most likely to be in poverty including:

- Lone Parent Families (38%)
- Minority Ethnic Families (43%)
- Families with a disabled child or adult (27%)
- Families with a younger mum (55%)
- Families with a child under 1 (34%)
- Larger families (3 or more children) (34%)

The percentage of all children in poverty is 24%.

In Highland one in three children and young people under 18 years live in remote rural areas. Remoteness from services and facilities is an important factor in relation to considering poverty and deprivation in Highland. In remote and rural areas, low incomes are exacerbated by additional costs of living in the area.

What will the impact of this work be? (see appendix 1 for list of protected characteristics and other groups that you may wish to identify)

Sex: Poverty and Child poverty specifically is most often experienced by women. Actions taken to tackle child poverty will therefore have a positive impact for women living in poverty. We should however, be mindful, that men with children can also be impacted by poverty and therefore should seek to ensure any actions take consideration of households where men are either lone parents or within families with children or that by targeting women we do not negatively impact on households with men.

Age: The Child Poverty Act is aimed at specifically children and young people up to the age of 18. The actions will therefore have a positive impact for this age group as well as families with young children. Specific priority should be given to families where there is a young mother, under the age of 25 and for children under the age of 1. Care should be taken to ensure that our proposed actions are aimed at this younger age group when targeting.

Disability: 27% of households with a disabled child or adult live in poverty and it is one of the identified 6 priority groups. Actions should be assessed as to whether targeting is taking place for these particular households and where needed more focus given to these households including capturing lived experience where appropriate.

Religion or belief: No identified impact

Race: 43% of Minority Ethnic Families live in poverty. In Highland there are fewer minority ethnic families living in communities which may result in the needs of these families being hidden. Where universal approaches are made it is important to collect data which might allow us to monitor whether minority ethnic families are supporting to engage with activities or to gain from interventions.

Sexual orientation: No identified impact

Gender reassignment: No identified impact

Pregnancy/Maternity: Actions taken within the child poverty report will have a positive impact for women who are pregnant or following the birth of a baby for those families in poverty. Actions taken at the earliest stage are more likely to support tackling child poverty and are therefore an important part of actions identified, however, we do not want to lose sight of families whose children are older and are living in poverty and therefore consideration is given within this plan to actions that can be taken across the life-stages of children and young people.

Marriage and Civil Partnership: No identified impact

Other Key identified Groups:

Unemployed: Actions taken within the plan will have a positive impact on those who are unemployed, however, it is noted that for many families living in poverty there is an adult in the household in employment so planned actions also need to ensure that these households are supported around income maximisation and cost of living support.

Lone Parent Families: 38% of lone parent families live in poverty across Scotland, we therefore need to ensure that actions taken are identifying and targeting these groups and ensuring that we consider barriers such as child care and others that might

present specific difficulties for lone parents in accessing services. It will be important to work alongside organisations that support lone parents to ensure that we are targeting our actions accordingly.

Those living in remote and rural areas or island communities: We know that for families and children living in remote and rural communities across Highland there are additional challenges both for cost of living which is higher for those communities but also in access to services and support where available. It will be important to consider the needs of those living in poverty who live in remote rural communities and are often more hidden as a result. We need to also ensure that any actions taken have considered ways in which services can be delivered in order to ensure access from a Highland population.

Fairer Scotland Duties: This plan is aimed at those in the lowest socio-economic groups and will therefore have a positive impact for those who live in poverty.

Given all of the above what actions, if any, do you plan to take?

1. **Discussions will take place about specific actions that may be required to consider the needs of the 10 identified small areas in Highland with the highest percentage of children under 16 in low income households.**
2. **Discussions will also take place about a consideration of any targeted interventions or partnership work that might be considered to specifically explore the needs of employees with families that work within identified industries where in-work poverty is more prevalent including hospitality, health and social care, retail, administrative support and manufacturing.**
3. **Discussions will take place about tracking where interventions are having most impact specifically in terms of identified priority groups but also in terms of geographical spread.**
4. **We will seek to work alongside organisations or community groups that work with identified priority groups e.g lone parents.**
5. **We will seek to include the voice and participation of young people and children in ongoing actions.**

Cathy Steer

What is the impact of this policy/service development on infants, children and young people? (The United Nations Convention on the Rights of the Child places a compatibility duty on public authorities including NHS Highland to ensure the rights of children are protected and promoted in all areas of their life). **Please view the EQIA Children's Rights Flowchart and Guidance** (see below)**. To ascertain whether completion of the EQIA Children's Rights Questions is required, first complete the Screening Sheet.** **For more information or support contact: NHSH Child Health Commissioner: deborah.stewart2@nhs.scot**
EQIA Children's Rights Questions – Please first complete the Children's Rights Screening Sheet to ascertain if completing the EQIA Children's Rights Questions below is required.
What impact will your policy/service change have on Children's Rights? Will the impact of your policy/service development on Children's Rights be Negative/Positive/Neutral? What articles of the UNCRC does the policy/service development impact on? Will there be different impacts on different groups of children and young people e.g. preschool children; children in hospital; children with additional support needs; care experienced children; children living in poverty?
The actions identified in the updated report are aimed at targeting children living in poverty. The actions will have a positive impact on children in this respect. It may impact on any of the articles of UNCRC but specifically the aim is to have a positive impact on article 27 (adequate standard of living). There are identified priority groups that we know are more at risk of experiencing poverty as already highlighted and we will seek to ensure that we are identifying targeted interventions that will meet the needs of those most vulnerable.
If a **negative impact is assessed** for any area of rights or any group of children and young people, can you explain why this is necessary and proportionate? What options have you considered to modify the proposal, or mitigate the impact?
There are no specific negative impacts assessed.
In what ways have you taken the views of children and young people in to consideration in the development of this policy/service change? What evidence have you used or gathered on children's views? How will you monitor the impact of the policy / service change and communicate this to children?
The views of children and young people have been collected through a variety of means including Cost of the School Day Voice Network which involved a number of primary schools in the area and Inverness High School. A survey was also undertaken in 2023 with 3,608

responses from young people which is completed by pupils in P7, S2 and S4 annually. The survey responses help to set ongoing measures of progress made in schools to support young people against key identified issues. Planet Youth have worked with five Highland secondary schools to develop an approach to tackling teen smoking and drug use. Young people are involved in the development of identified key actions which can help including a survey completed by 348 S4 pupils from the identified schools.
How will the policy / service change give better or further effect to the implementation of Children's Rights in NHS Highland?
The update report and identified actions will support the implementation of Children's Rights in NHS Highland.
Approved by: Cathy Steer. Head of Health Improvement.

EQIA Children's Rights – Guidance Notes

EQIA Children's Rights – Flowchart

Screening Sheet

General description of the policy/service development and its aims, supplemented by an initial assessment of the applicability of the policy/ service development to children and young people in NHS Highland.

Asks you to consider:

- What aspects will affect children and young people up to 18
- What the likely impact will be
- Which groups of children and young people will be most affected
- Will this require completion of the EQIA Children's Rights questions

Completion of EQIA Children's Rights Questions **NOT Required.**
Explain your reasons.

Sign the EQIA Children's Rights Screening Sheet and return to:

Completion of the EQIA Children's Rights Questions **IS Required**
Sign the EQIA Children's Rights Screening Sheet and return to:

Continue to next stage.

EQIA Children's Rights Questions – Completion

Asks you to set out:

What impact will your policy/service change have on Children's Rights? Will there be different impacts on different groups of children and young people e.g. preschool children; children in hospital; children with additional support needs; care experienced children; children living in poverty?

If a **negative impact is assessed** for any area of rights or any group of children and young people, can you explain why this is necessary and proportionate? What options have you considered to modify the proposal, or mitigate the impact?

In what ways have you taken the views of children and young people in to consideration in the development of this policy/service change? What evidence have you used or gathered on children's views? How will you monitor the impact of the policy / service change and communicate this to children?

How will the policy / service change give better or further effect to the implementation of Children's Rights in NHS Highland?

EQIA Children's Rights Questions Complete

Person Leading the Policy/Service Development and Line Manager (include Email) sign, date and return to:

Please consider publishing a child-friendly version.

EQIA Children's Rights – Screening Sheet

The United Nations Convention on the Rights of the Child places a compatibility duty on NHS Highland to ensure the rights of children are protected and promoted in all areas of their life. Completing this Screening Sheet will indicate if completing the **EQIA Children's Rights Questions** is required.

Please note that the actions, or inactions, of public authorities such as NHS Highland can impact children more strongly than any other group in society and every area of policy/service development affects children to some degree, whether directly or indirectly.

For information or support contact: NHSH Child Health Commissioner: deborah.stewart2@nhs.sc

Overview
Completing the Children's Rights Screening Sheet is a preliminary check on the proposed policy/service development to help determine whether completing the Children's Rights questions in the EQIA is required, and provide a record of that decision.

The Children's Rights screening questions below; ask basic information about the policy/service development and how it will affect children and young people specifically.

Decisions about whether or not to complete the Children's Rights Screening questions as part of the EQIA should take place as early as possible in the formation of the policy/service development.

This is the best way of ensuring that children's rights and wellbeing influence the way in which the policy develops, and that NHS Highland duties to act in a manner compatible with the UNCRC (Incorporation) (Scotland) Act 2024 are met.

Who takes part in the Screening exercise depends on the complexity and potential reach of the policy/service development under consideration.

1. What aspects of the policy/service development will affect children and young people up to the age of 18?

The Articles of the UNCRC apply to all children and young people up to the age of 18, including non-citizen and undocumented children and young people.

The actions identified in the updated report are aimed at targeting children living in poverty. The actions will have a positive impact on children in this respect. It may impact on any of the articles of UNCRC but specifically the aim is to have a positive impact on article 27 (adequate standard of living). There are identified priority groups that we know are more at risk of experiencing poverty as already highlighted and we will seek to ensure that we are identifying targeted interventions that will meet the needs of those most vulnerable.

2. What likely impact – direct or indirect – will the policy/service development have on children and young people?
'Direct' impact refers to policies/service developments where children and young people are directly affected by the proposed changes, e.g. in early years, education, child protection or looked after children (children in care). 'Indirect' impact refers to policies/service developments that are not directly aimed at children but will have an impact on them. Examples include: hospital visiting policy, treatment/support to parents, staff parental leave, access to play areas, transport schemes.

We anticipate direct positive impacts from the implementation and delivery of the identified actions in the report to tackle child poverty.

3. Which groups of children and young people will be affected?
Under the UNCRC, 'children' can refer to: individual children, groups of children, or children in general. Some groups of children will relate to the groups with protected characteristics under the Equality Act 2010: disability, race, religion or belief, sex, sexual orientation. 'Groups' can also refer to children by age band or setting, or those who are eligible for special protection or assistance: e.g. preschool children, children in hospital, care experienced children and young people, children in rural areas, young people who offend, victims of abuse or exploitation, child migrants, or children living in poverty.

We identify from the research and data as well as the guidance from Scottish Government that there are identified communities and groups of children and families that are most at risk of living in poverty. These are the groups that we plan to target in tackling child poverty in Highland.

4. Is completion of the EQIA Children's Rights Questions required?
Please state if completion of the Children's Rights Questions in the EQIA template will be carried out or not. Please explain your reasons.

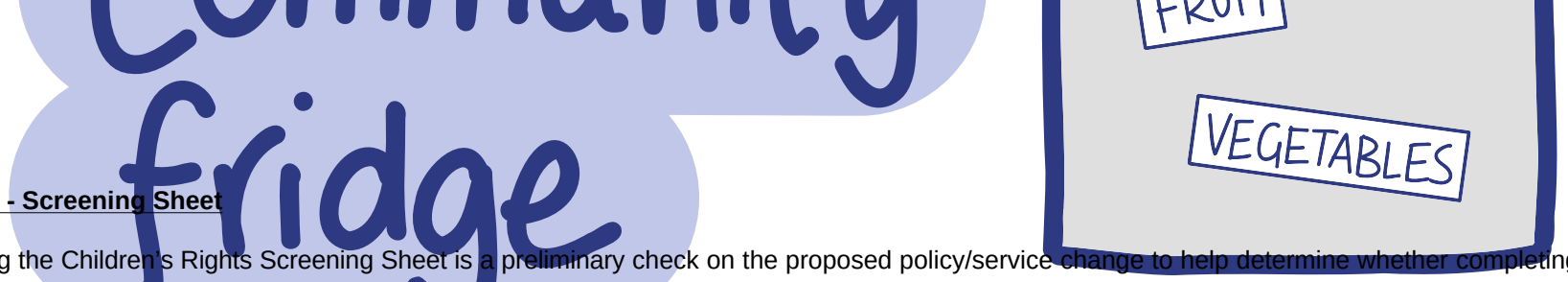
No – there is some work that we need to develop as identified in the Equality impact assessment under recommendations, but there are no direct negative impacts that have been identified as part of this process and therefore no need for a full EQIA to be completed.

5. Sign, Date and Authorise

Person Leading the Policy/Service Development:
Email: Lynda.thomson1@nhs.scot
Signature & Date of Sign Off: Lynda Thomson 19/08/25

Line Manager: Cathy Steer
Email: cathy.steer@nhs.scot

Signature & Date of Sign Off: 19/08/25



Guidance - Screening Sheet

Completing the Children's Rights Screening Sheet is a preliminary check on the proposed policy/service change to help determine whether completing the Children's Rights questions in the EQIA is required, and provide a record of that decision.
The Children's Rights Screening Sheet asks basic information about the policy/service change and how it will affect children and young people specifically.

Completion of the Children's Rights Screening Sheet as part of the EQIA should take place as early as possible in the formation of the policy/service change.

This is the best way of ensuring that children's rights and wellbeing influence the way in which the policy develops, and that NHS Highland duties to act in a manner compatible with the UNCRC (Incorporation) (Scotland) Act 2024 are met.

Who takes part in the Screening exercise depends on the complexity and potential reach of the policy/service change under consideration. Completion of the Screening Sheet will enable you to decide if completing the EQIA Children's Rights questions is required. The impact assessment process is designed to be proportionate - not every proposed policy/service change will affect children and young people and therefore not automatically require completion of the EQIA Children's Rights questions beyond the Screening stage.

Guidance on Completion of the EQIA Children's Rights Questions

When undertaking the EQIA, you must keep under consideration whether there are any steps which could be taken which would or might secure better or further effect of the UNCRC requirements, and if it is considered appropriate to do so, take any of the steps identified by that consideration.

There are two key considerations when completing the EQIA Children's Rights questions:

Participation: The UNCRC gives children the right to participate in decisions which affect them. When assessing the impacts of the policy/service development, you are recommended to consult with children and young people. You can do this directly, through organisations that represent children and young people or through using existing evidence on the views and experiences of children where relevant. Participation of children and young people should be meaningful and accessible.

Evidence: You are recommended to gather evidence when assessing the impact of the policy/service development on children's rights and also for measuring and evaluating the policy/service development.

The EQIA Children's Rights questions to be completed with guidance on what to consider are:

What impact will your policy/service change have on Children's Rights? Will the impact of your policy/service development on Children's Rights be Negative/Positive/Neutral? What articles of the UNCRC does the policy/service development impact on? Will there be different impacts on different groups of

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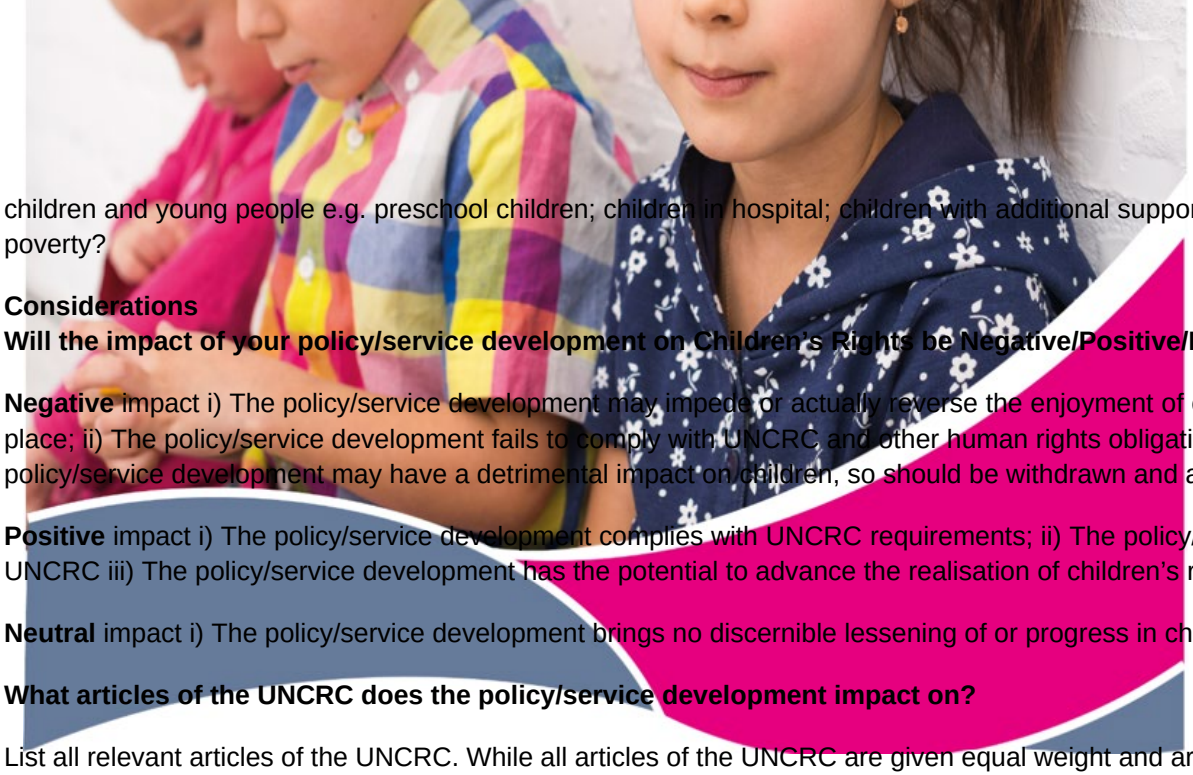


children and young people e.g. preschool children; children in hospital; children with additional support needs; care experienced children; children living in poverty?

Considerations
Will the impact of your policy/service development on Children's Rights be Negative/Positive/Neutral?

Negative impact i) The policy/service development may impede or actually reverse the enjoyment of existing rights, requiring mitigating measures be put in place; ii) The policy/service development fails to comply with UNCRC and other human rights obligations, requiring modification of the proposal; iii) The policy/service development may have a detrimental impact on children, so should be withdrawn and alternatives presented.

Positive impact i) The policy/service development complies with UNCRC requirements; ii) The policy/service development makes changes inline with the UNCRC iii) The policy/service development has the potential to advance the realisation of children's rights.

Neutral impact i) The policy/service development brings no discernible lessening of or progress in children's rights or their wellbeing.

What articles of the UNCRC does the policy/service development impact on?

List all relevant articles of the UNCRC. While all articles of the UNCRC are given equal weight and are seen as complementing each other, the four general principles of the UNCRC; non-discrimination (article 2); the best interests of the child (article 3); the right to life, survival and development (article 6); and the child's right to have their views given due weight (article 12) underpin all other rights in the Convention, and should always be considered in your assessment. Refer to the UNCRC summary for an overview of UNCRC articles. The most likely articles for consideration are the articles listed above plus; the right to health and health services (article 24). More detailed information on each article can be accessed at: https://www.unicef.org/child-rights-convention/convention-text

Will there be different impacts on different groups of children and young people?

Consideration of which groups of children will be affected by the policy/service development is required, along with any competing interests between different groups of children and young people, or between children and young people and other groups. Under the UNCRC, 'children' can refer to: individual children, groups of children, or children in general. Some groups of children will relate to the groups with protected characteristics under the Equality Act 2010: disability, race, religion or belief, sex, sexual orientation. 'Groups' can also refer to children by age band or setting, or those who are eligible for special protection or assistance: e.g. preschool children, children in hospital, care experienced children and young people, children in rural areas, young people who offend, victims of abuse or exploitation, child migrants, or children living in poverty.

If a negative impact is assessed for any area of rights or any group of children and young people, can you explain why this is necessary and proportionate? What options have you considered to modify the proposal, or mitigate the impact?

Considerations
Give careful thought to whether any negative impacts are necessary and proportionate when weighed against the purpose of the policy/service development. For example, are you clear that the public benefits demonstrably outweigh the negative impacts and that your proposals are both justified by evidence, and have the least possible impact on the enjoyment of the Children's Rights in question? Again, you are required to provide evidence, and where possible to have consulted with those groups and communities most likely to be affected. If the assessment indicates a negative impact, you must present options for modification or mitigation of the original proposals. Options should be proportionate, refer to any potential resource implications associated with the change in policy/service development, and indicate how the proposed change(s) will result in a positive impact on Children's Rights.

In what ways have you taken the views of children and young people in to consideration in the development of this policy/service change? What evidence have you used or gathered on children's views? How will you monitor the impact of the policy / service change and communicate this to children?

Considerations
As part of the EQIA Children's Rights process, you should ensure that children and young people's views and experiences are sourced, included and recorded, and make it clear how these views have informed the Children's Rights analysis, and conclusions. Participatory policy-making is at the heart of human rights frameworks. Anyone who will be affected by the policy/service development should be given the opportunity to contribute their views. This includes children and young people, their parents/carers, organisations which work with them. where children and young people's views are not known on a matter that is likely to have an impact on them, steps should be taken to obtain their views. Consultation with children and young people can take place using one or more of the following methods:

Consultations
• Adding specific questions aimed at children and young people to a broader public consultation;
• Targeted promotion of public consultations to children and young people through relevant websites, schools/colleges, social media – ensuring that consultation materials are written in a style that is accessible to and suitable for children;
• Making use of existing consultation mechanisms through rights, participation and youth work organisations/structures (including, e.g. local young person-led organisations);
• Setting up/commissioning public consultations with children and young people to gather their views on the proposed measure
• Targeted consultations with the specific groups of children and young people who will be affected by the proposed measure, e.g. children in care, traveller children and families, children affected by domestic violence, children in hospital, children accessing NHS Highland services.

Where direct consultation is not possible, consider the following:

• Relevant published research that involved and collected the views of children and young people;
• A re-analysis of children and young people's responses to a recent consultation that is relevant to this policy/service development area;

• Sending out a ‘call for evidence’ to service providers to ask them for any unpublished or difficult-to-locate information they have collected on the views and experiences of the children and young people who use them;
• Asking organisations which work with or on behalf of children and young people to submit the views of those they work with - this is particularly useful to identify case study information, or the experiences of groups of children and young people living in particular circumstances;
• Looking at inspection reports that reflect the views of children and young people.

However, existing evidence may need to be supplemented. Where there is insufficient, contradictory or only anecdotal evidence, you will have to decide whether you are able to make a well-informed assessment of the potential impact on Children’s Rights without commissioning further research and/or consulting with children and young people, and other stakeholder groups, to fill that evidence gap. The reasoning behind your decision should be recorded in the EQIA. If a consultation or the opportunity to work more collaboratively with children and young people are not possible at this stage additional efforts should be made to ensure children and young people are involved at a later date as part of the monitoring and review of the policy/measure.

National and local resources are available to support engagement with children and young people:

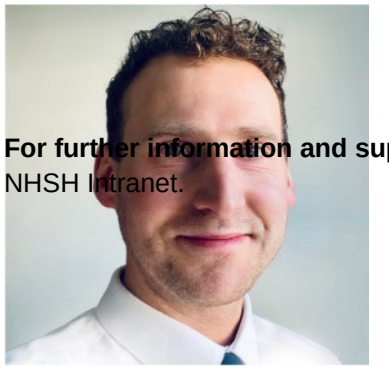
National Resource: Participation of Children and Young People in Decision-making
Local Resource: Insert link to the Highland Children and Young People Participation Strategy, once available.
Local Resource: NHS Highland Engagement Framework 2022 - 2025
Local Resource: Insert THC Children’s rights website, once available.

Training and awareness raising resources on Children's Rights (UNCRC) is available via Turas. Please note that you must be signed in to your Turas account to view and access the eLearning modules.

How will the policy / service change give better or further effect to the implementation of Children’s Rights in NHS Highland?

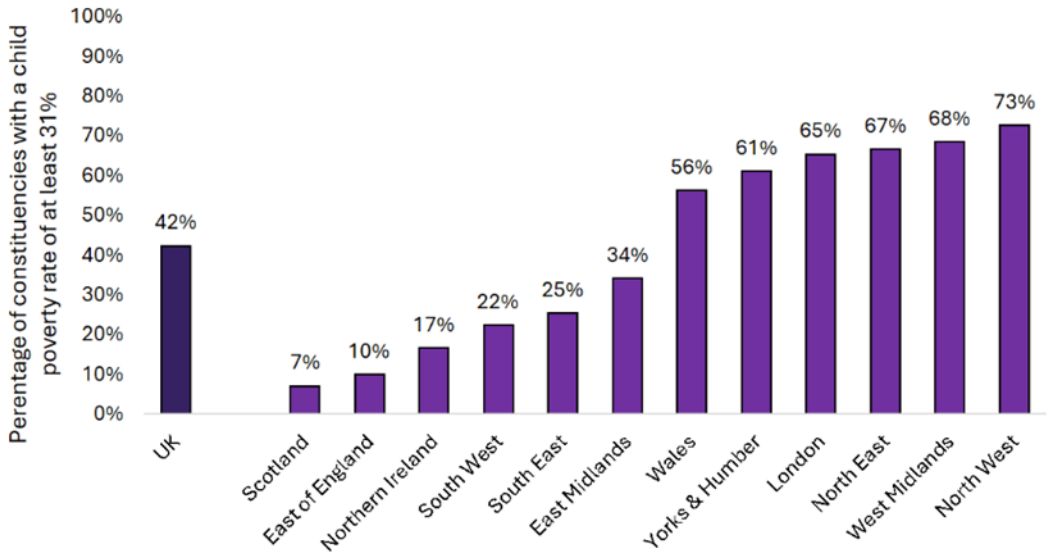
Considerations
Your assessment may reveal that the policy/service development not only complies with the articles of the UNCRC but takes things further and helps progress the realisation of children’s rights in Highland; i.e. gives better or further effect to the UNCRC. Completing the EQIA Children’s Rights questions can provide a means to record that policy development.

All the information you provide on the EQIA Children’s Rights screening sheet and EQIA Children’s Rights questions will inform a report by NHS Highland to the Scottish Government that is required by law every 3 years.



For further information and support contact NHSH Child Health Commissioner@deborah.stewart2@nhs.scot or visit the Children's Rights section of the NHSH Intranet.

Figure 3 **Percentage of constituencies where at least 31% of children are in poverty, by country/region: 2023/24**



Source: Local child poverty rates, AHC (2025)

Argyll and Bute Child Poverty

Action Plan Review 2024

2025

Argyll and Bute Child Poverty Action Plan Review 2024 – 2025

Contents

Argyll and Bute Child Poverty 1
Argyll and Bute Child Poverty Action Plan Review 2024 – 2025 2
Foreword 3
Introduction 5
Child Friendly Version of the Plan 8
Integrated Impact Assessments 8
Data and Child Poverty 9
Taking Action on Rural Poverty (TARP) 10
Child Poverty and Mental Health 12
The Promise and Whole Family Support 18
United Nations Charter on the Rights of the Child (UNCRC) 20
The Plan 21
A. Increasing income From Employment and Earning 21
B. Increasing income Through Benefits 39
C. The Cost of Living 45
D. Helping Families in Other Ways 56
E. Other Planned Work 62
F. References 63

Foreword

The Scottish Government has clearly stated its intention to tackle child poverty. On 22 May 2024, the First Minister, John Swinney MSP, set out the priorities that would underpin the work of the Scottish Government and reaffirmed its commitment to address child poverty, saying.

My first priority is to eradicate child poverty—not tackle or reduce child poverty but eradicate it. That will be the single most important objective of my Government and my Cabinet, because child poverty stunts the progress of any nation, and it stands in the way of social justice and economic growth. My Cabinet will do everything in our power—including listening to and working with members across the chamber—to achieve our aim.

Despite actions taken both nationally and locally in Scotland, we know that we have not yet delivered on this ambition. 2023 - 2024 figures were released in June 2025, by the End Child Poverty (ECP) coalition. The annual analysis by the Centre for Research in Social Policy at Loughborough University looks at local poverty rates after housing costs, which is seen as a more accurate assessment of disposable family income. The constituency Argyll and Bute and South Lochaber, shows a rate of 22.1%; the previous year was 23.5% so a small reduction can be seen. For the same period the Scottish rate of relative child poverty was 23%.

Danny Dorling in his Book “Seven Children; Inequality and Britain’s Next Generation” 2024, noted that:

In the seven most recent years surveyed by the United Nations Children’s Fund (UNICEF), 2014 – 2021, child poverty has risen faster in the UK than in any comparable country worldwide. (1)

In Argyll and Bute, we acknowledge these barriers to lifting children out of poverty. For us, they are added to others more specific to our area, including the cost of living in our remote, rural and island places, the cost and challenges of travel, housing shortages, wages lower than the national average and the need to address employment opportunities.

Despite all of this, the task of combatting child poverty remains a top priority and is coordinated by our Child Poverty Action Group and the Financial Advice and Inclusion Group. These groups, with leadership across the HSCP, Council and NHS Highland, bring together, departments, organisations and partners to tackle child poverty.

In all of this we listen to the voices of our communities and children and young people. We work with them to ensure their rights are respected. The United Nations Convention on the Rights of the Child and the UNCRC (Incorporation) (Scotland) Act 2024 makes these clear including the right to food, a decent standard of living and a safe home (article 27); the best interests of the child to be paramount in all actions affecting them (article 3) and the right to be heard (article 12).

We want to take this opportunity to thank the staff across our respective organisations, and also our partners across the statutory, independent and third sectors for their tireless work in tackling child poverty. That partnership is key. Finally, we want to thank the people of Argyll and Bute, without whose support for each other no progress would be possible.

Our vision remains

We want an Argyll and Bute where no-one lives in poverty. Everyone should be able to achieve their potential and feel healthy, happy and valued. We want to be a place where everyone understands that tackling poverty is a shared responsibility. We believe that if we act locally, and in partnership, we can make a difference.

Evan Beswick

Chief Officer

Argyll and Bute Health and Social Care Partnership and Chair Child Poverty Action Group

Pippa Milne

Chief Executive

Argyll and Bute Council

Fiona Davies

Chief Executive

NHS Highland

Introduction

In 2017 the Child Poverty (Scotland) Act came into force as an attempt to put in place measures that would reduce the concerning increase in child poverty, both on a national and local level. The 2017 Act set four targets, which the Scottish Government committed to achieving by 2024 - 2025 and 2030; these are all measured after housing costs are deducted.

The targets for 2024 - 25:

- Less than 18% of children are in relative poverty.
- Less than 14% of children are in absolute poverty.
- Less than 8% of children are in combined low income and material deprivation.
- Less than 8% of children are in persistent poverty.

Targets for 2030:

- less than 10% of children live in relative poverty (relative poverty is less than 60% of average household income for the year taking account of the size and composition of the household).
- less than 5% of children live in absolute poverty (absolute poverty is less than 60% of average household income for the financial year beginning 1 April 2010).
- less than 5% of children live in combined low income and material deprivation (low income is defined as less than 70% of average household income for the year, material deprivation is when families are unable to afford three or more items out of a list of basic necessities.
- less than 5% of children live in persistent poverty (persistent poverty is where a child has lived in relative poverty for three out of the last four years).

However, despite good intentions and efforts both locally and nationally, child poverty is still very much with us, albeit at a significantly lower rate than England and Wales.

Annual statistics published today show that compared with the previous year's statistics, relative child poverty in 2023-24 reduced from 26% to 22% in Scotland while absolute child poverty fell from 23% to 17%. UK Poverty statistics published today show levels of relative child poverty at 31% and absolute child poverty at 26%.

Scottish Government, 27/03/2025

Child poverty in Scotland falls - gov.scot

Child poverty rates in Scotland (24%) remain much lower than those in England (30%) and Wales (29%) and are similar (if slightly higher) than in Northern Ireland (23%). This is likely to be due, at least in part, to the Scottish Child Payment. This highlights the effect benefits can have in reducing poverty. (2)

UK Poverty 2025 The essential guide to understanding poverty in the UK. Joseph Rowntree Foundation.

This picture is reflected in 2023 – 2024 figures released in June 2025, by the End Child Poverty (ECP) coalition. The annual analysis by the Centre for Research in Social Policy at Loughborough University looks at local poverty rates after housing costs, which is seen as a more accurate assessment of disposable family income. The constituency Argyll and Bute and South Lochaber, shows a rate of 22.1%; the previous year was 23.5% so a small reduction can be seen. Figures for Scotland also show improvement and reflect the impact of the Scottish Child Payment and mitigation of the two-child cap.

A chart showing percentages of constituencies where at least 31% of children are in poverty across the UK in 2023 to 2024. Scotland has the lowest rate at 7%, the highest at 73% is the Northwest of England.

Research tells us that certain groups are overrepresented in terms of child poverty, these include:

- three or more children in the household.
- Households with a disabled member.
- Households with children under the age of 1.
- Minority ethnic households.
- Single parent households.

- Households where the mother is under the age of 25.

Where one or more of these factors exist within a household, the probability of child poverty being present increases. However, these groupings do not cover all the family types at higher risk of poverty, with nearly one in ten children in poverty living in households with none of these characteristics. As well, not all families in these groups live in poverty.

Geographical factors are also important when looking at child poverty. The Joseph Rowntree Foundation point out commonalties that connect rural areas:

The main drivers of poverty vary across different geographies – a greater reliance on renting and higher costs of housing are substantial drivers in larger cities in particular, while lower rates of employment, with fewer employment opportunities alongside a greater concentration of employment in lower paid roles and sectors, are more significant drivers of poverty across many post-industrial and coastal areas. (3)

Joseph Rowntree Foundation (2025) UK Poverty 2025

Rurality is an important factor and one which is key to tackling child poverty in Argyll and Bute. A research Project commissioned by the Scottish Government and carried out by Loughborough University, found that, because of specific additional costs, it is more expensive to reach a minimum socially acceptable standard of living in remote rural Scotland, than in other more urban areas. For remote rural areas, in 2023, this "uplift" figure was 14%, as it was for island places. (4)

Dr Jayne Glass looked at existing research and data and asked the question, where were the knowledge gaps? Dr Glass gave an overview of the factors that can make living in poverty, and addressing child poverty, particularly challenging in remote, rural and island locations. (5)

- Income from work and earnings.
- Volatile and unpredictable rural incomes.
- Limited access to training and skills development.
- Reliance on private vehicles.
- Lack of local and flexible childcare.
- Rural gender pay gap.
- Costs of living.
- Higher levels of fuel poverty in remote rural and island areas.
- Additional minimum living costs in remote rural and island areas (add 15-30%).
- Unaffordable housing and/or poor housing condition.

The importance of employability factors in rural areas is clear. In Argyll and Bute, the percentage of people employed in low pay sectors in 2023 was 33.3% as opposed to the Scottish average of 28.8% (Annual Population Survey 2023). When looking at earnings for that residence based and working full time, in Argyll and Bute, 2024, for male workers, it was £702.9 per week as opposed to the Scottish average of £740. For female workers it was £645.4, as opposed to the Scottish national average of £701. (Nomis).

However, having one parent in employment is often not enough to avoid poverty. In Scotland, six in ten children in poverty live in households where someone is working, and increasingly, only having two parents at work protects against the risk of poverty.

Children in Argyll and Bute appear to experience a higher level of in-work poverty; 71.2 percent of children of low-income families live in a household where at least one adult is working (6)

This demonstrates the importance of employability measures and the planned economic developments from the Rural Growth Deal. The Rural Growth Deal (RGD) is a 10-year programme that will deliver £70 million of investment to develop Argyll and Bute's economic potential into a successful future for the area. It is hoped this will generate at least 300 jobs, support business development and attract more visitors to the area. Importantly, it will also look to address key housing shortages that hinder such development.

Many of the causes and impacts of child poverty in Scotland's remote rural and island places are known. In Argyll and Bute, we work to address these and make a difference for our children, young people and families. Key to this is working with partners in the statutory and voluntary sectors, with businesses and with our communities. This report shows some of the ways in which we do that.

Child Friendly Version of the Plan

Children and young people are currently working with a Graphic Artist to update the existing graphic, plan on a page version of our Child Poverty Action Plan. This coproduced version will be accessible to children, young people and adults who prefer a more condensed / graphic presentation of the elements of this plan. The graphic plan will be published alongside the main version of the plan.

Integrated Impact Assessments

The council is committed to carrying out impact assessments both to meet our legal obligations and as a matter of good practice.

Impact Assessments:

- help officers to **check** they have considered implications and impacts which may arise from their proposals.
- help officers to **show** they have considered implications and impacts.

- help people interested in potential impacts to **see** impacts have been considered, and how.
- **enable better / more informed consultation and engagement** around proposals while they are still in development.
- **enable better scrutiny** around decisions as potential impacts are made more explicit and transparent.

Argyll and Bute Council reviewed its combined impact assessment process in 2024 and launched a new process and online tool in March 2025.

The council's Impact Assessment Tool has been adopted for use by the Argyll and Bute Health and Social Care Partnership.

The new Integrated Impact Assessment brings together five impact assessment frameworks into a single process. These relate to equality, the Fairer Scotland Duty, Islands Communities, the Consumer Duty, and Children's Rights and Wellbeing.

Work to include Children's Rights and Wellbeing Impact Assessments (CRWIAs) has been carried out as part of the council's activities relating to the incorporation of the United Nations Convention on the Rights of the Child.

As children's rights and wellbeing should be considered not only in the context of proposals targeted directly at children and young people but also proposals which may indirectly affect them, proposals from all parts of the council must be screened to check whether a full assessment of impacts relating to children and young people needs to be carried out.

In line with Scottish Government's approach to CRWIAs, our tool impact includes assessment relating to:

- The United Nations on the Convention of the Child's articles, and
- The eight wellbeing indicators which are key components with in the Getting it Right for Every Child (GIRFEC) approach.

In the course of the tool's development, we ran the text and questions relating to CRWIAs past our UNCRC Incorporation Group and took advice from the Improvement Service.

We will be assessing the tool over summer 2025 to monitor its usability and effectiveness.

Data and Child Poverty

In Argyll & Bute our council's Welfare Rights Team makes a real difference in outcomes for families by helping them maximise their uptake of available benefits grants and allowances, securing Client Financial Gain in excess of £4 million per year. However, they're very dependent on existing referral channels such as through social work and education, i.e. cases where there's "known" unmet need. There's a perennial risk that we're missing some households that don't come to light through these channels. Hence a lot of our focus is on trying to utilise data to identify

households where there's as yet "unknown" unmet need; those at risk of falling through the cracks.

So, the value to us of having data on families in receipt of Universal Credit and Scottish Child Payment is essentially the same regardless of which benefit they are in receipt of – if these families are known to us, we can:

- Check if they have already had a referral for support, such as through social work. If they have not, then…
- We would make contact with themg to look to maximise their uptake of other benefits, grants and allowances, especially Council Tax Reduction, School Clothing Grant, Disability Benefits, etc.
- We would also help to ensure they are making their claims at the correct rate, e.g. have they applied for Disability Benefits at the correct level, etc.

* There is a data governance challenge with a lack of legal gateways through which we could justify direct outreach to households. Working with the Improvement Service and Scalable Approach to Vulnerability Via Interoperability (SAVVI) has been extremely valuable in better understanding the legal constraints around this type of data reuse. In the short term though if we can obtain this data at some sort of aggregated level by location then it would at least allow us to consider targeted outreach say to specific schools where the data suggest, in aggregate, concentrations of unknown unmet need. We hope to achieve more going forward, in terms of being able to use legal gateways to allow us to identify unmet need and approach families directly. If we could increase the current rates of Client Financial Gain by say 15-20% by working with families who would otherwise be missed for lack of referral, but whom we've found through data sharing by DWP/SSS, then this would be a measurable and impactful outcome.

Taking Action on Rural Poverty (TARP)

TARP, set up by the Poverty Alliance, came about as a result of poverty awareness training undertaken as part of Argyll and Bute Council's child poverty action plan. It aims to

- build on the Child Poverty Action Group's work to strengthen infrastructure within A&B for lived experience to be included in decision making.
- support collaboration and networking amongst organisations that work to combat poverty or support their communities with the cost of living.
- using learning from these aims, work with local stakeholders to test and learn about locally appropriate ways to reduce the costs of rural living.

In the past year we have:

- developed and consolidated a citizens' panel of people with experience of living on a low income and/or with high costs due to their rural location.
- Panel members have participated in 12 sessions, exploring their experiences and priorities; learning about local support and providing a lived experience perspective to inform the work of partners including the Council's Revenues and Benefits team, Argyll and Bute Third Sector Interface and Citizen's Advice Bureau.
- We have also held joint sessions with our sister panel based in Aberdeenshire. These have been convened to respond to timely national issues of interest. Individual panellists have also participated in regional and national events including meeting with the First Minister during Challenge Poverty Week to discuss the "Best Start, Bright Futures" plan, and contributing to national panels such as the Trussell Trust's new Scotland-wide lived experience group.
- We recently co-reviewed our progress and aims and over the next year the panel's focus will be on seeking opportunities to engage with and influence decision-making by agencies around local food costs, community resilience and tenant rights.
- We have established quarterly networking and learning events, focused on topics of interest identified by local organisations and public sector partners and co-hosted with the TSI.
- Our quarterly events include updates and opportunities to share news and practice, and they have been well attended with extremely positive feedback. In the coming year we will continue with this successful model.
- Following extensive stakeholder engagement and based on prioritised by the citizens' panel, we have developed a test of change project in collaboration with ALIenergy. Poverty Alliance will provide funding and support. In dialogue with clients of their Affordable Warmth Service, ALIenergy and their partners will act as delivery partners to
    - explore the realised and potential cost savings to social tenants from moving to renewable energy (heat pumps with or without solar panels and battery storage).
    - generate specific information and support to ensure tenants gain the maximum benefit from their renewables.

The funding agreement is now in place and over the next year we anticipate the research element of the project will be completed; resource development and project evaluation will be underway. To ensure learning from the panel, network and test of change would best be integrated into strategic planning, TARP has a local oversight group including representation from Argyll and Bute Council and Argyll and Bute TSI. Updates and opportunities are shared via the local Child Poverty Action Group and Financial Inclusion and Advice Group, as well as Community Planning Partnership's

Area Community Planning Groups (the latter when possible) and by occasional newsletter to a mailing list of over 140 contacts.

Other collaborative activity:

- TARP's project team works closed with the Argyll and Bute Climate Action Network to integrate social justice more comprehensively into ABCAN's climate work across the region, and vice versa. Argyll and Bute Development Officer, Becky Hothersall, has joined ABCAN's steering group and over the next year will participate in work focused on food security and community resilience.
- The Poverty Alliance is building a broad coalition of organisations under the banner "Scotland Demands Better" including a national demonstration and march in October 2025.

Child Poverty and Mental Health

When planning to address child poverty it is important to consider the 3 drivers of poverty: income through employment, income through benefits, and the cost of living. Beyond that, it is equally important to tackle the impacts, which can harm individuals and families. The ongoing stress and anxiety caused by living in poverty and trying each day to pay the bills and provide for your children, cannot be underestimated. Children are not immune to this as they witness their parents struggle and live with the knowledge that they cannot have the things that their peers take for granted.

- Mental Health Foundation - mental health and poverty statistics
- Child Poverty Action Group - Priced Out of School.

Added to this are the pressures of not having any resources in reserve if things go wrong or wear out. Across the UK in 2023 - 2024, The proportion of families with less than £1,500 in savings was 48%, which was the same as last year. Twenty per cent of families reported that they had no savings, and a further 10% said they had less than £100. (7)

A growing body of evidence, mainly from high-income countries, has shown that there is a strong socioeconomic gradient in mental health, with people of lower socioeconomic status having a higher likelihood of developing and experiencing mental health problems.

- Children and adults living in households in the lowest 20% income bracket in Great Britain are two to three times more likely to develop mental health problems than those in the highest.
- In 2004, evidence from the Child and Adolescent Mental Health Survey found that the prevalence of severe mental health problems was around three times higher among children in the bottom quintile of family income than among those in the top quintile.

- Analysis of data from the Millennium Cohort Study in 2012 found children in the lowest income quintile to be 4.5 times more likely to experience severe mental health problems than those in the highest, suggesting that the income gradient in young people's mental health has worsened considerably over the past decade.

Mental Health Foundation

The Mental Health Foundation points out that employment status is linked to mental health outcomes, with the unemployed or economically inactive having higher rates of common mental health problems than those employed. However, mental health is also impacted on by low paid and insecure employment. (8)

Housing can also be a factor and those on housing benefit are more than twice as likely to have a common mental health problem than those not receiving it (35.1% vs 14.9%). (9)

Action For Children - how children are affected by poverty

However, it is the effect of poverty on parents' and children's mental health that continues to have the largest impact and accrues throughout all of childhood, thus intensifying mental health problems for both parents and children over time. (10)

Having the right kind of services and early intervention will help to mitigate the stresses and mental health impacts of poverty.

There are a number of services in Argyll and Bute that help to address and improve mental health and wellbeing, for children, young people and families, whatever the cause.

1. A new free service from Argyll and Bute Council, in partnership with Exchange Families is available for parents and carers to help support their child. A range of support, workshops and resources will be on offer to help better understand common issues and learn how you can help.

   Exchange Families offers support for parents and carers with concerns about the wellbeing of their children. They provide specialist guidance to families worried about their young people. The organisation helps adults to help their families through workshops, resources, guidance and advice.

   There are workshops (in person or on-line) with practical strategies for parents and carers to support their children and young people, covering a range of areas: anxiety, neurodiversity, low self-esteem, self-harm, low-mood, bereavement, family break up. Workshops available to book thus far are:

   - Workshops - Age 4-7 - Promoting confidence and self-esteem in young children
   - Workshops - Age 8-11 - Building confidence and self-esteem in children

- Workshops - Age 12+ - Techniques for preventing anxiety and panic. Stress management techniques for supporting teens
- An online Mental Health Hub - Living Well in Argyll and Bute

  Exchange Counselling | Mental Health Service Provider

2. Our children, their nurturing education (OCTNE) is the authority wide education strategy that brings together nurture, adverse childhood experiences and trauma-informed practice. This makes a significant contribution to the development of a trauma responsive education workforce. The strategy ensures that children and young people will have access to wellbeing programmes and supports to enhance prevention and early intervention while providing more specialist support where required.

   The continued support of 58 establishments, including 52 schools and 6 Partnership Providers, through the OCTNE journey has enabled sustained growth in nurturing environments.

3. Rollout of Trauma Informed and Trauma Skilled training has been offered to child and adult services this session. An additional ~120 staff have attended an in-person training since January. Another cohort of Transforming Connections training for trainers will take place in June, and all trainers now have access to a team's channel, with a view to continuing to roll out a programme of training over the coming year.

4. Best Beginnings
   Argyll & Bute Infant Mental Health Service, Best Beginnings launched in Spring 2022 and works to support early relationships between babies and their carer's. There is an ongoing training programme offered to professionals, volunteers and students by the Infant Mental Health Practitioner.

5. Family Nurse Partnership

   In April 2024 the Family Nurse Programme began to be rolled out across Argyll and Bute; it commenced in the Bute and Cowal area. This programme is established in many parts of the World such as the United States, Australia and Norway. In Scotland it has been successfully working in areas like Greater Glasgow and Clyde for several years. This is a preventative, educational behaviour programme that is run by Nurses and Midwives who have received training in skills that include motivational interviewing, agenda matching and the use of tools such as "Partners in Parenting Education" (PIPE).

   The programme works with mothers to be who are 21 years old and under; work will begin with participants as early as possible in the pregnancy and continue

until the child's second birthday. Co-working will take place with Midwives and when the child is born, programme staff will take the place of the Health Visitor until a planned handover to them when the child is two years old. This will be for first time mothers and will offer additional support and learning opportunities that they would otherwise not be able to access. The programme focuses on empowering the mother and listening to her needs and views as well as offering support, signposting to other agencies that will assist her and giving her skills to better care for her baby. FNP the person-centred, preventative intervention programme offered to young first-time mother is now being rolled out to include Mid Argyll Kintyre and Islay.

6. Kooth
   We now offer a free online mental health and wellbeing resource to all 10–18-year-olds in Argyll and Bute. Kooth offers a wide range of help, with a no-wait, no-referral service so any young person can reach out for support, whenever they need it. Read more about how to access Kooth

   Kooth – A new mental health and wellbeing tool for children and young people

7. Counselling in Schools

   School counselling services continues to be available across the authority. Approx. 700 pupils accessed over the past 12 months. 83% of young people and 81% of primary-aged children completing support reported positive clinical outcomes. This is further supported by positive parent feedback, with 100% of parents feeling more confident in supporting their child's emotional and developmental needs and 94% observing positive changes in their child's wellbeing.

8. Planet Youth
   Planet Youth is an Iceland-originated framework with the aim to improve young people's health, wellbeing and relationships. To achieve this aim parents, carers, schools, communities and organisers work together. Argyll and Bute is one of the six local authorities who piloted the framework in Scotland. In 2023 a survey was conducted during school hours among Year 3 and Year 4 students of five selected schools in Argyll and Bute. As part of this, the participants were asked to rate their mental health status. The majority, 38% (n=286), of respondents rated their mental health as 'good to very good', 28% (n=210) rated it as 'acceptable', 28% (n=208) rated it as 'bad to very bad'. 5% (n=40) of participants did not answer the question. Planet Youth work with children and young people to provide activities and engagement that improves their wellbeing and reduces their likelihood of drug, alcohol use and other negative behaviours.

9. Family Liaison and Health & Wellbeing Officers
   Family Liaison and Health & Wellbeing Officers have been further supported in a network created to offer opportunity for career long professional learning (CLPL) and to further strengthen the work they do and impact they are making. Evidence around their impact is strong. They are making a real difference to our most vulnerable pupils and their families through a wide range of support. Partnership work with Bute Advice Centre and ALIenergy for FL/HWB Officers led to co-creation of a 'Help Leaflet' signposting families to available supports. This has been distributed to all schools with a FLO/ HWB Officer.

10. Let's Grow Kids UK

    Work with parents in Argyll and Bute during the perinatal period and until a child's third birthday. All staff at LGKUK, (a third sector organisation) are trained in perinatal and infant mental health and infant nutrition. Providing one to one targeted support, they work alongside families helping them to navigate their way through the pressures of family life. Their core programme lasts for 16 weeks, and a parent can stay with the team for as long as they need or until their youngest child is 3. Let's Grow Kids UK use a combination of several parenting programmes including Solihull, Adult mental health and family programmes such as WRAP and support clients to access specialist services such as Bute Advice.

    Let's Grow Kids UK have a tiered system for accessing professional support within the team as well as general wellbeing assistance. Every introduction is triaged, and each parent is allocated the most appropriate professional to work with. We have 3 tests of change ongoing in addition to our core programme. These are

    - Working with Dads
    - Working with parents of children with ASN during their Nursery/School transition year
    - Working with parents with poor mental health by providing Psychotherapy sessions (this work is being delivered in partnership with University of Strathclyde)

    Let's Grow Kids Website

11. The HELP Project (Dunoon and Rothsay)

    This project helps young people with housing, debt and benefit advice, employment and wellbeing issues. Referral criteria are between the ages of 16-25-years, homeless, at threat of homelessness or care experienced. It offers a range of wellbeing supports, including parenting groups and life coaching.

    Help Project Website

Help Project Email: **info@helpltd.org.uk**

Help Project Phone: 0800 121 4990

12. Home Start Lorn

Home-Start Lorn has been supporting families with young children throughout the whole of the Oban and North Argyll area, including the outlying villages since 1988 and on the Isle of Mull since 2016. Through our home-visiting volunteers we offer a unique service providing practical and emotional support to parents/carers with one or more children under 5.

Contacts
Phone 01631 566749
Email: **homestartlorn@btconnect.com**

Home-Start Lorn

13. Argyll and Bute Third Sector Interface: Communities Mental Health and Wellbeing Fund

The Communities Mental Health and Wellbeing Fund has been awarded for another two years – this will be years five and six of the fund. Argyll and Bute has been awarded £285,765.57 for each of the two years. The Fund 'is to be made available to support community-based initiatives that promote and develop good mental health and wellbeing and mitigate and protect against the impact of distress and mental ill health within the adult population. Specifically, the Fund aims to:

- Tackle mental health inequalities through supporting a range of 'at risk groups.
- Address priority issues of social isolation and loneliness, suicide prevention and poverty and inequality with a particular emphasis on responding to the cost-of-living crisis and support to those facing socio-economic disadvantage.
- Support small 'grass roots' community groups and organisations to deliver such activities.
- Provide opportunities for people to connect with each other, build trusted relationships and revitalise communities.

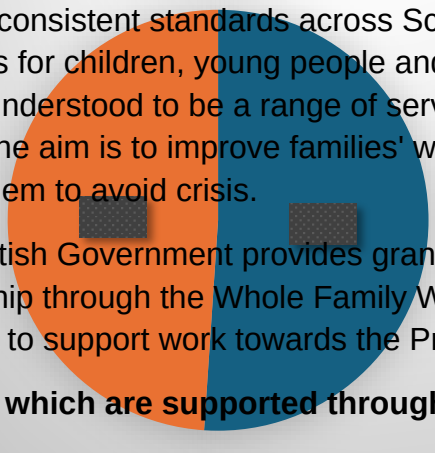
The Fund has a strong focus on prevention and early intervention and aims to support grass roots community groups in tackling mental health inequalities and address priority issues of social isolation and loneliness, suicide prevention and tackling poverty and inequality.

The Promise and Whole Family Support

The promise, made by the Scottish Government following work done by the Independent Care Review, to care experienced children and young people is built on five foundations: family, voice, care, people and scaffolding. They show what's important for any child to grow up loved, safe and respected. You can find out more about The Promise here:

The Promise – gov.scot

Coupled with this was the vision and Principles of Holistic Whole Family Support to promote consistent standards across Scotland which will help to deliver improved outcomes for children, young people and families. In Scotland, Family Support is broadly understood to be a range of services to help families meet their individual needs. The aim is to improve families' wellbeing by providing advice and support to enable them to avoid crisis.



The Scottish Government provides grant funding to the Argyll & Bute's Children's Partnership through the Whole Family Wellbeing Fund (WFWF). The money is designed to support work towards the Promise through innovative practice initiatives.

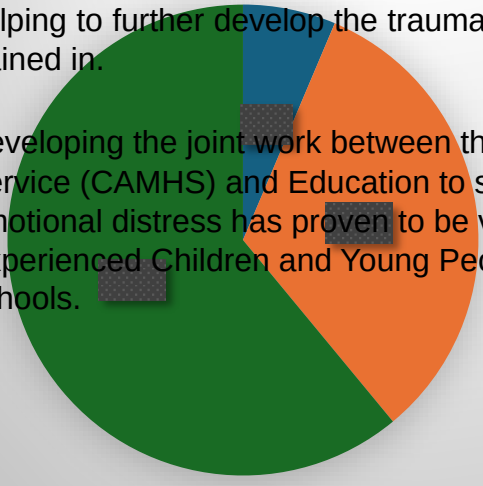
Projects which are supported through this fund include

- The Family Placement Team recruited two extra staff to do initial and full assessments on Kinship Carers.

- The Throughcare and Aftercare Team recruited two extra staff to work with young people during their care and aftercare journey.

- The Care Experience Health Team was further developed. This allowed for the CAMH's Team to have formulation meetings with staff from the three residential children and young people's houses (Shellach View, East King Street and Dunclutha).

- A Trauma Coordinator has been appointed, and this is proving to be a key post in helping to further develop the trauma informed approach that all our staff are trained in.



- Developing the joint work between the Child and Adolescent Mental Health Service (CAMHS) and Education to support families of children exhibiting emotional distress has proven to be very successful. A Head Teacher for Care Experienced Children and Young People has been appointed and works across schools.

Residential Children's Houses 2024 - 2025

Work has been undertaken to further develop training for staff in our residential children's houses. The impact of this training has supported achieving positive destinations for the young people who had been supported to transition to independent living. One house has recruited qualified social workers, colleagues from education and throughcare services. Having a suitably qualified workforce we can consider early intervention in the community to target support to families and provide a response to young people whose needs may be more complex.

Staff teams within the Houses have been trained in Therapeutic Theory training by CALM, along with Therapeutic Care Giving training facilitated by CAHMS care experienced team. There is progress in the number of practitioners trained in Dyadic Developmental Psychotherapy (DDP).

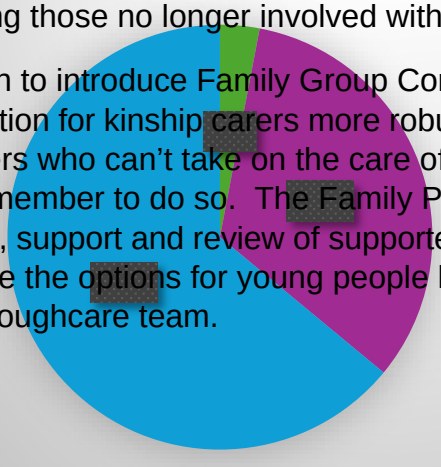
Family Placement 2024-2025

Recruitment of foster carers is a national problem. We get more inquiries from prospective adopters than people interested in fostering, but it would appear this mirrors the national picture. We continue to work to recruit more foster carers.

Continuing care arrangements with previous foster or kinship carers has been strengthened with the decision to retain a supervising social worker from the family placement team to work alongside the carers post conversion to continuing care providers, offering support to them in this new role of helping the young person transition to independence when ready; this will include annual reviews.

We have updated Kinship policy and procedures and taken most work associated with kinship into the family placement team. This has led to a quicker initial assessment when children go to stay with kin, as well as a smoother transition from Interim to permanent kinship arrangements. Kinship Carers have had opportunities to meet up with foster carers and adopters at joint events.

Going forward, we will develop our review process for kinship carers that will ensure we know the circumstances of all kinship carers and the children they care for, including those no longer involved with a child's social worker.



We plan to introduce Family Group Conferencing, which will make the initial exploration for kinship carers more robust and allow a full discussion including family members who can't take on the care of a child full time but can support another family member to do so. The Family Placement Team will undertake assessment, training, support and review of supported lodgings providers. It is hoped that this will increase the options for young people leaving Care, this will be a joint venture with the Throughcare team.

United Nations Charter on the Rights of the Child (UNCRC)

In October 2023 the Argyll and Bute UNCRC Implementation Group applied for a grant from the Scottish Government, CORRA Foundation led, UNCRC Innovations Fund. This was set up to give Councils the funds to embed children's rights in their area following the introduction of the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024. The bid was successful and £53,000 was awarded to achieve the following objectives.

1. In coproduction with children and young people, create a series of celebratory events that inform children, young people and their parents and carers about children's rights and the new act.
2. Create an awards scheme that, in coproduction with children and young people, will encourage embedding of children's rights into the work of the Council and its partners.
3. Create materials that can be used going forward to increase awareness of children's rights in Argyll and Bute.

All these outcomes were achieved; key things to note in the work of this project include:

- 17 events took place that celebrated children's rights and informed children, young people and parents / carers and staff about the new act. In total 2475 children and young people were directly involved with events and the coproduction of new materials for use going forward.
- An awards scheme was commenced, and children and young people have helped to design badges and plaques that will be used in the scheme.
- Two children's rights workshops were held for parents, carers, staff and other interested adults.
- Children and young people have been involved across Argyll and Bute, from our islands, rural places and towns. This has included those from early years, primary and high schools and young people not in school. The range of communities and groups included has been extensive and includes refugee and asylum-seeking children and young carers.
- Material created for future work in this area include small libraries of children's rights / inclusive and LGBTQ books in several schools including Tobermory and Rothsay high schools. Pens provided with the books that will read aloud, allowing children and young people to share them with parents where English may not be a first language etc. A new LBTQ+ flag designed by children and young people, a graphic version of the children's rights plan, a graphic poster for early years settings and parents that signposts to information about relevant rights and resources and has a QR code which directs people to a Council webpage on resources for parents with babies and young children. A film created by Young Carers about their challenges and the importance of their rights. A variety of materials from individual events that will be visible to children and those in communities going forward, for example bags, fridge magnets, t-shirts and mugs.

All of this combines with key elements like informed leadership, impact assessments that encompass children's rights, a child friendly complaints procedure, coworking with youth and community groups, the creating of child friendly documents, and the provision of training for staff. Going forward we will keep children's rights and voices at the centre of the Council's work and recognise that they must be respected if we are to effectively tackle child poverty.

The Plan

A. Increasing income From Employment and Earning

1. Employability

Delivery of the **Parental Employability Support Fund (PESF)** continues within the broader context of the **No One Left Behind (NOLB**) policy direction.

Eligible participants must have the right to live and work in the UK and are:

- Lone Parents who are unemployed or experiencing in work poverty
- Parents with a disability or families who are unemployed or experiencing in work poverty and have a disabled child
- Parents who are unemployed or experiencing in work poverty and have 3 or more children
- Parents from a minority ethnic background who are unemployed or experiencing in work poverty
- Parents who are unemployed or experiencing in work poverty and have a youngest child
- Parents who are aged <25 who are unemployed or experiencing in work poverty
- Other low-income parents, i.e. kinship carers who are unemployed or experiencing in work poverty.

The main objectives/expected outcomes are to support the delivery of the Scottish Government's Parental Employability Support Fund (PESF) to offer a flexible and user-based model of employability support for the parental groups identified in Best Start, Bright Futures: tackling child poverty delivery plan 2022 to 2026,

through appropriate support focusing on intensive Key Worker support.

Low-income families are supported to increase their income through work, both through supporting parents to access paid employment and in helping those in lower paid jobs to progress to higher paid employment. Argyll and Bute Council's Employability Team and Third Sector partner Inspiralba (lead of a large consortium across Argyll and Bute) deliver intensive in and out of work employability support to parents, including person centred support to upskill, apply for jobs, gain progression whilst employment, money advice, health support, motivational support, complete accredited training, etc. Bute Advice and ALIenergy are key partners within Inspiralba's consortium helping to assist parents to maximise their household income and reduce fuel costs.

The Argyll and Bute Employability Partnership (ABEP) identified lack of childcare as a barrier to work for parents. In response, our Third Sector partner Inspiralba developed a pilot programme to support parents through the process of becoming registered childminders utilising the Child Poverty funding. The pilot recognised that whilst support was available to access childminding, additional coaching and support would enable parents with limited confidence and on a low income to pursue this career and progress into self-employment. All parents who enter the childminding programme are supported by an Employability Coach to build confidence; coordinate training including Paediatric First Aid and Food Hygiene and guide them along their journey. The Scottish Childminding Association (SCMA) provide specialist support, including the 'Childminding Induction Programme' and Argyll and Bute Council's Early Years Team assist with area specific advice. Bute Advice provide specialist benefit advice, and an experienced local Childminder offers additional mentoring. Assistance with set up costs, including purchase of toys, equipment and minor adaptations to the home to ensure Care Commission Compliance is also available. InspirAlba ran the pilot in 2023/24, of the 5 parents who commenced, 4 of which are now in business and the 5th secured a post with Social Work. Due to the pilot's success a further 4 places were offered in 2024/25, all of which were filled and are doing extremely well working towards becoming fully qualified childminders. When operational these childminders will help to tackle the shortage in childcare in the rural communities of Islay, Tighnabruich, Ford and Tarbert. It is planned a further 2 places will be available in 2025/26.

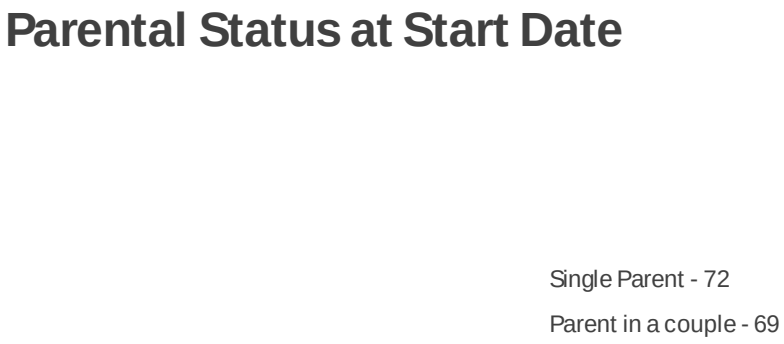
The ABEP also recognised specific gaps relating to family poverty (supporting parents with creative cookery skills for nutritious family meals and access to the hospitality sector). Inspiralba worked in partnership with Fyne Futures to devise a pilot programme. A programme was created to support parents to develop skills, confidence and accreditations to test trade as childminders, which will increase capacity for this gap. As with the childminding this pilot was also successful with further places being available in 2024/25 and 2025/26.

Parental Welfare Fund is aimed at parents receiving support through the PESF who successfully secure employment. Applications are welcomed by Argyll and Bute Council's Employability Team. These monies help with the transition to work and can alleviate any worries. The fund offers up to £1,000 payable over the first 13 weeks of employment. **Further information on the Parental Welfare Fund**

Funded by the Scottish Government a Child Poverty Co-Ordinator was recruited in June 2024 by Argyll and Bute Council's Employability Team. This post provides critical additional resource within Argyll and Bute Council to support the delivery of commitments set out in the Scottish Government's policy intent of 'No One Left Behind' and 'Best Start Bright Futures', by ensuring alignment between the Argyll and Bute Employability Partnership and wrap-around services that support parents' transition or progression within work, such as childcare and transport. The original postholder has since left however a replacement commenced the role in May 2025.

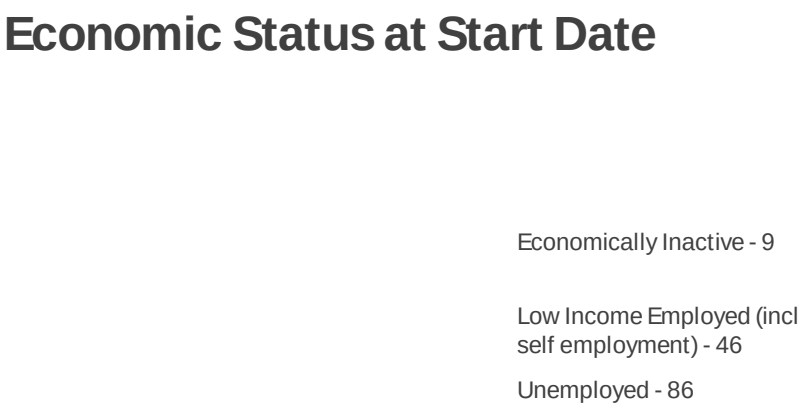
During 2024/25 a total of 141 parents commenced support under PESF/NOLB

A Pie Chart showing parental status at start date. 49% (69 people) were a parent in a couple. 51% (72 people) were single parents.



* Please note the above figures are based on parents who have engaged for the first time in 2024/25 and not those who are restarts to the service.

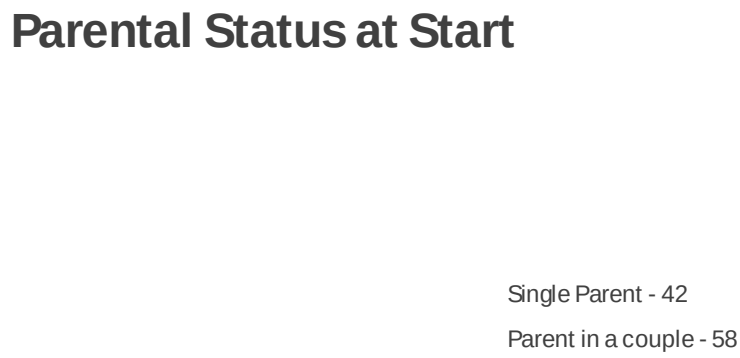
A Pie Chart showing economic status at the start date. 61% were unemployed (86 people), 33% were low income employed (including self-employed) (46 people) and 6% (9 people) were economically inactive.



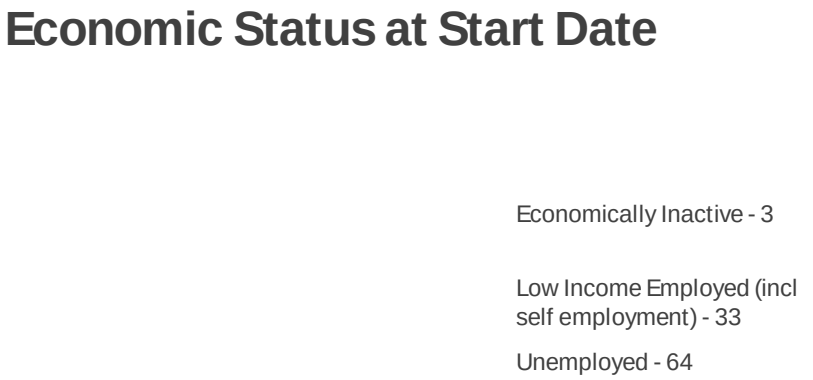
Of these 141 parents, 64 advised at the outset of support they had a physical or mental health condition or illness lasting or expected to last 12 months or more.

In addition to the 141 parents who joined the PESF Service in 2024/25, a further 100 parents still being supported at 31st March 2024, were carried over to continue support in 2024/25.

A Pie Chart showing parental status at start. 58% (58 people) were parents in a couple, 42% (42 people) were single parents.



A Pie Chart showing economic status at start date. 64% (64 people) were unemployed, 33% (33 people) were low income employed (including self-employed), 3% (3 people) were economically inactive.



Of these 100 parents carried over to continue support in 2024/25, 48 advised at the outset of support they had a physical or mental health condition or illness lasting or expected to last 12 months or more.

A total of 97 parents exited the PESF service in 2024/25: 32 commenced employment thus having a positive impact on their household income. Of these job starts, 18 (56.25%) entered self-employment being the ideal option to accommodate their family circumstances. A further 5 parents commenced volunteering, 4 moved into further/ higher education and 35 completed accredited training.

All PESF programmes continues to be available to continuing parents and new start parents in 2025/26. As an alternative to PESF and NOLB, unemployed parents also have the choice to receive support from the following employability options should they decide this support best meets their needs:

UKSPF Work Placements and Training delivered by Argyll and Bute Council's Employability Team. Both interventions funded by the UK Government.

Work placements offer the opportunity to gain skills and knowledge to assist with moving into future employment:

- 4, 13 or 26-week duration
- 16 or 30 hours per week
- Real living wage paid
- Up to £100 per person work clothing allowance
- Training can be funded on an individual basis
- Each participant will have a dedicated Employability Support Worker to assist with job search, interview skills, in work support, etc

A total of 10 unemployed parents (1 single parent/9 parent in a couple) completed a work placement in 2024/25. Of these 1 reported a disability or long-term health condition at start date. A total of 7 parents have moved into employment and 3 are currently job seeking.

Training monies are also available to apply for full or partially funded accredited training. The aim is to:

- Assist those who are unemployed move into work
- Help those in low-income employment (earning up to £17,000 per annum) to upskill/retrain to enable them to apply for higher paid positions

A total of 42 parents (21 lone parent / 21 parent in a couple) accessed the training intervention in 2024/25. Of these parents 7 were low income employed, 7 low-income self-employed, 26 unemployed and 2 economically inactive.

To date 9 parents who were previously unemployed have secured employment, 1 previously unemployed is now self-employed, 2 low income employed and 2 low income self-employed have increased their earnings as a direct result of the training, 1 low income employed remain in their current post and is seeking new employment, 4 have advised they no longer wish to undertake the approved training, 3 are job

seeking and 5 have disengaged and are uncontactable. The remaining 15 parents are still undertaking training.

UKSPF Work Placements and Training interventions continue to be available in 2025/26.

Parental Employability Support Successes

Case Study 1

M is a Ukrainian Refugee and a single parent with 2 children. She was referred to Argyll and Bute Council's PESF Engagement Worker by the Resettlement Team.

M was unemployed for over 6 months, her main barriers to employment were childcare, transport and English not being her first language. M was desperate to find part time employment to fit around school hours. Along with the help from an interpreter, M's PESF Engagement Worker supported her to complete a CV, look for employment, complete applications and go through mock interviews. She was also supported to attend her Job Centre appointments as she was lacking in confidence to attend alone. Through handing out her CV to hotels, M was offered a permanent job, 20 hours a week which fits around her children and still gives her time to study English. M's Engagement Worker supported her to complete all the necessary documentation to accept the position. M was able to apply for the Parental Welfare Fund which has been a great help with clothing and travel to and from work.

Out with employability support, M's Engagement Worker supported her to apply for a school clothing grant and look for local holiday clubs/activities for her children during the school holidays.

M is happy in her employment, in the future once her English improves, she would like to study.

Quote from participant:

'Thank you very much for your help. I admire your kindness and professionalism.'

Case Study 2

B and has 2 children, 1 is only 9 months old. She self-referred as she heard about the programme through a friend who had also benefitted from the programme.

B had just started a mobile nail business when she fell pregnant with her youngest. She was building some clientele and going to peoples' houses. Once she had her baby she was keen to get set back up again. She hoped to look into the possibility of having a shop to work from as this would give her the flexibility for childcare which was one of the biggest barriers.

B wanted to be able to expand her business and increase her income, she also wanted assistance with cash flow and business help to see if having a shop in town would be

viable. InspirAlba were able to help B through the process of taking on a lease for a property, provide some basic equipment and support with a cashflow analysis. They then referred her on to Business Gateway for further support and grant assistance.

B has now been operational for 10 weeks. She is fully booked with clients and has been successful in sub-letting a chair within her premises to another local person.

Case Study 3

J is a single mum of 28 with a young daughter aged 6 months at the beginning of contact. She struggled to find work due to the lack of public transport. J did not have access to a PC and her mobile phone was outdated making access to vacancies and online openings for employment and electronic applications a huge challenge.

The importance of face-to-face meetings with J proved valuable for social interaction and a better understanding of both her domestic situation alongside the challenges faced in seeking employment. Initially a laptop was purchased and an updated mobile phone, creating a fairer opportunity for J to approach employers and to have a wider look at local possibilities. This was met with a hugely grateful response from J, giving her an added positive outlook to her future.

A driving Theory test was organised and J passed with a score of 96%, this boosted her confidence enormously. This has been followed by driving lessons with a local Driving Instructor. She has concentrated very well on her driving lessons and is considered ready for her up-coming practical test date. J looks forward to with great excitement, recognising the life-changing possibilities this could bring.

J's indicated she would like to train as a massage therapist, but she believed this may not be possible due to her circumstances. She was open to other training offered, including a Paediatric First Aid course which she completed over a 2-day training weekend, with an extremely positive attitude and found the course of great value.

She also attended one of Inspiralba's Creative Cookery sessions. All attendees received a multi cooker and ingredients starter pack, which has been hugely appreciated and given an access to greater diet ideas and nutrition for J and her young daughter. She has been able to begin to introduce new foods and home cooked meals.

Feedback from J's successful completion of the 2-day Paediatric First-Aid course was extremely positive. She was a valued member of the course, with excellent interaction and involvement. J was a positive member of the Creative Cookery session, supporting others with ideas and an upbeat and friendly attitude for successful completion.

J received support to apply for jobs and after a successful interview, has now secured her 'dream job' as a trainee Massage Therapist in a nearby town.

Quote from participant:

"Learning to drive has given me confidence in myself and my abilities. In the long term, once I pass my test, it will open up so many opportunities for me such as driving to work and going for fun days out with my little girl. The freedom I will gain through driving is limitless."

Plans Ahead

To continue to play an active role in contributing to the reduction of child poverty in Argyll and Bute by marketing all employability support available to encourage parents to sign up to whichever support best meets their individual needs.

The receipt of the 2025/26 Offer of Grant from the Scottish Government on 31st March 2025 was much welcomed. This has allowed the Argyll and Bute Employability Partnership (ABEP) to discuss delivery priorities utilising the funding allocation available. As a result, the Parental Employability Support Fund continues to support unemployed and low income employed parents.

The Parental Transition Fund will also continue to be available in 2025/26 to provide financial assistance to parents in the first 3 months of employment.

The Employability Team has secured additional UK Government funding through the UK Shared Prosperity Fund (UKSPF) to offer unemployed residents of Argyll and Bute pre-employment support, training and work placements. Training will also be available to those in low-income employment who hope to upskill to enable them to apply for higher paid job opportunities. All interventions will continue to be available from April 2025 to March 2026.

Full details of all support currently available to assist parents to increase income through earnings

2. Skills Development Scotland Argyll and Bute

School Service Offer - Our careers advisers work in partnership with every state secondary school in Argyll and Bute, delivering career guidance to enable young people from S1-S6 to develop their Career Management Skills via a range of groupwork and 1-1 coaching conversations. We work closely with our partners within the school to identify young people who are considered to be most at risk of not making a positive progression from school, helping those young people to develop their career management skills and move onto education, employment or training when they leave school. From 1 June to 31 December 2024, we delivered **3,484** Career Information, Advice and Guidance engagements for **2,418** school pupils through a mix of group and one-to-one sessions.

What We Do - Scotland's Career Service

School Leaver Cohort 23/24 - **796** young people left school during the 23/24 school cohort and our team worked hard over the summer months to follow up whose had left to ensure support was offered. The December 2024 Interim Participation Snapshot showed that of the 3,250 16–19-year-olds in Argyll & Bute **93.7%** were in education, employment or training and personal development.

Post School Service Next Steps – Our service supports young people aged 16 – 18 (extended to 26 for care experienced young people) who are unemployed, helping them to build up their career management skills and move on to and sustain a range of options as appropriate: Training programmes, employability support, education and employment. From 1 April to 31 December 2024, we delivered **372** Career Information, Advice and Guidance engagements for 243 post-school customers through a mix of group and one-to-one sessions.

Post school service: adults & PACE - Working in partnership with a range of partners to support local hubs helping unemployed adults to develop their career management and employability skills and move into employment. In Argyll & Bute our advisers have worked closely with the employability partnership (DWP & CLD) to deliver support via our local community venues format.

PACE: Partnership Action for Continuing Employment (PACE) is the Scottish Government's initiative dedicated to responding to redundancy situations. Through providing skills development and employability support, PACE aims to minimise the time individuals affected by redundancy are out of work. PACE brings together 24 organisations, together with the Scottish Government to provide free and impartial advice, guidance and support for individuals affected by redundancy.

PACE support is available to **all individuals** affected by redundancy.

Advisers have extensive experience of dealing with redundancy situations and can:

- Help with CV's, job search, applications, and interviews.
- Advise on benefits, staff may be entitled to
- Provide information on learning and training opportunities.

PACE support is delivered using a variety of delivery methods including Face to face, PACE Helpline, through webinars and enhanced online resources. From 1 April to 31 December 2024, we supported **8** employers and **64** individuals dealing with redundancy.

Visit **www.redundancyscotland.co.uk** for more information or call 0800 917 8000 to speak to an adviser.

My World of Work- Our website provides trustworthy, expert information and advice and it's free to access for people at any stage in their career. The site is designed to support people of all ages and stages, with activities and tools to help them identify the opportunities open to them. Our school, post school and PACE career coaches have been supporting Argyll and Bute customers by sign posting them to my world of

work for opportunities and developing their career management skills. Parents and schools have been using this service to support pupils with their career journey. Find out more at **www.myworldofwork.co.uk**

Local Employability Partnership: Skills Development Scotland (SDS**)** supports the **Local Employability Partnership (LEP)** in Argyll and Bute by aligning skills and careers services with the region's child poverty priorities.
This includes:

- **Targeted support for parents and carers** through the ***No One Left Behind*** strategy, helping them access training, apprenticeships, and sustainable employment.
- **Collaboration with local partners** to deliver integrated, person-centred employability pathways that reflect Argyll and Bute's rural challenges and sectoral opportunities.
- **Contributing to key local priorities** such as increasing income from employment, reducing the cost of living, and supporting early years and whole-family wellbeing.
- **Embedding The Promise and trauma-informed practice** in service delivery, ensuring support is inclusive and responsive to families facing disadvantage.

3. UHI Argyll and University of the Highlands and Islands

Student enrolment and achievement has improved slightly in the academic year 2024-25 although it has remained a very challenging times for learners. More than 40% of learners now present with some level of learning need or disability, requiring more support arrangements or course adjustments being put in place to help learners to succeed. The greatest rise in support needs has been around mental health, increased numbers of students with neurodivergent conditions, and general social anxiety. The college Mental Health Counsellor has been working at capacity but so far has been able to keep waiting lists down to no more than two weeks.

The college has worked on changing some of the course delivery patterns to attempt to make the courses more accessible to students – fitting around school hours, offering shorter courses of 11 or 17 weeks rather than 34 weeks, building course work around projects rather than units, leading to a more holistic style of learning.

Cost of living support continues to be a key activity. Students are supported to access any relevant funding that they are eligible for and students who have remained on benefits have been supported with one-off uplift payments. SAAS and the Student Loan Company have increased loan amounts as well as providing a Special Support Loan of £2400 for full time Higher Education students. These measures appear to have been successful as fewer students have applied for college Hardship and Discretionary funds in the year 2024-25. Students are able to apply for the long-term loan of a college laptop for the duration of their course so that they can access online learning on more suitable devices.

Over this current year the college has worked in developing a trauma informed approach. This is an ongoing activity to ensure that the ethos is embedded across the college.

Looking forward to the next academic year we will:

- Continue to develop our support for Care Experienced students, Student Carers and Estranged students.
- Continue to develop our curriculum to better meet the needs of our learners and the communities we serve
- Provide more opportunities for work based learning and Modern Apprenticeship courses.

4. Education

Early Years

We continue to deliver a paid childcare service model on three of Argyll and Bute's rural island communities and are now looking to extend this into two urban areas in response to the needs of working parents. As we are acutely aware that we have areas where rurality can exacerbate parental difficulties in accessing paid employment, we hope to support parents back into work and/or training. As such, this service prioritises parents who require the childcare to attend work rather than another reason. Increased levels of collaboration centrally have produced an infographic overview of how children's rights are supported in a multiagency approach across Argyll and Bute. This has been shared with all ELC settings supporting workforce understanding of rights-based practices in relation to community services. Parents also have access to this information, supporting them to access services which support their children.

We have continued to develop and review our Career Long Professional Learning Offer (CLPL) approaches to ensure outcome-focused improvements in planning which will support children's developmental progress, especially those most at risk of diminished outcomes as a result of the poverty-related attainment gap.

Our ASN locality networks continue to attract participation and practice sharing across localities. Feedback shows this is developing our workforce understanding of strategies to support children with additional support needs.

16% of ELC settings received blocks of focused literacy interventions by EY excellence and equity leads, targeting children's listening skills. Data, in relation to closing the poverty-related attainment gap, was used to identify which groups of children were targeted to receive these play-based interventions. In all settings, children's listening skills improved as a result of the intervention, with almost all children's skills progressing at pace, as evidenced through tracking and monitoring

data. Practitioner feedback gathered demonstrates increased confidence by almost all staff involved to continue delivering the focused intervention independently, leading to improved literacy attainment within this curriculum organiser for all children within the settings involved.

4% of ELC settings received blocks of focused numeracy interventions by EY excellence and equity leads, targeting the five principles of counting. Data, in relation to closing the poverty-related attainment gap, was used to identify which groups of children were targeted to receive these play-based interventions. Observation and tracking data showed that 100% of children engaged in the project improved their understanding of number and counting and qualitative data from parental feedback reinforced this evaluation. In all 3 settings, practitioners reported that their understanding of teaching number concepts and counting had increased, and all were confident in their capacity to continue this work independently.

Our collaboration with health colleagues to deliver parental information sessions via community 'buggy walks' has increased, and we now have regular sessions in almost all mainland, urban towns. Parental engagement continues to grow in relation to numbers of parents attending regular sessions, and feedback shows the sessions are delivering early support for parents in the areas of dental health, speech and language development and parental mental health.

Primary/ Secondary Education

Education Officer for Scottish Attainment Challenge continues to support schools in their planning for Pupil Equity Funding allocations to ensure robust, targeted interventions are in place to help close the poverty related attainment gap. Proportionate visits and supports are made to all establishments in receipt of PEF and work continues to ensure these spends lead to quality impact in improved outcomes for learners and families most affected by the poverty related attainment gap. Schools have been supported in measuring this impact and its sustainability for accelerating progress. Case studies of effective practice have been produced and shared, giving schools the opportunity to learn from each other in a model of self-sustainable improvement.

New Lead Officer for data has worked with officers to refresh data packs produced for schools. The development of new school dashboards is assisting schools in analysis of data in a more accessible way with the ability to filter more effectively for children and young people in their settings experiencing / at risk of poverty. Education Management team continues to work closely with Head Teachers to support the analysis of attainment data. Stretch aims set for 23-24 were met in Literacy and Numeracy (P1, P4, P7) Targets set for pupils at SIMD Q1 were met in Numeracy and were within 2pp in Literacy. This reduced the poverty related attainment gap between the lowest and highest SIMD Quintile pupils by a further 2.41pp in Numeracy from the previous year (2023). Due to

increased attainment in SIMD Q5 pupils, the poverty related attainment gap between the lowest and highest SIMD Quintile pupils in Literacy slightly increased by 1.02pp from the previous year (2023).

PEF spends over the last 4 years evidence an encouraging **upward trend** in overall investment spend, rising from 63% investment in 2021/22 to 84% investment in 2024/25

Staffing remains the biggest investment of PEF within our schools. (87% of PEF schools committing to additional staff). The largest proportion is spent on Pupil Support Assistants (44 in post) who are working with targeted groups of pupils with identified gaps in learning to support increased progress in attainment. Additional teaching staff have also been recruited by some schools to target this type of intervention (17 in post) Progress and Achievement data and progress towards stretch aims point to improvements. Another significant proportion is allocated to FL / HWB Officers (19 in post).

Four Family Liaison Officers (FLOs) have also been appointed centrally to support the development of the Single Point of Access. With 1 FLO per locality area, this will help ensure a more equitable provision across the local authority. This is in addition to the FLOs who have the specific remit to support our care experienced young people or employed through PEF. Evidence around their impact is strong and features within a Scottish Government case study. They are making a real difference to our most vulnerable pupils and their families through a wide range of support. A research study will be undertaken between August-December 2025 on the work of our FLOs to identify the support areas which derive the greatest impact on our children and young people. This will be used to inform consistency and future planning.

Partnership work with Child Poverty Action Group (CPAG) has resulted in a number of schools further examining the cost of their school day. This is leading to strategic planning within those schools to consult with their community to plan and implement strategies to reduce the associated financial pressures facing families. A number of schools participate within CPAG's national Cost of the School Day Voice network. This ensures the issues associated with rural poverty are better represented.

An authority information leaflet will be shared with all schools in June 2025 which can be used to let families know about financial entitlements.

Liaison is taking place with Social Investment Scotland in relation to a financial inclusion pilot. This is with the aim of ensuring that every child leaves school with a bank account. We are working with them to consider piloting this in a secondary school where there is limited access to a bank. We are keen to

ensure that we are addressing some of the barriers that young people may have in accessing a bank account in our rural and island areas.

£5000 has been earmarked from SEF funding for a participatory budgeting (PB) project to benefit pupils experiencing poverty. Project planning for this is being taken forward to explore a pilot PB project with all the island schools on Islay in 2025/26.

28% of our schools currently provide a Breakfast Club. 95% of these are offered as a universal provision (open to all) and in over a third (38%) they also work with identified families to target the offer. 71% of the provision is funded through PEF with staffing and catering supplies being the highest committed spends. A third of the schools have been able to access additional community funding to support their provision. (33%) Over half of the schools' evidence impact in improved attendance (62%) and engagement in learning (67%) as a result of their Breakfast Clubs and all schools (100%) would like to continue their provision as a long term and sustainable feature for their establishments.

The recent announcement from the Scottish Government on 'Bright Starts' grants will give individual schools the opportunity to bid for this additional funding to either provide a new Breakfast Club or to augment / sustain current provision.

Professional learning has been offered to all education staff, considering education priorities alongside council wide priorities. An expanded Equity Network has enabled a wider reach beyond FLOs and HWBOs to all interested education staff.

Run in partnership with HSCP colleagues, Money Counts training was a new addition to the Education Career Long Professional Learning calendar in 24-25.

CLPL	Roles within Education	Number of attendees
Equity Network - CPAG	Family Liaison Officers Health and Wellbeing Officers MCR Pathway Coordinators Headteachers Education Support Officers	5
Equity Network – Breakfast Clubs	Family Liaison Officers Health and Wellbeing Officers	8
Equity Network – Cost of the School Day	Family Liaison Officers Health and Wellbeing Officers	12

CLPL	Roles within Education	Number of attendees
	Headteachers and senior leaders in schools	
Equity Toolkit	Family Liaison Officers Health and Wellbeing Officers Headteachers Education Support Officers	6
Planning for Impact in PEF	Headteachers and senior leaders in schools	19

Argyll and Bute remain committed to 'Keeping the Promise' for our care experienced children and young people CECYP). Our Care Experienced Education Team consists of a Virtual Head Teacher and four Health and Wellbeing Family Liaison Officers. At any one time, there are approximately 300 CECYP across our authority education settings. We also support young people who are hosted out-with our authority, both in mainstream and specialist settings. CLPL opportunities are supporting staff at all levels to better understand the needs of our CECYP. Comprehensive training such as Keeping the Promise and Designated Manager training is supporting an increased awareness of CECYP needs and how best to support this cohort. This has resulted in an authority wide commitment, including our Chief Officers Group, to continue to work towards Keeping the Promise and having high aspirations for our CECYP. This is demonstrated by CECYP voice being reflected in 'Our Children Their Future – Thriving Together.'

Ensuring our CECYP have all they require to thrive and achieve their potential, remains a key priority for the council. Education Service actions and data shared with both the Community Services Committee and the Corporate Parenting Board, has been received positively with endorsement given for the work to continue. The funding from the Scottish Government's Scottish Attainment Challenge CECYP Fund is demonstrating clear effectiveness with progress for our CECYP that align to our outcomes, as evidenced by our data.

Enhanced scrutiny and awareness of our CECYP is showing a very good impact on National 4 qualification pass rates. In 23-24, we maintained a 100% pass rate for Level 4 Literacy, Application of Mathematics – 15.5% above the national average. 72% of learners who presented for Higher/Advanced Higher achieved grades A – D, 32% achieved grades B – C. Achievement of Curriculum for Excellence Level (ACEL) data for P1, 4 and 7 evidence three-year positive progress since 2021. CECYP attainment has increased in every area and the attainment gap between CE and no-CE pupils has reduced (whilst non-CE pupils continue to improve).

Effective partnership working through Corporate Parenting Board attendance and wider Education Service continues to be refined, enhancing the support available to

our CECYP considering their post school destination. The positive impact of this work is evidenced by 94% of CECYP leaver obtaining a positive destination and 83% being in a sustained destination (2023-24).

CECYP Primary attendance in 23-24 was 91.5% and secondary 80.8%. Authority wide polices and effective training such as Maximising Attendance, OCTNE, RRS and We Promise is leading to earlier intervention to support CECYP attendance. This is resulting in personalised attendance support targeted CECYP, including multi agency approaches to offer whole family support. Pupil voice evidences the positive impacts on wellbeing and inclusion

Strategic commitment and prioritising of GIRFEC, The Promise and OCTF has led to greater awareness across settings of the positive impacts of bespoke approaches, early intervention and trauma informed approaches. This has resulted in a year-on-year decrease of exclusion since 2020. As a result of this commitment, zero CECYP were excluded in 2023 – 24. As at May 2025, zero CECYP have been excluded in the 2024-25 academic session.

As part of our involvement in the testing phase of Scottish Governments draft framework '***Improving the Educational Outcomes of CECYP'*** (soon to be finalised) we have developed key measures focused on attendance, exclusion, attainment and post-school destinations. In addition, we have identified local outcomes related to the enhancement of professional learning, which collectively support and strengthen our ongoing improvement efforts.

The Addressing Non-Attendance (ANA) procedures have been further strengthened by engagement with Education Scotland's Quality Improvement Programme (QIP) on Addressing Non-Attendance. We will be developing our approach to attendance by sharing the learning from that have been developed from ANA and the QIP. Attendance stretch aims will remain a discussion as part of Education Managers Quality Improvement Visits.

In August 2024, Argyll and Bute Council extended its partnership with MCR Pathways to add Rothesay Academy to the existing MCR programmes at Oban High School, Dunoon Grammar School and Hermitage Academy.

MCR Pathways is a national charity which seeks to improve the wellbeing and life chances of Care-Experienced or otherwise disadvantaged or vulnerable young people through its mentoring programme, which matches such young people in S3-S6 with volunteer adult mentors for weekly meetings of one hour.

The programme brings proven, measurable improvements in attendance, inclusion, attainment and achievement, as well as increasing self-confidence and wellbeing in young people. In each school, the Council employs an MCR Pathways Co-ordinator,

who works to recruit mentors, match identified young people with mentors and prepare identified young people in S1 and S2 for being matched with a mentor in S3. At the end of its second year of implementation, the MCR Pathways programme continues to be highly successful. All targets for recruiting mentors and successfully matching mentors to young people have been exceeded, and the feedback from young people, mentors and schools has been extremely positive. Across the four participating schools, 112 S3-S6 young people are being mentored weekly, and 90 S1/S2 pupils are working towards mentoring in S3.

The next steps for MCR Pathways in Argyll and Bute involve the further extension of the programme to Campbeltown Grammar School, Tarbert Academy and Lochgilphead High School. To overcome logistical and funding challenges, innovative approaches to finance and delivery are being put in place or explored. These include sponsorship by local business partners and the development of a hybrid model of delivering the programme in partnership with Developing the Young Workforce and Skills Development Scotland.

Over school session 2024/25, Argyll and Bute Council has further developed and extended its programme of Flexible Learning Plans (FLPs).

An FLP is an intervention within Getting it Right for Every Child (GIRFEC) which provides a bespoke and fully personalised curriculum to vulnerable young people in S4-S6 who are at risk of disengaging with education. Such disengagement can be the result of any number of factors, including mental health, neurodiversity and poverty-related home circumstances. In conjunction with the young person, parents/carers, employers or Further Education and any other appropriate agencies, schools plan an individualised timetable for each young person, focusing on achievement in Literacy, Numeracy and Health and Wellbeing, which runs in conjunction with learning activities outside of school for an agreed portion of the week. The external element most frequently comprises work placement relevant to the young person's chosen vocational pathway, or a relevant, appropriate further education course.

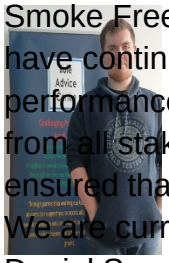
2024/25 has seen a 10% increase in the number of FLPs, with 41 in place across all secondary schools. As a result of training and rigorous quality assurance, schools' skills and capacity to construct appropriate, impactful FLPs for young people has also increased. Evaluation shows that FLPs revitalise engagement with education for disengaged young people and are supporting the young people most at risk of a negative post-school destination into productive and fulfilling participation in employment or further training.

Argyll and Bute Council has maintained its commitment to UNICEF's Rights Respecting Schools Programme; we have signed a MOU to ensure that we continue to develop this work beyond the March 2025 Scottish Government funded period.

We have ensured that 21 out of 22 schools that were inactive, are now accredited and expect the last remaining school to be accredited by the end of June 2025. We are currently on target to meet our goal of having 100% of our schools Rights Respecting Accredited. Since February 2024, we have increased Silver accreditations from 11 to 29 and Gold accreditations from 5 to 9. The development of Rights Respecting Schools Award continues to be important in connecting our school communities with local and global child poverty issues. An example of this would be the work that has been led by pupils in a Primary School on the cost of the school day. In taking a rights-based approach to education, schools have been developing or embedding pupil voice structures within their setting. This was particularly evident in a recent consultation on the Education Strategic Vision and Values with "Equity" being a high priority for our learners to see included in the revised document.

Argyll & Bute's Youth Voice Group continue to discuss issues that align with the Children and Young People's Commissioner Plan. Commercial Services attended one of these meetings on invite from the group who wanted to discuss the cost of school meals and the provision of fresh fruit.

Education has continued to be supported by the Alcohol and Drug Partnership to participate in Planet Youth. We had progressed this work from engagement with 2 secondary schools in 2021 to 5 secondary schools in 2023. In September 2025, we will have all 10 secondary schools engaged in the survey. This work, in partnership with colleagues in Public Health, is developing protective factors for young people with the intention of reducing risk factors. Staff that has been secured through grant funding have helped develop community engagement and awareness of the Planet Youth approach. Through this work, Dunoon have re-established a youth group in the area, making a safe social space accessible for young people. Data gained through the survey is shared with other services to help inform improvements. The ADP have also funded third sector organisations to provide the ADP School Support Services across aArgyll & Bute secondary schools. This provides support for young people who may be affected by drug or alcohol misuse (directly or indirectly). The service also supports the delivery of aspects of the health and wellbeing Curriculum as well as increasing awareness with parents/carers.



Smoke Free Me Drama (P7 Production) and You Are Not Alone Drama Productions have continued to be delivered to Argyll & Bute Schools. Changes to the performances were put in place this academic year based on evaluative feedback from all stakeholders. This supported the introduction of vaping as a theme and ensured that delivery of the You Are Not Alone performance was brought done to S2. We are currently working with our partners in health to plan for the introduction of the Daniel Spargo Mabs performances and workshops. A programme of staff and parent workshops will support this development. There will also be a parent/carer workshop

that is to support those with children with an additional support need. The impact of this new programme will be evaluated.

The Mentors in Violence Prevention (MVP) programme has continued to be developed across our secondary schools. The Programme is a mentor-based programme that addresses gender-based violence. This work [illegible] an important part of the Violence Against Women and Girls Project. Over the academic year 24/25, we have taken the number of secondary schools trained from 7 to 10. This has ensured that we met our ambitious target having staff trained in all secondary schools in Argyll & Bute. We have also developed our training staff team, taking this from 2 to 4 staff trained to deliver staff training and a further 4 trained for the newly introduced Primary and ELC training. Over the next year we will be delivering training to Primary and ELC. The work continues to bring together engagement from partners such as ADP School Support Services, Police Scotland and Argyll & Bute Rape Crisis. We will be looking to develop this work further by connecting this to the new iteration of the anti-bullying policy and increasing engagement in Equally Safe registered schools.

Partnership working is an important aspect of our curriculum delivery. We are currently exploring a pilot programme with the Financial Inclusion for Scotland Associate. The aim of the programme is to improve financial inclusion for young people by maximising the opportunity that they have to secure a bank account before they leave school. We will be taking a data informed approach to identifying a pilot school(s) for the programme considering aspects such as rurality, SIMD, ease of access to banks/banking hubs and post 16 destinations.

B. Increasing income Through Benefits

1. Benefits

The Benefits Team supported people in 2024-2025 with the following grants.

Scottish Welfare Fund Crisis Grants

Between 1 April 2024 and 31 March 2025 there were 748 awards paid out to the value of £88,171.

Scottish Welfare Fund Community Care Grants

Between 1 April 2024 and 31 March 2025 there were 790 applications made, and 386 awards paid out to the value of £460,964.

Total Programme Funding

For the scheme was £458,284 which resulted in overspend of £90,850, this was met by the Council to enable continued support to vulnerable claimants.

Flexible Food and Fuel Fund

From 1 April 2024 to 31 March 2025 the Council paid out £109,920 in grants to householders with food and fuel insecurity and successfully referred them for support to advice agencies for further support. The advice agencies were able to support 965 families achieving a combined client gain of £1.357 million in income maximisation through increasing benefit entitlements.

Discretionary Housing Payments

As of 31 March 2024, our spent and committed amount of Discretionary Housing Payment (DHP) was £0.968m out of a budget of £1.069m. The Council have a duty to pay DHPs to anyone on the benefit cap and looking at ways to automate DHP awards. A review of the DHP policy is being carried out and a new policy will be presented to the Council later this year.

Islands Cost Crisis Emergency Fund

In 2024/25 the Council received an allocation of £145,000 to support Island Communities from the Scottish Government.

The funds were spent as follows:

- Scotland Loves Local Cards – 1,256 cards issued in December value of £95. These cards were issued to Council Tax Reduction recipients on our islands. The money on the cards can be spent in a range of local shops. Food Banks - a grant of £16,000 was given to each of the 4 Community Food Organisations (Islay Foodbank, Bute Oasis, Tiree Food Project, and Mull and Iona Community Trust).

- Free School Meal Top Ups – 100 eligible pupils received payments of £1.60 per day for the school year from August 2024.

2. Social Security Scotland, Argyll and Bute

Headlines

Over 200 stakeholders in Argyll and Bute get regular communication/updates

There is excellent collaboration with stakeholders to get information out to clients using a range of tools including an increasing amount of social media releases. All of these are available on our website.

Stakeholder Resources

Total invested in Argyll and Bute (to Dec 2024) through benefits and grants to lowest income families:

£ 72,321,543

Best Start Grant Early Learning and School Age Payments are paid automatically to parents and carers who already receive Scottish Child Payment so no need to apply for this. Early Learning and School Age payments stats fluctuate depending on time of year (enrolment).

Social Security published statistics.

Apply for our benefits - Social Security Scotland - mygov.scot

or by calling our Freephone number on 0800 182 2222 (open from 8am – 6pm). Support to claim our benefits is available – just ask for Local Delivery.

Our organisation currently provides 15 benefits

3. Welfare Rights Update 2024-25

Achievements

In 2024-25 we have dealt with 1,219 clients generating a total financial gain of **£5.4 million** and increase of over 1 million from 2023-24

It should be noted this “client gain” is not just a figure. The support provided by Welfare Rights makes a significant impact on individual’s lives. For example, it may mean being able to put heating on, keep a car running, replace a broken appliance etc.

Continued engagement with partners and community groups to reach more clients

The team gained Scottish National standards for Information and Advice Providers accreditation.

Challenges 2024 - 25

Increased demand for benefit and income checks. It’s expected many clients will continue to experience hardship due to the cost-of-living crisis with fuel costs being a major factor.

Likely increase in number of clients approaching us for help with the Universal Credit managed migration process as the DWP are now in the process of transferring over the most vulnerable group of clients who typically need more support.

Priorities 2025 - 26

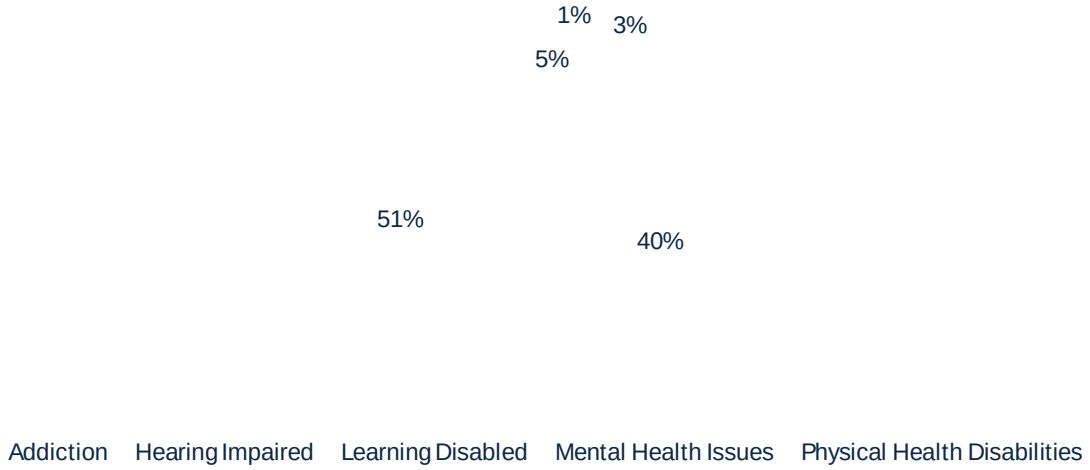
- Continue to promote and deliver a quality and consistent Welfare Rights Service to residents of Argyll and Bute.
- Ensure that the residents of Argyll and Bute are not missing out on their entitlement to both UK and Scottish Government administered benefits and other related help.
- Provide an enhanced Welfare Rights Service for people affected by cancer.
- continue to work closely with NHS colleagues and the improvement Service to develop Welfare Advice and Health Partnerships (WAHP'S) in Argyll and Bute.
- Ensure the service is able to deal with the probable increase in demand for assistance due to the continued roll out of UC managed migration and the roll out of further Social Security Scotland benefits such as Pension age Disability Payment, Scottish Adult DLA and Carer's Support Payment.
- Increase the profile of the service particularly in remote island communities and hard to reach groups.
- Engage effectively with partners and local community groups
- Explore data sharing opportunities in order to identify local vulnerabilities and engage with hard-to-reach clients.

4. Bute Advice Centre

Bute Advice Centre has been incredibly busy supporting communities across Argyll and Bute to access £2.45 million from April 2024 – March 2025 (inclusive). Our mission statement dictates that our priority is to "relieve poverty and distress", this we endeavour to do across the projects we deliver. Many of the client we support have a disability.

A Pie Chart showing that 469 disabled clients were supported across April 2024 - March 2025. 51% of these had physical health disabilities, 40% had mental health issues, 5% had addictions, 3% had a learning disability and 1% were hearing impaired.

469 Disabled Clients Were Supported Across April 24/ March 25



19 Carers were supported to claim £15,763.04 of grants.

From April 2024 – March 2025 advisers supported disability benefit claims totalling £947,302.34.

Advisers prioritise ensuring that households with children have access to child specific benefits, including Best Start, Scottish Child Payments, Child Benefit, Pregnancy & Baby Payments, Education Maintenance Allowance and Free School Meals. These claims resulted in a client gain across the year of £60,385.51.

Bute Advice Centre are proud to be part of the award-winning Flexible Food and Fuel Project that has a stand-alone gain of £4.5million across the term of the project, supporting many families since January 2021. In addition to the face to face and telephone advice sessions available to clients, staff also take part in events across the region that support engagement.

Elizabeth Officer, Welfare Rights Adviser, has been attending ARC on a regular basis in Dunoon to help support those suffering from addiction and their loved ones with welfare rights issues.

> Ross Semple, Student at Glasgow Caledonia University, supported the delivery of Digital Literacy Lessons in the summer of 2024, helping small groups to use tablets to engage with loved ones, set up internet banking, and use social media. Gifting each participant their own tablet at the end of the 6 introductory lessons, through the Good Things Foundation.

Paul Toop, Welfare Rights Adviser, has also played a major role in providing SIM cards/vouchers for mobile phones, helping alleviate digital poverty through the Good Things Foundation.

Heather Buchanan, Senior Welfare Rights Officer and Colum Buchanan Welfare Rights Adviser have regularly visited the Bute & Cowal area to support individuals requiring home visits and providing information sessions to community groups.
Promoting the ACHA Welfare Rights service and the Flexible Food and Fuel Fund.

Manager, Julie Semple, visited Oban for the Minority Ethnic Carers of Older People Project (MECOPP) event supporting the Gypsy & Travelling Community where several partner organisations came together to highlight services. Additionally visits to local foodbanks took place, along with the Community Food Forum meetings. Bute Advice Centre enjoy working in close partnership primarily with Inspiralba, Fyne Futures, Argyll Community Housing Association (ACHA), Argyll & Bute Council, ALIenergy and Argyll and Bute Citizen's Advice Bureau (ABCAB.)

Additionally, Bute Advice Centre took part in Poverty Awareness events in conjunction with Poverty Alliance locally and at government level and engaged with Migration Policy Scotland. Our plans include continuing collaborations with our trusted partners and broadening the scope of the work we do. Over the coming months we will be delivering community group sessions across the region highlighting ways to make budgets spread further including homemade cleaning recipes, growing your own fruit, veg and herbs, baking our daily bread and a host of other suggestions. We have engaged four new members of the team and look forward to an exciting new year.

C. The Cost of Living

1. Housing

In their Best Start, Bright Futures – Tackling Child Poverty Delivery Plan 2022-2026, the Scottish Government state that.

We will place the prioritisation of tackling child poverty at the heart of the Affordable Housing Supply Programme

There is a wide range of activities and actions being undertaken by the Council Housing Service and external partners which can help address levels of child poverty

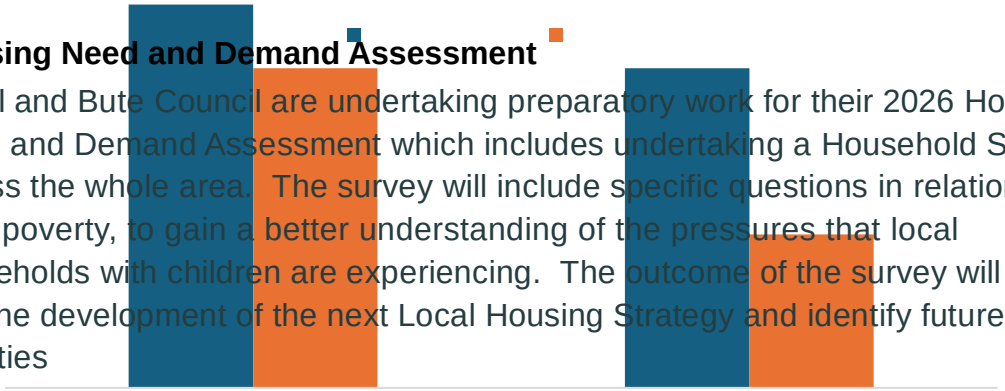
Housing Emergency

In July 2023, Argyll and Bute Council recognised the challenges facing the provision of adequate housing stock within its area by declaring a Housing Emergency, the first local authority in Scotland to do so. In addition to national trends and pressures common across Scotland, unique factors such as geographic isolation, the high number of island communities, dispersed communities, exacerbated the challenges for the housing system in Argyll and Bute. Following a multi-partner Housing Summit, an Action Plan was developed to help deliver improved affordable housing provision in Argyll and Bute. A series of metrics have been agreed to help measure progress annually, including the number of homeless applications helping to put one measure of housing related poverty at the heart of the housing emergency response.

Scottish Government Housing Bill

The Scottish Government's new Housing Bill is presently at stage 2 of its passage through parliament. Amongst the proposals in the Bill are powers to implement rent control areas. This would place a duty on local authorities to assess rent levels within their area and give powers to the Scottish Government to implement rent controls in areas of concern. There would also be limits on when, and by how much, rents can be increased in these areas.

The Bill will also extend duties relating to the prevention of homelessness to social landlords, and a range of public agencies.



Housing Need and Demand Assessment

Argyll and Bute Council are undertaking preparatory work for their 2026 Housing Need and Demand Assessment which includes undertaking a Household Survey across the whole area. The survey will include specific questions in relation to child poverty, to gain a better understanding of the pressures that local households with children are experiencing. The outcome of the survey will feed into the development of the next Local Housing Strategy and identify future priorities

Number of children in housing need in Argyll and Bute

As of March 2025, 3,069 households were on the HOMEArgyll Common Waiting List. 2,120 of these households were in housing need, and of these, 697 (33%) were households with children, with a total of 1,375 children in housing need.

Waiting list figures show that of the 909 households with children, 697 (77%) are considered to be in housing need. 54 of these households (encompassing 104 children) are on the homeless list.

Affordable Housing Supply

Affordable housing is key to tackling child poverty in Scotland. By pursuing an ambitious strategic new build programme in Argyll and Bute, the Council and its RSL partners are committed to a Green Standard which delivers high quality, energy efficient homes, helping to reduce overall housing costs for its tenants. The following actions are being undertaken in Argyll and Bute to increase the supply of affordable housing:

- **New Builds** – In Argyll and Bute, in 2024-2025, 42 new energy-efficient homes were built due to Argyll and Bute's Strategic Housing Investment Plan (SHIP).

- **Community Housing Network** – Housing Services has established a Community Housing Network to enable Community Housing Trusts and Community organisations to obtain the support they require to deliver affordable housing to their communities, and to share experiences and learning. Mull and Iona Community Trust, for example, are working with the Council to deliver worker housing on Mull with infrastructure improvements being supported by the housing element of the Rural Growth Deal funding.

- **Buy Backs** - The council and HOMEArgyll partners hope to increase the number of homes they are able to buy back from the private sector through the "Argyll and Bute Buy Back Initiative". This initiative has been promoted both by the Council and RSLs. During 2024/25, 14 private homes have been acquired and added to the affordable rented stock.

- **Short-Term Let Legislation** – The Scottish Government considered that introducing the legislation will increase the supply of homes available for local residents. In 2022-2023, applications for Short-Term Letting Licences commenced in Argyll and Bute, with the legal obligation to obtain a licence coming into force in 2023-2024. As of March 2025, 3,494 applications for short-term let licences have been received.

- **Supplying homes in the right places and homes for workers** – The Scottish Government Action Plan to address depopulation recognises the importance of housing for workers in addressing a range of linked social issues such as depopulation, employment and child poverty, stating that

  "***Secure and sustainable employment helps lift families out of poverty."***

  High house prices in remote rural and island communities, coupled with an "additional minimum living cost of 15-30%" can prevent the recruitment and retention of staff, especially those on lower levels of pay such as child-care workers. This is evidenced by the range and detail of support and interactions the Council has with developers of housing projects in remote and island locations.

  Thus, the links between employment and housing can be fundamental in offering opportunities to avoid falling into poverty.

  Through the Argyll and Bute SHIP programme, the Strategic Housing Fund (SHF), and the Community Housing Network, Argyll and Bute Council in 2024/25 have supported the development or provision of new homes in a variety of remote or island locations. Additionally, the Council has recently approved measures to allow the SHF to support housing feasibility studies undertaken by local community groups, thus offering financial support to some specific perceived community needs.

  An additional Empty Homes Officer post which is jointly funded by Argyll and Bute Council and the Health and Social Care Partnership (HSCP), with a focus directly on bringing empty and ineffective homes back into use specifically for HSCP staff. This enables easier recruitment of staff within the HSCP, thus supporting service provision for local communities.

  The Rural Growth Deal will also increase the number of homes available for workers. The housing element of the Rural Growth Deal is £3m. Two projects are being taken forward, the project in Bowmore, Isle of Islay will focus on housing for sale for principal occupation, and the one in Tobermory, Isle of Mull will provide accommodation for workers.

- **Supporting Young People**
  A lack of affordable housing opportunities for young people leaving the family home, or seeking employment in rural communities, can often press young people into unsuitable, insecure temporary arrangements such as sofa surfing or staying

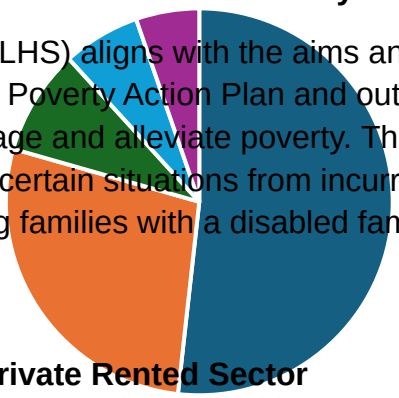
with friends. These insecure and precarious housing arrangements can easily result in homelessness.

Housing Summit surveys showed that a lack of affordable housing opportunities was a common concern with 64% of respondents stating that "***Young people are leaving my community due to a lack of housing options.***"

This concern has also been reflected in interactions with local communities seeking to identify local housing solutions to perceived local problems. Through its Community Housing Assessment Tool (CHAT) the Council Housing Service has been supporting communities in Arrochar and Dalavich to assess local housing needs. In both cases, lack of housing opportunities for young people, coupled with an ageing population, has been a major concern.

- **Housing vulnerable families who are more likely to be in poverty**

The Local Housing Strategy (LHS) aligns with the aims and objectives of the Argyll and Bute Council Child Poverty Action Plan and outlines a series of actions to address disadvantage and alleviate poverty. These include preventing families and young people in certain situations from incurring rent arrears, from becoming homeless, assisting families with a disabled family member and assisting larger families



- **Insecure tenancies in the Private Rented Sector**

Many families live in the private rented sector. This sector is often expensive, and tenancies are less secure, with some families living in this sector being pushed into poverty or even homelessness. This is evidenced by the authors of "Affordable Housing Need in Scotland Post 2021", which stated that the largest proportion of those subjected to formal homelessness assessments in Scotland lived in a private rented property. Scottish Government statistics for 2022/23 show a 74% increase in terminations of Private Rented Sector tenancies due to rent arrears in Scotland, a rate far higher than RSL sectors (21%).

In addition to the homelessness risk, there is a risk that the tenancy will end and that the family will have to move to a new area to find a new home, resulting in children having to move schools. Regularly changing schools can affect children's attainment and, therefore, their life chances.

- **Homelessness**

The Housing Options service assists households, including families and individual young people in identifying the type of home they need and can afford. This service also helps in reducing the number of failed tenancies, ensuring more tenants can remain in their homes. Preventative engagement with households reduces

incidences of homelessness, which contributes to reducing child poverty and outcomes that are more positive for households.

We have seen a significant decline in the number of homeless children in Argyll and Bute in recent years, from 319 in 2017/18, to 195 in 2024/25, however, this is 6 more children than in 2023/24. In 2024/25, 476 homeless cases were closed, of which 121 involved households with dependent children (amounting to 199 children) and 86 of these households received a positive outcome.

There has been a slight reduction in homeless applications between the 1st of April 2024 and the 31st of March 2025. During that period, 459 homeless applications were made, a decrease of 34 applications (7% down) in the same period in the previous year.

There are currently 244 statutory homeless households waiting for permanent accommodation, with 55 of these households having children in them. Although there has been a reduction in the number of homeless applications there has been a slight increase in the number of children in homeless households from 189 children in 2023/24 to 195 in 2024/25.

Homelessness applications continue to vary by location, with Cowal, Helensburgh and Lomond, and Lorn and the Isles seeing the highest levels of homeless applications.

- **Large households**

The Local Housing Strategy aims to provide families with access to housing that is the right size to meet their needs. Research shows that children who live in overcrowded housing find it challenging to find a place to do homework and study, negatively impacting their life chances and keeps them trapped in a cycle of poverty.

As of March 2025, of those in housing need with children under 16 years, 135 households on the HOMEArgyll waiting list needed a home with four or more bedrooms. This equates to 19% of households with children with a housing need.

Table *: Number of households with housing need, with children in Argyll and Bute by bedroom size in March 2025

Number of households with children under 16	Minimum bedroom size required
312	Two bed
250	Three bed
135	Four+ bed

Source: HOMEArgyll Common Housing Register March 2025

- **Families with a disabled family member**
  In Argyll and Bute, considerable work is undertaken to meet the needs of families with a disabled member. In 2024-2025, RSLs built 10 new homes to amenity standards and 2 homes suitable for wheelchair use. A full-time Housing Occupational Therapist (OT) has been employed to work within the housing service to ensure needs are met through the design of new-build housing or by adapting existing public and private sector homes. Children and young people with particular needs will benefit from the bespoke person-centred approach provided by the Housing OT.

Housing condition, energy efficiency and affordable warmth

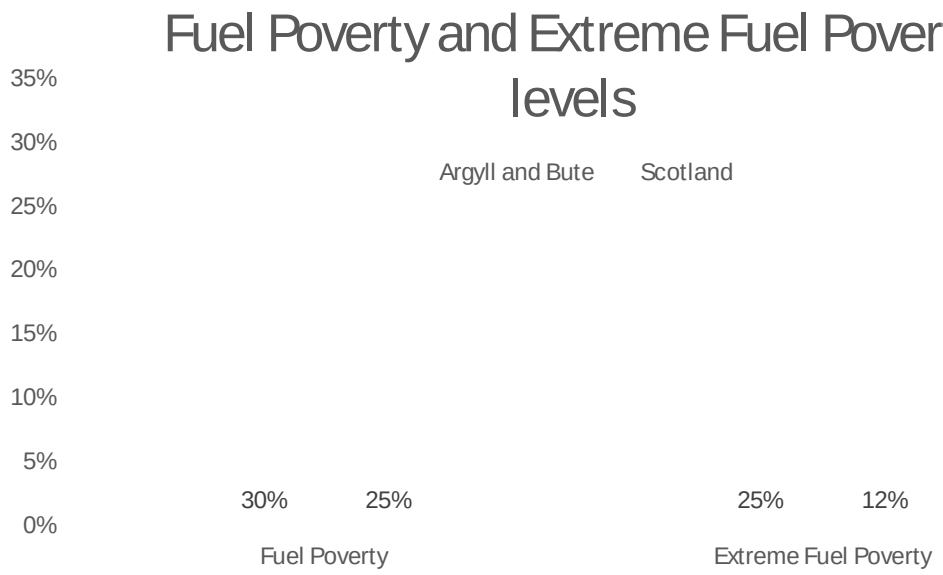
The "Improving our Understanding of Child Poverty in Rural and Island Scotland" report states that:

> "***fuel costs are known to be a particular contributor to fuel-related poverty in rural and island communities"***

The housing condition in Argyll and Bute does not compare favourably with the Scottish average. A higher proportion of homes are in poor condition and fail to meet tolerable standards, mainly due to their failure to meet energy efficiency standards. Living in a cold home has been linked to several health conditions. These conditions often result in children missing school, and this has an impact on their life chances.

Data shows that the average energy demand of homes in Argyll and Bute are 37% higher than the Scottish average, with this then being translated into a similar higher average fuel bill of £1,358 (again 37% higher than the national average). Levels of fuel poverty (30%) and extreme fuel poverty (25%) in Argyll and Bute are also significantly higher than the Scottish average, as shown in the graph below.

A Bar Chart showing Fuel Poverty and Extreme Fuel Poverty Levels in Argyll and Bute compared to Scotland. Fuel Poverty in Argyll and Bute is 30%, in Scotland it is 25%. Extreme Fuel Poverty in Argyll and Bute is 25% and in Scotland it is 12%.



Source; Home Analytics data and Energy Action Scotland

The Council supports discretionary repair and improvement work to private sector properties via the Private Sector Housing Grant. The Council also offers a statutory Scheme of Assistance which can fund housing adaptations.

The Local Housing Strategy outlines a series of actions to reduce energy consumption, such as:

The SHIP Programme- Houses built through the SHIP programme will have even higher insulation levels than the 'Greener Standard' requires. However, new build homes only account for a small portion of the housing stock.

Local Heat and Energy Efficiency Strategy (LHEES)- To tackle fuel poverty, the Scottish Government has placed a duty on all local authorities to develop a Local Heat and Energy Efficiency Strategy (LHEES) and delivery plan. The LHEES will be a locally led, tailored approach to transitioning to climate-friendly heating sources and ensuring local domestic and non-domestic buildings are more energy-efficient.
The council approved its LHEES in November 2024 and this will be accompanied by an Action Plan which will clarify roles and responsibilities. Homes that are more energy efficient will need less energy to reach a comfortable temperature, lowering heating bills and helping to alleviate child poverty.

Energy Efficient Scotland – Area Based Scheme (EES-ABS) – The Area Based Scheme offers grants for the installation of insulation measures to homes of eligible private owners and private rented tenants throughout all areas of Argyll and Bute. Effective insulation makes homes warmer and in turn helps in the reduction of household fuel costs. The Scheme is financed by the Scottish Government and administered by the Council. Argyll and Bute Council continues to utilise their full grant on an annual basis, regularly approaching the Scottish Government for

additional funds. £2,179,827 was awarded for the EES-ABS programme for 2024/25, with the current programme running until 30th June 2025, and the full amount projected to be spent.

Energy Efficiency Standards for Social Housing (EESSH)- Social housing landlords have been carrying out works in their housing stock to improve their energy efficiency. Most homes owned by social landlords now meet the Energy Efficiency Standard for Social Housing (EESSH), with most landlords having over 90% of their stock meeting the standard.

Gypsy/Travellers – The Housing Service continue to engage with the community and relevant partners through the Gypsy/Traveller Working Group. The purpose of the Working Group is to:

- Understand the accommodation needs and preferences of Gypsy/Travellers to inform future provision.
- Work with Gypsy/Traveller communities to raise awareness of rights and entitlements.
- Ensure that our public services are responsive to Gypsy/Travellers needs and preferences.
- Provide leadership to tackle racism and discrimination.
- Strengthen community development and engagement.
- Work with Gypsy/Travellers to improve their involvement in national and local decision-making.

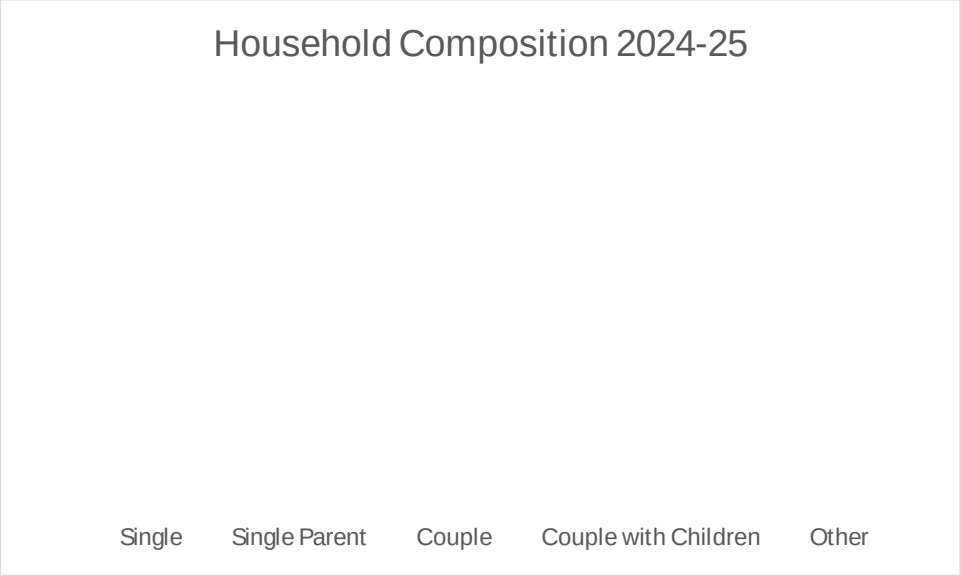
2. ALIenergy Fuel Poverty & Education Summary (2024–25)

Fuel Poverty Support:

- **Target Area:** Argyll, Lomond and the Islands, with a focus on rural households facing high energy costs due to lack of mains gas, poor housing, and low incomes.
- **Support Provided:** Crisis grants (e.g., prepayment vouchers, direct payments, white goods), energy advice (tariffs, meters, insulation, damp issues), and financial guidance.
- **Client Impact:**
    - Average client gain of **£500** (£200 in crisis funds, £300 in energy savings).
    - In 2024–25, **£72,105** in direct financial support was accessed for clients.
    - Over **£6,000** awarded for white goods to families with children; **£16,000** in prepayment vouchers issued.

- **Demographics:**
    - One-third of households helped had children; one-quarter were single parents.
    - Concerns continue over high summer energy use, especially among families with children.

A Pie Chart showing the housing composition of those helped. No figures are given but by far the largest group are couples with children, over 50%. About 25% are single parents, about 15% are single people and the rest are noted as other.



- **Challenges Ahead:** End of key funding streams (e.g., Home Heating Support Fund), and the upcoming **switch-off of radio-teleswitch meters** in June 2025, which may disrupt heating for many electric-only households.
- **Partnerships & Outreach:** Collaborated with **Argyll & Bute Council**, **Bute Advice Centre**, and others on the **Flexible Food & Fuel Fund**, which has achieved **£5 million in client gains** since 2020.
- Delivered **online Fuel Poverty Awareness Sessions** to 62 professionals.
- **Education & STEM Engagement:** Delivered **STEM workshops** and attended **career events** in six high schools to promote local career opportunities.

- Hosted **MAKSTEM Fest** with 20+ local employers for S2 students from Campbeltown and Lochgilphead.
- Distributed **P7 STEM career workbooks** to encourage long-term engagement in STEM fields.

- Aims to show young people paths to successful local careers, supporting long-term family and economic resilience in the region.

3. Free School Meals and Holiday Provision

Free school meals support for entitled pupils has remained a key way of tackling the cost of living challenges for families with children. All children in receipt of 1140 hours of childcare in early years' settings receive a free school meal, along with free milk and a healthy snack.

All pupils in P1 – P5 are now entitled to a free school meal, including children in P6 and P7 in receipt of the Scottish child payment. In addition, all children and young people attending our Learning centres receive a free school meal.

Cash payments in lieu of free school meals for those in receipt on the basis of need is currently paid via BACS transfer, at the rate of £2.40 during holiday periods; this is funded by Scottish Government.

Pupil feedback continues to be the basis for the development of school lunch menus, and they continue to meet the Food and Drink in Schools standards. One of the Menu Development Assistant key roles is to work with pupils on menu design. Free school meal uptake remains higher than the Scottish average.

The Catering service has worked alongside Education to roll out cashless catering and online ordering facilities to all schools, so that every child can access a meal in a non-stigmatising way that protects their identity. Through the pre-ordering app, each child should also be able to have their preferred meal every day at lunchtime, while enabling conversations with parents around meal choices to become normalised. The Council's Catering Service continues to hold its Soil Association Food for Life Served Here Award at Bronze level, across all primary and Early Years settings, demonstrating its commitment to providing locally produced, sustainable, ethical and locally prepared food, serving food that's good for pupil's health, for the environment and for the local economy.

The Catering team have been working on producing a food map to identify further opportunities for providing more local food through school meals while supporting community wealth building opportunities for our communities. Food cost inflation continues to put significant pressure on both public sector food provision and on household finances.

Paid for School Meals

The Council is applying the Cosla Good Practice Principles for school meals debt guidance, along with ensuring that discretionary school meals are available for children who need them when circumstances are appropriate.

4. Infant Food Insecurity Pilot

Infant food insecurity has been recognised as a national concern. In 2024 an Argyll and Bute Infant Food Insecurity Group was formed to look at this locally. The following actions were taken:

- A leaflet was created specifically for Health Visitors and Midwives to use to advise parents. Training on the use of the leaflet and offering assistance, was given.
- The leaflet itself was shared more widely, for example to advice services, Food banks and the Third Sector; a thousand in total were printed.
- Following a request from education, another leaflet was prepared for Family Support Officers to use, and training was also given to them.
- A Financial Inclusion Pathway has also been developed.
- A six-month, **Infant Food Insecurity Pilot** was also commenced on the 4th of December and was initially planned to run for 6 months. 60 supermarket gift vouchers, each to the value of £30 were purchased and placed across Health Visitor and Midwifery teams. These vouchers are sufficient for families with an infant to purchase 2 tins of baby formula when they are in crisis and the need is immediate and cannot quickly be met by other means. Third sector organisations can request a voucher for a family by contacting their Health Visiting or Midwifery team. The staff member dispensing the voucher must complete a basic information form.

The following information is being collated:

- What Area is covered by the team giving out the voucher?
- What is the basic family structure? (e.g. two parents, two young children.)
- What is the reason for the crisis? (e.g. benefits late)

No personal data is collected, and families are asked if they are happy for the basic data to be collected.

A leaflet is handed out with each voucher, explaining that this is a limited resource and part of a pilot study and giving information on where to seek advice on benefits etc. Referrals can be made to the Bute Advice Centre, ALIenergy and other services if families are agreeable to this happening. To date 10 vouchers have been given out, two by Midwives and 8 by Health Visitors. Factors contributing to the immediate crisis include no recourse to public funds, homelessness, parents on benefits and struggling to cope, sudden changes in circumstances, disability issues. The pilot will conclude in December, and a report of its findings made.

5. My Tribe Free Period Product Initiative.

My Tribe, Argyll and Bute's free period product initiative, plays a vital role in tackling child poverty by ensuring that no child misses out on education due to

lack of access to essential items. By providing free period products in over 150 community locations and through a user-friendly online ordering system that delivers directly to any household in Argyll and Bute, My Tribe helps ease financial pressures faced by families.

The initiative reaches children where they need it most—inside schools. Period products are made available in every secondary school and more than 30 primary schools across the region. Additionally, the My Tribe Champions initiative empowers students in several secondary schools to lead the conversation around period dignity, fostering awareness and peer support. Most young people access products through the My Tribe website, followed by availability in schools—ensuring discretion and convenience. Technical improvements to the platform have made it even easier for children and families to get the support they need, contributing to wider efforts to combat the effects of poverty on young people's wellbeing and education.

D. Helping Families in Other Ways

1. Public Health

The Argyll and Bute Community Link Worker service

A Community Link Worker is a member of the wider GP practice team that can provide support and advice on many social issues that may be affecting health and wellbeing. They have a wide range of knowledge on local services and community-based groups and activities.

Community Link Workers can help people find the right support and provide them with information on a wide range of social issues that can impact on health and wellbeing, this might include:

- housing issues
- employment and learning
- support groups
- money worries
- physical activity
- long-term conditions
- caring for relatives and friends
- improving emotional wellbeing
- social isolation

The service helps to address child poverty in a number of ways including supporting families who are experiencing financial difficulties, supporting people with health and wellbeing challenges that may have an impact on their financial situation, and through the service being targeted at the areas of highest social deprivation and remote/rural isolation in Argyll and Bute.

Third Sector organisation 'With You' (previously We Are With You) has been commissioned by NHS Highland to provide the Community Link Worker service in Argyll and Bute since April 2022. Rachel McLean, the team lead for Community Link Workers in Argyll and Bute, introduces the service in the this video. Further information on the service is available from - Social prescribing | NHS Highland and from With You website Community Links Scotland | WithYou.

In 2024/2025, the service began an expansion process so that more people would be able to benefit from this support. This included the recruitment of three additional Community Link Workers and provision of the service to a further 9 GP practices. This takes the total number of GP practices with patients who can benefit from the service to 21. This year also saw an increase in the number of referrals to the service – an increase from 522 in 23/24 to 699 in 24/25.

The top reasons for referrals were mental health and wellbeing, financial advice, housing/essential needs, stress management and loneliness/social isolation.

Those who get support from the service are invited to complete a wellbeing questionnaire. 64% of people who accessed support from the service completed wellbeing data at the start and end of the service; 86.5% of whom showed an improvement in wellbeing.

Patients also provided feedback in the form of quotes:

'I was feeling frustrated by answers of others' to my housing problems, but [the CLW] instilled a confidence I thought I'd lost & was concise & professional in handling the housing issues I had."

'Definitely feel that having the link worker support me and help me find the correct resources has made a huge difference and achieved so much. I am very grateful for the time, effort and compassion that was shown to me and I feel like a lot of people would really benefit from the same experience I had."

Money Counts training

The Money Counts Level 1 awareness session was co-developed by the Highland Money Counts Partnership including the Trussell Trust, NHS Highland, Highland Council and Social Security Scotland, in partnership with the Independent Food Aid Network and Nourish Scotland. This is a short, 45-minute awareness session, delivered remotely through Teams for anyone who may feel less confident and experienced about discussing money worries, but may be in a position to have a brief conversation with individuals and signpost on. This session is targeted at

anyone from health, education and social care staff; 3rd sector workers and volunteers; warm place volunteers and anyone who may be able to start a brief conversation about money worries. The session aims to:

- Increase understanding of poverty and its impact.
- Increase confidence to ask about money worries.
- Increase knowledge of support services for money matters.

The session helps to promote the Argyll and Bute Worrying about Money leaflet and are delivered jointly by Argyll and Bute and NHS highland

The ‘Worrying About Money?’ cash first referral leaflet is a straightforward resource both for people facing money worries and support workers. The step-by-step guide identifies which local agencies are best placed to help people maximise income and access any existing financial entitlements. These leaflets are available for many individual local authorities in the UK.

Argyll and Bute - Worrying About Money?

As well as in English, this leaflet is now available in Gaelic, Ukrainian, Polish and Arabic versions and all are available to download from the website link above. These leaflets are regularly promoted and distributed throughout Argyll and Bute.

In 2024/2025, 5 Money Counts courses were delivered to 33 attendees.

Living Well grants

In 2024-2025, Argyll and Bute HSCP Public Health team administered £23,000 of grants focused on improving health and wellbeing in rural island communities through ‘connecting people to community activities.’ The aims of the grant programme were:

- Connecting people in communities to the right support.
- Raise awareness of support available within local communities.
- Developing community support for local health, wellbeing and social issues, using collective knowledge, skills or resources within the community.

This fund sought to build capacity within communities for social prescribing, which may often involve addressing child poverty through the same routes as Community Link Workers – i.e. linking people experiencing hardship to support available within both statutory and community services.

Welfare Advice and Health Partnerships

In April 2023, the Scottish Government made funding available to develop Welfare Advice and Health Partnerships (WAHP’s) in Argyll and Bute. WAHP’s provide access to money and welfare rights advice in health care settings. This is achieved

by embedding welfare advice specialists in healthcare settings through partnership working between local authorities, health boards and GP practices.

Welfare advice specialists provide an effective support service on all matters relating to welfare benefits and entitlements. The overall aim of the service is to ensure that the correct amount of benefit is paid at the correct time and to assist with budgeting skills so that households can pay their bills, heat their homes, and have a better quality of life.

WAHP's provide GP practices with welfare advice specialists who can support patients to improve their financial situation. This initiative aims to address financial insecurity for individuals who may not seek support from other means of welfare advice. Funding was allocated to Argyll and Bute Council for additional resource for welfare advice specialists, for a 2-year remote and rural pilot for five GP practices.

From the start of the initiative in April 2023 to March 2025 the service has had 181 referrals across the five GP practices. Of the patients referred to Welfare rights 47% clients were over 65 years of age and 84% clients had a health condition. The total financial gain from Welfare Rights Intervention for this period was **£693,190.** The initiative has recently been extended for a further year from 01/04/2025 - 31/03/2026.

The pilot has been evaluated on behalf of the Scottish Ministers by the Improvement Service in collaboration with the Scottish Public Health Network. **Welfare and Health Partnerships 'Test and Learn' Programme Evaluation**

2. Young Carers

Throughout Argyll & Bute Young Carers are supported in their caring roles to access Young Carer Support from a range of commissioned third sector services; Crossroads Caring for Carers Cowal & Bute, Helensburgh & Lomond Carers Centre, Mid Argyll Youth Development Services (MAYDS) and North Argyll Carers Centre. These supports ensure that Young Carers are able to access Young Carers Statements, developing an action plan of support to meet individual need. Carers Centres and MAYDS can often be in the position to support Young Carers and their families to assist in times of financial need, for example with access to Benefit Advice, AliEnergy, additional funding, Young Scot's Young Carers Package, Young Carer Grant and referrals and signposting to a range of organisations.
With systems in place, Young Carers are known to our education colleagues, who in turn can ensure referrals and access to Young Carer support, working closely with the services listed above. Providing space and time for Young Carer Support Workers to visit the schools, provide drop in's, one to one sessions and attend community events in support of Young Carers.

Young Carers in Argyll & Bute have been active participants in Argyll & Bute's Children's Rights illustration, Child Poverty illustration, Youth Voice and in producing a Young Carers and Children's Rights in Argyll & Bute animation.
Working with colleagues we are able to ensure that appropriate and accessible information is shared with Young Carers and their families, such as access to the Argyll & Bute Unpaid Carers Consultation, opportunities for Young Carers as well as Benefit advice, Young Carers Action Day, Carers Week and Carers Rights.

3. Working with Refugees in Argyll and Bute

The Council's Resettlement Team works in partnership with other organisations through the Refugee Programme. Work began in 2015 and began with Syrian resettlement, a UK wide scheme whereby local authorities provided accommodation and support. In Argyll and Bute Syrian families and individuals were found homes on the island of Bute and organisations worked together to provide multi-agency, person centred support. This programme continues today and now includes other nationalities; it has proven highly successful, winning a number of awards, including COSLA Excellence Awards and is seen as a benchmark resettlement programme.

Work with Ukrainian families is different as it is community based but still resettlement led. Support remains multi-agency and person centred. Some 300 plus Ukrainian citizens have been welcomed to Argyll and Bute.

The Council's Resettlement Team provide support for Ukrainians and this has included:

- Housing;
- Interpreters;
- English Lessons;
- Employability support;
- Benefits and Grants;
- Physical and mental health supports and counselling.

Outcomes for people placed across Argyll and Bute are good and provision provided is a notable example of effective multi-agency partnership working.

Since the start of 2024, Afghan families have been resettled in Helensburgh through the Afghan Resettlement Programme. All those who are resettled through ARP scheme benefit from full rights and entitlements through Indefinite Leave to Remain, providing them with the certainty and stability they need to rebuild their life here. The local authority receives integration tariffs over 3 years to provide ongoing integration support. As per all resettlement schemes, support is person centred and multi-agency.

In autumn of 2023 we also reviewed our programme of support for unaccompanied asylum-seeking children and young people (UASC). These young people have made their way to the UK without parents or guardians and are seeking refugee status from the Home Office. Our new programme of support sees Resettlement and Social Work working together very closely to provide the best possible support for our young people.

4. Pre-loved School Uniform Project

The two-year funded pre-loved school uniform project has come to an end.
The project was set up to focus on the reuse of good quality preloved school uniform and the recycling of uniforms that are no longer fit for purpose. Working with schools, community groups, and parent councils across all seven of our main settlements to support Eco-friendly reuse school uniform schemes that cover school uniform for Early Learning Centres, Nurseries Primary and Secondary Schools linked to each school cluster. We investigated, supported and promoted the taking donations of uniform from parents and pupils, ways to launder them and methods of redistributing them as and when they are required.

The project has achieved many of the goals we envisaged and many more that developed during the project in a positive and meaningful way. It also highlighted that more work is needed to keep this momentum moving forward. Much of the work and schemes that are now running will continue into the future, but the work has shown that with a little support and encouragement much more could be achieved.

Here is a link to a Council web page that will give you details of the project report. School uniform scheme | Argyll and Bute Council

5. Schools Share and Recycle

- Rothesay Academy have a school “shop” where pupils can access not just school uniform items but also Christmas jumpers so that they can be used again, and everyone take part in Christmas jumper events. They also have a “shop” where pupils can access formal wear for the school’s Christmas Dance – the biggest event in the school year that replaces a Prom.

- Gigha Primary school have a community fridge, which they keep fully stocked with fresh items of food. They have been very surprised at the uptake and need to restock very regularly.
- Dalmally Primary School are actively involved with the charity Mary’s Meals – founded in Dalmally. Pupils fundraise and raise awareness. Most of our schools have a Uniform Bank where pupils can access pre-owned items of school uniform. Some extend this to items such as socks and tights.

- Quote from RRSA Silver report for Garelochhead Primary: Children spoke confidently about their involvement and opportunities to participate in many school groups such as House Teams and Garelochhead Guardians. Parents spoke of how proud their children were to belong to these groups. Pupils, staff and parents spoke of the Uniform Swap Shop, with children learning that not everything needs to be bought new. One parent commented, “As a parent, I find that really helpful.”

6. Street Connect

Street Connect is a charity that began in Glasgow in 2013. In Argyll and Bute, it is currently working in Dunoon and hopes to extend its activities to Rothsay shortly. It aims to support individuals struggling with addiction and associated issues such as homelessness and poor mental health. In Dunoon it hands out leaflets and runs a drop in café. On Tuesdays it offers a Support Group and can provide some one-to-one support if needed. People can self-refer, and the charity also receives referrals from churches, professionals and prison welfare.

E. Other Planned Work

Establishing a Dedicated Poverty Prevention Service

Work is currently going on looking to establish a dedicated, multi-skilled Poverty Prevention Team within Argyll and Bute Council to coordinate and deliver early intervention strategies aimed at mitigating poverty across the local authority area. The team will provide a strategic, long-term approach to reducing reliance on crisis services and improving life outcomes for residents, building financial resilience and family prosperity. It will look to:

- Bring departments and roles together to create a unified strategic framework.
- Coordinate funds and try to avoid short term, fragmented funding on key areas increasing impact and sustainability.
- Avoid duplication, missed opportunities for early intervention and achieve savings.

Key Elements of this change will be:

- Core multi-skilled team: Including expertise in welfare rights, housing support, employability, education, and community engagement.
- Dedicated budget: Reducing reliance on short-term grants and ensuring service sustainability.
- Coordinated strategy: Unifying current efforts and aligning with local and national priorities.
- Integrated data use: Identifying at-risk households early and enabling targeted, effective intervention.
- Partnership governance: Involving key stakeholders in health, education, social care, housing, and the third sector.

Alignment with National and Local Priorities

This proposal supports key local and national priorities, including:

- **Argyll and Bute Economic Strategy and Action Plan**
  – “People” (p.10) and “Prosperity” (p.22): Focusing on inclusive growth and wellbeing.
- **Community Wealth Building (CWB):**
  Aligns with the principles promoted by CLES and supports anticipated duties under the CWB Bill.
- **Argyll and Bute Climate Action Strategy**
  – Contributes to climate justice through fairer access to energy support, transport, and sustainable food systems (p.29).
- **Scottish Government’s Child Poverty Delivery Plan and Public Health Priorities:**
  Proactive, partnership-based work to prevent poverty and reduce health inequalities

F. References

Seven Children; Inequality and Britain’s Next Generation; Danny Dorling, Hurst & Company, London, 2024. (1)

UK Poverty 2025 The essential guide to understanding poverty in the UK. Joseph Rowntree Foundation. (2)

Joseph Rowntree Foundation (2025) UK Poverty 2025. (3)

The cost of remoteness: Reflecting higher living costs in remote rural Scotland when measuring fuel poverty 2023 update; Report produced on behalf of the Scottish

Government by the Centre for Research in Social Policy Loughborough University. March 2025. (4)

Improving our understanding of child poverty in rural and island Scotland Jayne Glass and Jane Atterton Rural Policy Centre, Scotland's Rural College; SRUC, Scot Gov. 2022. (5)

Child Poverty; Children and young people's health and wellbeing profiles: supplementary report, PHS / NHS Highland, Publication date: 22 July 2024 (6)

Accredited official statistics. Family Resources Survey: financial year 2023 to 2024. Gov.UK; Published 27 March 2025 (7)

Mental Health Foundation (8)

Action For Children (9)

Treanor et al 2023; The indivisibility of Parental and Child Mental Health and Why Poverty Matters. Journal of Adolescent Health 73 (3). (10)