NHS Highland
na Gàidhealtachd

NHS Highland Annual Report & Accounts 2025/26











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Introduction

This report contains information that Highland Health Board (Known as NHS Highland) is required to formally report each year. It gives a financial overview of Highland Health Board for the period 1st April 2025 to 31st March 2026. It includes the consolidation of the Endowment Funds and Integration Joint Board (IJB). The report contains:

1. Performance Overview
2. Performance Analysis (including Sustainability and Environmental Reporting)
3. Accountability Report
4. Independent Auditor's Report
5. Financial Statements
6. Directions by the Scottish Ministers

The Annual Accounts including the above reports were adopted and approved by the full meeting of the Highland Health Board on the 23rd June 2026.

This report is available to download from our website or alternatively a copy can be obtained by contacting the Communications department.

1. Performance Overview



This overview summarises the key issues faced by NHS Highland in 2025/26, provides a broad description of the Board and its governance, looks at performance in the year towards the achievement of operational targets and looks ahead to the priorities to be addressed in 2026/27.

Chair's Statement

A Year of Stabilisation and Readiness
2025/26 has been a year in which NHS Highland has found its footing: stabilising finances, sustaining performance improvements, and laying the groundwork for a population health-centred future. As Chair, I am proud to present this Annual Report and reflect on what our staff, partners, and communities have achieved together.

Financial Grip and Organisational Resilience
Financial sustainability has been one of the Board's most pressing concerns, and 2025/26 has seen a genuine strengthening of our financial management. The organisation has developed a stronger grip improving forecasting, managing resources more effectively, and demonstrating the discipline essential to long-term sustainability. This has ultimately been a collective effort: executive leadership and Board scrutiny provided the framework, but it is the staff and services across NHS Highland who delivered the change through service redesign and careful stewardship of resources. I want to acknowledge everyone who contributed.

Sustained Performance Improvement
Alongside financial control, 2025/26 has seen some of the most significant performance improvements in NHS Highland's recent history. Most notably, the number of patients waiting over a year for a new outpatient appointment fell by almost 80% over the past 12 months, a result that reflects the determination of our clinical and operational teams and gives the Board real confidence in the organisation's capacity to improve.



Orthopaedic staff at NHS Highland.

Strategy, Population Health, and Our Role as an Anchor Organisation
The most significant development of 2025/26 has been initiating work on NHS Highland's new organisational strategy, an opportunity to articulate a clear vision for serving the people of Highland and Argyll & Bute for years to come. Central to this is the establishment of our Population Health Planning Committee, ensuring strategic decisions are rooted in deep community understanding.

As one of the region's largest employers, NHS Highland takes its anchor responsibilities seriously. We are an accredited Real Living Wage employer and remain committed to increasing the proportion of our core spend that goes to local suppliers, supporting the resilience of small businesses across Highland and Argyll & Bute. Through our partnership with Highland and Argyll & Bute councils, we are developing NHS career pathways for young people in deprived areas and delivering Money Counts training across our workforce. This year, our partnership with Highland Council on the transfer of Moss Park Care Home into joint management, which prevented market failure and protected residents' continuity of care, illustrated the impact of anchor collaboration.

> As we move into 2026/27, NHS Highland does so with a clearer sense of direction, a stronger financial foundation, and a workforce that continues to deliver outstanding care in some of the most demanding circumstances in Scotland.



Our People and Culture
In 2025/26 we launched three new three-year Workforce Strategies covering Employability, Health & Wellbeing, and Equality, Diversity & Inclusion alongside Equality Outcomes for 2025–2029: a strategic commitment to NHS Highland being a great place to work where staff are supported, heard, and able to progress.

On equality and inclusion, we commenced Equally Safe at Work developmental accreditation and retained our Armed Forces Covenant Gold Award, Disability Confident, and Carer Positive status. The launch of OpenLine, our speak up service, reinforces our commitment to a culture where staff feel safe to raise concerns.



A therapist speaking at a patient information session.

Over the past year, both the Board and our executive team have prioritised visible connection with colleagues. As Chair, I have visited services across our geography, hearing first-hand from staff about their work and the care they deliver. Fiona has regularly connected with colleagues visiting hospitals, care homes, and community teams around the board area to hear directly from staff. This visible leadership at every level builds trust and demonstrates to our people that they are seen and valued.

Sustainability
The Board is committed to NHS Highland playing its part in addressing the climate emergency. This year has seen tangible progress, reflected in our Climate Emergency and Sustainability Action Report. As a signatory to the Highland Charter for Climate, Nature and Health, we have committed to placing climate, nature, and green and blue health at the centre of our decision-making recognising that the health of our environment and our communities are inseparable.

Board and Governance
Good governance is the foundation upon which everything else rests. This year the Board continued to develop its effectiveness and strengthen decision-making. We appointed a Head of Corporate Governance to provide dedicated leadership in this area.

We said farewell to Ann Clark, Alasdair Christie, Dr Tim Allison, Pam Stott, and Elspeth Caithness and Catriona Sinclair, whose valued contributions to NHS Highland are warmly acknowledged, and welcomed Dr Neil Wright, Brian Steven, Graham Illsley, Gavin Smith, Jennifer Davies, Arlene Johnstone, and Allyson Turnbull-Jukes. Our new members bring professional expertise, clinical knowledge, and local understanding reflecting the diversity of communities across our geography. The collaborative relationship between the Board and our executive team grounded in mutual trust has been central to the progress this report describes.

Looking Ahead
As we move into 2026/27, NHS Highland does so with a clearer sense of direction, a stronger financial foundation, and a workforce that continues to deliver outstanding care in some of the most demanding circumstances in Scotland. There is more to do, but I believe we are better placed than we have been for some time to meet it and I want to thank every member of staff for their commitment, compassion, and professionalism.

Sarah Compton-Bishop
Chair

Chief Executive's Statement

> 2025/26 has demonstrated what this organisation is capable of when focused leadership, committed staff, and effective partnerships come together.



A Year of Progress
This has been a year of real and meaningful progress. Across NHS Highland, our teams have continued to plan and deliver care in one of Scotland's most geographically complex health board areas, doing so against a backdrop of growing demand, ongoing financial sustainability considerations, and the commitment that is required to deliver change while maintaining services. The dedication of our staff, day in and day out, is something I want to acknowledge at the outset of this report. It does not go unnoticed, and it is the foundation upon which every improvement described here has been built.

Planned Care
This year has seen substantial progress in planned care. In April 2025, over 5,000 patients were waiting more than a year for their first new outpatient appointment. By 31 March 2026, that figure had fallen to 1,051, a reduction of almost 80% over 12 months. For patients waiting over a year for treatment, the picture is equally striking: from just under 1,000 in April 2025 to 105 by the end of March 2026.

Behind these numbers is an enormous volume of clinical activity over 73,000 new outpatient appointments and more than 21,000 treatments under the Treatment Time Guarantee. This represents thousands of individual patients whose lives have been improved by receiving the care they needed. Progress reflects sustained effort from clinical and operational teams alongside innovation in how we use capacity, including clinical validation, straight-to-test pathways, and targeted recovery plans in areas such as Ophthalmology and Gastroenterology where work continues.



MSK Day, is a Community Appointment Day that took place in Fort William, at Lochaber High School in November 2025.

In Psychological Therapies, performance rose from 87.9% in October 2025 to 93.1% by December, bringing NHS Highland above the national 90% standard.

CAMHS Improvement
During 2025/26 significant transformation has been achieved within our Child and Adolescent Mental Health Services. CAMHS in NHS Highland has faced serious and sustained challenges, with children and young people waiting too long to access the care they needed. Addressing this became a clear priority, and our teams responded with determination.

In December 2024, the Scottish Government set a stretching expectation: that NHS Highland would achieve 90% of patients commencing treatment within 18 weeks by December 2025. Our teams met that challenge and exceeded it. CAMHS achieved 96.7% compliance in December 2025, surpassing the national target and national average of 90.7%, and improved further to 100% compliance in January 2026.

Critically, this was achieved alongside a significant reduction in the overall waiting list, demonstrating that improvement was patient-centred. Behind this milestone is a comprehensive programme of change: revised clinical pathways, the introduction of Early Engagement Appointments, and a sustained focus on workforce stability. This marks a turning point for the service and for the children and young people it supports.

Integrated Care in Action
NHS Highland has long understood that the health and wellbeing of our population cannot be delivered by the NHS alone, and this year has seen that principle translate into tangible results. Our Musculoskeletal (MSK) Community Appointment Days exemplify what integrated care can achieve. Building on the success of an inaugural event in Inverness in February 2025, we brought the model to Fort William in November 2025, expanding its reach to include not only MSK patients but those awaiting chronic pain and falls prevention services. Over 350 people attended, the physiotherapy waiting list fell from eight months to seven weeks, patient satisfaction reached 4.86 out of 5, and 42% of attendees reported being able to self-manage their condition following the event.

The Inverness event demonstrated the model's potential, waiting times reduced from 60 weeks to eight, with 370 patients accessing NHS and third sector services in a single visit. Fort William built on that foundation to deliver whole-person, community-centred care closer to home.

This spirit of integration shapes our strategic partnerships too. Since the introduction of the Lead Agency model with Highland Council, we have learned a great deal about where integration has worked well and what has limited our ability to deliver the seamless, person-centred services our communities deserve. That honest reflection has created an important opportunity to examine whether the current model remains the right vehicle for delivering better outcomes, or whether a Body Corporate approach, bringing adult and children's social care together within a unified structure, could more fully realise the ambitions we share for the people of Highland.

Working jointly with Highland Council, we are now entering a period of staff and community engagement that will shape that decision. We welcome that conversation, particularly given what it could mean for people in rural and remote areas where joined-up services matter most. In Argyll and Bute, NHS Highland is an active partner in the Scottish Government's Single Authority Model programme, with national guidance and local engagement shaping what an effective new model might look like for that geography.

Looking Forward
As we move into 2026/27, NHS Highland does so with a clearer sense of direction. Work is underway on a new organisational strategy that will succeed Together We Care, due for completion in the second half of 2026/27. Central to that strategy will be our commitment to addressing health inequalities and taking a proactive lead on the health of our whole population, ensuring that improvement reaches those who need it most.

2025/26 has demonstrated what this organisation is capable of when focused leadership, committed staff, and effective partnerships come together. I also want to extend my sincere thanks to our community planning partners, as well as Highland Council and Argyll and Bute Council, whose unwavering commitment to collaboration has been essential to this year's progress. Together, we will continue to develop services that are smarter, more integrated, and better able to meet the needs of the communities we all serve.

Fiona Davies
Chief Executive

Fiona Davies

About NHS Highland

NHS Highland is one of 14 territorial health boards in Scotland, and one of the most distinctive. We serve a population of more than 320,000 people across the Highland and Argyll and Bute council areas, a geography that covers 42% of Scotland's entire landmass, stretching from the outskirts of Inverness to 36 inhabited islands, and from vibrant coastal communities to some of the most remote landscapes in the United Kingdom.

Ours is a place of real contrasts. Inverness is one of the fastest-growing cities in Western Europe. Our islands and rural communities are among the most beautiful and proudly self-sufficient in Scotland. Gaelic is spoken across parts of our region, and it shapes the identity of many of the people we serve. This is also an area where people face real challenges, from fuel poverty and the rising cost of living to complex transport pressures and an older-than-average population with increasingly complex health and care needs.

More than 10,700 people work within NHS Highland, including colleagues in Argyll & Bute Health and Social Care Partnership (HSCP) and that figure does not capture the many local authority staff and partner organisation colleagues without whom our services simply could not function. Together, we deliver care across four acute sites, 17 community hospitals, and a wide network of community settings and care homes.

We are unique among Scottish territorial boards in holding lead agency responsibility for adult social care in the Highland Council area, a model that places the full continuum of health and social care under one roof. In Argyll and Bute, we work within an Integration Joint Board alongside our council partners.

We are proud of the communities we serve, and they are proud of their place. Our ambition reflected throughout this report is to work alongside those communities to find new ways of delivering health and care as close to people's homes as possible, and to build a system that is as resilient, connected and compassionate as the region it serves.

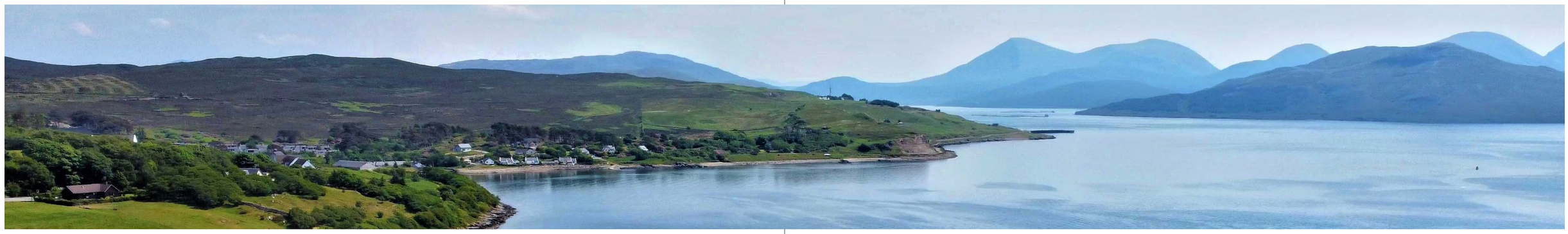
Mu NHS na Gàidhealtachd

'S e aon de 14 bòrd slàinte sgìreil ann an Alba a th' ann an NHS na Gàidhealtachd. Tha sinn a' frithealadh sluagh de chòrr is 320,000 neach air feadh sgìrean coimhairle na Gàidhealtachd agus Earra-Ghàidheal is Bhòid, sgìrean a tha a' còmhdachadh 42% de fhearann na h-Alba, a' sìneadh bho iomall Inbhir Nis gu 36 eileanan falamh agus bho choimhearsnachdan beòthail cladaich gu cuid de na cruthantìre as iomallaiche san Rìoghachd Aonaichte.

'S e àite làn eadar-dhealachaidhean a th' againn. 'S e Inbhir Nis aon de na bailtean as luaithe gus fàs ann n taobh an iar na Roinn Eòrpa. Tha na heileanan agus na coimhearsnachdan dùthchail againn am measg feadhainn as brèagha agus as fè in-sheasmhach ann an Alba. Tha a' Ghàidhlig ga bruidhinn air feadh iomadh pàirt den roinn againn, agus tha i a' cumadh dearbh-aithne mòran de na daoine air am beil sinn a' frithealadh. 'Se cuideachd sgìre a th' innte far am beil dùbhlain mhòra romh dhaoine, bho bhochdainn connaidh agus cosgaisean beatha ag èirigh gu cuideaman còmhdhail iomallach agus sluagh nas sine na a' chuibheasachd le feumalachdan slàinte is cùraim a tha a' sìor fhàs iom-fhillte.

Tha còrr is 10,700 neach ag oabir taobh a-staigh NHS na Gàidhealtachd, nam measg coobraicheanann an Com-pàirteachas Slàinte Earra-Ghàidheal is Bhòid (HSCP) agus chan eil an àireamh sin a' gabhail a-steach an iomadh neachobrach aig ùghdarrasan ionadail agus co-obraichean bho bhuidhnean compàirteach às an aonais cha b' urrainn dha na seirbheisean againn obrachadh idir. Còmhla, bidh sinn a' lìbhrigeadh cùram thar ceithir làraichean gèire, 17 ospadalan coimhearsnachd, agus lìonra farsain de shuidheachaidhean coimhearsnachd agus t aighean-cùraim.

Tha sinn gun samhail am measg bhùird sgìreil na h-Alba a thaobh a bhith a' cumail uallach prìomh bhuidhinn airson cùram sòisealta inbheach ann an sgìre Chomhairle na Gàidhealtachd, modail a chuireas làn shreth de shlàinte is cùram sòisealta fo aon mhullach. Ann an Earra-Ghàidheal agus Bòd, bidh sinn ag obair taobh a-staigh Bòrd Coaonaidh còmhla ri ar com-pàirtichean comhairle. Tha sinn moiteil às na coimhearsnachdan a tha sinn a' frithealadh, agus tha iadsan moiteil às an àite aca.
'S e ar n-amas, a chithear tron aithisg seo,a bhith ag obair còmhla ris na coimhearsnachdan sin gus dòighean ùra a lorg airson slàinte is cùram a lìbhrigeadh cho faisg air dachaighean dhaoine 's a ghabhas, agus siostam a thogail a tha cho seasmhach, ceangailte agus coibhneil ris an roinn a t ha sinn a' frithealadh.



An aerial view from Raasay looking towards the Cuillins of Skye.

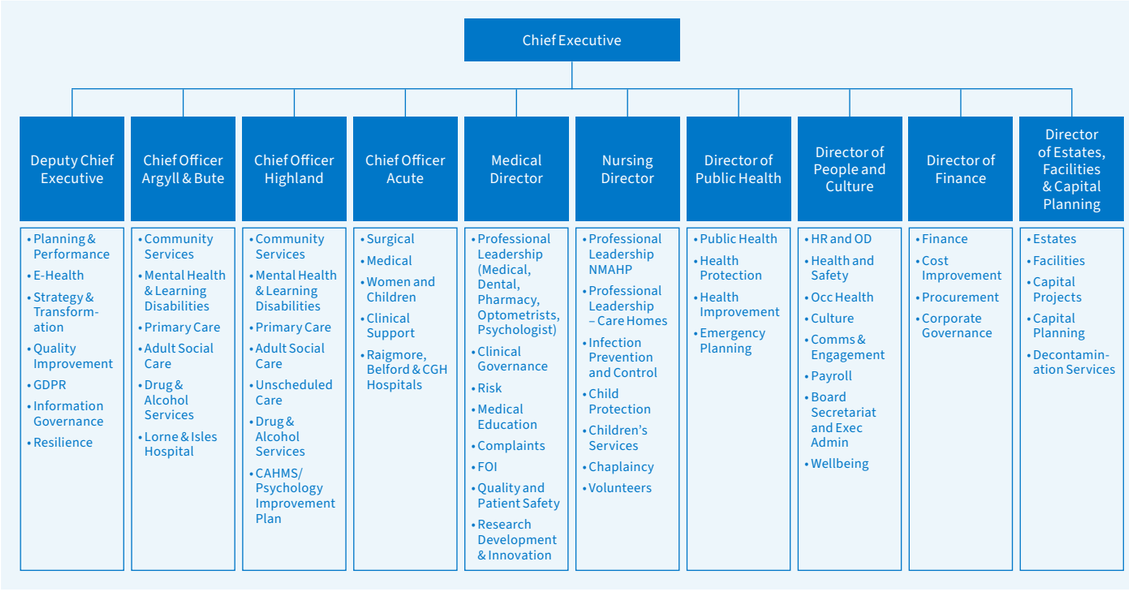
Structure and Governance Arrangements

NHS Highland is managed by a Board of 23 members, made up of 18 Non-Executive and five Executive Directors who are accountable to the Scottish Government through the Cabinet Secretary for Health and Social Care. The Executive Directors who are also board members are the Chief Executive, Board Medical Director, Director of Finance, Board Nurse Director, and Director of Public Health.

The Board is primarily responsible and accountable for setting the strategic direction, holding executives to account for delivery, managing risk, engaging with stakeholders, and influencing organisational culture. The Core Governance Committees are: Clinical Governance, Staff Governance, Finance, Resources and Performance, Population Health and Planning Committee, Highland Health and Social Care, and Audit Committees. These Committees are responsible for regularly reviewing and updating relevant policies in each of their areas of responsibility on behalf of the Board. Responsibilities for Health and Safety are reported directly to the Staff Governance Committee. The Remuneration Committee and Pharmacy Practices Committee also have a direct reporting link to the Board and perform a more focussed assurance role. The Board membership also includes representation from the Area Clinical Forum and the Area Partnership Forum. Board meetings are held every two months. Meetings continue to be held virtually, with members of the public able to attend online and a recording posted online afterwards.

The Board area extends over two Local Authority areas: Highland and Argyll & Bute. Operationally, activities are managed by the Highland Health and Social Care Partnership (coterminous with The Highland Council area) and Argyll & Bute Health and Social Care Partnership (coterminous with Argyll & Bute Council area).

The organisational structure promotes cross-service working and allows for an overview of services across the whole of the NHS Highland area, to better manage the impacts of changes across the system.



2. Performance Analysis

This section examines NHS Highland's performance in 2025/26 across our key service areas, from planned and urgent care to mental health, public health and financial management. It also sets out our priorities for 2026/27 and reports on sustainability, our charity, and capital investment.

Priorities, Approach and Objectives for 2025/26

The priorities for 2025/26 for NHS Highland remained in the continued delivery of the Together We Care strategy through the delivery of objectives captured as part of the board's Annual Delivery Plan.

The Together We Care strategy under each "Well" theme describes the high-level objectives to deliver for NHS Highland's people and population. Under each Well theme, a set of deliverables were agreed for 2026/27 and monitored through the NHS Highland Board.

This approach was complimented by a focus on NHS Scotland's Operational Improvement Plan (OIP). The OIP delivered a set of 20 deliverables which focused on key areas of service development and change required by 31st March 2026 across all of Scotland's boards.

NHS Highland prioritised the delivery of the OIP deliverables throughout 2025/26 to meet the following high-level objectives:

During 2025/26, there was a focus on reducing the number of people waiting over 52 weeks for new outpatient and treatment appointments. Funded by Scottish Government, additional activity was delivered throughout the year to significantly reduce the numbers waiting for this in Highland, from 5,000 waiting over > 52 weeks for New Outpatients in April 2025, to just over 1,000 by end of March 2026. For those awaiting treatment covered by the Treatment Time Guarantee over 52 weeks, this reduced from nearly 1,000 patients in April 2025 to just over 100 by end of March 2026.

Improving access to treatment

OIP area	Indicator	2025/26 result	Direction of travel
Reduce number of patients waiting over a year for appointment or treatment	New outpatients > 52 weeks	April 2025 = 5,143 March 2026 = 1,051	Met trajectory
	Treatment time guarantee > 52 weeks	April 2025 = 925 March 2026 = 105	Met trajectory
Increase percentage of people receiving imaging or endoscopy test within 18 weeks	Percentage of imaging/ endoscopy test within 18 weeks of referral	2024/25 = 58.8% 2025/26 = 76.5%	Improving performance towards short-term 80% target
Reduce waiting times for CAMHS	Percentage of CAMHS patients starting treatment within 18 weeks of referral	March 2025 = 79.5% March 2026 = 100%	Consistent performance improvement – target met in 3 out of the last 4 months in 2025/26
Improve cancer waiting times	Percentage of patients receiving first treatment within 62 days of referral for Urgent Suspect Cancer	2024/25 = 69.9% 2025/26 = 67.3%	Improvement trajectory to March 2026 not met

Part of the investment was to ensure additional diagnostic capacity to meet the requirements to maintain the levels of diagnostic investigation for new outpatients. Throughout 2025/26, this additional funding supported NHS Highland to improve performance for both radiology and endoscopy investigations undertaken, increasing both the volume and the percentage of people receiving this investigation within 12 weeks of referral.

Another part of this plan was to ensure that 90% of children referred to our CAMHS service receiving treatment within 12 weeks of referral. NHS Highland was set a target to achieve 90% by December 2025 – this was achieved. Performance monitoring continues to ensure this improvement is sustained.

Furthermore, this part of the OIP included an aspiration to improve 62-day Cancer Waiting Times. A performance trajectory was agreed with NHS Highland to achieve 80% by end of March 2026. However, due to challenges related to our workforce for Breast Cancer service, this performance trajectory was not achieved in 2026, despite earlier progress to improve our performance throughout the year. This is subject to a renewed action plan.

You can read more about the Treat Well indicators on pages 21 to 23.

Shifting the balance of care
The OIP included aspirations to shift the balance of care from Acute to Community based services. During 2025/26, this was a focus of NHS Highland's Urgent and Unscheduled Care Transformation Portfolio with a renewed approach to this area.

The OIP included 7 deliverables for NHS Highland aligned to the NHS Scotland plan:

- 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.
- 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.
- 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.
- Hospital at Home services will be progressed, starting with Inverness in 2025/26 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.
- 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.
- 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.
- 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.

As at the end of March 2026, while there has been significant progress towards meeting the deliverables, the impact to shifting the balance of care remains variable, demonstrated through the persistent high number of people impacted by Delayed Discharge, and the variable Emergency Department performance, including the number of people waiting over 12 hours.

These deliverables will remain a focus for 2026/27 in seeking to shift the balance of care and deliver the intended improvements as a result of these priorities.

Priorities, Approach and Objectives for 2025/26 *cont.*

Improving access to health and social care services through digital and technological innovation
NHS Highland has a developed Digital Delivery Plan for the year which outlines the priorities that support digital and technological innovation across the board. For 2025/26, the items in the OIP were a focus of delivery for those areas within our gift.

The biggest of these includes the scoping of our interface to the Digital Front Door application that is being progressed across NHS Scotland as a priority for patient access to certain health and care information. Our planning activities included engagement with the national programme on our readiness to adopt the technical solution, and managing communications in relation to the planned go-live of the first phase of the application in April 2026.

Further areas of digital innovation include the use of a theatre scheduled tool for which NHS Highland has been at the forefront. The integration of our first two specialities into the tool has allowed us to monitor effective use of our theatres, and further specialities are planned to come online in future years.

The roll-out of Digital Dermatology and Community Glaucoma Services digital tools to help manage the interface between acute and community services are exiting developments that NHS Highland has been at the forefront of. The OIP deliverables were achieved with further developments planned to embed these services, providing tools for communication between primary and secondary care clinicians for these specific skin and ophthalmology pathways.

Prevention – working with people to prevent illness and more proactively meet their needs
The final section of the OIP has aligned in NHS Highland with the beginnings of development on our next organisational strategy to replace Together We Care. Early work has focussed on a population health approach to the planning and delivery of NHS services, and aligns with approaches to embed prevention in core services.

Early examples in 2025/26 included adoption of pathways in primary care that are focussed on pathway that plan for community support of frailty and cardiovascular disease pathways, and aim to prevent unnecessary hospital admissions. These early activities are tests of this approach to planning prevention activities to help manage the demand for health and care services, supporting people in the Highland to live healthy and fulfilling lives.

The prevention agenda aligns with the Scottish Government's Population Health Framework, to which OIP is aligned, along with the Service Renewal Framework. These three products have focussed the approach for NHS Highland in 2025/26, and with the development of our next operational strategy, this will be continue to be a focus in future years.

Principal Risks to Delivery of our Strategy and Annual Delivery Plan
NHS Highland faced significant risks in 2025/26 that were captured and reported through our governance channels. These largely relate to resources available in the health board to meet our strategy and delivery of our change and improvement plans, most notably focused around the financial context of the board and maintaining the workforce required to deliver on our key commitments.

Throughout 2025/26, our focus remained on the delivery of the OIP priorities and there was regular reporting through our committee structure to provide assurance upon delivery.

Risks relating to finance will remain a key challenge for NHS Highland as it seeks to transform services to meet the sustainability required.

In 2025/26, several opportunities emerged including the development of the Sub-National Planning structure which has aligned NHS Highland to boards within Scotland West (NHS Greater Glasgow and Clyde, NHS Forth Valley, NHS Lanarkshire, NHS Dumfries and Galloway, NHS Ayrshire & Arran, NHS Western Isles).

In this forum there have been early discussions around how NHS boards can work together to collaboratively plan services that meet the requirements for collective financial sustainability amongst boards in Scotland West within the next three years. While the detail of planning priorities has yet to emerge, NHS Highland is taking a risk-based approach to identifying the priority areas where financial, performance and workforce sustainability may be best achieved through a sub-national approach.

It is expected that Sub-National Planning will take on a greater focus in 2026/27 and help boards manage risks in relation to delivery of strategy and annual delivery plans.

Going Concern
The accounts are prepared on a going concern basis, which provides that the NHS Board will continue in operational existence for the foreseeable future. NHS Highland has not been informed by Scottish Ministers of the intention for dissolution without transfer of services or functions to another entity.

Key Metrics 2025/26

In order to meet the Together We Care strategy, NHS Highland continues to drive improvement through monitoring a suite of key performance metrics. This is primarily achieved through the Integrated Performance and Quality Report (IPQR) reviewed by the NHS Highland Board and sub-committees.

NHS Highland continues to deliver emergency and planned care to a population of 320,860 across a landmass that represents 42% of Scotland. NHS Highland's main acute hospital is Raigmore in Inverness, with three Rural General Hospitals located in Caithness, Lochaber and Oban.

There are also a number of community hospitals across both Highland and Argyll & Bute, with outpatient and treatments taking place across the whole geography, from Wick in the North, to Skye in the West, Nairn in the East, extending south to Fort William in Highland, to Campbeltown in Argyll & Bute. The activity in the graphic to the right (page 17) captures the headlines of activity that took place in 2025/26.

Throughout 2025/26, there were a number of services that have demonstrated clear improvement over the course of the year, most notably CAMHS and Planned Care services, while improvement was sustained in timely access to Psychological Therapies.

A key focus for NHS Highland was to reduce the number of people waiting over one year for a new outpatient or treatment appointment. Trajectories agreed with Scottish Government saw this fall from 5,143 waiting over 52 weeks for New Outpatients appointments (such as for clinical assessment or investigation) to 1,051.

While for those waiting for surgery or other inpatient procedure for over 52 weeks, this fell from 925 to 105. Both of these were ahead of trajectories agreed with Scottish Government and significant achievements of NHS Highland's clinical and operational teams.

In total NHS Highland delivered over 73,000 new outpatient appointments and taken together with ongoing appointments for scheduled care and long-term conditions, delivered a total of 482,777 appointments across delivery units in Highland and Argyll & Bute.

In total, there were also a total of 21,000 treatments, such as surgery and other procedures, subject to a Treatment Time Guarantee provided in NHS Highland, all delivered by specialist teams working to deliver the right care, in the right place, at the right time.

482,777

Number of Outpatients Appointments (New and Return) carried out between April 2025 and March 2026.



17,389

Number of people receiving surgery in NHS Highland.



75,369

Number of attendances managed through Accident & Emergency departments.



1,852

Number of babies born across Highland and Argyll & Bute.



58,582

Number of inpatient admissions to NHS Highlands hospitals.



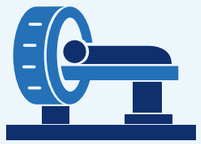
1,601

Number of cancers diagnosed in 2025/26.



68,022

Number of imaging and endoscopic tests carried out in NHS Highland in 2025/26.



42,770

Number of children and young people receiving health and care services in Highland and Argyll & Bute.



Chief Officer Acute Services Report

Improving Scheduled Care
This year we took decisive action to improve the efficiency and reliability of theatre services at Raigmore Hospital. Working with external improvement experts Meridian, we introduced a structured 6-4-2 planning model across all surgical specialties ensuring theatre sessions are staffed six weeks in advance, patients allocated four weeks out, and sessions confirmed two weeks before.

This has driven greater predictability, reduced late starts and early finishes, and created the conditions for more patients to be seen. A review of staffing across theatres and recovery areas has aligned rotas to evidenced requirements, improving utilisation.

The 18-week programme has enabled a move from eight to six operating theatres, generating financial savings that support NHS Highland's return to financial balance. We have seen a 16% improvement in theatre utilisation as a result of this work.

Transforming Urgent and Unscheduled Care
Demand on urgent and unscheduled care services has remained high throughout 2025/26. Our response has focused on improving front-door flow, reducing avoidable admissions, and building more proactive, person-centred pathways.

A major step forward has been the development of our Acute Frailty Assessment model. Clinical Frailty Scoring is now embedded across the Emergency Department and Acute Medical Unit, enabling earlier identification and more consistent delivery of Comprehensive Geriatric Assessment. A dedicated Frailty Multi-Disciplinary Team now operates five days per week, providing senior clinical input and coordinated care planning at the point of admission. Four designated beds within a new Frailty Assessment Area support short, intensive multidisciplinary intervention with a focus on discharge within 72 hours, improving patient flow and reducing length of stay.



Theatre staff at Raigmore Hospital.

SDEC (Same Day Emergency Care) has also expanded significantly, with more patients now managed through same-day pathways and a growing shift toward zero-day length of stay models. Plans are in place to increase direct access to SDEC, including across surgical and orthopaedic pathways.

Emergency Department waiting times and Scottish Ambulance Service turnaround remain challenging. Addressing these will require whole-system working: strengthening community alternatives to admission, improving patient handover, and continuing to develop the interface between acute, community and intermediate care services.

> "A consistent theme across this year's work has been the recognition that meaningful change in complex systems takes time, often six to twelve months from problem identification to visible impact. This understanding shapes how we will approach 2026/27.





A new arrival at the Raigmore Hospital maternity ward.

Stabilising Maternity Services
In December 2025, NHS Highland approved an increase of 7.04 WTE in Midwifery staffing at Raigmore following an evidence-based workforce review that identified increased clinical complexity within the Labour Suite. Carried out in line with the Health and Care (Staffing) (Scotland) Act, this investment has improved staffing stability, supported safer care delivery, and strengthened workforce resilience. A commissioned multidisciplinary maternity service review is now underway, with workforce options appraisal due by July 2026 and implementation commencing within 12 months.

CAMHS: A Milestone Achievement
In 2024, NHS Highland CAMHS faced a clear expectation from Scottish Government: achieve 90% compliance with the 18-week Referral to Treatment (RTT) target by December 2025. The service had been in Special Measures since 2018, as part of broader escalation relating to finance, culture and mental health performance.

Through sustained clinical and operational leadership, the service redesigned key pathways, developed its workforce, and introduced Early Engagement Appointments to improve access and flow. The result was transformational: CAMHS exceeded the national target, achieving 96% RTT compliance in December 2025 and rising to 100% in January 2026, alongside a significant reduction in the waiting list.

This landmark milestone demonstrates what NHS Highland can achieve for children and young people, even in the most challenging circumstances.

Looking Ahead
A consistent theme across this year's work has been the recognition that meaningful change in complex systems takes time, often six to twelve months from problem identification to visible impact. This understanding shapes how we will approach 2026/27.

Priorities include expanding frailty services toward a seven-day model, embedding digital solutions to improve data capture and performance oversight, and increasing SDEC utilisation. In maternity, we will implement the outcomes of the multidisciplinary review. In CAMHS, we will sustain the gains made and continue to develop the service.

Across all of these areas, progress will depend on greater clarity around strategic transformation priorities for NHS Highland ensuring that our acute services are well-shaped to meet current and future need, and that we are working effectively as part of a whole system.

Katherine Sutton
Chief Officer, Acute Services

Acute Sector Performance

The following performance areas fall within domain of Acute Services and cover a range of themes from our Together We Care strategy, including Treat Well and Journey Well. The strategic outcome of those priorities is to ensure that the people of Highlands can access scheduled care services in a time that meets the national standards.

Treat Well: Scheduled Care

Referrals to Acute Services

NHS Highland's acute services received **67,241 referrals in 2025/26,** representing people referred from Primary Care clinicians where further investigation into symptoms was required. This total increased fro the previous year but is above the three-year average.

Elective Admissions to Acute Services in 2025/26

NHS Highland received 20,950 elective admissions in 2025/26 – this was an increase from the previous two years due to an increase in the number of planned operations and treatments in the year, as part of our drive to reduce waiting lists, in particular for those who had been waiting longer than one year.

21,000 Planned Procedures/Surgeries

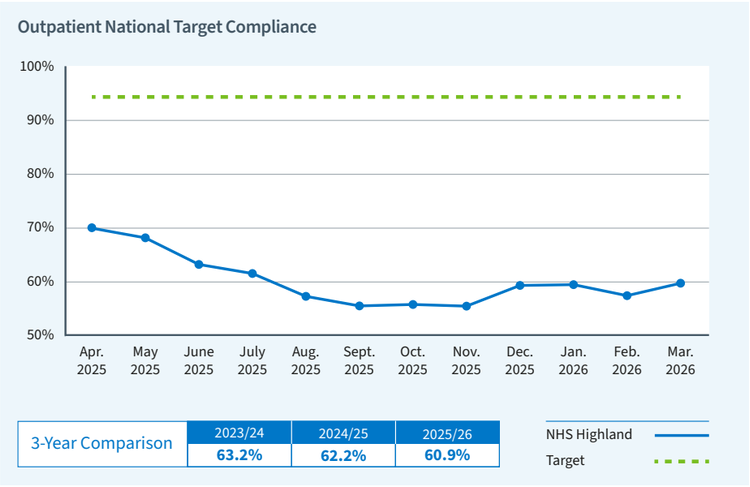
The number of inpatient procedures subject to the Treatment Time Guarantee carried out in 2025/26 – again targeting the longest waiting patients, with the number waiting over a year reducing from nearly 1,000 in April 2025, to just over 100 by March 2026.

73,000 New Outpatient Appointments

The number of New Outpatient Appointments delivered in 2025/26. This level of activity helped reduced the number of patients waiting over a year for a new outpatient appointment by 80%.

Figure 1: New Outpatients (>95% within 12 weeks of referral)

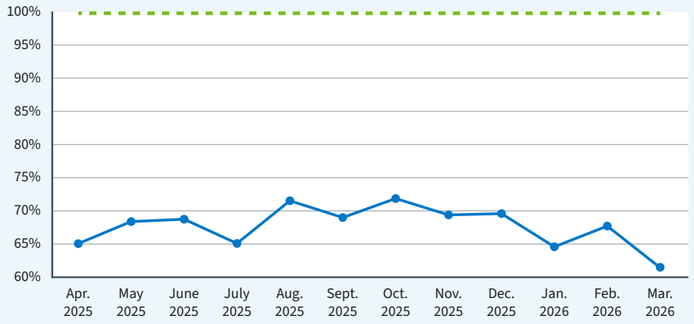
In 2025/26, NHS Highland delivered over 73,000 new outpatient appointments which included clinical assessments, diagnostics and other investigations supporting timely access to treatment pathways. As a result in this increase in activity, there was a decline in overall performance against this national standard.



Treat Well:
Scheduled Care *cont.*

Figure 2: Inpatient/Daycase (>95% within 12 weeks of referral)
NHS Highland delivered over 21,000 treatments in 2025/26, including over 17,000 operations subject to the Treatment Time Guarantee, and overall improved the performance seen in recent years.

Treatment Time Guarantee National Target Compliance



3-Year Comparison	2023/24	2024/25	2025/26
	56.1%	**57.6%**	**66.3%**

Figure 3: New outpatient waiting list > 52 weeks for appointment
NHS Highland cut the number of people waiting over a year for a new outpatient appointment by nearly 80% in 2025/26, from over 5,000 in April 2025, to just over 1,000 in March 2026

Outpatients: The number of patients waiting >52 weeks in NHS Highland against our agreed trajectory

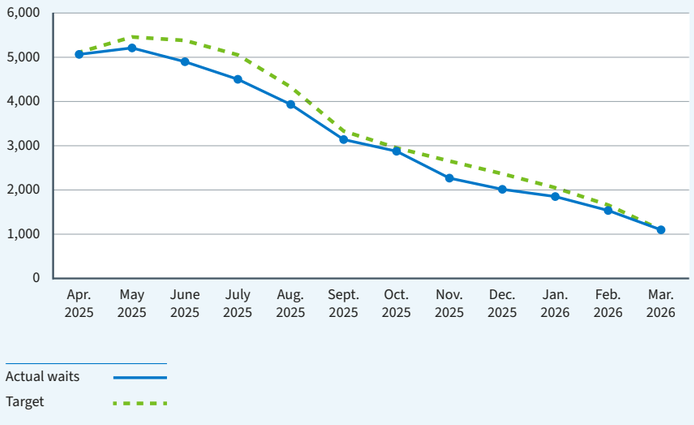
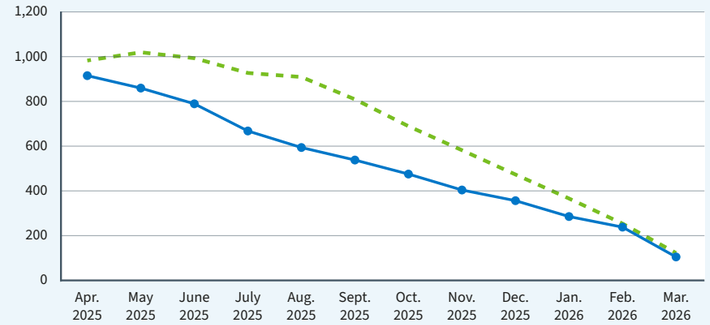


Figure 4: Inpatient/Daycase (TTG) waiting list > 52 weeks
NHS Highland reduced the number of patients waiting over a year for a planned treatment or operation. In April 2025, there were nearly 1,000 patients waiting over a year – this has been cut to just over 100 by March 2026, and below the trajectory agreed with Scottish Government.

TTG: The number of patients waiting >52 weeks in NHS Highland against our agreed trajectory



NHS Highland undertook over 73,000 outpatient appointments in 2025/26 including a focus on the longest waiting patients. This is on a backdrop of a total activity of 482,777 outpatient appointments across acute and community services (new and return outpatients).

As a result, the number of people awaiting a new outpatient appointment for more than one year reduced from over 5,143 in April 2025, to 1,051 by March 2026. This ensuring NHS Highland bettered the trajectory agreed with Scottish Government. Due to this focus, the overall percentage of new outpatients seen > 12 weeks from referral reduced throughout 2025/26.

NHS Highland undertook over 17,000 scheduled surgeries subject to the Treatment Time Guarantee in 2026/27. A focus on ensuring those who have been waiting the longest resulted in those waiting > 52 weeks reducing from 925 in April 2025, to 105 by March 2026 in a small number of specialty areas.

This ensured NHS Highland bettered the trajectory agreed with Scottish Government. Overall, this impacted the overall performance with NHS Highland seeing an average of 66% of patients on a TTG waiting list within 12 weeks – a significant increase on previous years.

Journey Well:
Cancer & Diagnostics Performance

NHS Highland continues to focus its diagnosis and treatment pathways in clinical priority, with cancer services forming a large part of our scheduled care services.

In 2025/26, there were an average of 800 referrals per month for secondary care investigation where cancer is suspected as per the nationally-agreed referral guidelines. This compares similarly to previous years in NHS Highland and national trends.

Performance for cancer pathways is measured through national standards from referral to treatment (62-day pathway) and diagnosis to treatment (31-day pathway).

As with all mainland cancer centres, there continues to be challenges in the delivery of the 62-day pathway. This largely relates to the diagnostic end of the pathway, and the requirement for clinical assessment within timescales to meet the 62-day standard.

NHS Highland's cancer services track and manage patients at risk of breaching this pathway, and seek an expedition of pathways to meet the standard. In some cases this is not possible due the demand on services, and the workforce available.

Improvements are being focused on high-volume pathways including Breast Cancer and Colorectal Cancer, particularly in relation to the diagnostic part of the pathway.

The 31-day cancer standard measures the time to treatment from diagnosis of cancer, with a target each month of 95%. For 2025/26, NHS Highland performance remains below the standard and reflects challenges within our Breast Cancer pathways relating to vacancy amongst key clinical positions. Recruitment plans are progressing and collaborative work with other health boards to support an improvement in this pathway. Breast Cancer represents 25% of the patients treated under this standard, while the standard is largely met for other tumor groups.

The 62-day cancer standard measures the time to USC (Urgent Suspected Cancer) referral to treatment, with a target each month of 95%. NHS Highland performance is subject to engagement with NHS Scotland Centre for Sustainable Delivery, supporting an improvement plan in this area since August 2025.

There were a number of pathway refinements throughout the year and operational arrangements to manage the flow of patients through diagnostics and treatment, however the 95% standard was not met, and the improvement trajectory to 80% by March 2026 was not met, despite some progress through the year.

This is again related to challenges in the Breast Cancer pathway, relating o the capacity for diagnostic investigations required for symptomatic and screening patients, and the availability of workforce to meet the demands for this pathway. This is subject to an action plan to deliver the required staffing to meet the demands for referrals.

There are also limitations in the capacity for treatment, particularly surgery, relating to specialist surgical workforce. There is currently support from other health boards for weekend activity to maintain surgical activity levels required in NHS Highland to meet the demand.

Figure 5: 31-Day Cancer Pathway Performance
Ensuring people get treatment within 31-days of cancer diagnosis is a key national standard and supports improved outcomes for patients. This remains below standard in 2025/26 and is impacted by workforce availability to manage current demands, in particular for surgery.

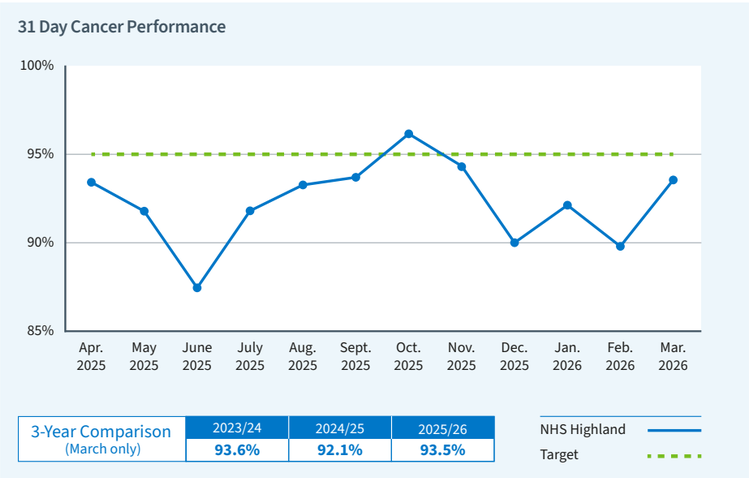
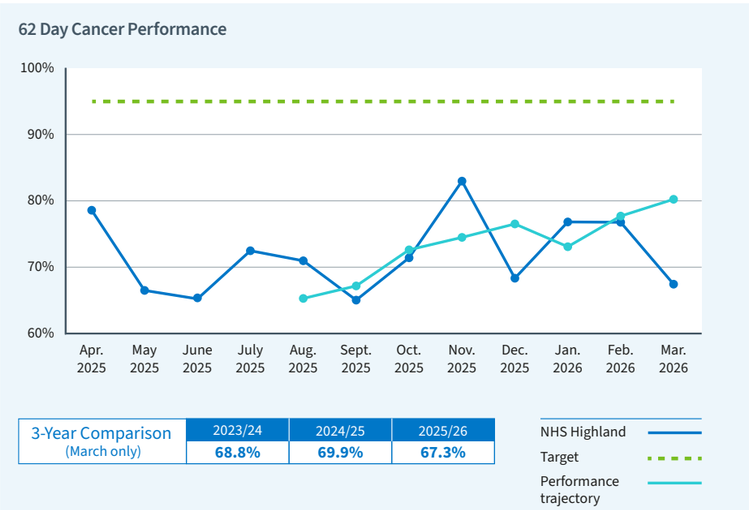
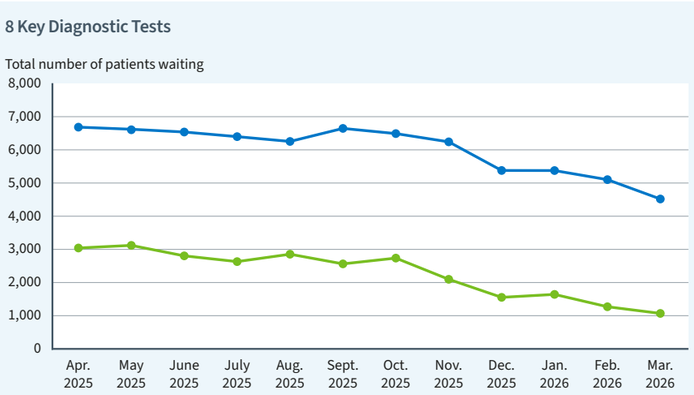


Figure 6: 62-Day Cancer Pathway Performance
NHS Highland has taken steps in 2025/26 to improve our 62-day cancer pathway but continues to be impacted by workforce availability to meet demand for timely diagnostics and treatment, particularly within the Breast Cancer pathway



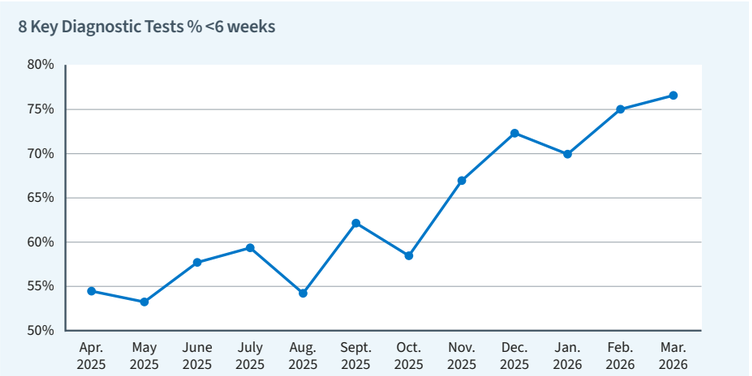
Journey Well:
Cancer & Diagnostics Performance *cont.*

Figure 7: Diagnostics – the 8 key investigative tests waiting list
NHS Highland has reduced the number of people waiting longer than 6 weeks for a key diagnostic test in 2025/26. The total waiting list has reduced across the year as a result of additional activity delivered for imaging tests such as CT and MRI, and endoscopic investigations, improving on the levels seen in March 2024.



3-Year Comparison	As at Mar 2024	As ar Mar 2025	As at Mar 2026
Total waiting list size	**4,858**	**6,624**	**4,517**
Wait >6 weeks	**1,480**	**2,732**	**1,062**

Figure 8: Diagnostics – test received within 6 weeks of referral
NHS Highland increased the percentage of people receiving their test within 6 weeks during 2025/26, delivering more timely diagnostics to support diagnosis and treatment for both planned and unplanned activity. As at March 2026, the performance figure was 76.5%, comparing favourably to the same time period in the last two reporting years.



3-Year Comparison (March only)	As at Mar 2024	As at Mar 2025	As at Mar 2026
	69.5%	**58.8%**	**76.5%**

The 8 key diagnostic tests are as follows:

- Upper Gastrointestinal (GI) Endoscopy
- Flexi Sigmoidoscopy
- Colonoscopy
- Cystoscopy
- MRI (Magnetic Resonance Imaging)
- CT (Computed Tomography)
- Ultrasound
- Barium Studies

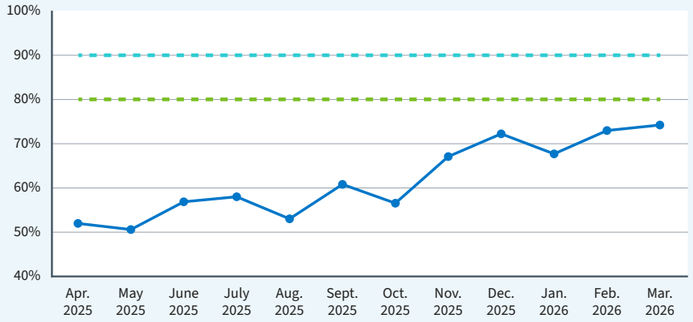
The 8 key diagnostic tests are national standards covering investigations that support pathways of care within acute services. Overall, throughout 2025/26, there has been a reduction in the overall number of people awaiting one of these tests in line with our Outpatient performance. Furthermore, the percentage of people receiving their investigation within 6 weeks of referrals increased throughout the year.

Journey Well:
Cancer & Diagnostics Performance *cont.*

Figure 9: Imaging Tests

NHS Highland improved the percentage of people receiving an imaging test within 6 weeks during 2025/26, supporting timely diagnosis and onward progressing to treatment pathways as required.

Imaging Tests: Maximum Wait Target 6 Weeks – Magnetic Resonance Imaging, Computed Tomography, Non-obstetric Ultrasound, Barium Studies



3-Year Comparison (March only)	As at Mar 2024	As at Mar 2025	As at Mar 2026
	68.9%	56.8%	74.1%

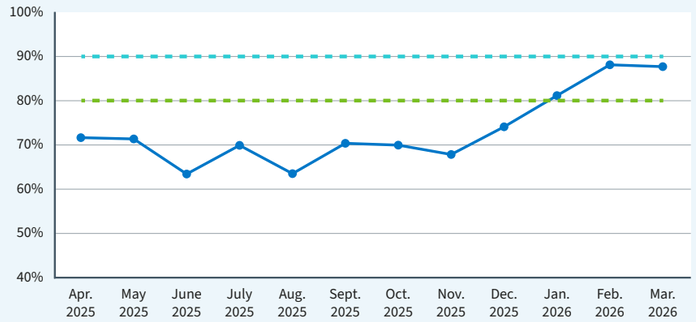
NHS Highland
Short-term target
Long-term target

Performance for the four key imaging investigations has improved throughout 2025/26 towards an interim target of 80%. This reflects an overall increase in activity and in particular relates to an increase in MRI activity for both planned and unplanned investigation. In total there were over 700 MRI and 2,200 CT scans undertaken on average each month in NHS Highland, supporting diagnostic pathways.

Figure 10: Endoscopy investigations

NHS Highland increased the percentage of patients receiving an endoscopic test within 6 weeks throughout 2025/26, exceeding the short-term target of 80% set at the start of the year. Further improvement is planned to drive forward this to 90% of patients being seen within 6 weeks of referral.

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



3-Year Comparison (March only)	As at Mar 2024	As at Mar 2025	As at Mar 2026
	72.2%	70.9%	87.8%

NHS Highland
Short-term target
Long-term target

Performance for the four key endoscopic investigations has improved throughout 25/26 and has exceeded the 80% short-term target for the <6 week waiting time in January 2026. This relates to additional capacity within Endoscopy pathways.

Further improvements are required to move towards the 90% target for < 6 weeks. This is in relation to the requirement for endoscopy within cancer pathways, with timely diagnostics supporting achievement of 62-day cancer performance.

Respond Well: Urgent & Unscheduled Care Performance

NHS Highland also delivers unscheduled care to our population, and we have an improvement programme seeking to prevent hospital admissions, and where emergency care is required to ensure this is received in a timely, safe and effective manner.

There are a number of performance metrics that oversee delivery of these services which include Accident & Emergency departments at our main acute hospital sites in Inverness, Caithness, Lochaber and Oban. We also have minor injuries units attached to our community hospitals in Highland HSCP, while there is a complex network of services supporting unscheduled and out-of-hours care throughout our geography.

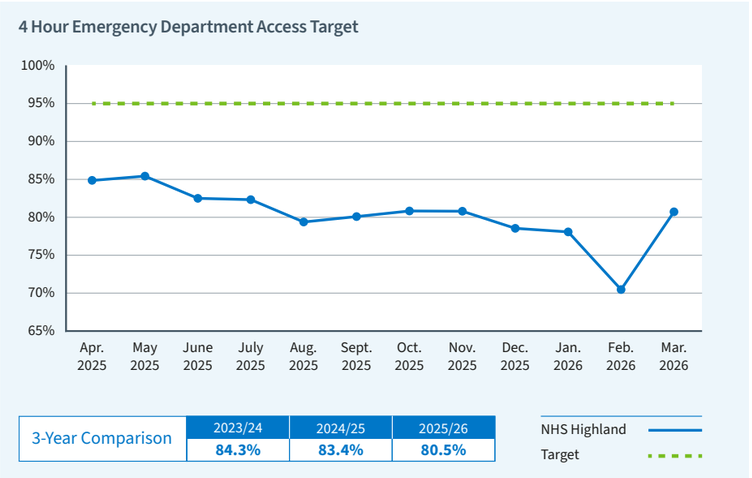
NHS Highland works closely with NHS Scotland's Centre for Sustainable Delivery to monitor and improve unscheduled care performance.

Mirroring national trends, there are increasing attendances at A&E departments, and this has presented challenges in delivery of waiting times. Initiatives such as establishing a Frailty Assessment Area at Raigmore and expanding the SDEC service at Raigmore are expected to sustain some improvements to performance of unscheduled care.

Further development of our Flow Navigation Centre is planned with other boards in the Scotland West region to enhance our local pathways, while exciting programmes such as embedding principles of Discharge Without Delay and Hospital at Home service are intended to help NHS Highland manage our current situation relating to the high number of people experiencing delayed hospital discharge.

The performance in these areas is monitored throughout the board on a daily basis to support an improved situation for our population. It is recognised the current performance in this area is challenging and while there has been little improvement in the performance position in 2025/26, it is hoped the scaling of these initiatives will begin to impact on the performance metrics positively in 2026/27.

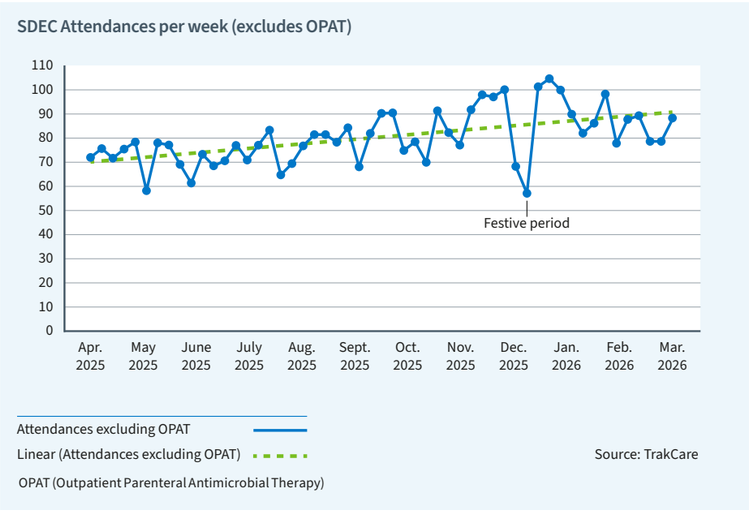
Figure 11: Emergency Department (ED) 4-hour performance
Timely emergency department performance is measured through a national standard for patients attending an A&E department who are admitted, transferred, or discharged within four hours of arrival. NHS Highland like other boards, remains challenged in this area but there are positive initiatives in development to support an improvement in performance.



NHS Highland has continued to be challenged in achieving the 4-hour emergency department national standard. This reflects challenges in flow and increasing attendance to A&E departments throughout the year.

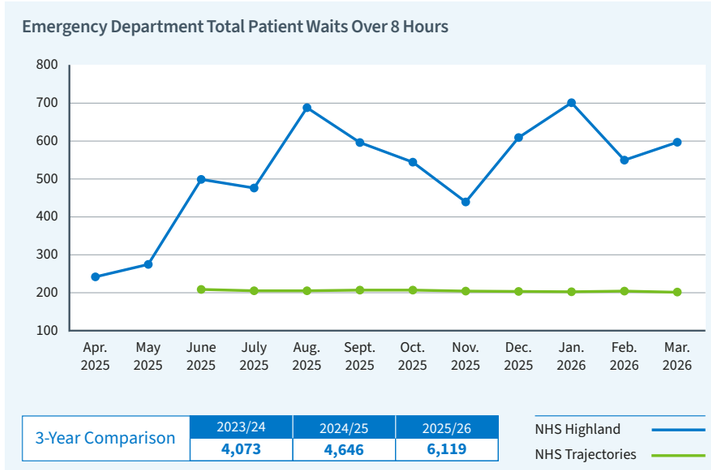
Actions have been taken including expanding pathways in our Flow Navigation Centre and establishing a SDEC service at Raigmore. As the chart to the right shows, attendances through the SDEC have increased throughout the year.

Furthermore A Frailty Assessment Area and pathways to manage people presenting with this condition to prevent admission are underway, however the total pressures continue to result in poor performance, although when benchmarked nationally, NHS Highland compares favourably to a national average of average performance around 60%.



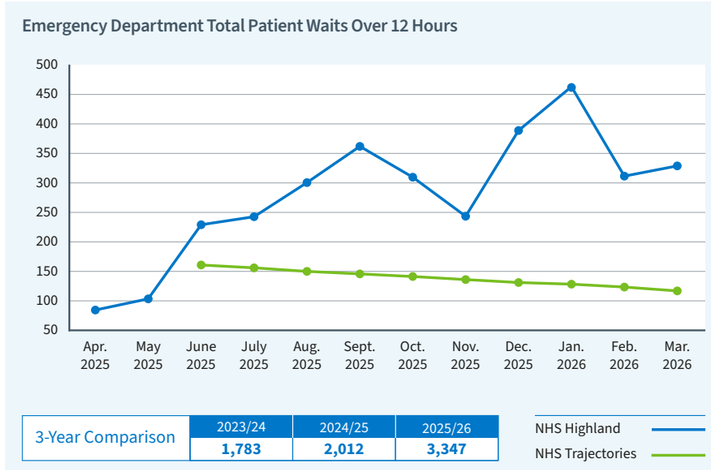
Respond Well: Urgent & Unscheduled Care Performance *cont.*

Figure 12: Emergency Department (ED) 8-hour performance
The number of patients waiting over 8 hours in Emergency Departments has increased throughout 2025/26, representing the sustained pressure on front door services.



The number of people waiting between 8 and 12 hours within Emergency Departments in NHS Highland remains at a high level and above the target level of improvement. The long waits in Emergency Departments are related to patient flow and the overall demands on services. Interventions are underway to try and manage this flow of patients through Emergency Departments to reduce the number of patients waiting over the standard. Compared to previous years, there is an increase in the total number of patients waiting longer.

Figure 13: Emergency Department (ED) >12-hour performance
The number of 12-hour delays reduced from the peak in January 2026 but remains persistently high. NHS Highland has established an escalation process at 10 hours to manage patients who are at risk of breaching this national standard.



NHS Highland continues to manage a high number of patients who wait longer than 12 hours within Emergency Departments.

The number has increased in recent years and is aligned to the national picture of increases. This peaked in January 2026 and within these hospitals, there was a pause to the elective surgery programme to create additional risk-assessed beds to help manage the increase in admissions following emergency presentation.

Despite a reduction from the peak, a high level of greater than 12-hour waits persists. An escalation process has been established which kicks-in at the 10-hour mark, to ensure those patients waiting the longest can be appropriately managed before the 12-hour mark.

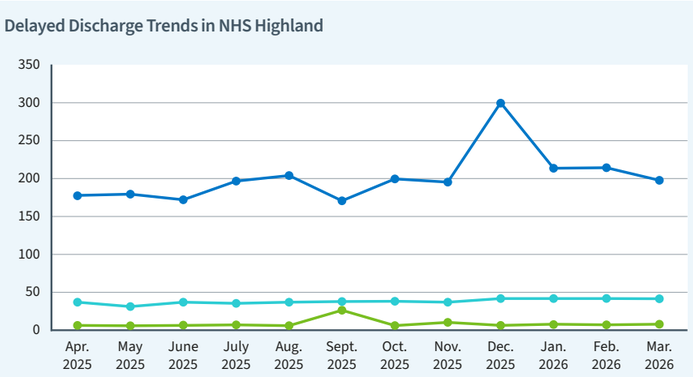
It is important to note that all presentations at Emergency Departments are clinically prioritised due to need.

Often the delay will relate to bed space availability within the main hospital to transfer patients from emergency departments. Reducing the persistent high levels of delayed discharges from hospital is key to supporting this whole system flow and improving the position.

An Adult Social Care commissioning strategy has been developed, and programmes to increase capacity in community services such as Discharge to Assess and Hospital at Home, all have the overall aim to reduce the number of people affected by Delayed Discharge. It is anticipated these interventions will begin to impact the overall numbers of people in delay in the first quarter of 2026/27.

Respond Well: Urgent & Unscheduled Care Performance *cont.*

Figure 14: Delayed Hospital Discharge
NHS Highland continues to manage persistent high levels of delayed discharge, and through our Unscheduled Care Improving Flow programme, is seeking to develop community solutions, such as Hospital at Home, Discharge without Delay and Discharge to Assess, to support an overall reduction in the number of people impacted within Highland and Argyll & Bute



3-Year Comparison (March only)	As at Mar 2024	As at Mar 2025	As at Mar 2026
Standard	143	184	198
Complex	7	6	6
Guardianship	35	43	40

Delayed Discharge rates have remained steadily high over 2025/26, and in comparison to previous years. This has been impacted by availability of Care Home and Care at Home services across the large geography of NHS Highland, including specific impacts over the winter period. People can be affected by delay from discharge from any hospital, including acute, community and mental health sites. All sites in NHS Highland are impacted.

Specifically during December 2025, there was a significant increase in the number of people in delay. This was partly related to residents from Argyll & Bute being treated in NHS Greater Glasgow and Clyde hospitals, where in order to manage winter pressures, there was an assessment of patients to be discharged. Argyll & Bute did not have the availability of the community resources to accept the required number of people into care packages at this time.

This also coincided with an increase within the Highland HSCP area across the winter period. While the position has recovered by March 2026, largely thanks to a response team spanning both acute and community sectors, the overall position has not improved over the 2025/26 year.

An Adult Social Care commissioning strategy has been developed, and programmes to increase capacity n community services such as Discharge to Assess and Hospital at Home, all have the overall aim to reduce the number of people affected by Delayed Discharge. It is anticipated these interventions will begin to impact the overall numbers of people in delay in the first quarter of 2026/27.

Care Well: Community-based Services

NHS Highland incorporates delivery of community-based services across our geography, delivered by two health and social care partnerships. This is to meet the strategic outcomes of Care Well from NHS Highland's board strategy.

Both Highland HSCP and Argyll & Bute HSCPs are responsible for a range of community care services and pathways in localities and districts across the area. To deliver these, both HSCPs have developed strategic plans that oversee the delivery of these services. The performance metrics used to measure performance in these areas are overseen, in Highland by the Highland Health and Social Care Committee, and through the Argyll & Bute Integration Joint Board.

In Highland, delivery of community services by NHS Highland is focused on adult services for social care, as well as primary care, mental health, learning disabilities and pathways through nine community hospitals.

In Argyll & Bute, there is an Integration Joint Board that manages community and some hospital-based services for the whole population, with interfaces to both acute services in Highland and Greater, Glasgow and Clyde.

The following bullet points show the breadth of community services delivered across both Highland and Argyll & Bute partnerships to deliver care for our people when they need it.

- 3,179 admissions to Community Hospitals in 2025/26
- 251 admissions to Mental Health Inpatient Services
- 1,649 long stay Care Home spaces per month, 86% within independent sector
- An average of 640 Care at Home clients seen by NHS Highland per month
- 95 General Practices across Highland and Argyll & Bute
- 84.2% of Highland and Argyll & Bute residents are registered with an NHS Dentist

84.2%

of Highland and Argyll & Bute residents are registered with an NHS Dentist



Live Well: Mental Health Performance

Across both HSCP areas in NHS Highland, there is a strong focus on performance improvement of Mental Health services for children and adults in the area. This to ensure compliance to national standards and meeting the National Health and Well-being outcomes.

Within both HSCP areas, there are different delivery mechanisms for mental health services. Within Highland, New Craigs Hospital provides inpatient mental health services, while there are a number of both acute and community-based services such as CAMHS, Psychological Therapies and Community Mental Health.

There are similar arrangements in Argyll & Bute, although there are closer links to other health boards for the treatment of inpatient mental health patients with commissioning arrangements in place for individual cases.

The following performance metrics are overseen at NHS Highland level and provide oversight of improvements in performance, most notable for CAMHS services in meeting the 95% national standard for treatment within 18 weeks of referral.

CAMHS
NHS Highland performance for CAMHS has improved during 2025/26 to meet the 95% target in 3 out of the last 4 months. This represents achievement of the Scottish Government target for improvement in these services. In line with this improvement in performance, there has also been an overall reduction in the waiting list for CAMHS services due the actions taken at service level to tackle the backlog waiting list.

Psychological Therapies
NHS Highland has continued on a performance improvement trajectory for Psychological Therapies treatment, with performance meeting the standard most recently in December 2025. There is variability in achieving the standard consistently as actions to target the backlog waiting list progress in tandem with ensuring new patients are seen within 18 weeks of referral. The service are planning to balance these objectives into 2026/27 with the overall waiting list reducing, consistent achievement of the 90% standard is anticipated.

Alcohol Brief Interventions
NHS Highland delivers this service as a preventive measure to support people who are at risk. The conversations take place in a number of clinical settings are recorded and reported as a key national metric.

Drug and Alcohol Recovery Services
NHS Highland performance continues to be slightly behind the 90% standard and the reasons for not meeting this performance standard are associated with the overall demand for these services.

Figure 15: CAMHS – Child and Adolescent Mental Health Services
NHS Highland has significant improved access times to CAMHS, moving from one of the worst performing boards to one of the best in Scotland.

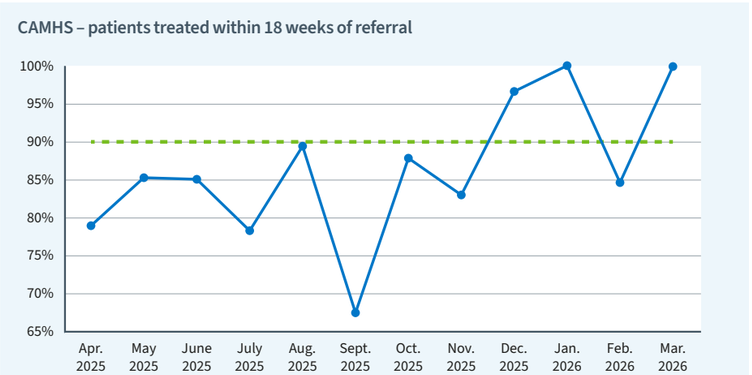
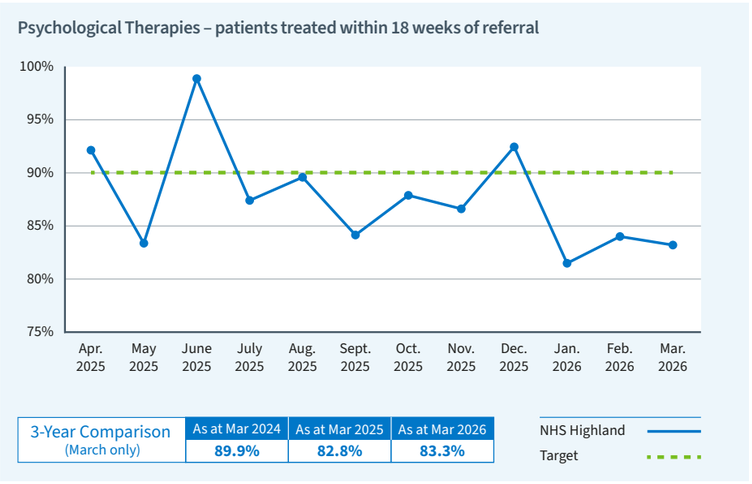


Figure 16: Psychological Therapies
NHS Highland has maintained consistent improved access times to Psychological Therapies services and is continuing to manage waiting lists to ensure 90% of people wait no longer than 18 weeks from referral.



Live Well:
Mental Health Performance *cont.*

Figure 17: Alcohol Brief Interventions undertaken by NHS Highland
NHS Highland continues to ensure it takes all opportunities for conversations with people at risk of harm through alcohol consumption, with 3,851 interventions recorded in 2025/26.

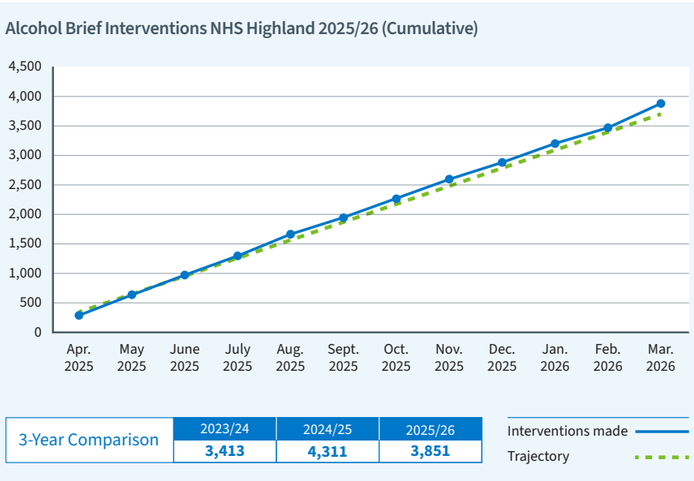
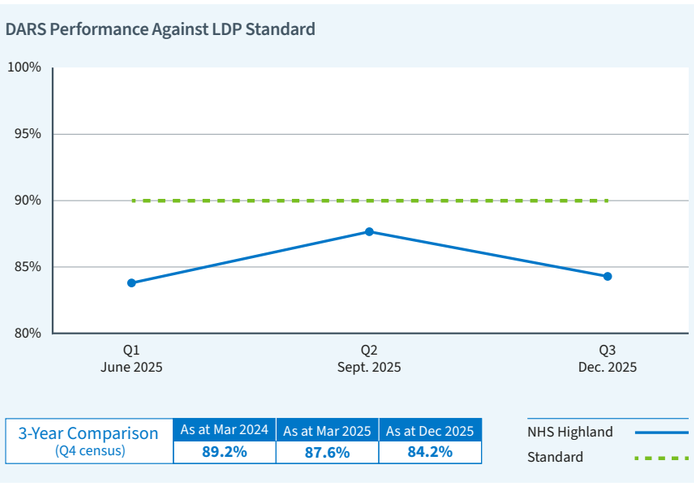


Figure 18: Drug and Alcohol Recovery Services
Supporting people presenting with drug and alcohol challenges is a key requirement of health boards. NHS Highland seeks to ensure patients are seen within 3 weeks of referral as an early intervention to support people at risk.

Note: Chart presents latest available data.



Stay Well:
Performance Metrics

NHS Highland delivers a number of preventative and early identification activities to support our population to stay well. Two examples of these that are underpinned by performance metrics are our vaccination and screening programmes. The following charts cover activity across NHS Highland area for vaccination and screening activity delivered within NHS Highland.

Why screenings and vaccinations matter

Screening and vaccination programmes are central to a prevention-focused health system, helping to stop illness before it starts or to identify health issues at an early stage when they can be treated most effectively. They are two examples of interventions that support the Population Health Framework's aim to improve healthy life expectancy and reduce health inequalities through secondary prevention and early intervention, respectively.

Screening helps to identify disease early, often before people experience symptoms. Early identification enables timely treatment and support, reduces avoidable harm and helps people to stay well for longer. This contributes to a health and care system that delivers equity, prevention and early intervention, particularly for those at higher risk of poorer outcomes.

Vaccinations prevent serious infectious diseases and reduce the spread of infection across communities. High uptake protects individuals and supports community resilience, particularly for babies, children, older people and those with long-term conditions. This aligns with the Framework's focus on promoting healthy living and reducing health-harming risks, while easing avoidable pressure on health and care services.

Delivered universally, with targeted action to reach those who face greater barriers, screening and vaccination programmes support a whole-system approach to population health. They help create the conditions for people and places across Highland to live longer, healthier lives supporting our long-term vision for prevention, equity and sustainable services.

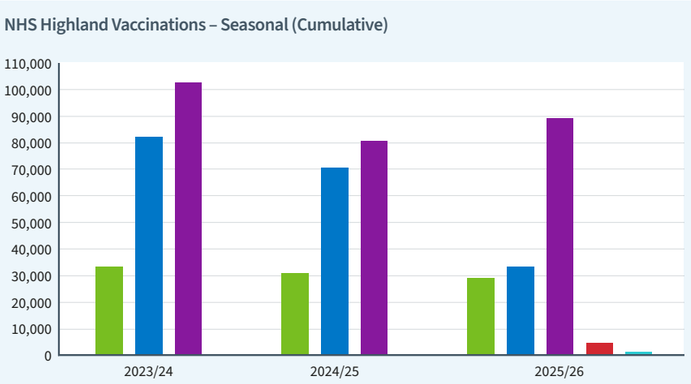
Jennifer Davies
Director of Public Health,
NHS Highland

Stay Well: Performance Metrics *cont.*

Figure 19: Vaccination Activity (Cumulative)

NHS Highland has maintained a high-level of activity for established seasonal vaccination programmes for Flu and COVID, and in 2025/26 introduced programmes for Pneumococcal and Shingles. These vaccination programmes are the first defence against these diseases and uptake is measured throughout the year.

Note: Both Pneumococcal and Shingles vaccination programmes began delivery in 2025/26 and therefore there is no benchmarking information available.



Vaccination type	2023/24	2024/25	2025/26
Spring Covid	**33,879**	**30,984**	**29,491**
Winter Covid	**82,173**	**70,432**	**33,671**
Winter Flu	**102,526**	**80,504**	**89,388**
Pneumococcal Programme	–	–	**5,013**
Shingle 2nd Dose	–	–	**766**

Figure 20: Screening uptake

NHS Highland continues to monitor and encourage the uptake of national screening programmes through public awareness activities. AAA (abdominal aortic aneurysm screening) is meeting national targets overall and has significantly closed the gap in rates for the most disadvantaged populations. Bowel and Cervical screening uptake rates have reduced in recent years and are below the national target with the most disadvantaged experiencing the lowest uptake. The NHS Highland Screening Inequalities Plan sets out actions to address equality gap and widen access to screening.

Note: Public Health Scotland (PHS) are investigating data quality issues and therefore Breast Screening data will not be available for this year's report.

Screening	2023/24	2024/25	2025/26
AAA	**71.4%**	**87.3%**	**87.9%**
Bowel	**70.4%**	**69.1%**	**68.8%**
Cervical	**66.7%**	**66.6%**	**59.3%**

NHS Highland continues to deliver a number of vaccination programmes. In 2025/26, the eligibility criteria for the Winter Covid vaccine changed which has impacted the overall number of vaccines delivered. Flu vaccines for 2025/26 exceeded the total for 2024/25. While new vaccination programmes for Pneumococcal and Shingles began for a small number of eligible patients. Further information follows to demonstrate these seasonal programmes.

Director of Public Health Report

NHS Highland is distinctive, we serve a population dispersed across 42% of Scotland's landmass, a geography that shapes everything we do, from how we plan services to how we think about health and what we know contributes to health outcomes. This year, we have focused on our uniqueness in advancing a population health approach that is place-based, partnership-driven and built around reducing inequality.

As we close 2025/26, we have made significant progress putting in foundations to the development of our strategic intentions. These will underpin NHS Highland's work for years to come: embedding the national population health framework into the development of our new organisational strategy, strengthening governance and making the most of our partnerships to support a healthy population.



Eligible people urged to take up COVID-19 vaccine this spring.

A Population Health Framework for NHS Highland

In January 2025, the Board approved the recommendations within the Director of Public Health's Annual Report on Health Inequalities. This signalled a genuine organisational commitment to tackling health inequalities. This decision established the direction of travel for much of the work that has followed during the year. It prompted a review of our internal governance structures, and the subsequent arrival of the Scottish Government's Population Health Framework provided the architecture within which to act. The framework is explicit that our role extends beyond healthcare provision, carrying a laser-like focus on inequalities and the wider conditions that shape people's lives.

For NHS Highland, this has prompted a deliberate repositioning of Together We Care through a population health lens building on its foundations while signalling a clearer, bolder commitment to tackling inequality as we develop our new organisational strategy, due later in 2026.

Working together with the Community Planning Partnership, we have developed a health inequalities dashboard co-designed with partners, tracking proposed indicators against each of the eight Marmot policy objectives, which is the evidence base that underpins the population health framework. This tool will be tested and refined in the year ahead.

To drive this work forward, we have established a new Population Health and Planning Committee. The committee's primary purpose at this stage is to support the development of the new organisational strategy, with its remit expected to evolve as that strategy matures. We recognise that we are already doing work in support of a population health approach as exemplified by our anchor plan which recognises that as an anchor institution, NHS Highland has both the responsibility and the reach to address the social and economic determinants of health in our communities.

> "At its heart, our unique approach to immunisation it is about how we work as a system, removing the barriers that make it harder than it should be for our population to access vaccination, and making it easier for staff to deliver it.



A Unique Approach to Immunisation

NHS Highland is currently in formal escalation with Scottish Government for vaccination uptake rates and we are responding with an innovative approach tailored to our unique challenges. We are developing a hybrid collaborative model for immunisation delivery that is genuinely place-based, designed around our geography, our communities, and our workforce. This model pursues better outcomes. At its heart, it is about how we work as a system, removing the barriers that make it harder than it should be for our population to access vaccination, and making it easier for staff to deliver it.

This spans the full life course, from vaccination in pregnancy through to later years, recognising that our staff are part of these communities too, and that gaps in coverage add pressure to an already stretched system. By looking across the whole system rather than optimising individual parts, we are creating a more consistent, reliable, and accessible service.

Progress this year has included testing new methods to increase healthcare worker vaccination rates which have led to measurable improvements. Flu vaccination uptake for healthcare workers increased from 32% to 44% between Winter 2024 and Winter 2025. National bodies, which on average achieved rates of 36% across Scotland, have expressed interest in learning from our approach.

Investing in Early Years and Child Health

The Director of Public Health (DPH) Annual Report for 2025 is focused on early years and child health as its theme. The evidence is clear: the conditions of early life are foundational to long-term health outcomes, and any serious commitment to reducing inequality for future generations must begin here. The report will be published in May 2026 and will make strategic recommendations to improve outcomes in for this population.

In partnership with colleagues across the system, we have completed a Children and Young Persons Needs Assessment, which will feed directly into a refreshed integrated children and young person's service plan. We also adopted a new approach to the DPH Annual Report, commissioning research to gather young children's lived experience, to ensure their voices shaped our response.

Looking Ahead

The coming year will be one of testing and embedding. Our new organisational strategy, with population health at its core and its supporting governance structures will be put to work. The health inequalities dashboard will move from development into active use. Our immunisation model will continue to evolve, and the early years agenda will gain further momentum as our needs assessment findings begin to shape commissioning decisions.

NHS Highland's geography will always require us to think and act differently. It means we need to be able to understand and work with our communities to find the right solutions for our unique context. This will lead to a health system that thinks and works as one, rooted in the places and communities it serves, and unequivocal in its commitment to reducing the inequalities that cut lives short.

Jennifer Davies
Director of Public Health

Chief Officer Highland Health & Social Care Partnership Report

NHS Highland is the lead agency for Integrated Health and Social Care for Adults, while Highland Council is the lead agency for Integrated Health and Social Care for Children. There are four coterminous managerial areas for NHS Highland and Highland Council children's services. There are also nine local Community Planning Partnerships.

The governance of the partnership is managed by the Joint Monitoring Committee which consists of: the two lead agencies; representatives from the Third Sector; independent partners, service users and carers. These partners are represented in strategic planning and governance processes.

Highland HSCP publishes a separate Performance report which can be accessed using the following link: **www.nhshighland.scot.nhs.uk/hhscp-pubs**

Chief Officer – Highland Health and Social Care Partnership
The past year has continued to test the resilience of the Highland Health and Social Care Partnership, with sustained financial pressure, workforce challenges and increasing demand across both health and social care. In this context, our focus throughout 2025/26 has been on maintaining safe, person-centred services while strengthening how we work together across organisational and professional boundaries. In particular, we have prioritised improving the interface between acute health systems and community health and social care to support flow, quality and workforce sustainability, recognising that progress in one part of the system depends on the whole.

Joint Transformation Programme
At a strategic level, the NHS Highland and Highland Council Joint Transformation Programme has provided a shared space to identify priorities, make deliberate choices and progress transformation across social care to embed the Highland Care Model. These arrangements have supported clearer oversight of system change while allowing collective effort to be focused on areas of greatest risk and opportunity.

Governance
The continued embedding of the Vincent Framework, a structured approach to safety and quality assurance that supports consistent, reliable practice across services, has strengthened our approach to assurance, providing consistent prompts across services and supporting more integrated governance, particularly at the interface with social work and adult protection colleagues.



Mental health specialist nurses and a mental health paramedic took part in Operation Respect, a multi-agency initiative supporting people in crisis in Inverness city centre.

Adult Mental Health Services
This year also brought important challenge and learning through the Care Inspectorate and Healthcare Improvement Scotland Joint Inspection of Adult Mental Health Services. The inspection found that the HHSCP delivered positive outcomes for most people living with mental illness, supported by effective early intervention and prevention initiatives. It recognised the commitment of staff to compassionate, person-centred practice across mental health and learning disability services, while setting out clear recommendations for improvement. These findings are now driving a structured programme of work, reinforcing the importance of learning, reflection and shared accountability.

Discharge Without Delay
Discharge Without Delay has highlighted interdependencies across acute, community and social care services, supporting clearer dialogue and shared responsibility for system flow. This work has informed more joined-up decision-making and a stronger collective understanding of system constraints.

Community Based Models
A significant area of progress has been the development of community-based models supporting people to remain at or return home sooner. Reablement and discharge-to-assess approaches have been strengthened across Inverness, East Ross and Caithness. In East Ross, targeted use of unscheduled care funding enabled reconfiguration of care-at-home capacity, demonstrating the impact of focused investment at the health and social care interface.

In Inverness, a consultant-led Hospital at Home model has strengthened the foundation for safe, home-based care and clarified requirements for scaling such models sustainably across Highland. The Frailty Programme Board has improved early identification and proactive intervention, while mental health services have continued to progress distress interventions, reflecting a broader shift towards earlier, community-based support.

Primary Care
The Scottish Government approved the introduction of a seven-day enhanced GP access and walk-in service in Invergordon. Working with the registered population of Alness and Invergordon, the pilot aims to improve timely access to urgent primary care, relieve pressure on existing services, and address significant health inequalities within a high-need population. The service will be delivered from County Community Hospital, Invergordon, maximising the benefits of co-location with the GP practice, Minor Injury Unit (MIU), Out of Hours (OOH) service, diagnostics,and multidisciplinary teams.

Digital Innovation
Digital tools are being progressed to support people with learning disabilities to live more independently at home. Working in partnership with TVI and Vocala, the initiative uses voice activated, AI-enabled technology to provide personalised prompts, reminders and accessible information to support daily living and communication.

Funded through The Highland Council Transformation Fund, devices are expected to be tested this Spring. The pilot will assess how this technology can support independence, reduce anxiety and offer reassurance to families and carers, with learning informing decisions on wider rollout.

Staff Resilience
The continued commitment and resilience of our workforce has been central to sustaining services through a highly pressured year. Staff across Highland have demonstrated professionalism, flexibility and a sustained focus on person-centred care. Supporting workforce wellbeing has therefore remained integral to our approach, recognising the direct link between staff experience, quality and safety. This has included leadership and management visibility, wellbeing engagement and listening activity, alongside practical support such as coordinated adverse weather responses. In primary care, improved GP recruitment and reduced reliance on locums have begun to stabilise the workforce after a prolonged period of challenge.

Looking ahead
Progress in reablement, discharge-to-assess, Hospital at Home and primary care development provides a strong platform for 2026/27. Establishment of the Flow Navigation Centre and a new approach to enhanced service commissioning are in place and the hybrid vaccination model is progressing, alongside ongoing strategic planning across adult social care and a review of the Joint Strategic Plan.

The challenge ahead is to sustain this momentum while remaining realistic about ongoing constraint. The progress outlined here reflects the collective effort of staff across health, social care, the independent sector and partner organisations and the importance of working as one system to deliver safe, high-quality care for the people of Highland.

Arlene Johnstone
Chief Officer, Highland Health and Social Care Partnership

> "Staff across Highland have demonstrated professionalism, flexibility and a sustained focus on person-centred care. Supporting workforce wellbeing has therefore remained integral to our approach, recognising the direct link between staff experience, quality and safety.



Chief Officer Argyll & Bute Health & Social Care Partnership Report

Argyll & Bute Integration Joint Board is a separate legal body set up under the Public Bodies (Joint Working) (Scotland) Act 2014 and publishes a separate Performance report which can be accessed using the following link: **www.nhshighland.scot.nhs.uk/abhscp-pubs**

This year has been one of significant challenge, but also of many successes. In common with many integration joint boards (IJBs) across Scotland, pressures associated with finance, workforce and demand have been felt keenly across our integrated system.

Year in reflection
That challenge has been demonstrated clearly in the number of people whose stay in hospital has been longer than it has needed to be over the past year, often referred to as delayed discharges. Aside from the numbers, what's important is that this has meant too many people have been in a place of care that hasn't met their needs or best supported their recovery. More often than not, that best place is their own home or place of residence and I want to acknowledge the impact on those people and their families during the times when our system has not been able to keep up with demands.

Whole System Plan
That pressure has brought with it renewed thinking, and a fresh drive to do the right thing for people, which is the hallmark of our integrated system within Argyll and Bute. Our integrated teams have responded with a Whole System Plan which brings together nationally recognised practice at each stage of people's care journey, from support for people experiencing symptoms of frailty, developing alternatives to hospital admission, rigorous discharge planning and a focus on reablement and 'home first' approaches. In addition, our Oban-based Hospital at Home service is up and running at 12 virtual beds and has prevented an estimated 248 hospital admissions (1877 bed days) over the course of the year. The team have been nationally recognised for their pioneering approach.



Partnership working
I would also like to recognise high performance right across our range of delegated services. Our Mental Health unscheduled care team has achieved 99.8% response rate within two hours for people experiencing mental health crisis, while our Child and Adolescent Mental Health services has met the target of seeing 90% of young people requiring tier one or two services within 18 weeks. We have opened eight new accommodation units for staff across Tiree, Islay and Oban, with a further project on Islay commencing in the coming weeks. This has been delivered with the support of the strategic housing fund representing the strength of our partnerships and a meaningful impact on Argyll's housing emergency. More units are planned for the year ahead, and our partnership with the housing sector continues with work underway to develop a Strategic Care Housing Improvement Plan. We will ensure that we work with the housing sector to enable our fantastic staff to live and work in Argyll.

> The professionalism, compassion and integrity that I've seen in the conversations members of the HSCP team have had with people has been really inspiring.





Primary Care
Over the past 12 months, Primary Care services across Argyll and Bute focused on stabilisation, governance and service redesign. Investment has been received to support the development of a GP Walk-In Service in Cowal Community Hospital, with service planning and enabling work now progressing to improve access and reduce pressure on unscheduled care. Alongside this, progress has been made across vaccination delivery, workforce sustainability and clinical governance, with enhanced oversight of risk, prescribing and adverse events. Sexual health services have continued to face challenges, particularly in rural areas; however, mitigations and interim solutions have been implemented while longer-term, more sustainable models of provision are developed. Overall, this work has strengthened the resilience, safety and sustainability of primary care and provides a firm platform for further delivery in 2026/27.

Joint Strategic Plan
In addition, this past year has seen a wholesale renewal of our joint strategic plan, driven in the main by conversations with our staff and the communities we serve. The strength and depth of our engagement with communities in 2025/26 has been a real highlight of the year across a number of fronts including our Joint Strategic Plan, our budget setting proposals, and through the Communities Working Together strand of our preventative Living Well programme.

The professionalism, compassion and integrity that I've seen in the conversations members of the HSCP team have had with people has been really inspiring. Our current context means we are required to confront the challenge, but that doesn't mean shying away from the detail or impact of those, or of simplifying the scale or complexity. The responses from people in our communities has demonstrated a deep understanding of the challenge we face and our ambition as an HSCP is to maintain and develop this partnership over the coming year.

In addition, we have commenced work with the Third Sector Interface in Argyll and Bute with a shared ambition of developing a new way of working which focusses on outcomes and innovation, rather than annual budgeting cycles. Taken together this presents a range of opportunities for the year ahead, despite the challenges which we know will continue. Improved performance at the start of 2026 in relation to delayed discharges provides some assurance that the foundations put in place over the past year are beginning to yield the outcomes we want for the people of Argyll and Bute. Our new Joint Strategic Plan will help us refine an ambitious programme of transformation across Health and Social Care, underpinned by further engagement with our staff and communities and the work of our professionals in driving and improving quality in our services.

Evan Beswick
Chief Officer, Argyll and Bute Health & Social Care Partnership

Forward Look to 2026/27

NHS Highland heads into the new financial year with a focus on improving the health and care outcomes for our population, aligned to emergency policy in the form of Population Health and Service Renewal frameworks, while continuing to reflect the ambitions of our population across Highland and Argyll & Bute.

NHS Highland is developing its 10-year organisational strategy with a population health focus by building on the foundations established by the NHS Highland Together we Care Strategy 2022-2027. This will enable fundamental shift in how we improve health outcomes and approach the delivery of health and care in collaboration. This approach will also prioritise working within resource and reprioritising investment in prevention and early intervention, and is aligned to Scottish Government policy.

Supporting this, we are developing our Annual Delivery Plan for 2026/27 that will capture the key actions and deliverables we will take in the year to support the delivery of Together We Care, covering services delivered across the Highland and Argyll & Bute area.

The ADP will reflect our key priorities for change and are aligned to NHS Scotland's 8 Annual Operating Priorities as follows:

1. **Reduce the longest waits for planned care**
2. **Increase productivity across elective and diagnostic services**
3. **Improve flow and performance in unscheduled care**
4. **Expand Hospital at Home as a mainstream model of care**
5. **Support safe and high-quality maternity and neonatal services**
6. **Improve support and services around Mental Health, Neurodiversity and Learning Disability**
7. **Accelerate digital access and modernisation**
8. **Become a population health organisation**

Great progress has already been made in relation to those waiting the longest for new outpatient and inpatient appointments and treatments, as well as improving waiting times for CAMHS and Psychological Therapies services.

A key area of focus will be on Unscheduled Care and reducing the current level of delayed hospital discharge in the NHS Highland system. Initiatives to shift the balance of care including an expanded number of pathways in our flow navigation centres, and increase in capacity within Hospital at Home services and a focused and consistent Discharge Without Delay programme will all seek to make the breakthrough.



Cabinet Secretary for Health meeting a Hospital at Home patient in Oban.



Supporting high quality maternity services.

This will build on the work undertaken in 2025/26 to establish Hospital at Home in Highland, as well moves on prevention through establishing a Frailty Assessment Area and expanding the operating hours of the Same Day Emergency Care service at Raigmore. These initiatives will be assessed for scaling-up to other areas in Highland in 2025/26.

NHS Highland is aligned to the Scotland West sub-national planning structure and will continue to work with partner boards NHS Ayrshire & Arran, NHS Borders, NHS Forth Valley, NHS Greater Glasgow & Clyde, NHS Forth Valley and NHS Western Isles) on collaborative opportunities that support financial balance within the sub-national boards.

It is expected that a significant amount of planning work will be undertaken in 2026/27 to understand the baseline position of boards and identify opportunities where collaboration can help reach a sustainable financial position required within the next three years.

While this work remains formative, the emergence of Scotland West will compliment our existing pathway arrangements as we work across the NHS Scotland planning community to deliver sustainable change in the identified areas.

Performance and delivery reporting will continue through our NHS Highland board structures to ensure alignment with strategic direction and ensure delivery of these priority areas in 2025/26. This will primarily be through reports on the Integrated. Performance and Quality Report and the Operational Improvement Plan for which bimonthly updates will be provided to board members.

It is anticipated that these priorities will help further shape NHS Highland's transformation and demonstrate our collective commitment to make positive steps in the design of the health and care system required to support our population now, and into the future.

Financial Performance and Financial Plan

2025/26 Financial Performance
The financial year 2025/26 was a year of intense financial pressure, requiring sustained delivery action across the organisation while maintaining statutory financial control.

The Scottish Government requires NHS Boards to meeting three key financial targets:

- Revenue Resource Limit
- Capital Resource Limit; and
- Cash Limit

Table 1 details performance against these targets.

NHS Highland met all statutory financial targets for 2025/26. This reflects strong in-year financial control, effective engagement with Scottish Government, and continued application of financial flexibility and sustainability funding. However, the underlying deficit is 3.25% of the core revenue resource limit presenting a challenging financial position as the Board moves into 2026/27.

Understanding the 2025/26 Outturn – from opening gap to year-end position
NHS Highland submitted a financial plan to Scottish Government for the 2025/26 financial year in March 2025. This plan presented an initial budget gap of £115.596m. Robust monitoring alongside additional support from Scottish Government enabled delivery of an underspend of £0.196m. The journey from financial plan submission to year end outturn is described in Table 2.

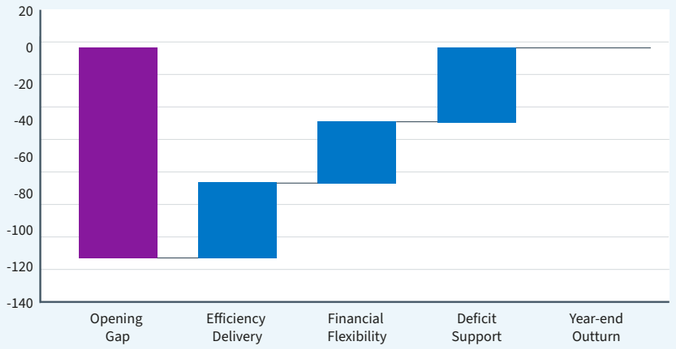
Table 1: Summary of Resource Outturn

Tile	Title	SGHSCD Limit £000	Outturn £000	Variance £000	
☑	Revenue resource limit	1,224,770	1,224,574	196	Delivered within limit
☑	Capital resource limit	24,507	24,502	5	Delivered within limit
☑	Cash	1,206,121	1,206,121	0	Managed within limit
⚠	Underlying position	(40,000)	(39,804)	–	Structural deficit remains

Table 2: Financial Plan to Outturn

	£m
Opening Gap	115.596
Deficit Support Funding	40.000
Efficiency Delivery	41.549
Financial Flexibility	33.851
Reported Underspend	0.196

From Opening Gap to Year-end Outturn (£m)



Financial Control
Table 3 illustrates the key drivers of the financial position for the operational areas of NHS Highland.

Analysis of Expenditure by Type
Table 4 provides details of the proportion of gross spend by category.

Capital
Across all funding categories total expenditure was £24.502m, net of capital disposals and donated assets.

This included £7.294m of formula funding and £13.877m to fund specific projects including the buy back of the New Craigs PFI. Full year spend was £21.171m. The largest areas of spend were:

- Various equipment purchases: £5.003m
- Lochaber Replacement project: £3.946m
- Fire compliance work at Raigmore Hospital: £2.317m

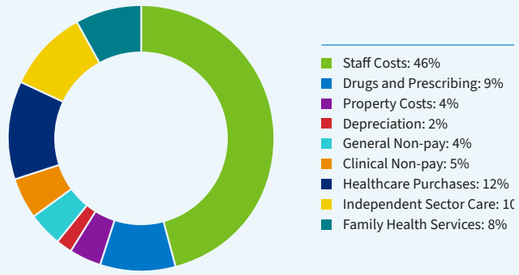
Further capital funding was received to support the costs associated with a number of leases held by the Board totalling £3.494m.

Table 3: Key drivers of the financial position 2025/26 by Unit

Area	Financial Position	Key Drivers	Overall Risk
Acute Services	Overspent	Workforce pressures, escalation costs, unscheduled care demand	🔴
HSCPs	Managed variance	Local cost controls, service redesign, non-recurrent support	🟠
Adult Social Care	High-cost pressure	Demand growth, market fragility, care package inflation	🔴
Support Services	Within budget	Vacancy controls, non-pay savings, central mitigations	🟢

🟢 Low risk/favourable 🟠 Moderate risk/emerging pressure 🔴 High risk/significant pressure

Table 4: Expenditure by Type



Financial Performance and Financial Plan *cont.*

Bad Debt
Bad debt provision of £3.293m this year (prior year £2.453m) is based on all non-government debt outstanding greater than one year old, except for Road Traffic Accident (RTA) reclaims. Bad debt of 24.62% of total net outstanding value of RTA income has been provided for based on historic patterns of recovery (as per Government guidance).Further details on the bad debt provision can be seen in Note 9 of the Financial Accounts.

Payment Policy
NHS Highland is committed to supporting the Scottish Government's objective of improving cash flow for businesses, particularly in the current economic climate, by paying suppliers promptly. The Scottish Government's policy is to achieve payment of all undisputed invoices within 10 working days across the public sector.

This accelerated payment target has been communicated to all public bodies, including non-departmental public bodies, and NHS Highland continues to work towards meeting this standard.

The improvement year on year has been driven by focus on the procure to pay process. Working with suppliers and reinforcing that all purchases must have a purchase order. NHS Highland will continue to improve drive improvements with our processes and ensure prompt payment to suppliers continues to improve.

Pension Asset/Liabilities
The accounting policy note for pensions is provided in Note 1 and disclosure of the costs is shown within Note 19 and the remuneration report.

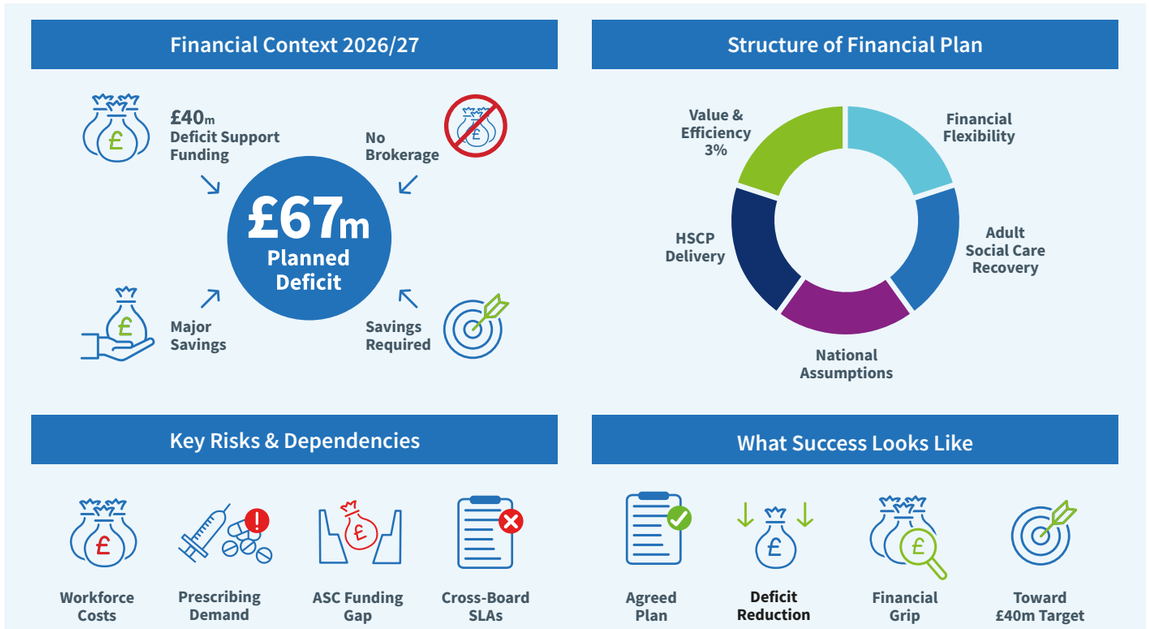
Statement of Best Value
NHS Highland is committed to securing the principles of best value in the use of public funds in line with arrangements within the Scottish Public Finance Manual. This is embedded with planning, performance monitoring and delivery ensuring that consideration of best value is integral to all decision making. The Board's Code of Corporate Governance provides specific guidance on the mechanisms in place to ensure that robust arrangements are in place to secure best value.

Financial Plan 2026/27
NHS Highland submitted a draft financial plan to Scottish Government in March 2026. This plan was prepared recognising the position set out within the 2026/27budget letter.

The plan submitted indicated a draft opening position for NHS Highland of £113.177m with a number of actions identified to reduce this to a net gap of £66.957m. Scottish Government has confirmed that deficit support funding of £40m and further action will be required to reduce the gap.

Delivery of an outturn position of £66.957m was built around a number of assumptions supported by structured work programmes as shown within the Structure of the Financial Plan to the right.

	2025/26	2024/25
Average period of credit taken	15 days	20 days
Percentage of invoices paid within 30 days:		
– by volume	90.23%	87.70%
– by value	89.65%	88.86%
Percentage of invoices paid within 10 days:		
– by volume	74.38%	69.54%
– by value	79.23%	76.83%



Forward Look – Financial Sustainability
Looking ahead to 2026/27, NHS Highland continues to face a significant and structural financial challenge. The Board has agreed a three-year financial plan which reflects rising demand, pay and service pressures, and a constrained national funding settlement. While the plan is supported by £40 million of recurring deficit funding from the Scottish Government, the underlying financial gap remains substantial, with a residual deficit projected even after planned savings and mitigations. This highlights that, despite progress in stabilising the in-year position, the organisation remains some distance from achieving a sustainable financial balance.

The Board's approach for 2026/27 is centred on a Value and Efficiency programme targeting recurring cost reductions, alongside continued collaboration with partners, particularly in Adult Social Care where pressure remains most acute. The Value and Efficiency programme will be continued through a specifically focussed Highland Improvement, Value and Efficiency (HIVE) team which is the process of being established pulling together skills from across the organisation. However, delivery of the plan is recognised as high risk, with savings requirements at a scale not previously achieved on a recurring basis and with some elements still under development. The Board will therefore maintain a strong focus on financial discipline, oversight and system-wide change, working with Scottish Government and regional partners to reduce reliance on non-recurring measures and build a more sustainable financial position over the medium term.

Directorate Spotlight
Estates, Facilities & Capital Planning

The Infrastructure of Care
Every appointment kept, every meal served, every safe handover none of it happens without the people who keep our buildings running. The Estates, Facilities & Capital Planning Directorate is the operational backbone of NHS Highland: managing 251 sites across 318,992m^2, ensuring compliance, delivering capital investment, and maintaining the environments in which care is given and received.

Covering more than 42% of Scotland's landmass, NHS Highland's estate is one of the most geographically dispersed in the country. The scale and complexity of what this directorate manages and the consistency it maintains is a significant organisational achievement.

What We Do
The directorate spans six core service areas, each essential to safe and sustainable healthcare delivery.

Estate management and compliance teams maintain the physical infrastructure – buildings, engineering systems, medical gases, fire safety, water hygiene, and the full range of statutory obligations – across every NHS Highland site.

Facilities and Soft FM teams manage the services patients and staff experience directly: domestic cleaning, catering, portering, security, and retail.

Capital Planning develops and delivers major investment programmes, from ward refurbishments to hospital redesigns. Central Decontamination provides specialist processing of reusable medical devices, a critical and often unseen contribution to infection prevention. And an embedded Environment and Sustainability function leads NHS Highland's response to the NHS Scotland Climate Emergency and Sustainability Strategy. Together, these teams manage more than 2,300 service contracts, respond to thousands of requests every year, and ensure that the conditions for care are in place 24 hours a day, every day of the year.



Our laundry facility at Raigmore Hospital.

Our People
The directorate employs approximately 820 members of staff, from engineers, maintenance technicians, domestic and catering teams, porters, security officers and decontamination specialists to capital project managers. Currently:
- Estates ~150
- Facilities ~650
- Capital Planning ~10
- Environment & Sustainability ~6
- CDU ~70

This is a workforce largely invisible to the public and to many within the organisation yet their contribution is indispensable. From the engineer responding to a boiler fault at 3am to the catering assistant ensuring a patient with complex dietary needs receives the right meal, these colleagues provide the foundation on which clinical care depends.

2025/26 in Numbers
- 855,000+ meals provided to patients, staff and visitors
- 2,304,000+ items laundered (1,024 tonnes)
- 17,830 preventative maintenance tasks completed
- 28,948 reactive maintenance tasks responded to
- 27,792 statutory maintenance tasks carried out
- 39,000+ patient moves supported by portering teams
- 2,300+ service contracts actively managed
- CDU reprocessed 69,227 traysets last year which was +5.7% compared to the prior year
- EDU reprocessed 11,458 scopes last year, +2.3%
- Business Continuity Capital Projects: 40
- Clinical waste reduction of 99.82tCO_2e in 2025/26 against 2024/25
- Non clinical waste increase of 69.6tCO_2e which is reflective of improved segregation and removal of these items from the clinical waste
- Energy carbon reduction outputs of 4746.95tCO_2e in 2025/26 against 2024/25

Scotland First:
New Craigs PFI Handback
In July 2025, NHS Highland became the first NHS board in Scotland to complete a full PFI contract expiry and take back direct operational responsibility for a major hospital facility.

New Craigs Hospital in Inverness was originally developed under a project agreement signed on 31 March 1999. When that 26-year contract expired on 14 July 2025, ownership of New Craigs Hospital and Aonach Mor transferred from the private contractor to Scottish Ministers and NHS Highland.

Sixty-five members of staff transferred from Robertson FM to NHS Highland on that date. The transition had been planned carefully over many months, with NHS Highland Estates and Facilities teams working alongside transferring colleagues both before and after handback to ensure continuity of service, compliance with TUPE obligations, and a positive experience for staff joining the organisation.

This was not simply an administrative milestone. It required detailed preparation across estates management, HR, finance, and compliance and it was delivered without disruption to the patients and services that depend on New Craigs every day. As PFI contracts across Scotland approach expiry, NHS Highland's approach will serve as a model for the sector.

Raigmore Hospital:
Ward 6C Redevelopment
Work began in September 2025 to transform Ward 6C at Raigmore Hospital, delivering improvements to fire safety, ward environment, and the creation of a new coronary care facility.

The first patients experienced the completed ward in March 2026, a project delivered within the year and representing a tangible improvement in the quality of the care environment for some of Raigmore's most acutely unwell patients.



Delivering nutritious meals for patients.

Food as Medicine: Nutrition and Hydration in Patient Care
NHS Highland's approach to food and nutrition recognises that what patients eat is not incidental to their care, it is part of it. Malnutrition affects around a quarter of UK hospital inpatients and is associated with increased risk of infection, longer stays, and higher treatment costs.

Our catering teams work alongside nursing and dietetics colleagues to ensure patients receive food that is safe, nutritious, and appropriate to their clinical needs. Menus are designed to meet energy and protein requirements for both well and nutritionally vulnerable adults. Where complex needs are identified, specialist diets, modified meals, and oral nutritional support are provided through a coordinated multidisciplinary approach.

The Facilities and Food, Fluid and Nutrition Group maintains food and hydration as a standing agenda item, ensuring standards remain a shared organisational priority. This is the integration of clinical and facilities thinking at its most direct.

Looking Ahead
The year ahead will see continued progress on capital investment across the NHS Highland estate, further development of the directorate's sustainability programme in line with the NHS Scotland Climate Emergency and Sustainability Strategy, and the ongoing integration of the New Craigs and Aonach Mor sites following handback.

Richard MacDonald, Director of Estates, Facilities and Capital Planning and the leadership team are focused on maintaining the standards that underpin safe care while driving the improvements in environment, efficiency, and sustainability that patients, staff, and communities deserve.

Sustainability and Environmental Reporting

Sustainability and Climate Action
NHS Highland operates one of the most geographically dispersed estates in Scotland, spanning remote rural communities, island services, and urban centres across the Highlands and Argyll & Bute. Meeting our statutory climate obligations in this context demands a coordinated, practical and ambitious approach, one that balances the scale of our environmental impact with the realities of delivering healthcare across a vast and varied region.

Statutory Obligations and Targets
NHS Highland's sustainability work is anchored in Scotland's statutory framework and the NHS Scotland Climate Emergency and Sustainability Strategy 2022-2026. The table below sets out the key obligations and our current position against each.

Decarbonising Our Estate
Heat and power remain the largest source of carbon emissions across our estate. Raigmore Hospital, our principal acute site, is among Scotland's top 20 emitting buildings and represents the most significant single opportunity for carbon reduction. NHS Highland is progressing funding requests and feasibility studies to develop a comprehensive decarbonisation plan for Raigmore, evaluating low-carbon heat and power solutions and building the business cases needed to unlock future investment. An additional request has been made for Argyll and Bute.

Position v target obligation

Obligation/Target	Requirement	NHS Highland Position
Net-zero emissions (NHS Scotland)	Net-zero by 2040 or earlier	NHS Highland has applied for funding to develop a decarbonisation plan for Raigmore Hospital and Oban, Lorne and Isles Hospital. This work will support the Board in establishing a clear, strategic pathway for future decarbonisation projects and investment across these sites, and will allow learnings from this work to be applied across the wider Board area.
Building energy emissions reduction	75% reduction from 1990 baseline by 2030; renewable heating in all NHS-owned buildings by 2038	Subject to successful funding, NHS Highland will utilise the decarbonisation plan to guide future actions. Across the Board's estate, energy audits will be undertaken to identify opportunities for the feasible installation of renewable heating systems and support their implementation where viable.
Fleet electrification – small/light commercial vehicles	All powered by renewable alternatives by 2025; no new large fossil-fuelled vehicles from 2030	NHS Highland car fleet: North Highland: 6.5% EV and 12.2% Hybrid Argyll & Bute: 42% EV and 8% Hybrid
Public Bodies Climate Change Duties reporting	Annual report to Sustainable Scotland Network (PBCCD)	2024/25 report submitted. 2025/26 report on track for submission November 2026.
Annual Climate Emergency & Sustainability Report	Each NHS body to publish annual report per DL (2021) 38	NHS Highland's Climate Emergency and Sustainability Action Report published on our website.

Across the wider estate, the Energy, Environment and Sustainability Team delivered a programme of operational improvements during 2025/26, including:

- Installation of EDF smart meters across multiple sites, improving energy monitoring and consumption data accuracy
- Migration of sites onto consolidated EDF energy supply contracts, streamlining procurement and optimising cost management
- Removal of Calor LPG tanks at several sites, supporting the long-term transition away from fossil fuels
- Replacement of ageing heat meters to improve measurement accuracy and support more reliable assessment of heat consumption
- Progress on removing the remaining heavy fuel oil tank at Raigmore, with transition to gas oil underway
- Active participation in the design of the new Lochaber Hospital, embedding sustainability principles via the NHS Scotland Sustainable Design and Construction requirements, with a focus on energy efficiency, materials, and climate resilience

Transport and Active Travel
NHS Highland has maintained a sustained commitment to electrifying its fleet, replacing fossil-fuel vehicles with electric and hybrid alternatives across a range of service-critical roles. During 2025/26, EV charging infrastructure was expanded at New Craigs, Tain, Invergordon, Ullapool and Lochshell, and work is continuing to upgrade electrical capacity at priority sites.

Given the geographic scale of our region, promoting active and sustainable travel requires tailored approaches. Significant progress has been made through the Active Travel Group, which reports directly to the Environment and Sustainability Board. Highlights include the installation of secure cycle storage at Stadium Road and Ullapool; redistribution of bike shelters to meet demand at Raigmore Hospital; support for a new e-bike docking station and HI-BIKE hub at Raigmore as part of the Better Connecting Inverness initiative; and development of a dedicated cycle route between Raigmore Hospital and the National Treatment Centre.

Successful funding from the Hi-Trans People and Place initiative has supported bike storage improvements and Dr Bike maintenance sessions across NHS Highland sites. A staff commute carbon assessment programme, delivered through the CalCommuter platform, is enabling employees to understand and reduce the environmental impact of their daily travel. We continue to review opportunities to extend active travel infrastructure where demand is evidenced across the region.

Waste Reduction and Resource Efficiency
NHS Highland has strengthened its approach to waste management significantly during 2025/26. The appointment of a dedicated Waste and Resource Manager in November 2024 has enhanced governance, oversight and delivery, with a refreshed Waste Management Plan now in place to direct priorities and monitor performance. The Waste Steering Group provides strategic oversight, ensuring compliance with legal requirements and alignment with national circular economy objectives.

Performance during 2025/26 demonstrates real progress: total waste arisings decreased by 1.3% year-on-year; clinical waste in the orange and yellow stream reduced by 21.87%, substantially exceeding the 10% national target; food waste fell by 28.57%; and the recycling rate increased by 6.35%. NHS Highland met several Scottish Government national benchmarks, including reducing domestic waste by at least 15% from the 2012/13 baseline, maintaining landfill disposal below 5% of domestic waste, and achieving the target to reduce food waste by 33% from the 2015/16 baseline.

Sustainability and Environmental Reporting *cont.*

Case Study
Turning Waste into Resource: The Paper Towel Recycling Project

Around 17% of domestic waste in healthcare settings across NHS Scotland consists of used paper towels, material that, if uncontaminated can be safely diverted from landfill into recycling or composting. NHS Highland introduced a dedicated Paper Towel Recycling Project to capture this high-volume waste stream, delivering tangible environmental, financial and operational benefits across the estate.

Working in close alignment with Infection Prevention and Control (IPC) guidance, the project introduced standardised segregation bins, clear signage and adjusted waste collection processes at suitable clinical and non-clinical sites. Each location underwent a site-specific IPC review before implementation to confirm suitability, making the approach both safe and scalable.

Outcomes and Impact
Environmental Benefits
- Reduced carbon emissions from residual waste disposal
- Increased material recovery, supporting circular economy principles
- Progress toward NHS Scotland sustainability commitments
- Visible improvement for clinical and patient groups

Financial Benefits
- Lower general waste and clinical waste volumes reduced disposal costs
- Potential long-term efficiencies through better-segregated waste streams

Operational Improvements
- Better alignment with NHS Highland's sustainability KPIs (Key Performance Indicators) and reporting obligations
- Improved staff awareness of sustainable practices

The project has improved staff awareness of sustainable practices and strengthened NHS Highland's alignment with national circular economy objectives. It demonstrates how low risk, well-governed operational change can deliver meaningful environmental progress and provides a replicable model for further rollout across the estate.

Green Healthcare
NHS Highland's Green Theatre Programme, pioneered at Raigmore Hospital, has become a nationally recognised model for clinical sustainability. By eliminating high-emission anaesthetic gases including desflurane, significantly reducing nitrous oxide use, and implementing low-flow anaesthesia machines alongside a suite of 12 operational sustainability measures, the programme has substantially reduced the carbon footprint of surgical activity at Raigmore. Its impact has been recognised at national level, with the programme adopted as the National Green Theatres Programme within the NHS Scotland Climate Emergency and Sustainability Strategy 2022–2026. Work continues to develop local provision of sterile water, piloting low-energy pre-cleaning of surgical instruments, and assessing alternative analgesics to reduce reliance on nitrous oxide.

Biodiversity and Greenspace
NHS Highland is reframing its Biodiversity and Greenspace Group to improve governance and ensure that future projects are properly planned, coordinated and sustainable. A revised Board-wide framework will set clear expectations and processes for biodiversity and greenspace activity, supported by Standard Operating Procedures for assessing and approving projects. This structured approach will allow the organisation to maximise environmental benefit from its estate while ensuring projects are operationally sound and aligned to our wider responsibilities.

Climate-Related Risks and Adaptation
NHS Highland recognises that climate change presents a significant and growing risk to the delivery of safe, effective healthcare services. Increasing temperatures, more frequent extreme weather events, and changing environmental conditions have the potential to impact healthcare infrastructure, service continuity, workforce resilience, and population health.

NHS Highland submitted a revised Climate Change Risk Assessment (CCRA) to NHS Assure in March 2026. This updated assessment refreshes timescales and identifies site specific actions, ensuring that adaptation planning remains evidence-based and aligned with both organisational and national priorities. It supports NHS Highland's ongoing commitment to strengthening resilience against the increasing frequency and severity of climate-related impacts on healthcare services and the communities they serve.

The CCRA identifies a range of priority risks, including:

- Flooding and severe weather affecting access to sites and continuity of care
- Overheating of buildings and equipment, impacting patient safety and staff wellbeing
- Disruption to supply chains and utilities, including energy, water, and critical materials
- Increased service demand associated with climate-sensitive health conditions

In response, NHS Highland is planning a programme of adaptation actions, including:

- Incorporating climate risk into estate planning, capital investment, and maintenance programmes
- Undertaking site-specific risk mitigation measures, such as flood resilience and overheating management
- Strengthening business continuity and emergency preparedness arrangements
- Embedding climate considerations into strategic decision-making and service planning

Adaptation planning is supported by ongoing collaboration with national partners, including NHS Assure, and aligns with the Scottish Climate Change Adaptation Programme and NHS Scotland sustainability policies.

NHS Highland will continue to review and update its CCRA and associated action plans on a regular basis, ensuring that emerging evidence, climate projections, and operational learning are incorporated. This approach ensures that the Board remains resilient and capable of delivering high-quality care in a changing climate.

NHS Highland is an active partner in the Highland Adapts initiative, part of the Scottish Government's Climate Ready Regions Programme. In March 2026, Highland Adapts launched the Highland Region Climate Adaptation Plan, establishing a shared framework for addressing climate risks across public, private and third-sector organisations in the region. NHS Highland's participation ensures that health service resilience is integrated within broader regional planning.

Greenhouse Gas Emissions
The NHS Scotland target is to achieve net-zero across direct and indirect emissions by 2040, with an interim ambition to reduce building energy emissions by 75% from the 1990 baseline by 2030.

NHS Highland reports annually through the Public Bodies Climate Change Duties Report. These reports are publicly available via the Sustainable Scotland Network (NHS Highland Sustainable Scotland Network).

Sustainability and Environmental Reporting *cont.*

Sustainability Governance and Oversight
The NHS Highland Board retains overall responsibility for the organisation's response to the climate emergency and takes an active interest in sustainability performance.

Operational and strategic oversight of sustainability sits with the Environment and Sustainability Board, chaired by the Director of Estates, Facilities and Capital Planning. This body oversees delivery across Active Travel and Transport, Energy Management, Waste and Resource Management, Green Theatres, Biodiversity and Greenspace. It reports the Financial Resource and Planning committee (FRP), ensuring that climate-related risks, opportunities and performance are visible at the most senior level of governance.

The Energy, Environment and Sustainability Team leads day-to-day delivery, identifying and implementing practical measures that support NHS Highland's journey to net zero and ensuring compliance with statutory reporting obligations.

Looking Forward
NHS Highland heads into 2026/27 with a clear sustainability agenda and a stronger foundation from which to accelerate progress. The priorities for the coming year include:

- Progressing decarbonisation planning for Raigmore Hospital and Oban, Lorn and Islands Hospital, subject to securing funding. This will enable the development and delivery of prioritised decarbonisation projects across NHS Highland's largest sites, supporting longterm emissions reduction and improved estate sustainability. Advancing fleet electrification where practical building on the infrastructure expanded in 2025/26.
- Embedding the refreshed CCRA findings where practical and including within estates planning cycles and maintenance programmes.
- Continuing active participation in Highland Adapts to strengthen regional climate resilience and progressing with projects jointly with the wider Board as part of the Highland Adapts programme.
- Developing active travel awareness and infrastructure to support this.
- Reducing clinical and food waste, increasing recycling and increasing staff awareness and education in this area.

The climate emergency represents both a responsibility and an opportunity for NHS Highland. Our geography demands innovative, place-based solutions, and our role as a major employer and anchor institution means that the choices we make about energy, travel, procurement and land management have real impact on the communities we serve. We are committed to pursuing that impact with ambition and accountability.

Events after the end of the reporting period
There are no events to report.

Fiona Davies

Chief Executive and Accountable Officer

23 June 2026

NHS Highland Charity
Highland Health Board Endowment Funds

NHS Highland Charity
Helping health and care thrive in every community

NHS Highland Charity* is the official charity of NHS Highland. Every day, we see the difference that kindness and generosity can make. Thanks to donations from patients, families, staff, local communities and partners, the Charity helps health and care thrive across the Highlands and Argyll & Bute.

While NHS Highland delivers frontline health and care services, the Charity exists to enhance and support that care. As a registered Scottish charity, we work in close partnership with NHS Highland, but we remain distinct in purpose and funding. This relationship allows us to respond flexibly and locally, directing charitable funds where they can make the greatest difference and every penny raised stays in our region.

Together, we share a common goal: helping people across the Highlands and Argyll & Bute to experience compassionate, high-quality care, close to home.

In 2025/26, the Charity focused on three key areas: improving patient and service users experience; supporting staff wellbeing and development; and investing in equipment, innovation and service improvement.

* NHS Highland Charity is the working name of Highland Health Board Endowment Funds, Scottish Charity No. SC016791.

Grants Programme and Impact
The Charity processed over 500 grant applications and awarded funds of £874,843 in aid of NHS Highland this year, delivering vital additional support for health and care services across the region. Highlights include:

- A grant of £37,908 was provided to deliver an innovative arts project for dialysis patients at Raigmore General Hospital. This year-long project will embed an artist in residence to work with over dialysis patients weekly which will culminate in a public exhibition of the artwork, developed collaboratively with patients and staff. This project has been made possible through a generous legacy donation from Christine Mackay, a former patient of the Renal Unit at Raigmore Hospital. Christine's husband, Nicholas, welcomed the project and said: "Christine spent many years attending the renal unit and understood first-hand the long hours patients spend receiving dialysis. She would have been pleased to know that her legacy is helping create something positive and engaging for others going through the same experience".
- A grant of £60,000 was made for a Green Health Grants scheme for Badenoch and Strathspey. The funding will support community-led activity that helps to improve physical and mental health, wellbeing and community resilience through engagement with, and appreciation of, the natural environment. This programme draws inspiration from Think Health



Members of the Caithness Boxing Club present their donation in aid of the Highland Critical Care Unit to Rachel Chalmers and Dr Sandy Hunter.

Think Nature, the Highland Green Health Partnership's work programme, which contributes to Our Natural Health Service, a national initiative led by NatureScot promoting the role of nature in supporting better health outcomes.

- A grant of £15,750 provided chemotherapy patients in Lochaber with access to scalp-cooling technology. Chemotherapy treatment, while lifesaving, often comes with side effects that can significantly affect a patient's wellbeing. One of the most visible and distressing of these is hair loss. For many, the loss of hair represents more than a physical change – it can be an emotional burden, impacting confidence, dignity, and self-identity at a vulnerable time. This system reduces scalp temperature during chemotherapy, slowing blood flow to hair follicles and helping to preserve hair.

NHS Highland Charity *cont.*

- Over the 2025 festive period, we provided nearly £18,000 to support staff across Highland and Argyll and Bute to create warmer, more welcoming experiences for staff, patients, residents and service users, helping ensure that no one felt forgotten at Christmas. Because of our donors, staff were able to provide festive gifts, activities, decorations and celebrations across hospital wards, care homes and day services throughout the region. These small but meaningful touches helped bring comfort, dignity and a sense of normality to people at a time when it mattered most.



Residents of Pulteney House residential home in Wick celebrating Christmas in 2025.

Looking Ahead
As we move into the coming year, the Charity will continue to work alongside NHS Highland and our community partners to ensure that charitable funding delivers meaningful, local impact.

We are continually inspired by the generosity of people and communities across the Highlands and Argyll & Bute. Every donation, no matter the size, contributes to better experiences of care.

NHS Highland Charity remains committed to using these funds responsibly and thoughtfully, supporting initiatives that reflect local priorities, strengthen services and bring care closer to home. Together, we are helping compassion, wellbeing and hope to flourish across every community we serve.

Catherine Myles
Charity Lead Officer

3. Accountability Report

This section sets out how NHS Highland governs itself and accounts for its use of public funds. It covers corporate governance, the Governance Statement, remuneration and staffing, and our Parliamentary Accountability Report for the year ended 31 March 2026.

Corporate Governance Report

(a) The Directors' report

The Directors present their report and the audited financial statements for the year ended 31 March 2026.

Date of issue
Financial statements were approved by the Board and authorised for issue by the Accountable Officer on 23 June 2026.

Appointment of Auditors
The Public Finance and Accountability (Scotland) Act 2000 places personal responsibility on the Auditor General for Scotland to decide who is to undertake the audit of each health body in Scotland. For the financial years 2023/24 the Auditor General appointed Audit Scotland to undertake the audit of NHS Highland. The general duties of the auditors of health bodies, including their statutory duties, are set out in the Code of Audit Practice issued by Audit Scotland and approved by the Auditor General. Audit Scotland did not undertake any non-audit work in year.

Board membership
Under the terms of the Scottish Health Plan, the Health Board is a board of governance whose membership will be conditioned by the functions of the Board. Members of Health Boards are selected based on their position or the particular expertise which enables them to contribute to the decision-making process at a strategic level.

The Health Board has collective responsibility for the performance of the local NHS system as a whole and reflects the partnership approach, which is essential to improving health and social care.

Chair	Sarah Compton-Bishop	
Vice Chair	Gerard O'Brien	Chair of Remuneration Committee Chair of the Highland Health & Social Care Committee Chair of the Population Health and Planning Committee
Executive Directors	Fiona Davies	Chief Executive
	Dr Boyd Peters	Medical Director
	Louise Bussell	Nurse Director
	Heledd Cooper	Director of Finance
	Jennifer Davies	Director of Public Health
Non-executive Directors	Alexander Anderson	Chair Finance, Resources & Performance Committee
	Emily Austin	Chair of Audit Committee
	Graham Bell	Chair Argyll and Bute Integration Joint Board
	Albert Donald	Nationally appointed Whistleblowing Champion
	Graham Illsley	Non Executive Director
	Brian Steven	Non Executive Director
	Karen Leach	Chair of Clinical Governance Committee Chair of Pharmacy Practices Committee
	Philip MacRae	Chair of Staff Governance Committee
	Janice Preston	Non Executive Director
	Joanne McCoy	Non Executive Director
	Steve Walsh	Non Executive Director
	Dr Neil Wright	Non Executive Director
Stakeholder Members	Muriel Cockburn	Highland Council Representative
	Garret Corner	Argyll and Bute Council Representative
	Gavin Smith	Employee Director
	Allyson Turnbull-Jukes	Chair of Area Clinical Forum

The statement of Board members' responsibilities
Under the National Health Service (Scotland) Act 1978, the Health Board is required to prepare accounts in accordance with the directions of Scottish Ministers which require that those accounts give a true and fair view of the state of affairs of the Health Board as at 31 March 2026 and of its operating costs for the year then ended. In preparing these accounts, the Directors are required to:

- Apply on a consistent basis the accounting policies and standards approved for the NHS Scotland by Scottish Ministers
- Make judgements and estimates on a reasonable basis
- State where applicable accounting standards as set out in the Financial Reporting Manual have not been followed where the effect of the departure is material
- Prepare the accounts on the going concern basis unless it is inappropriate to presume that the Board will continue to operate

The Health Board members are responsible for ensuring that proper accounting records are maintained which disclose with reasonable accuracy at any time the financial position of the Board and enable them to ensure that the accounts comply with the National Health Service (Scotland) Act 1978 and the requirements of the Scottish Ministers. They are also responsible for safeguarding the assets of the Board and hence taking reasonable steps for the prevention of fraud and other irregularities.

The NHS Board members confirm they have discharged the above responsibilities during the financial year and in preparing the accounts.

Board members' and senior managers' interests
In line with statutory requirements, the Board maintains a register of Board Members' interests which is available online on our Internet site and is updated annually. Board Members must notify the Nominated Standards Officer of any submission changes within one month. The Standards Officer updates the register upon receiving notifications and issues regular process reminders. The register is refreshed when a new Board Member joins.

During the year, several current Directors/Senior Employees registered the following interests:

Alexander Anderson		Scrabster Harbour Trust Board
Dr Tim Allison	Retired mid year	ARMA Inequalities Panel Daughter employed by Action for Children which has NHS Highland contracts with the organisation Wife employed as Chaplain by NHS Highland
Emily Austin		Management Consultant – DWS Associates Ltd Trading as 'Glic' – Glic provide some services to NHSH
Graham Bell		Director – The Leader Scotland Community Justice Scotland Cove Burgh Hall
Louise Bussell		Nothing to register
Elspeth Caithness	Term ended mid year	Royal College of Nursing Trade Union
Alasdair Christie	Term ended mid year	Inverness, Badenoch, and Strathspey Citizen's Advice Bureau Elected Member of The Highland Council Culduthel Woods Charity Inverness BID Eden Court Theatre
Muriel Cockburn		Elected Member of The Highland Council
Sarah Compton-Bishop		Freelance Project Management Isle of Jura Development Trust Jura Care Centre Group Board member Development Trust Association Scotland
Heledd Cooper		Nothing to register

Corporate Governance Report *cont.*

Garret Corner		Elected Member of Argyll and Bute Council
Fiona Davies		Board Member Lochaber Music School Husband – Associate Lead Nurse, Mental Health
Albert Donald		Scottish Professional Football League Scottish Football Association NHS Grampian Non-Executive Director, Whistleblowing Champion Rotary Club Member, Laurencekirk Church Elder, Laurencekirk Parish Church Trustee of Dickson Hall, Laurencekirk Share Portfolio managed by Acumen Financial Planning Wife – Nurse in NHS Grampian
Karen Leach		Nothing to register
Philip MacRae		Royal Bank of Scotland
Joanne McCoy		Manager – MySelfManagement The Reel McCoy, quilting and textiles art MS Society Scotland Volunteer MS Society Ross-shire Board Member Health and Social Care Alliance
Gerard O'Brien		Director & Chair of Voluntary Action Orkney (to 16/09/2025)
Dr Boyd Peters		Nothing to register
Janice Preston		Non-Executive Board Member Health and Social Care Alliance Apprentice for Art of Hosting Work Public Health/NHS Highland
Dr Neil Wright		Partner is a Community Podiatrist Partner at Craig Nevis Surgery to 5th Oct 2025
Catriona Sinclair	Term ended mid year	Director Spa Pharmacy Director Community Pharmacy Scotland Board member Royal Pharmaceutical Society Director CPS Services Edinburgh
Steve Walsh		CEO Highlife Highland Ltd
Graham Illsley	Joined November 2025	Trustee of Starfish Way
Brian Steven	Joined November 2025	Community Councillor for South Knapdale Community Council Independent Turnaround contractor for NHS Ayrshire and Arran (BRAG Consultancy)
Jennifer Davies	Started July 2025	Nothing to register

All Board Members are Highland Health Board Endowment Fund Trustees.

Directors third party indemnity provisions
There have been no third-party indemnity provisions in place for any of the Directors at any time during the year.

Remuneration for non-audit work
Our external auditors, Audit Scotland, did not undertake any non-audit work on behalf of the Board.

Value of land
The value of land (excluding land that has been declared surplus to requirements) recorded in our SoFP is at current value. Surplus land has been valued at Open Market Value.

Public Services Reform (Scotland) Act 2010
Sections 31 and 32 of the Public Services Reform (Scotland) Act 2010 impose new duties on the Scottish Government and listed public bodies to publish information on expenditure and certain other matters as soon as is reasonably practicable after the end of each year. Data is published on our website – click here.

Personal data related incidents reported to the Information Commissioner
During the period 1 April 2025 to 31 March 2026 NHS Highland has reported three Data Breaches to the ICO. The ICO confirmed that they did not intend to take action in relation to any of the three matters.

Disclosure of information to Auditors
The directors who held office at the date of approval of this directors' report confirm that, so far as they are each aware, there is no relevant audit information of which the Board's auditors are unaware; and each director has taken all the steps that they ought reasonably to have taken as a director to make themselves aware of any relevant audit information and to establish that the Board's auditors are aware of that information.

(b) The statement of the Chief Executive's responsibilities as accountable officer

Under Section 15 of the Public Finance and Accountability (Scotland) Act, 2000, the Principal Accountable Officer (PAO) of the Scottish Government has appointed me as Accountable Officer of NHS Highland.

This designation carries with it, responsibility for:

- The propriety and regularity of financial transactions under my control; the economical, efficient and effective use of resources placed at the Board's disposal; and
- Safeguarding the assets of the Board.

In preparing the Accounts, I am required to comply with the requirements of the Government's Financial Reporting Manual and, in particular, to:

- Observe the accounts direction issued by the Scottish Ministers including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed and disclose and explain any material departures; and
- Prepare the accounts on a going concern basis.

I confirm that the Annual Report and Accounts as a whole are fair, balanced and reasonable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that is fair, balanced and understandable.

I am responsible for ensuring proper records are maintained and that the Accounts are prepared under the principles and in the format directed by Scottish Ministers. To the best of my knowledge and belief, I have properly discharged my responsibilities as accountable officer as intimated to me in the Departmental Accountable Officers letter dated 7 March 2024.

Signed:

Fiona Davies

Chief Executive and Accountable Officer

23 June 2026

Governance Statement

Scope of responsibility
As Accountable Officer, I am responsible for maintaining an adequate and effective system of internal control that supports compliance with the organisation's policies and promotes achievement of the organisation's aims and objectives, including those set by Scottish Ministers. Also, I am responsible for safeguarding the public funds and assets assigned to the organisation.

I took responsibility for governance when I was appointed Accountable Officer by Scottish Government on 7 March 2024.

In accordance with IAS 27 – Consolidated and Separate Financial Statements, these Financial Statements consolidate the Highland Health Board Endowments Funds. This statement includes any relevant disclosure in respect of these Endowment Funds Accounts. The external auditors of the Endowment Funds accounts are the firm of accountants, Mackenzie Kerr Ltd.

Purpose of internal control
The system of internal control is based on an ongoing process designed to identify, prioritise and manage the principal risks facing the organisation. The system aims to evaluate the nature and extent of risks and to manage risks efficiently, effectively, and economically.

The system of internal control is designed to manage rather than eliminate the risk of failure to achieve the organisation's aims and objectives. As such, it can only provide reasonable and not absolute assurance.

The process within the organisation accords with guidance from Scottish Ministers in the Scottish Public Finance Manual (SPFM) and supplementary NHS guidance and has been in place for the year up to the date of approval of the annual report and accounts.

The SPFM is issued by Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds. The SPFM sets out the relevant statutory, parliamentary, and administrative requirements, emphasises the need for efficiency, effectiveness and economy and promotes good practice and high standards of propriety.

Governance framework
NHS Highland is responsible for commissioning and providing health care services for the residents of Highland and Argyll & Bute. An NHS Board, primarily composed of Non-Executive members, sets strategic direction aligned with national and local priorities and gains assurance on objectives and service quality through its governance committees.

The Board has collective responsibility for health improvement, the promotion of integrated health and community planning through partnership working, involving the public in the design of healthcare services and staff governance.

The NHS Board's work is linked with that of the Argyll & Bute Integration Joint Board which is a separate legal body set up under the Public Bodies (Joint Working) (Scotland) Act 2014 which aims to better integrate Health and Social Care services. The planning, commissioning, and oversight of a range of health services and adult social care are delegated by the Board and the Local Authority to the Integration Joint Board.

The Highland Partnership (The Highland Council and NHS Highland) commits to achieving the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Public Bodies (Joint Working) (Scotland) Act 2014 through a Lead Agency arrangement.

Members of Health Boards are selected based on their position, or their expertise, which enable them to contribute to the decision-making process at a strategic level.

NHS Highland Board meets every two months to progress its business. All Board meetings are held in public with Board papers and agendas being published on our website. Items of business that are commercially sensitive will be discussed in private session. Public accessibility to Board meetings has been maintained throughout 2025/26 with access for stakeholders and public through MS Teams.

The Board also holds Development/Briefing Sessions ten times per year to update Board members on current hot topics, horizon scan, and engage the Board in the strategic direction of the organisation. Sessions are held throughout the year focussing on Board members' development needs to improve skills and knowledge across the Board. As an example, in November 2025 Board members held a workshop, facilitated by our Director of People & Culture Executive Lead for Governance, to improve knowledge and understanding of Governance Models we have in Highland.

The Code of Corporate Governance, revised on an annual basis, identifies Committees that report to the Board to enable it to fulfil its duties. Each Governance Committee has a clear role and remit, chaired by a Non-Executive Director, with a Non-Executive Vice Chair and at least two Non-Executive Director members.

The Board's Governance Committees which support compliance with relevant laws, regulations, policies and procedures and provide assurance to the Board, are Audit Committee; Clinical Governance Committee; Staff Governance Committee; Finance, Resources and Performance Committee; Remuneration Committee; Population Health and Planning Committee and Pharmacy Practices Committee. All Governance Committee minutes are available to the public on our website except for the Remuneration Committee. The principal function of each committee is:

Clinical Governance – To carry out the statutory duties as outlined in NHS MEL(1998~)75, NHS MEL (2000)29 and NHS MEL (2001)74 and to give the Board assurance that clinical and care governance systems are in place and working throughout the organisation.

Audit Committee – To provide the Board with the assurance that the activities of NHS Highland Board are within the law and regulations governing the NHS in Scotland that an effective system of internal control is maintained and that a strong corporate governance culture is in operation. The duties of the Audit Committee are in accordance with the Scottish Government Audit & Assurance Handbook, dated March 2018.

Staff Governance – The purpose of the Staff Governance Committee is to support and maintain a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system and is built upon partnership and collaboration. It will ensure that robust arrangements to implement the Staff Governance Standard are in place and monitored.

Remuneration – To consider and agree performance objectives and performance appraisals for staff in the Executive cohort and to oversee performance arrangements for designated senior managers. The Committee will be responsible for applying the remit detailed in NHS: MEL (2000) 25, NHS HDL (2002) 64 and subsequent guidance.

Finance, Resources & Performance – The Committee provides assurance to the Board on the financial position and performance against key financial and non-financial targets of the Board, to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources and that the arrangements are working effectively.

Highland Health and Social Care – The purpose is to provide assurance to NHS Highland Board that the planning, resourcing and delivery of those community health and social care services that are its statutory or commissioned responsibility are functioning efficiently and effectively, ensuring that services are integrated so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care.

Area Clinical Forum – The Area Clinical Forum provides coordinated, system wide clinical and professional advice to the NHS Highland Board on strategic, quality, safety and service issues. It brings together advice from across the professional advisory committees to ensure a coherent clinical perspective informs Board strategies, plans and decisions, supports effective prioritisation of resources, and enables escalation where there are significant concerns about the quality or safety of care.

Population Health and Planning Committee – The Population Health and Planning Committee advises and assures the NHS Highland Board on the development and delivery of strategic plans that improve population health, strengthen prevention, and reduce health and care inequalities. It provides oversight of the Board's population health strategy and

Governance Statement *cont.*

associated programmes, ensuring that decisions are evidence based, outcomes focused, aligned with partnership working, and make best use of available resources, while monitoring progress, impact and effectiveness over time.

Pharmacy Practices Committee – The Pharmacy Practice Committee (PPC) is a Committee of the Health Board, with delegated responsibility for considering applications received to join the Board's Pharmaceutical List. The Committee is constituted under Schedule 4 of the General Pharmaceutical Services (Scotland) Regulations 2009 as amended.

Membership of committees as at March 2026 is reflected below:

	HHSCC	HHSCP JMC	A&B IJB	Audit	Population Health & Planning	Finance Resources Performance	Clinical Gov	Staff Gov	RemCom	Pharmacy Practices	Endowment Funds Committee
Alex Anderson		●		●	●	● ●					
Emily Austin			●	● ●	●						
Graham Bell			● ●			● ●					
Muriel Cockburn	●						●			●	
Sarah Compton-Bishop		● ● *							●		
Garret Corner				●		●				●	●
Albert Donald				● ●				●	● ●		
Graham Illsley							●				
Karen Leach			●		●		● ●		●	● ●	
Philip MacRae	● ●				●			● ●			● ●
Joanne McCoy	●						● ●				● ●
Gerry O'Brien	● ●	●			● ●	●			● ●	●	
Janice Preston			●					●			
Gavin Smith					●			●	●		●
Brian Steven				●							●
Allyson Turnbull-Jukes					●		●				
Steve Walsh						●		● ●	●		
Dr Neil Wright	●	●									

● Chair ● Vice Chair *Co-Chair ● Member

Blueprint for Good Governance
Work has continued this year to improve Board effectiveness through delivery of the remaining actions in Board's Blueprint for Good Governance Improvement Plan. This plan was agreed in July 2023 following the Board's participation in a pathfinder exercise to establish a national approach to self-assessment against the Blueprint or Good Governance, issued in document DL (2022) 38 in December 2022.

The plan contained 17 actions across the following themes: Performance, Finance and Best Value, Risk, Culture, Quality, Board Members development, SBAR development, and Engagement.

The board received an update in July 2025 against the plan with 12 of these actions completed and the remaining actions focussed on Quality and Risk. Work to progress these remaining actions has continued and will continue into 2026-2027 as we await further guidance from Scottish Government on the next phase of self-evaluation.

In parallel, NHS Highland has continued to review and improve Board governance arrangements over the course of the year, supported by Board development sessions. This has included:

- Changes to the layout of Board and Committee templates to ensure a concise summary is included at the start of papers, providing clarity on the purpose of each paper and the specific actions or decisions required. This has improved the clarity and accessibility of papers for Board members.
- Introduction of a standardised Board Committee summary template to provide Board members with a concise overview of key matters discussed, in advance of submission of formal Committee minutes.
- Changes to the running order of Board agendas to ensure Committee updates are considered in a structured way, reducing duplication where matters have already been reviewed in depth at Committee level.

These changes were developed in response to collective discussion amongst Board members and have supported improvements in the efficiency and effectiveness of Board and Committee business.

In addition, the Board has reviewed its approach to Committee self-assessment. Previously based on a standardised question set, a tailored set of questions has now been developed for each Committee, aligned to its specific remit and responsibilities. These will be used in facilitated sessions to support Board members in reviewing Committee effectiveness and identifying further improvement actions. This will form a key element of the Board's ongoing governance improvement activity, alongside the completion of the remaining actions within the Improvement Plan.

Further governance improvements embedded during the year include:

- Board and Committee Chairs meetings have taken place throughout the financial year. This Group maintains oversight of Governance Committee remits and priorities with agendas from across all the committees reviewed each governance cycle to provide a holistic view of the committee business.
- The updated Framework Document for NHS Boards (DL 2025-13) which sets out how the Scottish Government and NHS Boards work together including accountabilities of the board has been reviewed to ensure board and committee workplans align with the reporting duties outlined in the document.
- This range of activity, both completed and ongoing, demonstrates NHS Highland's continued focus on strengthening governance arrangements in line with the principles of the Blueprint for Good Governance and supporting effective Board leadership, decision-making and oversight.

Other governance arrangements
NHS Highland's Governance Framework operates under a Code of Corporate Governance which was revised throughout the financial year and approved by the Board in March 2026. The Code includes the following documents:

- NHS Highland Board Committee Structure
- Standing Orders for NHS Highland Board
- Governance Committee Terms of Reference
- Code of Conduct for Board Members
- Standing Financial Instructions
- Reservation of Powers and Scheme of Delegation
- Counter Fraud Policy and Action Plan
- Standards of Business Conduct for Staff

The conduct and proceedings of the NHS Board are set out in the Standing Orders. These specify the matters which are solely reserved for the NHS Board to determine, the matters which are delegated under the scheme of delegation and the matters which are remitted to a Governance Committee of the NHS Board.

All Committees of the Board provide an Annual Statement of Assurance to the Audit Committee and Board, describing their membership, attendance, frequency of meetings, business addressed, outcomes and assurances provided, risk management and demonstrating they have fulfilled their roles and remit.

The Board continues to apply a standardised assurance approach to all Board and Governance Committee business throughout the financial year. The reporting format lays particular emphasis not only on the level of assurance being offered but also on the delivery of objectives associated with the five-year Strategy 'Together We Care, for you with you', and the risks that are being addressed.

Governance Statement *cont.*

Our Annual Review took place on Tuesday 18 November 2025 and was held in Aviemore. This was a non-ministerial review which was open to members of the public to attend in person and online. A recording of the main public session has been uploaded to the NHS Highland website. NHS Highland Board Chair and Chief Executive chose to hold individual meetings with public/patient representatives, Partnership Forum and Area Clinical Forum members in addition to the public meeting. The whole day was a very positive event which built on existing good relations with partnership, public representatives and professional colleagues.

The development needs of Executive and Non-Executive Directors are identified through a process of regular appraisal. New Non-Executive Directors receive an induction which forms part of training for all Board members. Regular development sessions are held to address the needs of Non-Executive Directors.

The Board and Governance Committee have continued to maintain oversight of the organisation's performance through the bi-monthly Integrated Performance and Quality report, visible throughout the leadership structure as a high-level overview of the performance of our system of health and care. Reporting on aspects of Clinical, Operational, Financial and Staff governance, the report ensures a holistic view of the organisation which is overseen by the Board's Governance Committees.

The NHS Highland Board appoints four of its members to the Argyll & Bute IJB who can provide assurance to the Board regarding the IJB's overall performance and financial position. NHS Highland Board also receives a copy of the IJB performance report as per its production frequency to consider as part of its Board business schedule. The financial position relating to health services provided in Argyll & Bute is reported to each meeting of NHS Highland Board within the Financial Assurance report and the overall financial position of the IJB is reported to each IJB meeting.

Other forms of assurance flow through the operational management structure, with the IJB's Chief Officer being jointly accountable to the Board's Chief Executive and the Council's Chief Executive. The IJB's Chief Finance Officer has a professional link to the Board's Director of Finance and there is a regular dialogue regarding the financial position.

The Board seeks to promote good governance throughout its joint working with a wide range of organisations: local authorities, third sector and other organisations both within and external to the NHS, through the Highland and Argyll & Bute Community Planning Partnerships.

Escalation status
NHS Highland is currently sitting at Stage 2 of the NHS Performance Escalation Framework in respect of Governance, Leadership and Culture, and vaccinations. Scottish Government continue to monitor and support the Board as longer-term cultural changes become embedded in the organisation.

NHS Highland remains at Stage 3 for Financial Management and Mental Health Performance until further progress is made in the provision of mental health services, this status is subject to ongoing review. Measures remain in place for Scottish Government to support the Board for these two areas.

The Executive team review the escalated areas at every Executive Directors Group meetings and the Board continues to receive enhanced assurance and oversight in these areas through its governance committees and associated improvement programmes.

Leadership
Sarah Compton-Bishop has remained as NHS Highland Chair throughout the whole of the year. Ms Compton-Bishop has served on the Board since November 2017 as a Non-Executive Board member and was appointed to the position of Board Chair with effect from 1 April 2023.

We have recruited two new Non-Executive Board Directors. These appointments were to fill two Non-Executive vacancies that occurred due to two Non-Executives coming to the end of their respective terms during the year.

We have maintained a stable Executive leadership team throughout the year, delivering on our transformation agenda and role modelling the culture and behaviours we wish to see across the organisation. The new position of Head of Corporate Governance has also been created and recruited to within this financial year which has further strengthened Governance arrangements.

People
Under our four strategic People intentions – **Grow Well**, **Nurture Well**, **Listen Well** and **Plan Well** – we have made significant progress towards our objective **to be a great place to work**.

The **People and Culture Portfolio Board** provides oversight of the People strategic portfolio and seeks assurance that priorities for NHS Highland are being progressed across the following portfolios:

- Leadership & Development
- Employability
- Health & Wellbeing
- Equality, Diversity and Inclusion
- Health & Care Staffing Act

In 2025/26, we launched the following three-year Workforce Strategies: **Employability, Health & Wellbeing**, and **Equality, Diversity & Inclusion**, alongside **Equality Outcomes 2025–2029**, following organisation-wide consultation and consideration.

Employability
We are committed to being an exemplar employer that builds community wealth by widening access to work, including for those who face barriers to entering the labour market. Our focus includes:

- Early pathways: schools' engagement, work experience, and expanded entry routes for young people.
- Access and support: placements and work trials (including paid placements), supported by mentoring, supervisor training, and third sector partnerships.
- Progression and pipelines: expansion of apprenticeships and learning pathways with providers, strengthening local talent pipelines and career-change opportunities.

Key progress during 2025/26
- Development of a secondary school engagement plan.
- Delivery of a Careers in the NHS pilot day for S2/S3 pupils, with participation from eight schools.
- Delivery of six career weeks, with 72 pupils achieving an SCQF Level 4 work placement.
- Successful RD&I funding secured for VR headsets to support virtual role exploration.
- Pilot of a successful seven-week programme with Barnardo's to support young people not engaged in education, focusing on employability skills, career exploration, work experience placements and mock interviews.

NHS Highland continues to develop innovative models of care through workforce transformation, working in close partnership with colleagues across health and social care. Central to this work has been the expansion of advanced, specialist, consultant and lead roles for nurses, midwives and allied health professionals creating new clinical pathways and deepening expertise in areas where it matters most, including unscheduled care, dementia, and palliative care. These roles represent a fundamental shift in how care is planned and delivered, with nurses and their colleagues leading improvements that make a tangible difference to patients and families across Highland.

Health & Wellbeing
Our ambition is for NHS Highland to be a great place to work, with the wellbeing of our workforce as a key priority under our **Nurture Well** commitment.

We aim to support colleagues' physical and mental health and wellbeing throughout all stages of their life and career, fostering an inclusive and kind culture where difference is valued and respected. During 2025/26, our main focus was to improve staff access to support, prevention and early intervention.

These arrangements support the Board in discharging its staff governance responsibilities and provide assurance in relation to workforce sustainability, staff wellbeing, equality, diversity and inclusion, and organisational culture.

Governance Statement *cont.*

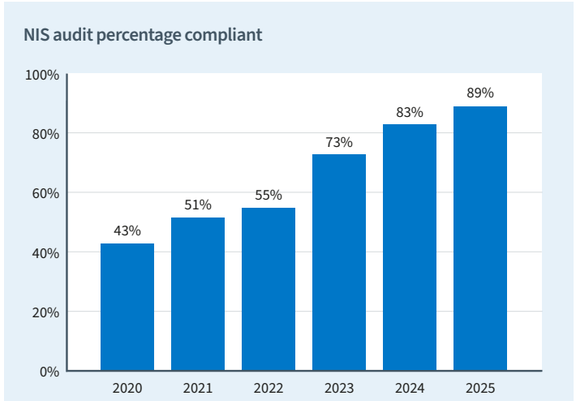
Key progress during 2025/26

- Review of the Employee Assistance Programme to provide 24/7 support and advice, alongside promotion of the refreshed service through wellbeing roadshows and engagement events.
- Improved visibility of health and wellbeing resources through refreshed intranet content and practical guidance for staff and managers.
- Establishment of a project group focused on stress-at-work initiatives and launch of an employee psychological support service.
- Targeted awareness campaigns focusing on financial wellbeing, mental health and physical health conditions.
- Launch of the internal Speak Up service (Openline), providing confidential support and alternative routes for listening, helping to resolve issues and rebuild trust and confidence.

Information governance and security

Responsibility for oversight of information governance within NHS Highland lies primarily with the Information Assurance Group. The Information Assurance Group meets on a quarterly basis and is chaired by the Deputy Chief Executive/SIRO who also represents information governance and information security at board level. The composition of the Information Assurance Group membership ensures that Information Governance, Information Security and Data Protection matters are considered from diverse organisational viewpoints. To ensure appropriate governance, bi-annual reports are provided by the Information Assurance Group to both the Clinical Governance Committee and the Audit Committee. Additional quarterly updates on cyber resilience are provided to the Resilience Committee.

Being classified as an operator of an essential service, NHS Highland is subject to the Network and Information Systems (NIS) regulations. Compliance to the NIS regulations is monitored by the Scottish Government appointed regulator, the Scottish Health Competent Authority (SHCA). The SHCA commissions annual audit assessments to be conducted by an independent external auditor against all NHS Scotland Health Boards. The NIS audit uses the Scottish Government's Public Sector Cyber Resilience Framework as the control set with which to measure compliance to the NIS regulations. The Scottish Government set NIS compliance standards in 2023 that NHS Scotland Health Boards are expected to meet. The standards include an expectation that Boards achieve an overall NIS compliance score of at least 60%.



The NIS audit conducted in 2025 resulted in NHS Highland achieving an overall compliance score of 89%. As shown above, NHS Highland continues to show year on year improvements in its compliance with the control set defined in the Public Sector Cyber resilience Framework.

Assessing risk

Risk management is a core component of NHS Highland's system of internal control and underpins effective corporate governance. The Board is responsible for ensuring that robust arrangements are in place to identify, assess and manage risks that could impact the delivery of its strategic objectives, including the quality and safety of care, financial sustainability and compliance with statutory and regulatory requirements. The Board considers its risk appetite in setting strategic objectives and in monitoring risk exposure.

NHS Highland operates a structured risk management process supported by Board and operational risk registers. Risks are identified and assessed based on their likelihood and impact, with mitigating actions and controls assigned to named risk owners. This approach enables the organisation to respond to emerging risks and supports informed decision-making and effective use of resources.

The Audit Committee provides independent assurance to the Board on the effectiveness of risk management and internal control arrangements. This includes oversight of the risk management framework, review of risk reporting, and consideration of assurance provided by internal audit, external audit and management. The Governance Statement is informed by these assurance processes.

Strategic risks are reviewed regularly by the responsible Executive Director and the relevant governance committees. The Board Risk Register is considered by the Executive Directors Group, which is responsible for overseeing the identification, escalation and management of significant risks. Board-level risks are reported to the Board at each meeting, ensuring visibility of the organisation's risk profile and the actions being taken to manage key risks.

Through these arrangements, the Board is able to maintain oversight of principal risks, ensure that appropriate controls are in place, and support the delivery of its objectives while safeguarding public funds and services.

Risk management

NHS Highland operates a risk management strategy aligned with the Scottish Public Finance Manual and relevant NHS Scotland guidance. This strategy supports delivery of organisational objectives and the safeguarding of public funds.

Risk management is embedded within the organisation's system of internal control and is applied consistently across strategic and operational levels. Risks are identified, assessed and managed through a structured process, supported by Board and operational risk registers, and underpinned by defined controls and mitigating actions.

NHS Highland faces a range of significant risks reflecting the scale and complexity of the services it provides. The Board Risk Register highlights a number of key strategic risks, including the challenges associated with delivering services across remote and rural geographies, workforce availability and affordability, and the impact of wider social, economic and political factors on staff sustainability. In addition, the organisation continues to operate within a financially constrained environment, with increasing demand and real-terms resource pressures.

These factors create risks to the organisation's ability to deliver all services in all locations as currently configured and reinforce the need for service redesign and prioritisation. Other key risks reflected in the Board Risk Register include statutory and mandatory training compliance, cyber security, organisational culture, and the condition of the estate, including backlog maintenance and fire safety.

Risk management supports the delivery of safe, effective and person-centred care by enabling the organisation to identify emerging issues, respond proactively and learn from experience. The integration of risk information with performance, quality and safety data supports continuous improvement and informed decision-making across the organisation.

Financial plan 2026/27

NHS Highland submitted its financial plan to the Scottish Government in March 2026, prepared in accordance with the requirements set out in the 2026/27 Budget Letter. The plan outlined an initial projected deficit position of £113.177m, with a range of mitigating actions identified to reduce this to a net gap of £66.957m.

Scottish Government has confirmed the availability of up to £40m in deficit support funding. Notwithstanding this, a residual gap remains and further action will be required throughout 2026/27 to deliver financial balance.

In addressing this challenge, NHS Highland recognises the need to prioritise sustainable, recurring interventions that align financial recovery with the delivery of improved population health outcomes. This includes a continued focus on value-based decision-making, service redesign, and investment in preventative and community-based models of care, ensuring that actions taken to reduce the financial gap are both clinically appropriate and support long-term system sustainability.

This financial position represents a significant strategic risk for the organisation, which is being actively managed through the Board's financial recovery and planning processes.

Governance Statement *cont.*

Review of adequacy and effectiveness
As Accountable Officer, I am responsible for reviewing the adequacy and effectiveness of the system of internal control. My review is informed by:

- Regular interaction and discussion with executive directors and senior managers who are responsible for developing, implementing and maintaining internal controls across their respective areas.
- Reviewing any reports received from relevant inspection bodies.
- The work of the internal auditors, who submit to the Audit Committee regular reports which include their independent and objective opinion on the effectiveness of risk management, control and governance processes, together with recommendations for improvement;
- The work of the external auditors, including their independent and objective opinion on the audit of the annual report and accounts and their review of key financial systems and controls
- Financial plans, service plans and related organisational performance reports presented to the Board and relevant governance committees;
- Annual reports and statements of assurance prepared by each of the Board's governance committees, along with the results of a self-assessment exercise undertaken by committee members.
- The range of topics explored at Board Development Sessions and other fora, enhancing the knowledge, awareness, and engagement of both executive and non-executive board members on strategic matters.
- The thorough and comprehensive approach to risk management, reviewed and agreed by the Board.
- The depth and range of items discussed by governance committees and other groups in support of the Board and its agreed strategies and Corporate Objectives.
- Assurance from the External Auditor of the Highland Health Board Endowment Funds, Mackenzie Kerr in their management letter, that expenditure complies with the charitable purpose and that endowment Funds have not been used retrospectively for expenditure originally authorised as a commitment against exchequer funds;
- The National Service Audit Reports which report on the effectiveness of the following systems of control managed on the Board's behalf:
  - National Single Instance Financial Ledger Services (NHS Ayrshire & Arran)
  - National IT Services (Public Services Delivery Scotland)
  - Practitioner and Counter Fraud Services (Public Services Delivery Scotland)

The Audit Committee meets regularly throughout the year with the specific remit to review and give assurances on the system of internal control. The Committee agrees the internal audit plan, considers the internal audit reports, reviews recommendations, and ensures actions are undertaken that result from these reports.

Internal Audit reviews identified agreed actions to be undertaken which are subsequently followed up to ensure they have been completed within the timescales agreed. The Executive Directors Group has been reviewing these on an ongoing basis, ensuring that these are completed by the revised agreed dates. The Audit Committee continues to monitor and receive reports on progress to completion of all the actions and continues to take active and positive steps to improve implementation of Internal Audit recommendations.

The committee has reviewed the progress of 148 actions during the year and obtained sufficient evidence to close 53 (36%) of these, with one further action removed and placed on the relevant risk register. Of the remaining 94 actions, 14 (15%) are complete subject to evidence being provided to audit, 22 (24%) are on track or being progressed with a revised completion date, and 58 (62%) are not yet passed their original due date.

For 2025/26 the Audit Committee agreed a wide range of audit review areas, and together with management, identified the areas where there were known issues and used the findings and recommendations arising from internal audit work to strengthen the control environment. Audit Committee also requested the key themes to be drawn out of these audits. These are the areas covered by internal audit review for 2025/26:

1. Third Sector Allocations
2. Financial Management and Savings Plan
3. Workforce Staffing Levels
4. Health and Safety
5. Resident Doctor Compliance – Working Time and Reward
6. SSTS Processes
7. Inventory Control
8. Operational Performance and Compliance Monitoring
9. Remote Access
10. Change Controls
11. Performance Management
12. Children's Services – Transition Arrangements

A range of themes have arisen through the audits undertaken throughout the year which centre around Policies & Procedures, Performance Monitoring, and Reporting and Oversight. Management continues to make progress in implementing agreed actions from internal audit reports.

In 2025/26 Internal Audit gave the opinion that "NHS Highland has a framework of governance, risk management and controls that provides reasonable assurance regarding the effective and efficient achievement of objectives, except in relation to specific aspects of Health and Safety (particularly regarding ensuring that Water Risk Assessments have been undertaken in line with requirements, and ensuring appropriate assurances are obtained from third party owned properties that the required assessments have been undertaken)."

The Audit Committee has reported to the Board regularly and highlighted key issues throughout the year. Management have continued to make progress in implementing agreed actions from internal audit reports. All grade 3 actions identified in 2025/26 are being progressed and implemented, these are all either complete, on track or in progress with revised implementation dates.

The systems have been in place for the year under review and up to the date of the approval of the annual report and accounts. While the overall framework provides reasonable assurance, specific areas requiring continued management focus include Health and Safety controls and the timely completion of internal audit actions.

Conclusion
No other significant control weaknesses or issues have been identified during the financial year beyond those set out in this statement and no significant failures have arisen in the overall standard for good governance, risk management and control.

Based on the range of assurance received, including the work of internal and external audit and the assurances provided by the Board's Committees, I am able to conclude that, taking account of the matters set out above, corporate governance operated effectively throughout the financial year to 31 March 2026.

Signed:

Fiona Davies

Chief Executive and Accountable Officer

23 June 2026

Remuneration Report and Staff Report

Board members' and senior employees' remuneration
Board Members and Senior Employee Remuneration is subject to ministerial direction and the arrangements for payment are covered by Health Department instruction (currently PCS (ESM) 2019/01).

The implementation of these instructions is monitored by the Remuneration Committee, whose membership is:

Membership from 1 April 2025-March 2026:
Gerry O'Brien, Board Vice Chair (Committee Chair)
Albert Donald, Non-Executive Director (Committee Vice Chair)
Sarah Compton-Bishop, Board Chair
Elspeth Caithness, Employee Director (Until 31st October 2025)
Gavin Smith, Employee Director (From 1st November 2025)
Steve Walsh, Non-Executive Director
Karen Leach, Non-Executive Director (From 1st February 2026)

Performance is assessed through a standardised performance management process which measures achievement against objectives.

All Non-Executive Directors are appointed by the Scottish Government Ministers for a fixed term.

All other Senior Managers are on permanent contracts.

Remuneration report for the year ended 31 March 2026 (audited)
Board members' and Senior Employees' Remuneration 2025/26

	Note	Date of change	Gross salary (bands of £5,000) 2025/26	Bonus payments (bands of £5,000) 2025/26	Benefits in kind (£000) 2025/26	Total earnings in year (bands of £5,000) 2025/26	Pension benefits (£000) 2025/26	Total remuneration (bands of £5,000) 2025/26
Executive Members								
Dr Boyd Peters – Medical Director			200-205	–	–	200-205	41	240-245
Fiona Davies – Chief Executive			135-140	–	–	135-140	57	190-195
Heledd Cooper – Director of Finance			130-135	–	–	130	36	165-170
Jennifer Davies – Director of Public Health	a	From 1 Jul 2025	135-140	–	8	145-150	36	180-185
Louise Bussell – Nurse Director			135-140	–	–	135-140	99	235-240
Tim Allison – Director of Public Health & Health Policy	b		40-45	–	–	40-45	16	55-60
Non Executive Members								
Albert Donald			10-15	–	–	10-15	–	10-15
Alexander Anderson			15-20	–	–	15-20	–	15-20
Brian Steven	e	From 1 Nov 2025	5-10	–	–	5-10	–	5-10
Dr Neil Wright		From 1 Apr 2025	10-15	–	–	10-15	–	10-15
Emily Austin			15-20	–	–	15-20	–	15-20
Gerard O'Brien – Vice Chair			25-30	–	–	25-30	–	25-30
Graham Bell			20-25	–	–	20-25	–	20-25
Graham Illsley	c	From 1 Nov 2025	5-10	–	–	5-10	–	5-10
Janice Preston			10-15	–	–	10-15	–	10-15
Joanne McCoy			10-15	–	–	10-15	–	10-15
Karen Leach			15-20	–	–	15-20	–	15
Philip MacRae			15-20	–	–	15-20	–	15-20
Sarah Compton-Bishop – Board Chair			50-55	–	–	50-55	–	50-55
Steve Walsh			10-15	–	–	10-15	–	10-15
Alasdair Christie	g		5-10	–	–	5-10	–	5-10
Catriona Sinclair	h		5-10	–	–	5-10	–	5-10
Elspeth Caithness	i		50-55	–	–	50-55	7	60-65
Stakeholders								
Allyson Turnbull-Jukes			0-5	–	–	0-5	–	0-5
Garret Corner – Argyll and Bute Council Stakeholder member			10-15	–	–	10-15	–	10-15
Gavin Smith	d	From 1 Oct 2025	55-60	–	–	55-60	17	70-75
Muriel Cockburn – The Highland Council Stakeholder member			10-15	–	–	10-15	–	10-15
Senior Employees								
Arlene Johnstone – Chief Officer, Highland Health and Social Care Partnership	j	Interim 12 Jun 2025, permanent from 1 Oct 2025	110-115	–	–	110-115	111	225-230
David Park – Deputy Chief Executive			145-150	–	–	145-150	46	190-195
Evan Beswick – Chief officer A&B IJB			100-105	–	–	100-105	34	135-140
Gareth Adkins – Director of People & Culture			120-125	–	–	120-125	56	180-185
Katherine Sutton – Chief Operating Officer Acute			130-135	–	–	130-135	41	170-175
Pamela Cremin – Chief Officer North Highland	k	From 30 Sep 2025	55-60	–	–	55-60	35	90-95
Richard MacDonald – Director of Estates and Capital Planning			100-105	–	–	100-105	29	130-135

Table continued on next page

Remuneration Report and Staff Report *cont.*

Notes to remuneration table
The value of pension benefits accrued during the year is calculated as: the real increase in pension multiplied by 20 plus the real increase in any lump sum less the contributions made by the individual. In accordance with the Financial Reporting Manual (FReM) and the Companies Act, this calculation aims to bring public bodies in line with other industries in disclosing an assessed cumulative pension benefit for a standard 20 year period, which is the estimated life span following retirement.

The 'total earnings in year' column shows the remuneration relating to actual earnings payable in year.

The real increase in CETV will be less than the movement from opening to closing due to inflation.

a) The gross salary for Jennifer Davies is for period shown, the full year effect is 140-145.
b) The gross salary for Tim Allison is for period shown, the full year effect is 170-175.
c) The gross salary for Graham Illsley is for period shown, the full year effect is 10-15.
d) The gross salary for Gavin Smith is for period shown and includes full time salary in range 50-55. The full year effect of salary and employee Director role is in range 65-70.
e) The gross salary for Brian Steven is for period shown, the full year effect is 10-15.
f) The gross salary for Allyson Turnbull-Jukes is for period shown, the full year effect is 10-15.
g) The gross salary for Alasdair Christie is for period shown, the full year effect is 10-15.
h) The gross salary for Catriona Sinclair is for period shown, the full year effect is 10-15.
i) The gross salary for Elspeth Caithness is for the period shown and includes full time salary in range 45-50. The full year effect of salary and employee Director role is in range 60-65.
j) The gross salary for Arlene Johnstone is for period shown, the full year effect is 115-120.
k) The gross salary for Pamela Cremin is for period shown, the full year effect is 115-120.

Non executive directors pay is non pensionable.

Board members' and Senior Employees' cash equivalent transfer (CETV) of deferred pension rights 2025/26

	Note	Date of change	Total accrued pension at pensionable age as at 31 March 2026 (bands of £5,000)	Total accrued lump sum at pensionable age (bands of £5,000)	Real increase in pension at pensionable age (bands of £2,500)	Real increase in lump sum at pensionable age (bands of £2,500)	Cash equivalent transfer value (CETV) at 31 March 2026 £000	Cash equivalent transfer value (CETV) at 31 March 2025 £000	Real increase in CETV in year £000
Executive Members									
Dr Boyd Peters – Medical Director			10-15	–	2.5-5	–	223	163	32
Fiona Davies – Chief Executive			40-45	100-105	2.5-5	2-2.5	927	824	54
Heledd Cooper – Director of Finance			5-10	–	2.5-5	–	129	87	22
Jennifer Davies – Director of Public Health	a	From 1 Jul 2025	0-5	–	2.5-5	–	45	5	23
Louise Bussell – Nurse Director			65-70	175-180	5-7.5	7.5-10	1,532	1,355	108
Tim Allison – Director of Public Health & Health Policy	b		15-20	–	0-2.5	–	271	241	16
Non Executive Members									
Elspeth Caithness	i		20-25	60-65	0-2.5	0-2.5	564	525	15
Stakeholders									
Gavin Smith	d	From 1 Oct 2025	10-15	–	0.2.5	–	159	136	12
Senior Employees									
Arlene Johnstone – Chief Officer, Highland Health and Social Care Partnership	j	Interim 12 Jun 2025, permanent from 1 Oct 2025	40-45	105-110	5-7.5	10-12.5	930	777	109
David Park – Deputy Chief Executive			25-30	–	2.5-5	–	441	371	38
Evan Beswick – Chief officer A&B IJB			25-30	–	2-2.5	–	328	285	19
Gareth Adkins – Director of People & Culture			45-50	110-115	2.5-5	2.5-5	1,011	905	55
Katherine Sutton – Chief Operating Officer Acute			60-65	145-150	2.5-5	0-2.5	1,441	1,341	33
Pamela Cremin – Chief Officer North Highland	k	From 30 Sep 2025	50-55	140-145	0-2.5	0-2.5	1,305	1,200	52
Richard MacDonald – Director of Estates and Capital Planning			5-10	–	0-2.5	–	122	86	20

Table continued on next page

The real discount rate used to evaluate CETV has been advised by the Government Actuaries Department.

Unless also subject to an employment contract with the Board, non-executive members have no deferred pension rights under the NHS Superannuation Scheme for Scotland. Such members are therefore not included in the schedule of CETV transfer values above.

Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgment. The Public Service Pensions Remedy applies to individuals that were members, or eligible to be members, of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the NHS Scotland scheme for the period from 1 April 2015 to 31 March 2022.

Remuneration Report and Staff Report *cont.*

Prior year remuneration report
Remuneration report for the year ended 31 March 2025 (audited)
Remuneration report

	Note	Date of change	Gross salary (bands of £5,000) 2024/25	Bonus payments (bands of £5,000) 2024/25	Benefits in kind (£000) 2024/25	Total earnings in year (bands of £5,000) 2024/25	Pension benefits (£000) 2024/25	Total remuneration (bands of £5,000) 2024/25
Executive Members								
Dr Boyd Peters – Medical Director			210-215	–	–	210-215	112	320-325
Fiona Davies – Chief Executive			125-130	–	–	125-130	135	260-265
Heledd Cooper – Director of Finance			120-125	–	8	130-135	32	165-170
Louise Bussell – Nurse Director			125-130	–	–	125-130	92	220-225
Tim Allison – Director of Public Health & Health Policy			165-170	–	–	165-170	45	210-215
Non Executive Members								
Alasdair Christie			10-15	–	–	10-15	–	10-15
Albert Donald			10-15	–	–	10-15	–	10-15
Alexander Anderson			10-15	–	–	10-15	–	10-15
Catriona Sinclair			10-15	–	–	10-15	–	10-15
Elspeth Caithness	a		55-60	–	–	55-60	29	85-90
Emily Austin			10-15	–	–	10-15	–	10-15
Gerard O'Brien			15-20	–	–	15-20	–	15-20
Graham Bell			15-20	–	–	15-20	–	15-20
Steve Walsh			0-5	–	–	0-5	–	0-5
Janice Preston	d	From 6 Jan 2025	10-15	–	–	10-15	–	10-15
Joanne McCoy			10-15	–	–	10-15	–	10-15
Karen Leach			10-15	–	–	10-15	–	10-15
Philip MacRae			45-50	–	–	45-50	–	45-50
Sarah Compton-Bishop – Board Chair			10-15	–	–	10-15	–	10-15
Gaener Rodger	b	Until 30 Sep 2024	5-10	–	–	5-10	–	5-10
Pamela Clark (known as Ann)		Until 31 Mar 2025	15-20	–	–	15-20	–	15-20
Susan Ringwood	c	Until 31 Dec 2024	5-10	–	–	5-10	–	5-10
Stakeholders								
Garret Corner – Argyll and Bute Council Stakeholder member			10-15	–	–	10-15	–	10-15
Muriel Cockburn – The Highland Council Stakeholder member			10-15	–	–	10-15	–	10-15
Senior Employees								
David Park – Deputy Chief Executive			140-145	–	–	140-145	42	180-185
Evan Beswick – Chief officer A&B IJB			95-100	–	–	95-100	77	170-175
Gareth Adkins – Director of People & Culture			115-120	–	–	115-120	105	220-225
Katherine Sutton – Chief Operating Officer Acute			120-125	–	–	120-125	84	205-210
Pamela Cremin – Chief Officer North Highland			110-115	–	–	110-115	161	270-275
Richard MacDonald – Director of Estates and Capital Planning			95-100	–	–	95-100	26	120-125

Notes
The value of pension benefits accrued during the year is calculated as: the real increase in pension multiplied by 20 plus the real increase in any lump sum less the contributions made by the individual. In accordance with the Financial Reporting Manual (FReM) and the Companies Act, this calculation aims to bring public bodies in line with other industries in disclosing an assessed cumulative pension benefit for a standard 20 year period, which is the estimated life span following retirement.

The 'total earnings in year' column shows the remuneration relating to actual earnings payable in year.

The real increase in CETV will be less than the movement from opening to closing due to inflation.

a) The gross salary for Elspeth Caithness includes full time salary in range 40-45 for Employee director role
b) The gross salary for Gaener Rodger is for period shown, the full year effect is 5-10
c) The gross salary for Susan Ringwood is for period shown, the full year effect is 10-15
d) The gross salary for Janice Preston is for period shown, the full year effect is 10-15

Non executive directors pay is non pensionable.

Cash equivalent transfer value (CETV) of deferred pension rights prior year 2024/25

	Note	Total accrued pension at pensionable age as at 31 March 2025 (bands of £5,000)	Total accrued lump sum at pensionable age (bands of £5,000)	Real increase in pension at pensionable age (bands of £2,500)	Real increase in lump sum at pensionable age (bands of £2,500)	Cash equivalent transfer value (CETV) at 31 March 2025 £000	Cash equivalent transfer value (CETV) at 31 March 2024 £000	Real increase in CETV in year £000
Executive Members								
Fiona Davies – Chief Executive		35-40	95-100	5-7.5	12.5-15	824	670	126
Dr Boyd Peters – Medical Director		85-90	235-240	5-7.5	7.5-10	2,159	1,993	108
Tim Allison – Director of Public Health & Health Policy		15-20	–	2.5-5	–	241	182	34
Heledd Cooper – Director of Finance		5-10	–	0-2.5	–	87	52	17
Louise Bussell – Board Nurse Director		60-65	160-165	5-7.5	7.5-10	1,355	1,219	99
Non Executive Members								
Alasdair Christie		–	–	–	–	–	–	–
Albert Donald		–	–	–	–	–	–	–
Alexander Anderson		–	–	–	–	–	–	–
Catriona Sinclair		–	–	–	–	–	–	–
Elspeth Caithness	a	20-25	55-60	0-2.5	0-2.5	525	478	34
Emily Austin		–	–	–	–	–	–	–
Gaener Rodger – until 30 September 2024	b	–	–	–	–	–	–	–
Garret Corner – Argyll and Bute Council Stakeholder member		–	–	–	–	–	–	–
Gerard O'Brien		–	–	–	–	–	–	–
Graham Bell		–	–	–	–	–	–	–
Joanne McCoy		–	–	–	–	–	–	–
Karen Leach		–	–	–	–	–	–	–
Muriel Cockburn – The Highland Council Stakeholder member		–	–	–	–	–	–	–
Pamela Clark (known as Ann) – until 31 March 2025		–	–	–	–	–	–	–
Philip MacRae		–	–	–	–	–	–	–

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Remuneration Report and Staff Report *cont.*

	Note	Total accrued pension at pensionable age as at 31 March 2025 (bands of £5,000)	Total accrued lump sum at pensionable age (bands of £5,000)	Real increase in pension at pensionable age (bands of £2,500)	Real increase in lump sum at pensionable age (bands of £2,500)	Cash equivalent transfer value (CETV) at 31 March 2025 £000	Cash equivalent transfer value (CETV) at 31 March 2024 £000	Real increase in CETV in year £000
Non Executive Members (continued)								
Sarah Compton-Bishop – Board Chair		–	–	–	–	–	–	–
Steve Walsh		–	–	–	–	–	–	–
Susan Ringwood – until 31 December 2024	c	–	–	–	–	–	–	–
Janice Preston – from 6 January 2025	d	–	–	–	–	–	–	–
Senior Employees								
David Park – Deputy Chief Executive		20-25	–	2.5-5	–	370	314	33
Gareth Adkins – Director of People & Culture		40-45	105-110	5-7.5	7.5-10	905	774	103
Katherine Sutton – Chief Operating Officer Acute		55-60	140-145	2.5-5	5-7.5	1,341	1,205	99
Pamela Cremin – Chief Officer North Highland		50-55	130-135	7.5-10	15-17.5	1,200	991	178
Richard MacDonald – Director of Estates and Capital Planning		5-10	–	0-2.5	–	86	55	17
Evan Beswick – Chief Officer A&B IJB		20-25	–	2.5-5	–	285	222	46

Fair pay disclosure (subject to audit)

	2026 (£000)	2025 (£000)	Change
Range of staff remuneration	5-300	5-300	0
Highest earning Director's total remuneration	205	213	-4%
Median (total pay and benefits)	41	39	5%
Median (salary only)	41	39	5%
Ratio	4.94	5.39	-8%
25th percentile (total pay and benefits)	33	32	3%
26th percentile (salary only)	33	32	3%
Ratio	6.20	6.72	8%
75th percentile pay (total pay and benefits)	52	50	4%
76th percentile pay (salary only)	52	50	4%
Ratio	3.91	4.26	-8%

The increase in the percentiles is due to nationally agreed pay awards, including incremental rises in 2025/26.

For part time employees the total pay for calculation of the median is grossed up.

Contracts of less than 2 hours were removed, as this led to very high annual salaries when grossed up and distorted the median result.

Agency staff are excluded, as they are not employees and are charged via invoice, not via payroll.

Number of senior staff by band (subject to audit)

Employees whose remuneration fell within the following ranges (higher paid employee remuneration):

Salary band	2026 clinicians	2026 other	2025 clinicians	2025 other
£70,001 to £80,000	–	–	148	24
£80,001 to £90,000	–	–	68	16
£90,001 to £100,000	64	12	50	18
£100,001 to £110,000	60	16	47	7
£110,001 to £120,000	43	1	36	2
£120,001 to £130,000	34	1	57	1
£130,001 to £140,000	33	3	38	4
£140,001 to £150,000	36	4	34	1
£150,001 to £160,000	24	–	31	–
£160,001 to £170,000	30	–	30	–
£170,001 to £180,000	21	–	21	–
£180,001 to £190,000	22	–	18	–
£190,001 to £200,000	17	–	14	–
£200,001 and above	63	–	36	–

Staff numbers and costs (subject to audit)

Staff costs	Executive Board Members £000	Non-Executive Members £000	Permanent staff £000	Inward secondee £000	Other staff £000	Outward secondee £000	2026 Total £000	2025 Total £000
Salaries and wages	789	318	513,982	–	–	(1,598)	513,491	469,977
Taxation and social security costs	114	33	64,199	–	–	(224)	64,122	48,588
NHS scheme employers' costs	169	–	98,422	–	–	(346)	98,245	91,318
Other employers' pension costs	–	–	(204)	–	–	–	(204)	4,211
Inward secondees	–	–	–	431	–	–	431	478
Agency and other directly engaged staff	–	–	–	–	29,263	–	29,263	34,989
	1,072	**351**	**676,399**	**431**	**29,263**	**(2,168)**	**705,348**	**649,561**
Compensation for loss of office/ early retirement	–	–	–	–	–	–	–	–
Pensions to former Board members	–	–	–	–	–	–	–	–
Total	**1,072**	**351**	**676,399**	**431**	**29,263**	**(2,168)**	**705,348**	**649,561**

Included in the total employee expenditure above were costs of staff engaged directly on capital projects, charged to capital expenditure of:

	£000
Employee expenditure as above	705,348
Employee income included in Note 4 and IAS19 costs excluded from above (Note 19)	2,168
Total employee expenditure disclosed in Note 3	**707,516**

The Highland Council (THC) Pension fund costs have been reclassified to staff costs in 2022, shown under other employers pension costs above.

Remuneration Report and Staff Report *cont.*

Staff numbers (subject to audit)

Staff numbers	Executive Board Members	Non-Executive Members	Permanent staff	Inward secondee	Other staff	Outward secondee	2026 Total	2025 Total
Whole time equivalent (WTE)	5	17	9,995	4	47	(23)	10,045	9,963
Included in the total staff numbers above were:								
– staff engaged directly on capital projects, charged to capital expenditure of:							–	–
– disabled staff of:							359	255

Staff composition (information not subject to audit)

	2026 Male	2026 Female	2026 Total	2025 Male	2025 Female	2025 Total
Executive Directors	1	4	5	2	3	5
Non-Executive Directors and Employee Director	11	7	18	8	11	19
Senior Employees	258	221	479	332	369	701
Other	2,316	10,932	13,248	2,134	10,456	12,590
Total headcount	**2,586**	**11,164**	**13,750**	**2,476**	**10,839**	**13,315**

An analysis of the number of persons of each sex who were directors and employees.

Sickness absence (information not subject to audit)

	2026	2025
Sickness absence	6.4%	6.1%

Equality, Diversity and Inclusion

NHS Highland remains committed to an inclusive workplace where colleagues are treated with compassion, dignity and respect, and where difference is valued and where we meet our obligations under the Equality Act 2010 and the Public Sector Equality Duty (PSED), with equality considerations embedded in governance, risk, and decision making processes.

The Board receives updates on equality outcomes, workforce metrics and statutory publications through established governance arrangements.

In line with the Equality Act 2010 (Specific Duties) (Scotland) Regulations, NHS Highland maintains a suite of public equality publications – Mainstreaming Equality Reports, Equality Outcomes, Equal Pay & Pay Gap, and Workforce Monitoring – on the NHS Highland website. Equality, diversity and inclusion | NHS Highland. These publications support accountability and enable external scrutiny of progress on equality outcomes.

Workforce equality information is monitored across protected characteristics to identify trends, inform action and improve data completeness over time. Improving the completeness of equality data – particularly self reporting by staff – remains a priority.

During 2025/26, we strengthened our approach to mainstreaming equality through continued alignment with the following commitments and accreditations:

- Disability Confident Employer.
- Young Person's Guarantee.
- Armed Forces Covenant – Gold Award.
- Carer Positive (Established).

Key progress during 2025/26

- Launch of staff networks to support inclusion and peer support.
  - **Staff Networks** – NHS Highland Launched 6 Staff Networks in 2025 with the aim of providing peer support, social events, networking and a voice of lived experience on equality and diversity issues. Staff networks | NHS Highland
  - **Equally Safe at Work** – NHS Highland is participating in the Equally Safe at Work (ESAW) accreditation programme which supports employers to advance gender equality and prevent violence against women. We are aiming to achieve 'Developmental Employer' accreditation by December 2026 and have established an ESAW steering group to take forward actions to support our accreditation journey. Equally Safe at Work
  - **Learning and development** – As part of Scotland's national Protected Learning Time programme, NHS Scotland moved to a single, standardised set of nine Statutory and Mandatory training modules, known as the Once for Scotland module suite. These modules went live nationally on 2 March 2026 and are to be completed by all NHS Scotland staff, regardless of role, profession or Board. One of the new modules is Introduction to Equality, Diversity and Human Rights.
  - **Gaelic Language Plan** – NHS Highland is one of the public sector organisations in Scotland that is required to produce a Gaelic Language Plan. A grant from Bord Na Gaidhlig permitted the recruitment of a new Gaelic Development Co-ordinator. This role has progressed the actions in the current Gaelic Language Plan and contributes to the increased visibility and usage of Gaelic in NHS Highland. Gàidhlig | NHS Highland
- Recruitment of a Gaelic Development Co-ordinator to operationalise the Gaelic Language Plan 2023–2028.
- Delivery of targeted programmes on workplace adjustments and equality impact assessments.
- Commencement of Equally Safe at Work developmental accreditation.
- Improvement of the quality and use of workforce equality data, including delivery of a Board-wide equalities data campaign to support informed decision-making and targeted action to address workforce inequalities.

Equality Impact Assessment (EQIA)

The organisation continues to promote the systematic use of EQIAs to inform policy and service change, recognising the need to sustain improvement in awareness and consistency of application.

Equality Outcomes 2025-2029

The Board strives to be an inclusive and accessible organisation seeking to end discrimination in all aspects of its operation. NHS Highland published its Equality Outcomes 2025-2029 Report in April 2025 which summarised how NHS Highland would meet its statutory requirements under the Scotland Specific Duties of Equality Act 2010.

Equal opportunities

As an equal opportunities employer, the Health Board welcomes applications for employment from disabled persons and actively seeks to provide an environment where they, and any employees who become disabled during their career, can continue to work with us. NHS Highland is also a Disability Confident Level 2 Employer.

The Once for Scotland Guide to Reasonable Adjustments was launched and adopted by NHS Highland in August 2025. This guide helps managers understand the requirements for making reasonable adjustments to positively and constructively support disabled employees.

All NHS Highland colleagues have access to free membership of the Business Disability Forum which provides expert advice, support, knowledge and resources on best practice to support disability inclusion.

Exit packages – current year (subject to audit)

There was one exit package totalling £10k in 2025/26 and one exit package totalling £5k in 2024/25.

Parliamentary Accountability Report

Losses and special payments
On occasion, the Board is required to write off balances which are no longer recoverable. Losses and special payments require formal approval to regularise such transactions and their notation in the annual accounts.

The write-off of the following losses and special payments has been approved by the board:

	No. of cases	£000
Losses	214	2,229

There were three claims individually greater than £300,000 settled under the CNORIS scheme in 2025/26 and four in 2024/25. Further details on the scheme can be found in Note 1 (accounting policies) of the annual accounts.

The Board is also required to provide for CNORIS claims notified to it and which will be settled at a future date; details of these provisions can be found in Note 13.

Remote contingent liabilities
Contingent liabilities that meet the disclosure requirements in IAS37 Provisions and Contingent Liabilities are included in Note 14 of the Notes to the Accounts.

In addition, due to the nature of activities of NHS Highland there are contingent liabilities for which IAS37 does not require disclosure because the probability of any requirement on the Board to meet future liabilities is considered to be remote.

Fees and charges
The board had no commercial trading activity during 2025/26 where the full annual cost exceeded £1m.

Signed:

Fiona Davies

Chief Executive and Accountable Officer

23 June 2026

4. Independent Auditor's Report

Independent auditor's report

to the members of Highland Health Board, the Auditor General for Scotland and the Scottish Parliament

Reporting on the audit of the financial statements

Opinion on financial statements

I have audited the financial statements in the annual report and accounts of Highland Health Board and its group for the year ended 31 March 2026 under the National Health Service (Scotland) Act 1978. The financial statements comprise the Consolidated Statement of Comprehensive Net Expenditure, the Consolidated Statement of Financial Position, the Consolidated Statement of Cash Flows, the Consolidated Statement of Changes in Taxpayers' Equity and notes to the accounts, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards, as interpreted and adapted by the 2025/26 Government Financial Reporting Manual (the 2025/26 FReM).

In my opinion the accompanying financial statements:

- Give a true and fair view of the state of the affairs of the board and its group as at 31 March 2026 and of the net expenditure for the year then ended;
- Have been properly prepared in accordance with UK adopted international accounting standards, as interpreted and adapted by the 2025/26 FReM; and
- Have been prepared in accordance with the requirements of the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing (UK) (ISAs (UK)), as required by the **Code of Audit Practice** approved by the Auditor General for Scotland. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I was appointed by the Auditor General on 05 June 2023. My period of appointment is five years, covering 2022/23 to 2026/27. I am independent of the board and its group in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. Non-audit services prohibited by the Ethical Standard were not provided to the board. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern basis of accounting

I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ability of the board and its group to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

These conclusions are not intended to, nor do they, provide assurance on the current or future financial sustainability of the board and its group. However, I report on the board's arrangements for financial sustainability in a separate Annual Audit Report available from the **Audit Scotland website**.

Risks of material misstatement

I report in my separate Annual Audit Report the most significant assessed risks of material misstatement that I identified and my judgements thereon.

Responsibilities of the Accountable Officer for the financial statements

As explained more fully in the Statement of the Chief Executive's Responsibilities as the Accountable Officer, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view in accordance with the financial reporting framework, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ability of the board and its group to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless there is an intention to discontinue the board's operations.

Auditor's responsibilities for the audit of the financial statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities outlined above to detect material misstatements in respect of irregularities, including fraud. Procedures include:

- Using my understanding of the health sector to identify that the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers are significant in the context of the board;
- Inquiring of the Accountable Officer as to other laws or regulations that may be expected to have a fundamental effect on the operations of the board;
- Inquiring of the Accountable Officer concerning the board's policies and procedures regarding compliance with the applicable legal and regulatory framework;
- Discussions among my audit team on the susceptibility of the financial statements to material misstatement, including how fraud might occur; and
- Considering whether the audit team collectively has the appropriate competence and capabilities to identify or recognise non-compliance with laws and regulations.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the board's controls, and the nature, timing and extent of the audit procedures performed.

Irregularities that result from fraud are inherently more difficult to detect than irregularities that result from error as fraud may involve collusion, intentional omissions, misrepresentations, or the override of internal control. The capability of the audit to detect fraud and other irregularities depends on factors such as the skilfulness of the perpetrator, the frequency and extent of manipulation, the degree of collusion involved, the relative size of individual amounts manipulated, and the seniority of those individuals involved.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website **www.frc.org.uk/auditorsresponsibilities**. This description forms part of my auditor's report.

Reporting on regularity of expenditure and income

Opinion on regularity

In my opinion in all material respects the expenditure and income in the financial statements were incurred or applied in accordance with any applicable enactments and guidance issued by the Scottish Ministers.

Responsibilities for regularity

The Accountable Officer is responsible for ensuring the regularity of expenditure and income. In addition to my responsibilities in respect of irregularities explained in the audit of the financial statements section of my report, I am responsible for expressing an opinion on the regularity of expenditure and income in accordance with the Public Finance and Accountability (Scotland) Act 2000.

Independent auditor's report *cont.*

to the members of Highland Health Board, the Auditor General for Scotland and the Scottish Parliament

Reporting on other requirements

Opinion prescribed by the Auditor General for Scotland on the audited parts of the Remuneration Report and Staff Report

I have audited the parts of the Remuneration Report and Staff Report described as audited. In my opinion, the audited parts of the Remuneration Report and Staff Report have been properly prepared in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers.

Other information

The Accountable Officer is responsible for the other information in the annual report and accounts. The other information comprises the Performance Report and the Accountability Report excluding the audited parts of the Remuneration Report and Staff Report.

My responsibility is to read all the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon except on the Performance Report and Governance Statement to the extent explicitly stated in the following opinions prescribed by the Auditor General for Scotland.

Opinions prescribed by the Auditor General for Scotland on the Performance Report and Governance Statement

In my opinion, based on the work undertaken in the course of the audit:

- The information given in the Performance Report for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers; and
- The information given in the Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and that report as been prepared in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers.

Matters on which I am required to report by exception

I am required by the Auditor General for Scotland to report to you if, in my opinion:

- Adequate accounting records have not been kept; or
- The financial statements and the audited parts of the Remuneration Report and Staff Report are not in agreement with the accounting records; or
- I have not received all the information and explanations I require for my audit.

I have nothing to report in respect of these matters.

Conclusions on wider scope responsibilities

In addition to my responsibilities for the annual report and accounts, my conclusions on the wider scope responsibilities specified in the Code of Audit Practice are set out in my Annual Audit Report

Use of my report

This report is made solely to the parties to whom it is addressed in accordance with the Public Finance and Accountability (Scotland) Act 2000 and for no other purpose. In accordance with paragraph 108 of the Code of Audit Practice, I do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

Claire Gardiner

Claire Gardiner CPFA
Audit Scotland, 4th Floor, 102 West Port, Edinburgh, EH3 9DN
23 June 2026

5. Financial Statements

Consolidated Statement of Comprehensive Net Expenditure

for the year ended 31st March 2026

2025 £000		Note	2026 £000
651,860	Employee expenditure	3a	707,516
	Other operating expenditure		
119,051	Independent Primary Care Services	3b	128,298
174,133	Drugs and medical supplies	3b	176,438
772,820	Other health care expenditure	3b	823,957
1,717,864			**1,836,209**
(542,969)	Less: operating income	4	(566,351)
(435)	Associates and joint ventures accounted for on an equity basis		(5,164)
1,174,460	**Net expenditure for the year**		**1,264,694**
	Other comprehensive net expenditure		
4,507	Net (gain)/loss on revaluation of property, plant and equipment		(49,233)
(12,620)	Actuarial change in Local Government Pension		(331)
(8,113)	**Other comprehensive expenditure**		**(49,564)**
1,166,347	**Comprehensive net expenditure**		**1,215,130**

The notes to the accounts, numbered 1 to 26 form an integral part of these accounts.

Consolidated Statement of Financial Position

for the year ended 31st March 2026

Consolidated 2025 £000	Board 2025 £000		Note	Consolidated 2026 £000	Board 2026 £000
		Non-current assets			
478,803	478,803	Property, plant and equipment	7a	527,482	527,482
2,138	2,138	Intangible assets	6	1,580	1,580
63,164	63,164	Right of Use assets	17a	60,337	60,337
		Financial assets			
10,284	791	Investments	10	12,113	790
10,374	–	Investments in associates and joint ventures	26b	15,538	–
78,548	78,548	Trade and other receivables	9	86,351	86,351
643,311	**623,444**	**Total non-current assets**		**703,401**	**676,540**
		Current assets			
8,603	8,603	Inventories	8	8,326	8,326
		Financial assets			
56,419	56,519	Trade and other receivables	9	73,437	73,571
1,567	411	Cash and cash equivalents	11	(9,964)	(10,539)
66,589	**65,533**	**Total current assets**		**71,799**	**71,358**
709,900	**688,977**	**Total assets**		**775,200**	**747,898**
		Current liabilities			
(21,616)	(21,616)	Provisions due within one year	13a	(28,056)	(28,056)
		Financial liabilities			
(141,626)	(141,601)	Trade and other payables	12	(189,112)	(189,087)
(163,242)	**(163,217)**	**Total current liabilities**		**(217,168)**	**(217,143)**
546,658	**525,760**	**Non-current assets less net current liabilities**		**558,032**	**530,755**
		Non-current liabilities			
(39,216)	(39,216)	Provisions due outwith one year	13a	(49,731)	(49,731)
		Financial liabilities			
(55,118)	(55,118)	Trade and other payables	12	(53,291)	(53,291)
(94,334)	**(94,334)**	**Total non-current liabilities**		**(103,022)**	**(103,022)**
452,324	**431,426**	**Assets less liabilities**		**455,010**	**427,733**
		Taxpayers' equity			
188,200	188,200	General fund	SoCTE	137,303	137,303
135,447	135,447	Revaluation reserve	SoCTE	182,524	182,524
107,779	107,779	Other reserves	SoCTE	107,906	107,906
10,374	–	Other reserves – associates and joint ventures	SoCTE	15,538	–
10,524	–	Fund held on trust	SoCTE	11,739	–
452,324	**431,426**	**Total taxpayers' equity**		**455,010**	**427,733**

The notes to the accounts, numbered 1 to 26 form an integral part of these accounts.
The Accountable Officer authorised these financial statements for issue on 23rd June 2026.

Heledd Cooper

Director of Finance

Fiona Davies

Chief Executive and Accountable Officer

Consolidated Statement of Cash Flows

for the year ended 31st March 2026

2025 £000		Note	2026 £000
	Cash flows from operating activities		
(1,174,460)	Net operating cost	SoCTE	(1,264,694)
49,707	Adjustments for non-cash transactions	2b	24,010
2,416	Add back: interest payable recognised in net operating cost	2b	1,759
(7)	Deduct: interest receivable recognised in net operating cost	4	(14)
(2,986)	Movements in working capital	2b	56,326
(1,125,330)	**Net cash outflow from operating activities**	26c	**(1,182,613)**
	Cash flows from investing activities		
(16,264)	Purchase of property, plant and equipment		(23,376)
(368)	Purchase of intangible assets		(136)
(6,478)	Investment additions	10	(1,916)
470	Proceeds of disposal of property, plant and equipment		274
5,666	Receipts from sale of investments		634
7	Interest received		14
(16,967)	**Net cash outflow from investing activities**	26c	**(24,506)**
	Cash flows from financing activities		
1,155,053	Funding	SoCTE	1,216,660
–	Movement in general fund working capital	SoCTE	(10,539)
1,155,053	Cash drawn down		1,206,121
(9,836)	Capital element of payments in respect of on-balance sheet PFI and HUB contracts		(8,774)
(27)	Interest paid	2b	273
(2,389)	Interest element of leases and on-balance sheet PFI/PPP and HUB contracts	2b	(2,032)
1,142,801	**Net financing**	26c	**1,195,588**
504	Net increase/(decrease) in cash and cash equivalents in the period	11	(11,531)
1,063	Cash and cash equivalents at the beginning of the period		1,567
1,567	**Cash and cash equivalents at the end of the period**		**(9,964)**
	Reconciliation of net cash flow to movement in net debt/cash		
504	Increase/(decrease) in cash in year		(11,531)
1,063	Net cash at 1 April		1,567
1,567	**Net debt/cash at 31 March**		**(9,964)**

The notes to the accounts, numbered 1 to 26 form an integral part of these accounts.

Consolidated Statement of Changes in Taxpayers' Equity

for the year ended 31st March 2026

Changes in taxpayers' equity for 2025/26

	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Associates and joint ventures £000	Funds held on trust £000	Total reserves £000
Balance at 31 March 2025		188,200	135,447	107,779	10,374	10,524	452,324
Retrospective restatements for changes in accounting policy and material errors	21	–	–	–	–	–	–
Balance at 1 April 2025		**188,200**	**135,447**	**107,779**	**10,374**	**10,524**	**452,324**
Changes in taxpayers' equity for 2025/26							
Net gain/(loss) on revaluation/indexation of property, plant and equipment	7a	–	49,222	–	–	–	49,222
Net gain on revaluation of investments	10	–	–	–	–	559	559
Net gain on revaluation of Right of Use assets	17a	–	11	–	–	–	11
Impairment of property, plant and equipment	7a	–	(100)	–	–	–	(100)
Revaluation and impairments taken to operating costs	2b	–	100	–	–	–	100
Release of reserves to the statement of comprehensive net expenditure		1	–	–	–	–	1
Transfers between reserves		2,156	(2,156)	–	–	–	–
Other non cash costs Highland Council ASC pension in year	2b	800	–	127	–	–	927
Net operating cost for the year	CFS	(1,270,514)	–	–	5,164	656	(1,264,694)
Total recognised income and expense for 2025/26		**(1,267,557)**	**47,077**	**127**	**5,164**	**1,215**	**(1,213,974)**
Funding							
Drawn down	CFS	1,206,121					1,206,121
Movement in general fund (creditor)/debtor	CFS	10,539					10,539
Balance at 31 March 2026	**SoFP**	**137,303**	**182,524**	**107,906**	**15,538**	**11,739**	**455,010**

The notes to the accounts, numbered 1 to 26 form an integral part of these accounts.

Consolidated Statement of Changes in Taxpayers' Equity *cont.*

for the year ended 31st March 2026

Changes in taxpayers' equity for 2024/25

	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Associates and joint ventures £000	Funds held on trust £000	Total reserves £000
Balance at 31 March 2024		206,680	142,135	90,948	9,939	9,848	459,550
Prior year adjustments for changes in accounting policy and material errors	20	–	–	–	–	–	–
Balance at 1 April 2024		**206,680**	**142,135**	**90,948**	**9,939**	**9,848**	**459,550**
Changes in taxpayers' equity for 2024/25							
Net gain/(loss) on revaluation/indexation of property, plant and equipment	7a	–	(4,516)	–	–	–	(4,516)
Net loss on revaluation/indexation of intangible assets	6	–	–	–	–	–	–
Net loss on revaluation of investments	10	–	–	–	–	(136)	(136)
Net gain on revaluation of Right of Use assets	17a	–	9	–	–	–	9
Impairment of property, plant and equipment	7a	–	(1,099)	–	–	–	(1,099)
Impairment of intangible assets	6	–	–	–	–	–	–
Revaluation and impairments taken to operating costs	2b	–	1,099	–	–	–	1,099
Release of reserves to the statement of comprehensive net expenditure		(7)	–	–	–	–	(7)
Transfers between reserves		2,181	(2,181)	–	–	–	–
Pension reserve movements		–	–	–	–	–	–
Other non cash costs – PFI PY revaluation and The Highland Council ASC pension in year	2b	–	–	16,831	–	–	16,831
Net operating cost for the year	CFS	(1,175,707)	–	–	435	812	(1,174,460)
Total recognised income and expense for 2024/25		**(1,173,533)**	**(6,688)**	**16,831**	**435**	**676**	**(1,162,279)**
Funding							
Drawn down	CFS	1,155,053					1,155,053
Balance at 31 March 2025	**SoFP**	**188,200**	**135,447**	**107,779**	**10,374**	**10,524**	**452,324**

The notes to the accounts, numbered 1 to 26 form an integral part of these accounts.

Accounting Policies

1. Authority

In accordance with the accounts direction issued by Scottish Ministers under section 19(4) of the Public Finance and Accountability (Scotland) Act 2000 appended, these Accounts have been prepared in accordance with the Government Financial Reporting Manual (FReM) issued by HM Treasury, which follows International Financial Reporting Standards (IFRS) as adopted by the United Kingdom, Interpretations issued by the IFRS Interpretations Committee (IFRIC) and the Companies Act 2006, to the extent that they are meaningful and appropriate to the public sector. They have been applied consistently in dealing with items considered material in relation to the accounts.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements, are disclosed in section 30 below.

a. **Standards, amendments and interpretations effective in the current year.** IFRS 17 Insurance Contracts have been included within the FReM for 2025/26.
b. **Standards, amendments and interpretation early adopted this year.** There are no new standards, amendments or interpretations early adopted in the 2025/26 financial year.
c. **Standards, amendments and interpretation issued but not adopted this year.** The table below summarises recent standards, amendments and interpretations issued but not adopted in the 2025/26 financial year.

Standard	Current status
IFRS 18 Presentation and disclosure in financial statements	Effective for accounting periods beginning on or after 1 January 2027, this Standard is not yet been endorsed by the UKEB or adopted by HM Treasury
IFRS 19 Subsidiaries without public accountability: disclosures	Effective for accounting periods beginning on or after 1 January 2027, this Standard is not yet been endorsed by the UKEB or adopted by HM Treasury

2. Basis of consolidation

In accordance with IFRS 10 – Consolidated Financial Statements, the Financial Statements consolidate the Highland Health Board Endowment Funds.

NHS Endowment Funds were established by the NHS (Scotland) Act 1978. The legal framework under which charities operate in Scotland is the Charities and Trustee Investment (Scotland) Act 2005. Under the 1978 Act Endowment Trustees are also members of the NHS Board. The Board members (who are also Trustees) are appointed by Scottish Ministers.

The Highland Health Board Endowment Funds is a Registered Charity with the Office of the Charity Regulator of Scotland (OSCR) and is required to prepare and submit Audited Financial Statements to OSCR on an annual basis.

The basis of consolidation used is Merger Accounting. Any intragroup transactions between the Board and the Endowment Fund have been eliminated on consolidation.

The integration of health and social care services under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 and associated secondary legislation impacts on Health Board disclosure requirements in the annual accounts.

In line with statutory guidance issued by the Integrated Resources Advisory Group (IRAG) IJBs are deemed to be joint ventures. In accordance with IFRS 11 Joint Arrangements, the primary financial statements have been amended for the additional disclosure required to accurately reflect the Board's interest in IJBs using the equity method of accounting.

Note 26, provides further details on the consolidation of the Endowment Fund and IJBs within the Financial Statements.

Accounting Policies *cont.*

3. Retrospective restatements
There are no retrospective restatements in respect of changes in accounting policy or correction of material errors in accordance with IAS 8.

4. Going concern
The accounts are prepared on a going concern basis, which provides that the NHS Board will continue in operational existence for the foreseeable future, unless informed by Scottish Ministers of the intention for dissolution without transfer of services or functions to another entity.

5. Accounting convention
The accounts are prepared on a historical cost basis, as modified by the revaluation of property, plant and equipment, intangible assets, inventories and financial assets and liabilities (including derivative instruments) at fair value as determined by the relevant accounting standards and the FReM.

6. Funding
Most of the expenditure of the Health Board as Commissioner is met from funds advanced by the Scottish Government within an approved revenue resource limit (RRL). Cash drawn down to fund expenditure within this approved RRL is credited to the general fund.

All other income receivable by the Board that is not classed as funding is recognised in the year in which it is receivable.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

Non-discretionary funding out with the RRL is allocated to match actual expenditure incurred for the provision of specific Family Health Services (comprised of General Pharmaceutical Services, General Medical Services, General Dental Services and General Ophthalmic Services as designated by the Scottish Government. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the RRL in the Statement of Resource Outturn (SORO).

Funding for the acquisition of capital assets received from the Scottish Government is credited to the general fund when cash is drawn down.

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in the Consolidated Statement of Comprehensive Net Expenditure (SOCNE) except where it results in the creation of a non-current asset such as property, plant and equipment.

7. Property, plant and equipment
The treatment of capital assets in the accounts (capitalisation, valuation, depreciation, particulars concerning donated assets) is in accordance with the NHS Capital Accounting Manual.

Title to properties included in the accounts is held by Scottish Ministers.

7.1 Recognition
Property, plant and equipment is capitalised where: it is held for use in delivering services or for administrative purposes; it is probable that future economic benefits will flow to, or operational capacity be provided to, the Board; it is expected to be used for more than one financial year; and the cost of the item can be measured reliably.

All assets falling into the following categories are capitalised:

1. Property, plant and equipment assets which are capable of being used for a period which could exceed one year; and have a cost equal to or greater than £5,000.
2. In cases where a new hospital would face an exceptional write off of items of equipment costing individually less than £5,000, the Board has the option to capitalise initial revenue equipment costs with a standard life of 10 years.
3. Assets of lesser value may be capitalised where they form part of a group of similar assets purchased at approximately the same time and cost over £20,000 in total (including VAT where this is not recoverable), or where they are part of the initial costs of equipping a new development and total over £20,000 (including VAT where this is not recoverable).

7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Thereafter, valuations of all land and building assets are reassessed by valuers under a 5-year programme of professional valuations and are adjusted in intervening years to take account of movements in prices since the latest valuation. The valuations are carried out in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual (Red Book) insofar as these terms are consistent with the agreed requirements of the Scottish Government.

In general, operational assets which are in use delivering front line services or back-office functions are valued at current market value in existing use. However, to meet the underlying objectives established by the Scottish Government the following accepted variations of the RICS Appraisal and Valuation Manual are adopted:

- Specialised operational assets are valued on a replacement cost basis for a modern equivalent asset.
- Non-specialised equipment, installations and fittings are valued at fair value, using the most appropriate valuation methodology available. A depreciated historical cost basis is considered an appropriate proxy for fair value in respect of assets which have short useful lives or low values (or both).

All assets that are not held for their operational capacity (i.e. investment properties and assets held for sale), including operational assets which are surplus to requirements where there are no restrictions on disposal which would prevent access to the market, are measured subsequently at fair value.

Surplus assets with restrictions on their disposal, are valued at current value in existing use. Assets have been assessed as surplus where there is no clear plan to bring the asset back into future use as an operational asset.

Assets under construction are valued at current cost. No depreciation should be charged or indexation applied to assets under construction. These are also subject to impairment review.

Subsequent expenditure
Subsequent expenditure is capitalised into an asset's carrying value when it is probable the future economic benefits associated with the item will flow to the Board and the cost can be measured reliably. Where subsequent expenditure does not meet these criteria, the expenditure is charged to the Statement of Comprehensive Net Expenditure. If part of an asset is replaced, then the part it replaces is de-recognised, regardless of whether or not it has been depreciated separately.

Accounting Policies *cont.*

Revaluations and impairment
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in the Statement of Comprehensive Net Expenditure, in which case they are recognised as income. Movements on revaluation are considered for individual assets rather than groups or land/buildings together. Gains and losses on revaluation are reported in the Statement of Comprehensive Net Expenditure.

Permanent decreases in asset values and impairments arising from a reduction in operational capacity or consumption of economic benefit are charged to the Statement of Comprehensive Net Expenditure. Any related balance on the revaluation reserve is transferred to the general fund.

Temporary decreases in asset values or impairments arising from a change in market price are charged to the revaluation reserve where there is an available balance for the asset concerned, and thereafter are charged to the Statement of Comprehensive Net Expenditure.

7.3 Depreciation
Items of Property, Plant and Equipment are depreciated to their estimated residual value over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Depreciation is charged on each main class of tangible asset as follows:

1. Freehold land is considered to have an infinite life and is not depreciated.
2. Assets in the course of construction and residual interests in off- Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Board, respectively.
3. Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification.
4. Buildings, installations and fittings are depreciated on current value over the estimated remaining life of the asset, as advised by the appointed valuer. They are assessed in the context of the maximum useful lives for building elements.
5. Equipment is depreciated over the estimated life of the asset.
6. Leased property, plant and equipment held under leases are depreciated over the shorter of the lease term and the estimated useful life. Unless there is reasonable certainty the Board will obtain ownership of the asset by the end of the lease term in which case it is depreciated over its useful life.

Depreciation is charged on a straight-line basis.

The following asset lives have been used:

Asset category/component	Useful life (years)
Structure (shell)	25 – 100
Engineering	25 – 100
External works	25 – 60
Medical equipment	3 – 10
Other non clinical equipment	3 – 10
Furniture	5 – 10
Vehicles	3 – 7
IT mainframe installations	3 – 7
IT equipment	3 – 7
Intangible assets	3 – 7

8. Intangible assets
8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Board's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or operational capacity be provided to, the Board and where the cost of the asset can be measured reliably.

Intangible assets that meet the recognition criteria are capitalised when they are capable of being used in a Board's activities for more than one year and they have a cost of at least £5,000.

The main classes of intangible assets recognised are:

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Board intends to complete the asset and sell or use it;
- the Board has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Board to complete the development and sell or use the asset; and
- the Board can measure reliably the expenses attributable to the asset during development.

Expenditure so deferred is limited to the value of future benefits.

Software
Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Software licences
Purchased computer software licences are capitalised as intangible assets where expenditure of at least £5,000 is incurred.

Websites
Websites are capitalised only when it is probable that future economic benefits will flow to, or operational capacity be provided to, the Board; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

8.2 Measurement
Cost
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured as per the cost model, carried at historic cost less accumulated amortisation and impairment losses.

Accounting Policies *cont.*

Revaluation and impairment
The Financial Reporting Manual removes the requirement for public sector bodies to apply a revaluation model to intangible assets. Instead, entities must move to a cost model for subsequent measurement.

The transition is made using a retrospective approach in line with IAS 8, but practically implemented using the deemed cost exemption, meaning no recalculation of prior periods, no restatement of accumulated revaluation reserves, and existing balances simply become the opening position for the cost model going forward.

The carrying amount of each intangible asset held at 1 April 2025 becomes its deemed historic cost. No revaluation or indexation of intangible assets is permitted after this date. Subsequent expenditure is capitalised only where it enhances or extends the asset's operational capacity.

8.3 Amortisation
Intangible assets are amortised to their estimated residual value over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Amortisation is charged to the Statement of Comprehensive Net Expenditure on each main class of intangible asset as follows:

1. Internally generated intangible assets. Amortised on a systematic basis over the period expected to benefit from the project.
2. Software. Amortised over their expected useful life.
3. Software licences. Amortised over the shorter term of the licence and their useful economic lives.
4. Other intangible assets. Amortised over their expected useful life.
5. Intangible assets which have been reclassified as 'Held for Sale' ceases to be amortised upon the reclassification.

Amortisation is charged on a straight-line basis.

The following asset lives have been used:

Asset category/component	Useful life (years)
Software	3 – 7
Software licences	3 – 7

9. Non-current assets held for sale
Non-current assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

1. the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
2. the sale must be highly probable i.e.:
   - management are committed to a plan to sell the asset;
   - an active programme has begun to find a buyer and complete the sale;
   - the asset is being actively marketed at a reasonable price;
   - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
   - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation/amortisation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

10. Donated assets
Non-current assets that are donated or purchased using donated funds are included in the Statement of Financial Position initially at fair value. Donated assets are revalued, depreciated/amortised and subject to impairment in the same way as other non-current assets in accordance with the NHS Capital Accounting Manual.

11. Sale of property, plant and equipment, intangible assets and non-current assets held for sale
Disposal of non-current assets is accounted for as a reduction to the value of assets equal to the net book value of the assets disposed. When set against any sales proceeds, the resulting gain or loss on disposal will be recorded in the Statement of Comprehensive Net Expenditure. Non-current assets held for sale will include assets transferred from other categories and will reflect any resultant changes in valuation.

12. Leases
Scope and classification
Leases are contracts, or parts of a contract that convey the right to use an asset in exchange for consideration. The FReM expands the scope of IFRS 16 to include arrangements with nil consideration. The standard is also applied to accommodation sharing arrangements with other government departments.

Contracts or parts of contract that are leases in substance are determined by evaluating whether they convey the right to control the use of an identified asset, as represented by rights both to obtain substantially all the economic benefits from that asset and to direct its use.

The following are excluded:

- Contracts for low-value items, defined as items costing less than £5,000 when new, provided they are not highly dependent on or integrated with other items; and
- Contracts with a term shorter than twelve months (comprising the non-cancellable period plus any extension options that are reasonably certain to be exercised and any termination options that are reasonably certain not to be exercised).

Initial recognition
At the commencement of a lease (or the IFRS 16 transition date, if later), a right-of-use asset and a lease liability are recognised. The lease liability is measured at the present value of the payments for the remaining lease term (as defined above), net of irrecoverable value added tax, discounted either by the rate implicit in the lease, or, where this cannot be determined, the rate advised by HM Treasury for that calendar year. The liability includes payments that are fixed or in-substance fixed, excluding, for example, changes arising from future rent reviews or changes in an index. The right-of-use asset is measured at the value of the liability, adjusted for any payments made or amounts accrued before the commencement date; lease incentives received; incremental costs of obtaining the lease; and any disposal costs at the end of the lease. However, for peppercorn or nil consideration leases, the asset is measured at its existing use value.

Subsequent measurement
The asset is subsequently measured using the fair value model. The cost model is considered to be a reasonable proxy except for leases of land and property without regular rent reviews. For these leases, the asset is carried at a revalued amount. In these financial statements, right-of-use assets held under index-linked leases have been adjusted for changes in the relevant index, while assets held under peppercorn or nil consideration have been valued using market prices or rentals for equivalent land and properties. The liability is adjusted for the accrual of interest, repayments, and reassessments and modifications. These are measured by re-discounting the revised cash flows.

Accounting Policies *cont.*

Lease expenditure
Expenditure includes interest, straight-line depreciation, any asset impairments and changes in variable lease payments not included in the measurement of the liability during the period in which the triggering event occurred. Lease payments are debited against the liability. Rental payments for leases of low-value items or shorter than twelve months are expensed.

Estimates and judgements
The Board determines the amounts to be recognised as the right-of-use asset and lease liability for embedded leases based on the stand-alone price of the lease and non-lease component or components. This determination reflects prices for leases of the underlying asset, where these are observable; otherwise, it maximises the use of other observable data, including the fair values of similar assets, or prices of contracts for similar non-lease components. In some circumstances, where stand-alone prices are not readily observable, the entire contracts are treated as a lease as a practical expedient. The FReM requires right-of-use assets held under "peppercorn" leases to be measured at existing use value.

13. Impairment of non-financial assets
Assets that are subject to depreciation and amortisation are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use. Where an asset is not held for the purpose of generating cash flows, value in use is assumed to equal the cost of replacing the operational capacity provided by the asset, unless there has been a reduction in operational capacity. For the purposes of assessing impairment, assets are grouped at the lowest levels for which there are separately identifiable cash flows (cash-generating units). Non-financial assets that suffer an impairment are reviewed for possible reversal of the impairment. Impairment losses charged to the SoCNE are deducted from future operating costs to the extent that they are identified as being reversed in subsequent revaluations.

14. General fund receivables and payables
Where the Health Board has a positive net cash book balance at the year end, a corresponding creditor is created and the general fund debited with the same amount to indicate that this cash is repayable to the SGHSCD. Where the Health Board has a net overdrawn cash position at the year end, a corresponding debtor is created and the general fund credited with the same amount to indicate that additional cash is to be drawn down from the SGHSCD.

15. Inventories
Inventories are valued at the lower of cost and net realisable value. Taking into account the high turnover of NHS inventories, the use of average purchase price is deemed to represent current cost. Work in progress is valued at the cost of the direct materials plus the conversion costs and other costs incurred to bring the goods up to their present location, condition and degree of completion.

16. Losses and special payments
Operating expenditure includes certain losses which would have been made good through insurance cover had the NHS not been bearing its own risks. Had the NHS provided insurance cover, the insurance premiums would have been included as normal revenue expenditure.

17. Employee benefits
Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the year in which the service is received from employees. The cost of annual leave and flexible working time entitlement earned but not taken by employees at the end of the year is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following year.

Pension costs
The Board participates in the NHS Superannuation Scheme (Scotland). This scheme is an unfunded statutory pension scheme with benefits underwritten by the UK Government. The scheme is financed by payments from employers and those current employees who are members of the scheme and paying contributions at progressively higher marginal rates based on pensionable pay as specified in the regulations. The Board is unable to identify its share of the underlying notional assets and liabilities of the scheme on a consistent and reasonable basis and therefore accounts for the scheme as if it were defined contribution scheme, as required by IAS 19 'Employee Benefits'. As a result, the amount charged to the Statement of Comprehensive Net Expenditure represents the Board's employer contributions payable to the scheme in respect of the year. The contributions deducted from employees are reflected in the gross salaries charged and are similarly remitted to the Exchequer. The pension cost is assessed every four years by the Government Actuary and this valuation determines the rate of contributions required. The most recent actuarial valuation is published by the Scottish Public Pensions Agency and is available on their website.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the Statement of Comprehensive Net Expenditure at the time the Board commits itself to the retirement, regardless of the method of payment.

18. Clinical and medical negligence costs
Employing health bodies in Scotland are responsible for meeting medical negligence costs up to a threshold per claim. Costs above this threshold are reimbursed to Boards from a central fund held as part of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) by the Scottish Government.

NHS Highland provide for all claims notified to the NHS Central Legal Office according to the value of the claim and the probability of settlement. Claims assessed as 'Category 3' are deemed most likely and provided for in full, those in 'Category 2' as 50% of the claim and those in 'Category 1' as nil. The balance of the value of claims not provided for is disclosed as a contingent liability. This procedure is intended to estimate the amount considered to be the liability in respect of any claims outstanding and which will be recoverable from the Clinical Negligence and Other Risks Indemnity Scheme in the event of payment by an individual health body. The corresponding recovery in respect of amounts provided for is recorded as a debtor and that in respect of amounts disclosed as contingent liabilities are disclosed as contingent assets.

NHS Highland also provides for its liability from participating in the scheme. The Participation in CNORIS provision recognises the Board's respective share of the total liability of NHS Scotland as advised by the Scottish Government and based on information prepared by NHS Boards and the Central Legal Office. The movement in the provisions between financial years is matched by a corresponding adjustment in AME provision and is classified as non-core expenditure.

19. Related party transactions
Material related party transactions are disclosed in the Note 24 in line with the requirements of IAS 24. Transactions with other NHS bodies for the commissioning of health care are summarised in Note 3.

20. Value added tax
Most of the activities of the Board are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

21. PFI/HUB/NPD schemes
Transactions financed as revenue transactions through the Private Finance Initiative or alternative initiatives such as HUB or the Non-Profit Distributing Model (NPD) are accounted for in accordance with the HM Treasury application of IFRIC 12, Service Concession Arrangements, outlined in the FReM.

Schemes which do not fall within the application of IFRIC 12 are deemed to be off-balance sheet. Where the Board has contributed assets, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by

Accounting Policies *cont.*

charge to the Statement of Comprehensive Net Expenditure. Where, at the end of the PFI contract, a property reverts to the Board, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up on the balance sheet over the life of the contract by capitalising part of the unitary charge each year.

Transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-balance sheet' by the Board. The underlying assets are recognised as Property, Plant and Equipment and Intangible Assets at their fair value. An equivalent liability is recognised in accordance with IFRS 16. Where it is not possible to separate the finance element from the service element of unitary payment streams this has been estimated from information provided by the operator and the fair values of the underlying assets. Assets are subsequently revalued in accordance with the treatment specified for their applicable asset categories.

The total unitary payment is then divided into three: the service charge element, repayment of the capital element of the contract obligation and the interest expense on it (using the interest rate implicit in the contract).

The service charge and the finance cost interest element are charged in the Statement of Comprehensive Net Expenditure.

An IFRS 16 approach requires the liability to be remeasured if there is a change in future lease payments resulting from a change in an index/rate used to determine those payments. The liability does not include estimated future indexation linked increases.

22. Provisions
The Board provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated cash flows are discounted using the discount rate prescribed by HM Treasury.

23. Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Board's control) are not recognised as assets but are disclosed in Note 14 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 14, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control;

or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

24. Corresponding amounts
Corresponding amounts are shown for the primary statements and notes to the financial statements. Where the corresponding amounts are not directly comparable with the amount to be shown in respect of the current financial year, IAS 1 'Presentation of Financial Statements', requires that they should be adjusted and the basis for adjustment disclosed in a note to the financial statements.

25. Financial instruments
Financial assets
Business model
The Board's business model refers to how it manages its financial assets in order to generate cash flows and is determined at a level which reflects how groups of financial assets are managed to achieve a business objective, rather than assessment of individual instruments.

Classification
When the Board first recognises a financial asset, it classifies it based on its business model for managing the asset and the asset's contractual flow characteristics. The Board classifies its financial assets in the following categories: at fair value through profit or loss, amortised cost, and fair value through other comprehensive income. The default basis for financial assets is to be held at fair value through profit or loss, although alternative treatment may be designated where receivables are held to collect principal and interest and/or for sale.

a. Financial assets at fair value through profit or loss

   This is the default basis for financial assets.

b. Financial assets held at amortised cost

   A financial asset may be held at amortised cost where both of the following conditions are met:
   i. the financial asset is held within a business model where the objective is to collect contractual cash flows; and
   ii. the contractual terms of the financial asset give rise to cash flows that are solely payments of principal and related interest.

c. Financial assets at fair value through other comprehensive income

   A financial asset may be held at fair value through other comprehensive income where both of the following conditions are met:
   i. the financial asset is held within a business model where the objective is to collect contractual cash flows and sell the asset; and
   ii. the contractual terms of the financial asset give rise to cash flows that are solely payments of principal and related interest.

Impairment of financial assets
Provisions for impairment of financial assets are made on the basis of expected credit losses. The Board recognises a loss allowance for expected credit losses on financial assets and this is recognised in other comprehensive income, rather than reducing the carrying amount of the asset in the Statement of Financial Position.

Lifetime expected credit losses are recognised and applied to financial assets by the Board where there has been a significant increase in credit risk since the asset's initial recognition. Where the Board does not hold reasonable and supportable information to measure lifetime expected credit losses on an individual instrument basis, the losses are recognised on a collective basis which considers comprehensive credit risk information.

Recognition and measurement
Financial assets are recognised when the Board becomes party to the contractual provisions of the financial instrument.

Financial assets are derecognised when the rights to receive cash flows from the asset have expired or have been transferred and the Board has transferred substantially all risks and rewards of ownership.

a. Financial assets at fair value through profit or loss.

   Financial assets carried at fair value through profit or loss are initially recognised at fair value, and transaction costs are expensed in the Statement of Comprehensive Net Expenditure.

   Financial assets carried at fair value through profit or loss are subsequently measured at fair value. Gains or losses arising from changes in the fair value are presented in the Statement of Comprehensive Net Expenditure.

b. Financial assets held at amortised cost.

   Loans and receivables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method. This is calculated by applying the effective interest rate to the gross carrying amount of the asset.

Accounting Policies *cont.*

c. Financial assets held at fair value through other comprehensive income.

Financial liabilities
Classification
The Board classifies its financial liabilities in the following categories: at fair value through profit or loss, and amortised cost. The Board classifies all financial liabilities as measured at amortised cost, unless:

i. these are measured at fair value on a portfolio basis in accordance with a documented risk management or investment strategy;
ii. they contain embedded derivatives; and/or
iii. it eliminates or reduces 'accounting mismatch' that would otherwise arise from measurement or recognition on an amortised costs basis.

a. Financial liabilities at fair value through profit or loss

Financial liabilities at fair value through profit or loss comprise derivatives. Liabilities in this category are classified as current liabilities. The NHS Board does not trade in derivatives and does not apply hedge accounting.

b. Financial liabilities held at amortised cost

Financial liabilities held at amortised cost are disclosed in current liabilities, except for maturities greater than 12 months after the Statement of Financial Position date. These are classified as non-current liabilities. The NHS Board's financial liabilities held at amortised cost comprise trade and other payables in the Statement of Financial Position.

Recognition and measurement
Financial liabilities are recognised when the NHS Board becomes party to the contractual provisions of the financial instrument.

A financial liability is removed from the Statement of Financial Position when it is extinguished, that is when the obligation is discharged, cancelled or expired.

a. Financial liabilities at fair value through profit or loss

Financial liabilities carried at fair value through profit or loss are initially recognised at fair value, and transaction costs are expensed in the income statement.

Financial liabilities carried at fair value through profit or loss are subsequently measured at fair value. Gains or losses arising from changes in the fair value are presented in the Statement of Comprehensive Net Expenditure.

b. Amortised costs

Financial liabilities held at amortised cost are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method.

26. Segmental reporting
Operating segments are reported in Note 5 in a manner consistent with the internal reporting provided to the chief operating decision-maker, who is responsible for allocating resources and assessing performance of the operating segments. This has been identified as the senior management of the Board.

Operating segments are unlikely to directly relate to the analysis of expenditure shown in Note 3.

27. Cash and cash equivalents
Cash and cash equivalents includes cash in hand, deposits held at call with banks, cash balances held with the Government Banking Service, balances held in commercial banks and other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities on the Statement of Financial Position. Where the Government Banking Service is using the National Westminster Bank to provide the banking services, funds held in these accounts are not classed as commercial bank balances.

28. Foreign exchange
The functional and presentational currencies of the Board are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Board has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expenditure in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

29. Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Board has no beneficial interest in them.

However, they are disclosed in Note 25 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual. In addition, where third party monies have been held in a public bank account, commentary is provided in Note 11.

30. Key sources of judgement and estimation uncertainty
The Board makes subjective and complex judgements in applying its accounting policies and relies on a range of estimation techniques and assumptions concerning uncertain future events. It is recognised that sources of estimation uncertainty are likely to vary from year to year and the resulting accounting estimates will, by definition, seldom equal the related actual results. As such, key judgements and estimates are continually reviewed, based on historical experience and other factors, including changes to past assumptions and expectations of future events that are believed to be reasonable under the circumstances.

The key judgements exercised in the application of the Board's accounting policies which have the most significant effect on the carrying amounts in the financial statements are summarised below:

Assessment of leases
The Board determines the amounts to be recognised as the right-of-use asset and lease liability for embedded leases based on the stand-alone price of the lease and non-lease component or components. This determination reflects prices for leases of the underlying asset, where these are observable; otherwise, it maximises the use of other observable data, including the fair values of similar assets, or prices of contracts for similar non-lease components. In some circumstances, where stand-alone prices are not readily observable, the entire contracts are treated as a lease as a practical expedient. The FReM requires right-of-use assets held under "peppercorn" leases to be measured at existing use value.

Accounting Policies *cont.*

Pension provision
Pension Liability for The Highland Council Pension Fund used by Social Care staff transferred to NHS Highland

In accordance with SGHSCD guidance, obligations under the defined benefit pension scheme are fully funded via Scottish Government funding in advance and therefore as a departure from IAS 19: Employee Benefits, the defined benefit obligations are not recognised as a long term liability and instead recognised through other reserves as SGHSCD funding received in advance. For further information see Note 19.

Estimation of the liability to pay pensions for these staff depends on a number of complex judgements relating to the discount rates used, the rate at which salaries are projected to increase, changes in retirement ages, mortality rates and expected returns on pension fund assets.

Reliance is placed on significant details provided by the actuary of the Pension Fund to establish the value of this liability.

See Note 19 for detailed information on this liability.

Other estimates and judgements
The key estimates and assumptions, for example provisions, accruals and depreciation that are deemed to present a significant risk of a causing material adjustment to the carrying amounts of assets and liabilities within the next financial year are summarised below.

Estimates
Clinical and medical negligence provision
The clinical and medical negligence provision is calculated using information received from the Central Legal Office regarding claims they have received relating to NHS Highland. The provision covers all claims classified as category 3 and 50% of the full cost of category 2 claims which have been assessed as having a probability of settlement. The provisions are reported in Note 13a. The element of claims in Categories 1 and 2 not covered by the provision is recorded as a contingent liability under Note 14. The sensitivities regarding the categorisation of claims is set out as follows:

	Increase in provision £000	Decrease in contingent liability £000
Sensitivities at 31st March 2026		
5% increase in claims needing to be fully provided for	785	(785)

Property, plant and equipment
All property, plant and equipment assets are measured initially at cost. NHS Highland revalues 20% of all its property, land and dwellings each year. The most recent tranche of valuations being as at 31 March 2026 carried out by independent valuer, FG Burnett and Newmark. All remaining property, land and buildings are subject to a desktop valuation of local market related indices as at 31 March 2026. The professional valuer's estimates, assumptions and judgements are relied upon in relation to the values disclosed for land and property. The useful economic life applied to an asset is estimated in relation to the class and type of the asset and its components, with a consistent approach taken across each asset category.

	2025/26 £000
Sensitivities at 31st March 2026	
Value of land, buildings and dwellings	481,588

The carrying value of land, buildings and dwellings is shown above, with analysis in Note 7. If there was an estimated change in value of 10% to the value of these assets, the impact would be £48.2m.

Notes to the Accounts
for the year ended 31st March 2026

Note 2a – Summary of resource outturn (SORO)

	Note	2026 £000
Summary of core revenue resource outturn		
Net operating costs	SoCNE	1,264,694
Total non-core expenditure (see below)		(43,707)
Family Health Services non-discretionary allocation		(45,940)
Endowment net income/(expenditure)	26	656
Associates and joint ventures accounted for on an equity basis	26	5,164
Total core expenditure		**1,180,867**
Core revenue resource limit		**1,181,063**
Saving against core revenue resource limit (RRL)		**196**
Summary of non-core revenue resource outturn		
Capital grants from other bodies		–
Depreciation/amortisation		21,100
Annually managed expenditure – impairments		100
Annually managed expenditure – provisions		11,748
Annually managed expenditure – depreciation of donated assets	2b	139
Annually managed expenditure – pension valuation		(204)
Annually managed expenditure – fair value adjustments		–
Additional SGHSCD non-core funding		3,006
Donated assets income	7d	(91)
PFI depreciation		1,019
PFI remeasurement (gain)/loss		806
Right of Use (RoU) asset depreciation		5,184
Right of Use (RoU) peppercorn leases depreciation		900
Total non-core expenditure		**43,707**
Non core revenue resource limit		**43,707**
Excess against non-core revenue resource limit (RRL)		**–**

Summary resource outturn

	Resource £000	Expenditure £000	Saving £000
Core	1,181,063	1,180,867	196
Non-core	43,707	43,707	–
Total	**1,224,770**	**1,224,574**	**196**

The notes to the accounts, numbered 1 to 26 form an integral part of these accounts.

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Note 2b – Notes to the Cash Flow Statement

Consolidated adjustments for non cash transactions

2025 £000		Note	2026 £000
22,623	Depreciation	7a	21,373
708	Amortisation	6	694
135	Depreciation of donated assets	7a	139
6,522	Depreciation of Right of Use (RoU) assets	17b	6,137
–	Right of Use asset peppercorn leases	17a	800
2,351	PFI remeasurement (gain)/loss		806
1,099	Impairments on PPE charged to SoCNE		100
(8)	Funding of donated assets	7a	(91)
(119)	Loss/(profit) on disposal of property, plant and equipment		(218)
(435)	Associates and joint ventures accounted for on an equity basis	SoCNE	(5,164)
16,831	The Highland Council IAS19		127
–	ROU asset peppercorn lease net disposal		(693)
49,707	**Total expenditure not paid in cash**	CFS	**24,010**

Interest payable recognised in operating expenditure

2025 £000		Note	2026 £000
	Interest payable		
2,002	PFI finance lease charges allocated in the year	18	1,697
387	Lease interest	17b	335
27	Provisions – unwinding of discount		(273)
2,416	**Total interest payable**	CFS	**1,759**

Consolidated movements in working capital

2025 £000		Note	Opening balances £000	Closing balances £000	2026 net movement £000
	Inventories				
(40)	Balance sheet	8	8,603	8,326	
(40)	**Net decrease/(increase)**		**8,603**	**8,326**	**277**
	Trade and other receivables				
7,368	Due within one year	9	56,419	73,437	
(15,835)	Due after more than one year	9	78,548	86,351	
(8,467)	**Net decrease/(increase)**		**134,967**	**159,788**	
–	Less: general fund debtor included in above	9	–	(10,539)	
(8,467)	**Net decrease/(increase)**		**134,967**	**149,249**	**(14,282)**
	Trade and other payables				
(5,724)	Due within one year	12	141,626	189,112	
(4,332)	Due after more than one year	12	55,118	53,291	
3,673	Less: property, plant and equipment (capital) included in above		(3,673)	(1,329)	
4,057	Less: lease and PFI creditors included in above	12	(54,361)	(48,988)	
(2,326)	**Net (decrease)/increase**		**138,710**	**192,086**	**53,376**
	Provisions				
7,847	Statement of financial position	13a	60,832	77,787	
7,847	**Net (decrease)/increase**		**60,832**	**77,787**	**16,955**
(2,986)	**Net movement (decrease)/increase**	CFS			**56,326**

Other general fund non-cash costs shown on the face of the SoCTE

2025 £000		2026 £000
	Other non-cash costs	
–	New peppercorn lease	800
–	**Total other non-cash costs**	**800**

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Note 3 – Operating expenses

Note 3a – Employee expenditure

2025 Consolidated £000		2026 Consolidated £000	2026 Board £000
	Staff costs		
142,033	Medical and dental	151,733	151,733
221,564	Nursing	253,835	253,835
288,263	Other staff	301,948	301,948
651,860	**Total staff costs**	**707,516**	**707,516**

Further detail and analysis of employee costs can be found in the Remuneration and Staff Report forming part of the Accountability Report.

Note 3b – Other operating costs

2025 Consolidated £000		2026 Consolidated £000	2026 Board £000
	Independent Primary Care Services		
71,946	General Medical Services	77,258	77,258
18,669	Pharmaceutical Services	20,309	20,309
21,239	General Dental Services	22,975	22,975
7,197	General Ophthalmic Services	7,756	7,756
119,051		**128,298**	**128,298**
	Drugs and medical Supplies		
80,826	Prescribed drugs Primary Care	80,102	80,102
55,937	Prescribed drugs Secondary Care	58,354	58,354
37,370	Medical supplies	37,982	37,982
174,133		**176,438**	**176,438**
	Other health care expenditure		
308,561	Contribution to Integration Joint Boards	336,259	336,259
128,508	Goods and services from other NHS Scotland bodies	136,641	136,641
748	Goods and services from other UK NHS bodies	1,153	1,153
16,394	Goods and services from private providers	17,433	17,433
7,414	Goods and services from voluntary organisations	9,328	9,328
5	Loss on disposal of assets	–	–
310,363	Other operating expenses (analysed in Note 3c below)	322,361	322,361
243	External Auditor's remuneration – statutory audit fee	254	254
584	Endowment fund expenditure	528	–
772,820		**823,957**	**823,429**
1,066,004	**Other operating expenditure**	**1,128,693**	**1,128,165**

Note 3c – Analysis of other operating expenses reported in Note 3b above

2025 Consolidated £m		2026 Consolidated £m	2026 Board £m
	Other operating expenses reported above includes		
145	Social work healthcare	159	159
32	Other admin supplies	33	33
24	Capital charges	22	22
21	Other supplies	23	23
222	**Other operating expenses included in Note 3b above**	**237**	**237**

Note 4 – Operating income

2025 Consolidated £000		2026 Consolidated £000	2026 Board £000
	NHS		
662	Income from Scottish Government	621	621
48,329	Income from other NHS Scotland bodies	50,491	50,491
2,797	Income from NHS non-Scottish bodies	2,945	2,945
13	Income from private patients	12	12
291,814	Income for services commissioned by Integration Joint Board	310,661	310,661
4,286	Patient charges for primary care	4,578	4,578
9	Donations	91	91
125	Profit on disposal of assets	218	218
4,544	Contributions in respect of clinical and medical negligence claims	1,900	1,900
7	Interest received	14	14
	Non NHS		
1,096	Overseas patients (non-reciprocal)	1,135	1,135
1,396	Endowment fund income	1,184	–
187,891	Other	192,501	192,501
542,969	**Total income**	**566,351**	**565,167**

Note 4 – Analysis of other operating income

2025 Consolidated £000		2026 Consolidated £000	2026 Board £000
	Other operating income reported above includes		
150,155	Contributions public sector	155,681	155,681
18,472	Board residents	19,229	19,229
6,311	Other operating income	4,036	4,036
3,274	Healthcare to Local Authority	3,445	3,445
178,212		**182,391**	**182,391**

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Note 5 – Segmental information

	Acute £000	North Highland Communities inc ASC £000	ASC funding £000	Mental Health £000	Primary Care £000	Children's Services £000
Net operating cost	343,926	302,437	(149,282)	64,961	171,618	12,194
Net operating cost prior year	317,383	266,518	(141,522)	60,040	165,698	12,194

	Corporate Ehealth & Tertiary £000	Central £000	Facilities £000	A&B £000	NTC £000	Total £000
Net operating cost	96,037	50,338	53,539	295,698	29,048	**1,270,514**
Net operating cost prior year	98,357	34,784	54,545	281,252	26,459	**1,175,708**

Note 6 – Intangible assets (non-current): Board and Consolidated

Current year

	Note	Software licences £000	IT – software £000	Total £000
Cost or valuation				
At 1 April 2025		2,748	8,144	10,892
Additions		–	136	136
At 31 March 2026		**2,748**	**8,280**	**11,028**
Amortisation				
At 1 April 2025		2,522	6,232	8,754
Provided during the year		118	576	694
At 31 March 2026		**2,640**	**6,808**	**9,448**
Net book value at 1 April 2025		**226**	**1,912**	**2,138**
Net book value at 31 March 2026	SoFP	**108**	**1,472**	**1,580**

Prior year

	Note	Software licences £000	IT – software £000	Total £000
Cost or valuation				
At 1 April 2024		2,748	7,776	10,524
Additions		–	368	368
At 31 March 2025		**2,748**	**8,144**	**10,892**
Amortisation				
At 1 April 2024		2,371	5,675	8,046
Provided during the year		151	557	708
At 31 March 2025		**2,522**	**6,232**	**8,754**
Net book value at 1 April 2024		**377**	**2,101**	**2,478**
Net book value at 31 March 2025	SoFP	**226**	**1,912**	**2,138**

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Note 7a – Property, plant and equipment: Consolidated and Board

Current year

	Land (inc under buildings) £000	Buildings (excluding dwellings) £000	Dwellings £000	Transport equipment £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	Assets under construction £000	Total 2026 £000
Cost or valuation									
At 1 April 2025	21,120	441,545	6,788	148	96,029	17,577	1,769	11,985	596,961
Additions – purchased	–	–	–	–	4,650	1,341	–	15,041	21,032
Additions – donated	–	–	–	–	91	–	–	–	91
Completions	–	8,878	–	–	–	–	–	(8,878)	–
Revaluations	660	33,694	105	–	–	–	–	–	34,459
Impairment charges	–	(1,813)	–	–	–	–	–	–	(1,813)
Disposals – purchased	(20)	(46)	–	–	(790)	–	–	–	(856)
Disposals – donated	–	–	–	–	–	–	–	–	–
At 31 March 2026	**21,760**	**482,258**	**6,893**	**148**	**99,980**	**18,918**	**1,769**	**18,148**	**649,874**
Depreciation									
At 1 April 2025	–	34,027	239	102	70,555	11,468	1,767	–	118,158
Provided during the year – purchased	–	11,034	403	10	8,131	1,794	1	–	21,373
Provided during the year – donated	–	101	7	1	30	–	–	–	139
Revaluations	–	(14,600)	(163)	–	–	–	–	–	(14,763)
Impairment charges	–	(1,713)	–	–	–	–	–	–	(1,713)
Disposals – purchased	–	(12)	–	–	(790)	–	–	–	(802)
Disposals – donated	–	–	–	–	–	–	–	–	–
At 31 March 2026	**–**	**28,837**	**486**	**113**	**77,926**	**13,262**	**1,768**	**–**	**122,392**
Net book value at 1 April 2025	**21,120**	**407,518**	**6,549**	**46**	**25,474**	**6,109**	**2**	**11,985**	**478,803**
Net book value at 31 March 2026	**21,760**	**453,421**	**6,407**	**35**	**22,054**	**5,656**	**1**	**18,148**	**527,482**
Open market value of land in Land and Dwellings included above	272		239						–
Asset financing									
Owned – purchased	21,715	401,864	6,174	33	21,948	5,656	1	18,148	475,539
Owned – donated	45	3,684	233	2	106	–	–	–	4,070
On-balance sheet PFI contracts	–	47,873	–	–	–	–	–	–	47,873
Net book value at 31 March 2026	**21,760**	**453,421**	**6,407**	**35**	**22,054**	**5,656**	**1**	**18,148**	**527,482**

Prior year

	Land (inc under buildings) £000	Buildings (excluding dwellings) £000	Dwellings £000	Transport equipment £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	Assets under construction £000	Total 2025 £000
Cost or valuation									
At 1 April 2024	20,665	449,819	7,717	127	93,420	15,374	1,769	16,792	605,683
Additions – purchased	–	–	–	21	3,807	2,218	–	6,545	12,591
Additions – donated	–	–	–	–	8	–	–	–	8
Completions	–	11,352	–	–	–	–	–	(11,352)	–
Revaluations	803	(18,430)	(929)	–	–	–	–	–	(18,556)
Impairment charges	(8)	(1,196)	–	–	–	–	–	–	(1,204)
Disposals – purchased	(340)	–	–	–	(1,182)	(15)	–	–	(1,537)
Disposals – donated	–	–	–	–	(24)	–	–	–	(24)
At 31 March 2025	**21,120**	**441,545**	**6,788**	**148**	**96,029**	**17,577**	**1,769**	**11,985**	**596,961**
Depreciation									
At 1 April 2024	–	35,298	565	92	63,180	9,862	1,761	–	110,758
Provided during the year – purchased	–	11,972	466	9	8,549	1,621	6	–	22,623
Provided during the year – donated	–	103	7	1	24	–	–	–	135
Revaluations	–	(13,241)	(799)	–	–	–	–	–	(14,040)
Impairment charges	–	(105)	–	–	–	–	–	–	(105)
Disposals – purchased	–	–	–	–	(1,174)	(15)	–	–	(1,189)
Disposals – donated	–	–	–	–	(24)	–	–	–	(24)
At 31 March 2025	**–**	**34,027**	**239**	**102**	**70,555**	**11,468**	**1,767**	**–**	**118,158**
Net book value at 1 April 2024	**20,665**	**414,521**	**7,152**	**35**	**30,240**	**5,512**	**8**	**16,792**	**494,925**
Net book value at 31 March 2025	**21,120**	**407,518**	**6,549**	**46**	**25,474**	**6,109**	**2**	**11,985**	**478,803**
Open market value of land in Land and Dwellings included above	272		243						–
Asset financing									
Owned – purchased	21,075	357,787	6,319	43	25,429	6,109	2	11,985	428,749
Owned – donated	45	3,658	230	3	45	–	–	–	3,981
On-balance sheet PFI contracts	–	46,073	–	–	–	–	–	–	46,073
Net book value at 31 March 2025	**21,120**	**407,518**	**6,549**	**46**	**25,474**	**6,109**	**2**	**11,985**	**478,803**

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Note 7b – Assets held for sale

There were no assets held for sale in 2025/26.

Note 7c – Property, plant and equipment disclosures

Consolidated 2025 £000	Board 2025 £000		Note	Consolidated 2026 £000	Board 2026 £000
474,822	474,822	Purchased	7a	523,412	523,412
3,981	3,981	Donated	7a	4,070	4,070
478,803	**478,803**	**Net book value of property, plant and equipment at 31 March**		**527,482**	**527,482**
272	**272**	**Net book value related to land valued at open market value at 31 March**		**272**	**272**
243	**243**	**Net book value related to buildings valued at open market value at 31 March**		**239**	**239**
		Total value of assets held under:			
46,073	46,073	PFI and PPP contracts		47,873	47,873
46,073	**46,073**			**47,873**	**47,873**
		Total depreciation charged in respect of assets held under:			
1,597	1,597	PFI and PPP contracts		1,019	1,019
1,597	**1,597**			**1,019**	**1,019**

20% of land and of buildings were revalued by an independent valuer, FG Burnett and Newmark, as at 31/03/2026 on the basis of fair value (market value or depreciated replacement costs where appropriate). The values were computed in accordance with the Royal Institute of Chartered Surveyors Statement of Asset Valuation Practice and Guidance notes, subject to the special accounting practices of the NHS.

The net impact was an increase of £49,233m (2024/25: an increase of £4,507m) which was credited to the revaluation reserve. Impairment of £0.1m (2024/25: £1.099m) was charged to the Statement of Comprehensive Net Expenditure and Summary of Resource Outturn.

Note 7d – Analysis of capital expenditure

Consolidated 2025 £000	Board 2025 £000		Note	Consolidated 2026 £000	Board 2026 £000
368	368	Acquisition of intangible assets	6	136	136
12,591	12,591	Acquisition of property, plant and equipment	7a	21,032	21,032
8	8	Donated asset additions	7a	91	91
408	408	GP loans advances	10	–	–
3,660	3,660	Right of Use (RoU) additions	17a	3,494	3,494
17,035	**17,035**	**Gross capital expenditure**		**24,753**	**24,753**
348	348	Net book value of disposal of property, plant and equipment	7a	54	54
286	286	Right of Use disposals	17a	195	195
3	3	HUB – repayment of investment		2	2
637	**637**	**Capital income**		**251**	**251**
16,398	**16,398**	**Net capital expenditure**		**24,502**	**24,502**
		Summary of capital resource outturn			
15,982	15,982	Core capital expenditure included above		24,411	24,411
15,982	15,982	Core capital resource limit		24,416	24,416
–	**–**	**Saving against core capital resource limit (CRL)**		**5**	**5**
416	416	Non-core capital expenditure included above		91	91
416	416	Non-core capital resource limit		91	91
–	**–**	**Saving against non-core capital resource limit (CRL)**		**–**	**–**
16,398	16,398	Total capital expenditure		24,502	24,502
16,398	16,398	Total capital resource limit		24,507	24,507
–	**–**	**Saving against total capital resource limit**		**5**	**5**

Note 8 – Inventories

Consolidated 2025 £000	Board 2025 £000		Consolidated 2026 £000	Board 2026 £000
8,603	8,603	Raw materials and consumables	8,326	8,326
8,603	**8,603**		**8,326**	**8,326**

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Note 9 – Trade and other receivables

Consolidated 2025 £000	Board 2025 £000		Note	Consolidated 2026 £000	Board 2026 £000
242	242	Scottish Government		116	116
9,922	9,922	Boards		4,479	4,479
10,164	**10,164**	**NHS Scotland receivables due within one year**		**4,595**	**4,595**
683	683	NHS non-Scottish bodies		871	871
–	–	General fund receivable		10,539	10,539
1,748	1,748	VAT recoverable		1,736	1,736
6,065	6,065	Prepayments		13,125	13,125
4,912	4,912	Accrued income		4,968	5,102
3,977	4,077	Other receivables		4,710	4,710
8,090	8,090	Reimbursement of provisions		6,480	6,480
20,780	20,780	Other public sector bodies		26,413	26,413
56,419	**56,519**	**Total receivables due within one year**	SoFP	**73,437**	**73,571**
58,771	58,771	Other public sector bodies		59,103	59,103
1,075	1,075	Prepayments		1,009	1,009
4,731	4,731	Accrued income		2,985	2,985
9,983	9,983	Other receivables		11,617	11,617
3,988	3,988	Reimbursement of provisions		11,637	11,637
78,548	**78,548**	**Total receivables due after more than one year**	SoFP	**86,351**	**86,351**
134,967	**135,067**	**Total receivables**		**159,788**	**159,922**
		Provision for impairment included above			
2,453	2,453	The total receivables figure above includes a provision for impairments of:		3,293	3,293
		WGA classification			
9,922	9,922	NHS Scotland		4,479	4,479
1,990	1,990	Central Government bodies		1,852	1,852
20,780	20,780	Whole of Government bodies		18,073	18,073
683	683	Balances with NHS bodies in England and Wales		871	871
101,592	101,692	Balances with bodies external to Government		134,513	134,647
134,967	**135,067**	**Total Current Receivables**		**159,788**	**159,922**
		Movement on the provision for impairment of receivables			
2,076	2,076	At 1 April		2,453	2,453
680	680	Provision for impairment		1,038	1,038
195	195	Receivables written off during the year as uncollectable		(161)	(161)
(498)	(498)	Unused amounts reversed		(37)	(37)
2,453	**2,453**	**As at 31st March**		**3,293**	**3,293**

As of 31 March 2026, receivables with a carrying value of £3.293m (2024/25: £2.453m) were impaired and provided for. The ageing of these receivables is as follows:

Consolidated 2025 £000	Board 2025 £000		Consolidated 2026 £000	Board 2026 £000
–	–	3 to 6 months past due	–	–
2,453	2,453	Over 6 months past due	3,293	3,293
2,453	**2,453**	**As at 31st March**	**3,293**	**3,293**

The receivables assessed as individually impaired were mainly overseas patients, research companies and private individuals. It was assessed that not all of the receivable balance may be recovered.

Receivables that are less than three months past their due date are not considered impaired. As at 31 March 2026, receivables with a carrying value of £5.068m (2024/25: £5.547m) were past their due date but not impaired. The ageing of receivables which are past due but not impaired is as follows:

Consolidated 2025 £000	Board 2025 £000		Consolidated 2026 £000	Board 2026 £000
1,770	1,770	Up to 3 months past due	1,153	1,153
1,469	1,469	3 to 6 months past due	921	921
2,308	2,308	Over 6 months past due	1,449	1,449
5,547	**5,547**	**As at 31st March**	**3,523**	**3,523**

The receivables assessed as past due but not impaired were mainly NHS Scotland Health Boards and NHS Other Health Authorities and there is no history of default from these customers recently.

Concentration of credit risk is limited due to customer base being large and unrelated/government bodies. Due to this, management believe that there is no future credit risk provision required in excess of the normal provision for doubtful receivables.

The credit quality of receivables that are neither past due nor impaired is assessed by reference to external credit ratings where available. Where no external credit rating is available, historical information about counterparty default rates is used.

Receivables that are neither past due nor impaired are shown by their credit risk below:

Consolidated 2025 £000	Board 2025 £000		Consolidated 2026 £000	Board 2026 £000
		Currencies		
134,967	135,067	Pounds	159,788	159,922
134,967	**135,067**		**159,788**	**159,922**

All non-current receivables are due within 9 years (2024/25: 10 years) from the balance sheet date. The carrying amount of short term receivables approximates their fair value. The fair value of long term other receivables is £86.351m (2024/25: £78.548m). The effective interest rate on non-current other receivables is 0% (2024/25: 0%). Pension liabilities are discounted at 2.95% (2024/25: 2.40%).

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Note 10 – Investments

Consolidated 2025 £000	Board 2025 £000		Note	Consolidated 2026 £000	Board 2026 £000
492	–	Government securities		390	–
9,792	791	Other		11,723	790
10,284	**791**	**Total**	SoFP	**12,113**	**790**
9,606	385	**At 1 April**		10,284	791
6,070	–	Additions	CFS	1,916	–
408	408	GP loans advances	CFS	–	–
(5,668)	(2)	Disposals		(635)	(1)
(132)	–	Revaluation surplus/(deficit) transferred to equity	SoCTE	548	–
10,284	**791**	**At 31 March**		**12,113**	**790**
–	–	Current	SoFP	–	–
10,284	791	Non-current	SoFP	12,113	790
10,284	**791**	**At 31 March**		**12,113**	**790**

We have a small shareholding in HUB North of Scotland Ltd, an unlisted investment denominated in UK pounds; £92k in the form of non-equity long term loans repayable in full with interest over 25 years to HUB North of Scotland Ltd as part of the financing arrangements for the Forres, Woodside and Tain Health Centre Project. The carrying value of £92k of these investments is cost less impairment as there is no active market.

Stocks and Bonds relate to the Highland Health Board Charitable Endowment Funds which are invested in a portfolio of bonds and equity investments, managed by the Funds appointed Investment Managers Adam & Company Investment Management Limited., in line with a medium risk strategy to deliver a balance between income and capital growth. The carrying value of Stocks and Bonds is market value.

In 2024/25, in accordance with the National Code of Practice for GP Premises, two GP Sustainability were issued. Each loan was £204k and they were both issued to Practices in Argyll and Bute. In 2023/24 a GP Sustainability Loan of £290k was issued to a GP Practice, also in Argyll and Bute.

Note 11 – Cash and cash equivalents

Consolidated 2025 £000	Board 2025 £000		Note	Consolidated 2026 £000	Board 2026 £000
1,063	132	Balance at 1 April		1,567	411
504	279	Net change in cash and cash equivalent balances	CFS	(11,531)	(10,950)
1,567	**411**	**Balance at 31 March**	SoFP	**(9,964)**	**(10,539)**
1,567	**411**	**Total cash – Cash Flow Statement**		**(9,964)**	**(10,539)**
		The following balances at 31 March were held at			
76	76	Government Banking Service		(10,607)	(10,607)
335	335	Commercial banks and cash in hand		68	68
1,156	–	Endowment cash		575	–
1,567	**411**	**Balance at 31 March**		**(9,964)**	**(10,539)**

The Government banking line is showing an overdrawn position on our ledger. This is due to a timing difference where a bacs run was processed on the last day of the month, and recorded in our ledger, and the physical cash leaving our bank on the 1st April when we received Government funding.

Note 12 – Trade and other payables

Consolidated 2025 £000	Board 2025 £000		Note	Consolidated 2026 £000	Board 2026 £000
		Payables due within one year NHS Scotland			
19,250	19,250	Boards	SFR 30	32,857	32,857
19,250	**19,250**	**Total NHS Scotland payables**		**32,857**	**32,857**
1,668	1,668	NHS non-Scottish bodies		3,888	3,888
13,776	13,776	FHS practitioners		13,663	13,663
2,501	2,501	Trade payables		(96)	(96)
32,597	32,572	Accruals		30,069	30,044
1,174	1,174	Deferred income		1,253	1,253
2	2	Payments received on account		–	–
5,592	5,592	Net obligations under finance leases	17b	4,356	4,356
3,614	3,614	Net obligations under PPP/PFI contracts	18	2,940	2,940
–	–	Bank overdrafts		–	–
12,091	12,091	Income tax and social security		14,419	14,419
10,502	10,502	Superannuation		11,645	11,645
9,273	9,273	Holiday pay accrual		9,374	9,374
26,382	26,382	Other public sector bodies		48,068	48,068
2,948	2,948	Other payables		2,410	2,410
256	256	Other significant payables – pension contribution to local Government Pension Scheme		257	257
–	–	Other significant payables – IR35 Employers NI & Band 5-6 accruals		14,009	14,009
122,376	**122,351**	**Other payables due within one year**		**156,255**	**156,230**
141,626	**141,601**	**Total payables due within one year**	SoFP	**189,112**	**189,087**
1,763	1,763	Net obligations under finance leases due within 2 years	17b	1,394	1,394
6,699	6,699	Net obligations under finance leases due after 2 years but within 5 years	17b	6,410	6,410
8,560	8,560	Net obligations under finance leases due after 5 years	17b	7,598	7,598
2,836	2,836	Net obligations under PPP/PFI contracts due within 2 years	18	3,097	3,097
9,222	9,222	Net obligations under PPP/PFI contracts due after 2 years but within 5 years	18	8,644	8,644
16,075	16,075	Net obligations under PPP/PFI contracts due after 5 years	18	14,549	14,549
9,963	9,963	Other payables		11,599	11,599
55,118	**55,118**	**Total payables due after more than one year**	SoFP	**53,291**	**53,291**
196,744	**196,719**	**Total payables**		**242,403**	**242,378**

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Note 13a – Provisions: Consolidated and Board

Current year

	Pensions and similar obligations £000	Clinical and medical legal claims against NHS Board £000	Participation in CNORIS £000	Other (non-endowment) £000	Total 2026 £000
At 1 April 2025	9,314	12,437	38,840	241	60,832
Arising during the year	6,703	7,618	5,814	626	20,761
Utilised during the year	(665)	(1,378)	(917)	(431)	(3,391)
Unwinding of discount	(273)	–	–	–	(273)
Reversed unutilised	(71)	(55)	–	(16)	(142)
At 31 March 2026	**15,008**	**18,622**	**43,737**	**420**	**77,787**

The amounts shown above in relation to clinical and medical legal claims against NHS Highland are stated gross and the amount of any expected reimbursements are separately disclosed as receivables in Note 9.

	Pensions and similar obligations £000	Clinical and medical legal claims against NHS Board £000	Participation in CNORIS £000	Other (non-endowment) £000	Total 2026 £000
Payable in one year	9,890	6,812	10,934	420	28,056
Payable between 1-5 years	1,743	11,535	26,592	–	39,870
Payable between 6-10 years	1,649	–	2,274	–	3,923
Thereafter	1,726	275	3,937	–	5,938
At 31 March 2026	**15,008**	**18,622**	**43,737**	**420**	**77,787**

Prior year

	Pensions and similar obligations £000	Clinical and medical legal claims against NHS Board £000	Participation in CNORIS £000	Other (non-endowment) £000	Total 2025 £000
At 1 April 2024	6,609	8,876	37,298	202	52,985
Arising during year	3,386	6,923	4,842	217	15,368
Utilised during year	(685)	(3,274)	(3,300)	(160)	(7,419)
Unwinding during year	27	–	–	–	27
Reversed unutilised	(23)	(88)	–	(18)	(129)
At 31 March 2025	**9,314**	**12,437**	**38,840**	**241**	**60,832**
Payable in one year	3,229	8,437	9,710	240	21,616
Payable between 1-5 years	2,108	4,000	23,614	–	29,722
Payable between 6-10 years	1,931	–	2,020	–	3,951
Thereafter	2,046	–	3,496	1	5,543
At 31 March 2025	**9,314**	**12,437**	**38,840**	**241**	**60,832**

Pensions and similar obligations
The Board meets the additional costs of benefits beyond the normal National Health Service Superannuation Scheme for Scotland benefits in respect of employees who retire early by paying the required amounts annually to the National Health Service Superannuation Scheme for Scotland over the period between early departure and normal retirement date. The Board provides for this in full when the early retirement programme becomes binding by establishing a provision for the estimated payments discounted by the Treasury discount rate of 2.95% (2024/25: 2.40%) in real terms. The Board expects expenditure to be charged to this provision for a period of up to 33 years (pension 13 years and injuries 33 years per life tables provided by Office for National statistics for Scotland). Please also see accounting policies.

Clinical and medical legal claims against NHS Board
The Board holds a provision to meet costs of all outstanding and potential clinical and medical negligence claims. All legal claims notified to the Board are processed by the Scottish NHS Central Legal Office who will decide upon risk liability and likely outcome of each case. The provision contains sums for settlement awards, legal expenses and third party costs. Clinical and medical negligence cases lodged can be extremely complex. It is expected that expenditure will be charged to this provision in future years. The amounts disclosed are stated gross and the amount of any expected reimbursements are shown separately as debtors in the notes to the accounts. Please also see accounting policies.

Other (non-endowment)
The Board has provided for Employers and Third Party claims by reviewing all outstanding and potential claims which the Board may be liable for. The Board has provided 100% for claims assessed as Category 3, 50% of all claims assessed as Category 2. The balance of Category 2 and all of Category 1 being disclosed as Contingent Liabilities in Note 14. The provision is based on an estimate of the possible cost together with adverse legal costs. Please also see accounting policies.

Review of Band 5-6 nursing posts
The 2023/24 Pay Award for Agenda for Change Staff included three elements of reforms, one of which was the review of Band 5-6 nursing posts. An accrual, provision and contingent liability have been included in the annual accounts based on the individual's stage in the job evaluation process but there remains uncertainty over final costs relating to those who have not yet started the process. It is anticipated that final costs will be funded in full by Scottish Government. Further detail can be found in Note 9 and Note 14.

Note 13b – Clinical Negligence and Other Risks Indemnity Scheme (CNORIS)

2025 £000		Note	2026 £000
12,678	Provision recognising individual claims against the NHS Board as at 31 March	13a	19,042
(12,078)	Associated CNORIS receivable at 31 March	9	(18,117)
38,840	Provision recognising the NHS Board's liability from participating in the scheme at 31 March	13a	43,737
39,440	**Net total provision relating to CNORIS at 31 March**		**44,662**

The Clinical Negligence and Other Risks Scheme (CNORIS) has been in operation since 2000. Participation in the scheme is mandatory for all NHS boards in Scotland. The scheme allows for risk pooling of legal claims in relation to clinical negligence and other risks and works in a similar manner to an insurance scheme. CNORIS has an agreed threshold of £25k and any claims with a value less than this are met directly from within boards' own budgets. Participants e.g. NHS boards contribute to the CNORIS pool each financial year at a pre-agreed contribution rate based on the risks associated with their individual NHS board. If a claim is settled the board will be reimbursed by the scheme for the value of the settlement, less a £25k "excess" fee. The scheme allows for the risk associated with any large or late in the financial year legal claims to be managed and reduces the level of volatility that individual boards are exposed to. When a legal claim is made against an individual board, the board will assess whether a provision or contingent liability for that legal claim is required. If a provision is required then the board will also create an associated receivable recognising

Notes to the Accounts *cont.*

for the year ended 31st March 2026

reimbursement from the scheme if the legal claim settles. The provision and associated receivable are shown in the first two lines above. The receivable has been netted off against the provision to reflect reimbursement from the scheme. As a result of participation in the scheme, boards should also recognise that they will be required to make contributions to the scheme in future years. Therefore a second provision that recognises the board's share of the total CNORIS liability of NHS Scotland has been made and this is reflected in third line above. Therefore there are two related but distinct provisions required as a result of participation in the scheme. Both of these provisions as well as the associated receivable have been shown in the note above to aid the reader's understanding of CNORIS. Further information on the scheme can be found at: **http://www.clo.scot.nhs.uk/our-services/cnoris.aspx**

Note 14 – Contingent liabilities

The following contingent liabilities have not been provided for in the accounts:

2025 £000		2026 £000
5,183	Clinical and medical compensation payments	15,537
72	Employer's liability	153
10	Third party liability	13
16,218	Other – Band 5-6 rebanding	19,322
21,483	**Total contingent liabilities**	**35,025**
4,658	Clinical and medical compensation payments	12,470
30	Employer's liability	40
4,688	**Total contingent assets**	**12,510**

Note 15 – Events after the end of the reporting year

There are no events after the end of reporting period to disclose.

Note 16 – Capital commitments

The Board has the following capital commitments which have not been provided for in the accounts:

2025 £000		2026 £000
–	**Total capital commitments**	**–**
	Authorised but not contracted	
197,000	Lochaber Hospital replacement	197,000
48,500	Caithness redesign project	48,500
245,500	**Total authorised but not contracted**	**245,500**

Note 17a – Right of Use assets

Current year

Total future minimum payments under leases are stated below.

	Note	Buildings £000	Dwellings £000	Transport equipment £000	Plant and machinery £000	2026 £000
Cost or valuation						
At 1 April 2025		68,007	673	7,511	1,813	78,004
Additions (include new dilapidation provisions)		1,287	134	1,273	–	2,694
Additions – peppercorn leases		800	–	–	–	800
Revaluations		41	–	–	–	41
Disposals		(340)	(29)	(1,371)	(273)	(2,013)
At 31 March 2026		**69,795**	**778**	**7,413**	**1,540**	**79,526**
Depreciation						
Depreciation		10,331	311	3,642	556	14,840
Provided during the year (include dilapidation provisions)		2,990	144	1,873	230	5,237
Provided during the year – peppercorn leases		900	–	–	–	900
Revaluations		30	–	–	–	30
Disposals		(314)	(17)	(1,214)	(273)	(1,818)
At 31 March 2026		**13,937**	**438**	**4,301**	**513**	**19,189**
Net book value at 1 April 2025		**57,676**	**362**	**3,869**	**1,257**	**63,164**
Net book value at 31 March 2026	SoFP	**55,858**	**340**	**3,112**	**1,027**	**60,337**

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Prior year

	Note	Buildings £000	Dwellings £000	Transport equipment £000	Plant and machinery £000	2025 £000
Cost or valuation						
At 1 April 2024		67,006	588	6,011	2,234	75,839
Additions (include new dilapidation provisions)		1,578	94	1,988	–	3,660
Additions – peppercorn leases		–	–	–	–	–
Revaluations		27	–	–	–	27
Disposals		(604)	(9)	(488)	(3)	(1,104)
Disposals – peppercorn leases		–	–	–	(418)	(418)
At 31 March 2025		**68,007**	**673**	**7,511**	**1,813**	**78,004**
Depreciation						
At 1 April 2024		6,574	216	2,169	619	9,578
Provided during the year (include dilapidation provisions)		3,184	104	1,960	303	5,551
Provided during the year – peppercorn leases		874	–	–	55	929
Asset transfers (to)/from other SG consolidation entities		–	–	–	–	–
Revaluations		18	–	–	–	18
Revaluations – peppercorn leases		–	–	–	–	–
Disposals		(319)	(9)	(487)	(3)	(818)
Disposals – peppercorn leases		–	–	–	(418)	(418)
At 31 March 2025		**10,331**	**311**	**3,642**	**556**	**14,840**
Net book value at 1 April 2024		**60,432**	**372**	**3,842**	**1,615**	**66,261**
Net book value at 31 March 2025	SoFP	**57,676**	**362**	**3,869**	**1,257**	**63,164**

Note 17b – Lease liabilities

Current year

	Buildings £000	Dwellings £000	Transport equipment £000	Plant and machinery £000	2026 £000
Amounts falling due					
Not later than one year	2,605	98	1,480	173	4,356
Later than one year, not later than 2 years	830	(33)	356	241	1,394
Later than two year, not later than five years	4,963	84	1,159	204	6,410
Later than five years	6,784	194	(4)	624	7,598
Less: Unaccrued interest	–	–	–	–	–
Balance at 31 March 2026	**15,182**	**343**	**2,991**	**1,242**	**19,758**

Prior year

	Buildings £000	Dwellings £000	Transport equipment £000	Plant and machinery £000	2025 £000
Amounts falling due:					
Not later than one year	3,096	109	2,175	212	5,592
Later than one year, not later than 2 years	1,122	(17)	391	267	1,763
Later than two year, not later than five years	5,199	91	1,182	227	6,699
Later than five years	7,637	181	(6)	748	8,560
Balance at 31 March 2025	**17,054**	**364**	**3,742**	**1,454**	**22,614**

Amounts recognised in the Statement of Comprehensive Net Expenditure

	2026 Consolidated £000	2026 Board £000
Depreciation	6,137	6,137
Interest expense	335	335
Total	**6,472**	**6,472**

Amounts recognised in the Statement of Cash Flows

	2026 Consolidated £000	2026 Board £000
Interest expense	335	335
Repayments of principal of leases	5,450	5,450
Total	**5,785**	**5,785**

Note 18 – Commitments under PFI contracts on Balance Sheet

The Board has not entered into any new on-balance sheet PFI projects in 2025/26.

The New Craigs PFI ended 15th July 2025 and was handed back to NHS Highland.

Easter Ross start date February 2005 ending January 2030: This scheme is the redevelopment of County Hospital, Invergordon into a Primary Care Centre and combines a community hospital and a health centre, integrating primary and community care into one community health resource. There is a twenty five year contract with an original estimated capital value of £8.8m and the PFI property will revert to the board at the end of the contract.

Mid Argyll Community Hospital and Integrated Care Centre, Lochgilphead: We finance the development of the Mid Argyll Community Hospital and Integrated Care Centre in Lochgilphead by way of a PFI scheme. The period of the contract runs from June 2006 to May 2036 at which point the ownership of the asset will be transferred to the Board. The original estimated capital value of the project is £19.2m.

Tain Health Centre: We have a service concession agreement with HUB North of Scotland Ltd for occupancy of the Tain Health Centre effective 24th May 2014. Under the terms of the agreement NHS Highland have a legal commitment to occupy the building for a period of 25 years and will incur annual charges for occupancy, maintenance and running costs. The ownership of the asset will transfer to the Board at the end of the 25 year agreement.

Notes to the Accounts *cont.*

for the year ended 31st March 2026

2025 £000		Note	New Craigs £000	Easter Ross £000	Mid Argyll £000	Tain HC Hub £000	2026 £000
	Gross minimum lease payments						
5,268	Rentals due within 1 year		–	1,398	2,597	473	4,468
4,310	Due within 1 to 2 years		–	1,397	2,597	475	4,469
12,712	Due within 2 to 5 years		–	2,561	7,793	1,432	11,786
19,673	Due after 5 years		–	–	13,421	3,942	17,363
41,963	**Total**		**–**	**5,356**	**26,408**	**6,322**	**38,086**
	Less interest element						
(1,654)	Rentals due within 1 year		–	(218)	(988)	(322)	(1,528)
(1,474)	Due within 1 to 2 years		–	(157)	(907)	(308)	(1,372)
(3,490)	Due within 2 to 5 years		–	(120)	(2,190)	(832)	(3,142)
(3,598)	Due after 5 years		–	–	(1,598)	(1,216)	(2,814)
(10,216)	**Total**		**–**	**(495)**	**(5,683)**	**(2,678)**	**(8,856)**
	Present value of minimum lease payments						
3,614	Rentals due within 1 year	12	–	1,180	1,609	151	2,940
2,836	Due within 1 to 2 years	12	–	1,240	1,690	167	3,097
9,222	Due within 2 to 5 years	12	–	2,441	5,603	600	8,644
16,075	Due after 5 years	12	–	–	11,823	2,726	14,549
31,747	**Total**		**–**	**4,861**	**20,725**	**3,644**	**29,230**
	Service elements due in future periods						
3,380	Rentals due within 1 year		–	487	693	81	1,261
1,254	Due within 1 to 2 years		–	504	711	79	1,294
3,865	Due within 2 to 5 years		–	971	2,240	222	3,433
5,555	Due after 5 years		–	–	4,269	513	4,782
14,054	**Total**		–	1,962	7,913	895	10,770
45,801	**Total commitments**		**–**	**6,823**	**28,638**	**4,539**	**40,000**

Amounts charged to the Statement of Comprehensive Net Expenditure in respect of on balance sheet PFI transactions comprises:

2025 £000		Note	2026 £000
2,002	Interest charges	2b	1,697
5,416	Services charges		2,501
4,226	Principle repayment		3,324
16	Other charges		17
11,660			**7,539**

2025 £000		Note	2026 £000
16	Contingent rents (including other charges)		**17**

Note 19 – Pension costs

IAS 19 multi-employer plans

a) The Board participates in the NHS Pension Scheme (Scotland). The scheme is an unfunded statutory public service pension scheme with benefits underwritten by the UK Government. The scheme is financed by payments from employers and from those current employees who are members of the scheme and paying contributions at progressively higher marginal rates based on pensionable pay, as specified in the regulations. The rate of employer contributions is set with reference to a four-yearly funding valuation undertaken by the scheme actuary.

The valuation carried out as at 31 March 2020 confirmed that an increase in the employer contribution rate from 20.9% to 22.5% will be required from 1 April 2024 to 31 March 2027. In addition, member pension contributions since 1 April 2024 have been paid within a range of 5.7% to 12.7% and have been anticipated to deliver a yield of 9.8%.

b) The Board has no liability for other employers' obligations to the multi-employer scheme.

c) As the scheme is unfunded there can be no deficit or surplus to distribute on the wind-up of the scheme or withdrawal from the scheme.

d) i. The scheme is an unfunded multi-employer defined benefit scheme.

ii. It is accepted that the scheme can be treated for accounting purposes as a defined contribution scheme in circumstances where the Board is unable to identify its share of the underlying assets and liabilities of the scheme.

iii. The employer contribution rate for the period from 1 April 2024 is 22.5% of pensionable pay. The employee rate applied is variable and is anticipated to provide a yield of 9.8% of pensionable pay.

iv. While a valuation was carried out as at 31 March 2016, work on the cost cap valuation was suspended by the UK Government following the decision by the Court of Appeal (McCloud (Judiciary scheme)/Sergeant (Firefighters' Scheme) cases which found that the transitional protections provided as part of the 2015 reforms unlawfully discriminated on the grounds of age. Following consultation and the introduction of statutory measures to remedy the discrimination, the UK Government confirmed that the cost control element of the 2016 valuations could be completed. In parallel, the Government Actuary was asked to review whether, and to what extent, the employer cost cap mechanism continues to meet its original policy objectives. The findings of that review were taken into account in the completion of the 2020 actuarial valuations, which were substantially delayed as a result of the McCloud remedy and wider economic changes. Employer contribution rates were implemented from 1 April 2024 following the completion of the 2020 valuations and will remain in force pending the outcome of the current 2024 valuation cycle, which is now underway.

v. The Board's level of participation in the scheme is 4.98% based on the proportion of employer contributions paid in 2024/25.

Description of schemes

The new NHS Pension Scheme (Scotland) 2015

From 1 April 2015 the NHS Pension Scheme (Scotland) 2015 was introduced. This scheme is a Career Average Re-valued Earnings (CARE) scheme. Members will accrue 1/54 of their pay as pension for each year they are a member of the scheme. The accrued pension is re-valued each year at an above inflation rate to maintain its buying power. This is currently 1.5% above increases to the Consumer Prices Index (CPI). This continues until the member leaves the scheme or retires. In 2025/26 members paid tiered contribution rates ranging from 5.7% to 12.7% of pensionable earnings. The normal pension age (NPA) is the same as the State Pension age. Members can take their benefits earlier but there will be a deduction for early payment.

Notes to the Accounts *cont.*

for the year ended 31st March 2026

The existing NHS Superannuation Scheme (Scotland)
This scheme closed to new joiners on 31 March 2015 but any benefits earned in either NHS 1995 or NHS 2008 sections are protected and will be paid at the section's normal pension age using final pensionable pay when members leave or retire. Some members who were close to retirement when the NHS 2015 scheme launched will continue to earn benefits in their current section. This affected members who were paying into the scheme on 1 April 2012 and were within 10 years of their normal retirement age. Some members who were close to retirement but did not qualify for full protection will remain in their current section beyond 1 April 2015 and join the 2015 scheme at a later date.

All other members automatically joined the NHS 2015 scheme on 1 April 2015. Further information is available on the Scottish Public Pensions Agency (SPPA) website at: **https://pensions.gov.scot/nhs**

National Employment Savings Trust (NEST)
The Pensions Act 2008 and 2011 Automatic Enrolment regulations required all employers to enrol workers meeting certain criteria into a pension scheme and pay contributions toward their retirement. For those staff not entitled to join the NHS Superannuation Scheme (Scotland), the Board utilised an alternative pension scheme called NEST to fulfil its Automatic Enrolment obligations.

NEST is a defined contribution pension scheme established by law to support the introduction of Auto Enrolment. Contributions are taken from qualifying earnings, which are currently from £6,240 up to £50,270, but will be reviewed every year by the government. The initial employee contribution was 1% of qualifying earnings, with an employer contribution of 1%. This has been increased in stages to meet levels set by government, as set out in the table below.

Date	Employee contribution*	Employer contribution	Total contribution
2025/26	5%	3%	8%

* Worker 4% and tax relief 1%

Pension members can choose to let NEST manage their retirement fund or can take control themselves and alter contribution levels and switch between different funds. If pension members leave the Board, they can continue to pay into NEST.

NEST Pension members can take money out of NEST at any time from age 55, this will increase to age 57 in April 2028. If suffering from serious ill health or incapable of working due to illness members can request to take money out of NEST early. They can take the entire retirement fund as cash, use it to buy a retirement income or a combination. Additionally, members can transfer their NEST retirement fund to another scheme.

NEST is run by NEST Corporation, a trustee body which is a non-departmental public body operating at arm's length from government and is accountable to Parliament through the Department for Work and Pensions.

2025 £000		2026 £000
91,597	Pension cost charge for the year	98,591
1,052	Provisions/liabilities/pre-payments included in the SoFP	931
4,211	Pension costs for the year for staff transferred from Highland Council	(204)

Pension costs for staff transferred from Highland Council
As part of the terms and conditions of employment for the staff transferred from The Highland Council, the Board participates in the Local Government Pension Scheme administered by The Highland Council. This is a funded scheme, meaning that the authority and employees pay contributions into a fund, calculated at a level intended to balance the pension liabilities with investment assets.

The Fund is constituted under legislation governing the Local Government Superannuation Scheme – details are contained in the 2010 regulations. The Highland Council is required to publish the Pension Fund annual report which is available at **www.highland.gov.uk** or from The Highland Council, Glen Urquhart Road, Inverness.

NHS Highland recognises the costs of these retirement benefits in the Statement of Net Comprehensive expenditure when they are earned by these employees, rather than when the benefits are eventually paid as pensions.

The Highland Council recognises the liability of the Pension Fund at 31 March 2012 attributable to these NHS Highland staff in The Highland Council accounts.

In line with the departure from IAS 19 based on SGHSCD guidance (details in Accounting Policies 30 – Key sources of Judgment and estimation uncertainty), NHS Highland recognises the gain in the Fund for the year from 1 April 2025 to 31 March 2026 of £0.535m, giving a total asset as at 31st March 2026 of £10.300m, after the effect Asset ceiling of up to £1.826 is applied (total as at 31st March 2025: asset of £9.765m). This is included in two parts in NHS Highland's accounts:

a) £48.803m of cumulative realised deficit in SOCNE, from the date of staff transfer to 31 March 2026, which has been covered by AME funding from Scottish Government. A credit of £0.204m of this cumulative amount relates to 2025/26.

and

b) £59.103m of cumulative unrealised gains due to actuarial assumptions, from the date of staff transfer to 31 March 2026, which is recorded as other Comprehensive Net Expenditure and offset against Reserves in the SoFP. This cumulative amount includes a £0.331m gain recognised in 2025/26.

The net effect of the 2025/26 amounts detailed above (£0.127m) is recognised through other reserves as per the Consolidated Summary of Changes in Taxpayers' Equity.

The charge to the Statement of Comprehensive Net Expenditure consists of:

2025 £000		2026 £000
3,643	Current service cost	2,634
3,937	Interest cost	4,271
(3,833)	Interest income	(4,827)
3,747	**IAS 19 charge to service costs**	**2,078**
12,620	Financial assumptions gain/(loss)	331
12,620	**Gain/(loss) through other comprehensive net expenditure**	**331**

Notes to the Accounts *cont.*

for the year ended 31st March 2026

The current assets and liabilities are made up of:

2025 £000		2026 £000
	Present value of the scheme liabilities	
80,817	Opening defined benefit obligation	72,892
3,643	Current service cost	2,634
3,937	Interest cost	4,271
(13,483)	Change in financial assumptions	(2,402)
(1,951)	Estimated benefits paid	(1,934)
(140)	Changes in demographic assumptions	432
(799)	Other experience	658
868	Contributions by scheme participants	799
72,892	**Closing value**	**77,350**

2025 £000		2026 £000
	Fair value of the scheme assets	
79,219	Opening fair value of scheme assets	82,657
(1,802)	Expected return on scheme assets	845
3,833	Interest income	4,827
2,490	Contributions by employer	2,282
868	Contributions by scheme participants	799
–	Other experience	–
(1,951)	Estimated benefits paid (net of transfers in)	(1,934)
82,657	**Closing value**	**89,476**

The expected return on fund assets is determined by considering the expected returns available on the assets underlying the current investment policy. Expected yields on fixed interest investments are based on gross redemption yields as at the SoFP date. Expected returns on equity investments reflect long-term real rates of return experienced in the respective markets.

The total contributions expected to be made to The Highland Council Pension Scheme by NHS Highland in the year to 31 March 2027 is £2.282m.

Basis for estimating assets and liabilities of the Pension Scheme
Liabilities have been assessed on an actuarial basis using the projected unit credit method, an estimate of the pensions that will be payable in future years dependent on assumptions about mortality rates, salary levels, etc. The Local Government Pension Scheme has been assessed by Hymans Robertson LLP, an independent firm of actuaries, estimates for The Highland Council Pension Fund being based on the latest full valuation of the scheme as at 31 March 2023.

The principal actuarial assumptions adopted as at 31 March 2026 are as follows:

2025		2026
	(a) Life expectancy from age 65 (years)	
	Retiring today:	
20.2	– Males	20.6
23.3	– Females	23.5
	Retiring in 20 years:	
21.3	– Males	21.6
24.9	– Females	25.1
	(b) Financial assumptions	
3.60%	Rate of increase in salaries	3.80%
2.80%	Rate of increase in pensions (CPI)	3.00%
5.80%	Rate of discounting scheme liabilities	6.20%
65%	Take up of option to convert annual pension into retirement lump sum	65%
	(c) The local Government Pension Scheme's assets consist of the following categories by proportion of the total assets held	
20%	Securities	11%
32%	Debt securities	31%
7%	Private equity	6%
9%	Real estate	7%
26%	Investment funds and unit trusts	42%
6%	Cash	3%
100%	**Total**	**100%**

Note 20 – Retrospective restatements

No retrospective restatements in financial year 2025/26.

Note 21 – Restated primary statements

There have been no restated primary statements in these accounts.

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Note 22a – Financial instruments – financial assets and liabilities

2025 £000		Note	Financial assets at fair value through Other Comp Income £000	Financial assets at amortised cost £000	Financial assets at fair value through Profit & Loss £000	2026 £000
	Financial assets – Consolidated					
10,284	Investments	10	–	–	12,113	12,113
103,837	Trade and other receivables excluding prepayments, reimbursements of provisions and VAT recoverable	9	–	110,667	–	110,667
1,567	Cash and cash equivalents	11	–	(9,964)	–	(9,964)
115,688	**Financial assets per Balance Sheet**		**–**	**100,703**	**12,113**	**112,816**
	Financial assets – Board					
791	Investments	10	–	–	790	790
103,937	Trade and other receivables excluding prepayments, reimbursements of provisions and VAT recoverable	9	–	110,810	–	110,810
411	Cash and cash equivalents	11	–	(10,539)	–	(10,539)
105,139	**Financial assets per Balance Sheet**		**–**	**100,262**	**790**	**101,052**

2025 £000		Note	Financial liabilities at amortised cost £000	2026 £000
	Financial liabilities – Consolidated			
22,614	Finance lease liabilities	12	19,758	19,758
31,747	PFI liabilities	12	29,230	29,230
90,093	Trade and other payables excluding statutory liabilities (VAT and income tax and social security), deferred income and superannuation	12	123,867	123,867
144,454	**Financial liabilities per Balance Sheet**		**172,855**	**172,855**
	Financial liabilities – Board			
22,614	Finance lease liabilities	12	19,758	19,758
31,747	PFI liabilities	12	29,230	29,230
90,068	Trade and other payables excluding statutory liabilities (VAT and income tax and social security), deferred income and superannuation	12	123,842	123,842
144,429	**Financial liabilities per Balance Sheet**		**172,830**	**172,830**

The above prior year balance has been restated due to a change in guidance. This is because money payable to the Scottish Government will not in practice be repaid unless a board is wound up. The holiday pay accrual amounting to £9,273,000 has therefore been removed from the prior year lines.

Note 22b – Financial risk factors

The NHS Board's activities expose it to a variety of financial risks:

Credit risk	The possibility that other parties might fail to pay amounts due.
Liquidity risk	The possibility that the NHS Board might not have funds available to meet its commitments to make payments.
Market risk	The possibility that financial loss might arise as a result of changes in such measures as interest rates, stock market movements or foreign exchange rates. Because of the largely non-trading nature of its activities and the way in which government departments are financed, NHS Ayrshire and Arran is not exposed to the degree of financial risk faced by business entities.

Credit risk
Credit risk arises from cash and cash equivalents, deposits with banks and other institutions, as well as credit exposures to customers, including outstanding receivables and committed transactions. For banks and other institutions, only independently rated parties with an minimum rating of 'A' are accepted. Customers are assessed, taking into account their financial position, past experience and other factors, with individual credit limits being set in accordance with internal ratings in accordance with parameters set by the NHS Board.

The utilisation of credit limits is regularly monitored. No credit limits were exceeded during the reporting period and no losses are expected from non-performance by any counterparties in relation to deposits.

Liquidity risk
The Scottish Parliament makes provision for the use of resources by the NHS Board for revenue and capital purposes in a Budget Act for each financial year. Resources and accruing resources may be used only for the purposes specified and up to the amounts specified in the Budget Act. The Act also specifies an overall cash authorisation to operate for the financial year. The NHS Board is not therefore exposed to significant liquidity risks.

The table below analyses the financial liabilities into relevant maturity groupings based on the remaining period at the balance sheet to contractual maturity date. The amounts disclosed in the table are the contractual undiscounted cash flows. Balances due within 12 months equal their carrying balances as the impact of discounting is not significant.

Liquidity

	Less than 1 year £000	Between 1 and 2 years £000	Between 2 and 5 years £000	Over 5 years £000
As at 31 March 2026				
PFI liabilities	2,940	3,097	8,644	14,549
Trade and other payables excluding statutory liabilities	112,243	3,663	3,449	4,488
Total	**115,183**	**6,760**	**12,093**	**19,037**
At 31 March 2025				
PFI liabilities	5,268	4,310	13,187	19,198
Trade and other payables excluding statutory liabilities	80,103	3,149	3,388	3,427
Total	**85,371**	**7,459**	**16,575**	**22,625**

Market risk
The NHS Board has no powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day-to-day operational activities and are not held to manage the risks facing the NHS Board in undertaking its activities.

Notes to the Accounts *cont.*

for the year ended 31st March 2026

i. Cash flow and fair value interest rate risk
The NHS Board has no significant interest bearing assets or liabilities and as such income and expenditure cash flows are substantially independent of changes in market interest rates.

ii. Foreign currency and price risks
The NHS Board is not exposed to foreign currency risk or equity security price risk.

Note 22c – Fair value estimation

The fair value of financial instruments that are not traded in an active market is determined using valuation techniques. The carrying value less impairment provision of trade receivables and payables are assumed to approximate their fair value. The fair value of financial liabilities for disclosure purposes is estimated by discounting the future contractual cash flows at the current HM Treasury interest rate that is available for similar financial instruments.

Note 23 – Derivative financial instruments – Consolidated and Board

The Board has no transactions of this type.

Note 24 – Related party transactions

The Board enters into transactions with other Scottish Government and United Kingdom Government agencies and publicly funded bodies (such as Councils and educational institutions) in the ordinary course of its operations. These transactions take place at arms length. Scottish Ministers issue instructions and guidance on special transactions between publicly funded bodies in areas such as property transfers and joint venture investments.

NHS Highland enters into significant transactions with other Scottish Boards including:

- NHS Grampian
- NHS Greater Glasgow and Clyde
- NHS National Services Scotland
- NHS National Education for Scotland
- NHS National Waiting Times Centre Board (Golden Jubilee NWTC)
- NHS Western Isles
- NHS Lothian
- NHS Tayside.

Integrated adult services
From 1 April 2012, The Highland Council and NHS Highland integrated health and social care services. Under the partnership agreement effective from that date, NHS Highland is the lead agency for integrated adult services and The Highland Council for the delivery of integrated children's services. From 1 April 2012, NHS Highland and its adult social care staff contributed to the Pension Fund run by The Highland Council which provides pensions for the social care staff of NHS Highland.

In 2025/26 NHS Highland has the following transactions with Highland Council:

2025 £000		2026 £000
141,522	Income	149,282
12,194	Expenditure	12,194
6,413	Payables	18,608
19,670	Receivables	24,629

Officers
Senior officers have control over the Board's financial and operating policies. The total remuneration to senior officers is shown in the Remuneration Report. Officers have the responsibility to adhere to a Code of Conduct, which requires them to declare an interest in matters that directly may influence or thought to influence, their judgment or decisions taken during their work. In terms of any relevant parties, officers with declarations of interest did not take part in any discussion or decisions relating to transactions with these parties. The full list of Directors and senior staff declarations of interest are publicly available on NHS Highland's website. Details of significant transactions are shown in the table below.

Name	Registered interest	Supplier invoices received in 2025/26	Supplier invoices raised in 2025/26
Steve Walsh	CEO Highlife Highland Ltd	£276,857	0

Argyll & Bute IJB
The integration of adult health and social services resulted in the creation of the Argyll and Bute Health and Social Care Partnership (IJB) established between Highland NHS Board and the Argyll and Bute Council. The voting members of the IJB are appointed through nomination by NHS Highland and Argyll and Bute Council. The voting membership of the IJB Board is split equally between both organisations. Nomination of the IJB Chair and Vice Chair post holders alternates between a councillor and a health board representative.

Highland has the following transactions with Argyll & Bute IJB:

2025 £000		2026 £000
291,814	Income	310,661
308,561	Expenditure	336,259
18,500	Payables	28,850

Senior officers have control over the Board's financial and operating policies. The total remuneration to senior officers is shown in the Remuneration Report. Officers have the responsibility to adhere to a Code of Conduct, which requires them to declare an interest in matters that directly may influence or thought to influence, their judgment or decisions taken during their work. In terms of any related parties, officers with declarations of interest did not take part in any discussion or decisions relating to transactions with these parties. The full list of Directors & senior staff declarations of interest are publicly available on NHS Highland's website.

Reconciliation to IJB accounts

	£000
Income to NHS Highland from A&B IJB	310,661
Cost of services per IJB accounts	336,259
Difference	**25,598**
Being items recorded in the social work element of the IJB accounts (but funded by NHS Highland):	
Resource transfer to A&B Council	15,248
Agreed budget transfer to A&B Council for ASC	10,350
	25,598

NHS Highland endowments
The trustees of the Highland Health Board Endowment fund are all members of NHS Highland Board.
As a result the Endowment fund accounts are consolidated with the NHS Highland Accounts.
All trustees are listed in the remuneration report on page 78.

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Scottish Government
Where the public body falls within the Scottish Government consolidated boundary, other bodies within the boundary (e.g. agencies and health boards) are related parties. Scottish Government has significant influence over other public bodies in Scotland, e.g. local authorities and universities, through legislation and grant funding. All public bodies in Scotland are, therefore, related parties, with the exception of Audit Scotland, due to its independence from government. Details of transactions with Scottish Government are included in the Financial Performance and Position Section of the Performance Report and in Notes 3, 4, 9 and 12. Details of transactions with other Scottish NHS Boards are included in Notes 3, 4, 9 and 12.

Note 25 – Third party assets

These are not departmental assets and are not included in the accounts. The assets held at the reporting period date to which it was practical to ascribe monetary values comprised monetary assets, such as bank balances and monies on deposit, and listed securities. They are set out in the table immediately below.

2025 £000		Gross inflows £000	Gross outflows £000	2026 £000
4,071	Monetary amounts such as bank balances and monies on deposit	4,387	(4,060)	4,398

Note 26a – Consolidated Statement of Comprehensive Net Expenditure

2025 Group £000		Note	2026 Board £000	2026 Endowment £000	2026 Intra group adjustment £000	2026 IJB £000	2026 Group £000
	Total income and expenditure						
651,860	Employee expenditure	3a	707,516	–	–	–	707,516
	Other operating expenditure						
119,051	Independent Primary Care Services	3b	128,298	–	–	–	128,298
174,133	Drugs and medical supplies		176,438	–	–	–	176,438
772,820	Other health care expenditure		823,429	875	(347)	–	823,957
1,717,864	**Gross expenditure for the year**		**1,835,681**	**875**	**(347)**	**–**	**1,836,209**
(542,969)	Less: operating income	4	(565,167)	(1,531)	347	–	(566,351)
(435)	Associates and joint ventures accounted for on an equity basis		–	–	–	(5,164)	(5,164)
1,174,460	**Net expenditure for the year**		**1,270,514**	**(656)**	**–**	**(5,164)**	**1,264,694**

Other health care expenditure and income relates to the consolidation of the Endowment Accounts.

Joint Ventures accounted for on an equity basis discloses the Board's share of any current year surplus or deficit for each integration Joint Board.

Note 26b – Consolidated Statement of Financial Position

2025 Group £000		Note	2026 Board £000	2026 Endowment £000	2026 Intra group adjustment £000	2026 IJB £000	2026 Group £000
478,803	Property, plant and equipment	SOFP	527,482	–	–	–	527,482
2,138	Intangible assets		1,580	–	–	–	1,580
63,164	Right of Use assets	SOFP	60,337	–	–	–	60,337
	Financial assets						
10,284	Investments	SOFP	790	11,323	–	–	12,113
10,374	Investments in associates and joint ventures		–	–	–	15,538	15,538
78,548	Trade and other receivables	SOFP	86,351	–	–	–	86,351
643,311	**Total non-current assets**		**676,540**	**11,323**	**–**	**15,538**	**703,401**
	Current assets						
8,603	Inventories	SOFP	8,326	–	–	–	8,326
	Financial assets						
56,419	Trade and other receivables	SOFP	73,571	–	(134)	–	73,437
1,567	Cash and cash equivalents	SOFP	(10,539)	575	–	–	(9,964)
66,589	**Total current assets**		**71,358**	**575**	**(134)**	**–**	**71,799**
709,900	**Total assets**		**747,898**	**11,898**	**(134)**	**15,538**	**775,200**
	Current liabilities						
(21,616)	Provisions	SOFP	(28,056)	–	–	–	(28,056)
	Financial liabilities						
(141,626)	Trade and other payables	SOFP	(189,087)	(159)	134	–	(189,112)
–	Derivatives financial liabilities		–	–	–	–	–
(163,242)	**Total current liabilities**		**(217,143)**	**(159)**	**134**	**–**	**(217,168)**
546,658	**Non-current assets less net current liabilities**		**530,755**	**11,739**	**–**	**15,538**	**558,032**
	Non-current liabilities						
(39,216)	Provisions	SOFP	(49,731)	–	–	–	(49,731)
	Financial liabilities						
(55,118)	Trade and other payables	SOFP	(53,291)	–	–	–	(53,291)
(94,334)	**Total non-current liabilities**		**(103,022)**	**–**	**–**	**–**	**(103,022)**
452,324	**Assets less liabilities**		**427,733**	**11,739**	**–**	**15,538**	**455,010**
	Taxpayers' equity						
188,200	General fund	SoFP	137,303	–	–	–	137,303
135,447	Revaluation reserve	SoFP	182,524	–	–	–	182,524
107,779	Other reserves	SoFP	107,906	–	–	–	107,906
10,374	Other reserves – joint venture	SoFP	–	–	–	15,538	15,538
10,524	Funds held on trust	SoFP	–	11,739	–	–	11,739
452,324	**Total taxpayers' equity**		**427,733**	**11,739**	**–**	**15,538**	**455,010**

Notes to the Accounts *cont.*

for the year ended 31st March 2026

Note 26c – Consolidated Statement of Cash Flows

2025 Consolidated £000		2026 Board £000	2026 Endowment £000	2026 Intra group adjustment £000	2026 IJB £000	2026 Consolidated £000
	Cash flows from operating activities					
(1,174,460)	Net operating cost	(1,270,514)	656	–	5,164	(1,264,694)
49,707	Adjustments for non-cash transactions	29,174	–	–	(5,164)	24,010
2,416	Add back: interest payable recognised in net operating cost	1,759	–	–	–	1,759
(7)	Deduct: interest receivable recognised in net operating cost	(14)	–	–	–	(14)
–	Investment income	–	–	–	–	–
(2,986)	Movements in working capital	56,281	45	–	–	56,326
(1,125,330)	**Net cash outflow from operating activities**	**(1,183,314)**	**701**	**–**	**–**	**(1,182,613)**
	Cash flows from investing activities					
(16,264)	Purchase of property, plant and equipment	(23,376)	–	–	–	(23,376)
(368)	Purchase of intangible assets	(136)	–	–	–	(136)
(6,478)	Investment additions	–	(1,916)	–	–	(1,916)
–	Transfer of assets to/(from) other NHS bodies	–	–	–	–	–
470	Proceeds of disposal of property, plant and equipment	274	–	–	–	274
–	Proceeds of disposal of intangible assets	–	–	–	–	–
5,666	Receipts from sale of investments	–	634	–	–	634
7	Interest received	14	–	–	–	14
(16,967)	**Net cash outflow from investing activities**	**(23,224)**	**(1,282)**	**–**	**–**	**(24,506)**
	Cash flows from financing activities					
1,155,053	Funding	1,216,660	–	–	–	1,216,660
–	Movement in general fund working capital	(10,539)	–	–	–	(10,539)
1,155,053	Cash drawn down	1,206,121	–	–	–	1,206,121
(9,836)	Capital element of payments in respect of leases and on-balance sheet PFI contracts	(8,774)	–	–	–	(8,774)
(27)	Interest paid	273	–	–	–	273
(2,389)	Interest element of leases and on-balance sheet PFI/PPP contracts	(2,032)	–	–	–	(2,032)
1,142,801	**Net financing**	**1,195,588**	**–**	**–**	**–**	**1,195,588**
504	Net increase/(decrease) in cash and cash equivalents in the period	(10,950)	(581)	–	–	(11,531)
1,063	Cash and cash equivalents at the beginning of the period	411	1,156	–	–	1,567
1,567	**Cash and cash equivalents at the end of the period**	**(10,539)**	**575**	**–**	**–**	**(9,964)**
	Reconciliation of net cash flow to movement in net debt/cash					
504	Increase/(decrease) in cash in year	(10,950)	(581)	–	–	(11,531)
1,063	Net debt/cash at 1 April	411	1,156	–	–	1,567
1,567	**Net debt/cash at 31 March**	**(10,539)**	**575**	**–**	**–**	**(9,964)**

6. Directions by the Scottish Ministers

Directions by the Scottish Ministers

The Scottish Ministers, in exercise of their functions under section 86(1) and (3) of the National Health Service (Scotland) Act 1978, in relation to the functions of Health Boards in that section which apply to NHS Highland by virtue of that Act, and all other powers enabling them to do so, hereby DIRECT that:

1. NHS Highland must prepare a statement of accounts for each financial year in accordance with the accounting principles and disclosure requirements set out in the edition of die Government Financial Reporting Manual which is applicable for the financial year for which the statement of accounts is prepared.
2. In preparing a statement of accounts in accordance with paragraph I, NHS Highland must use the NHS Highland Annual Accounts template which is applicable for the financial year for which the statement of accounts is prepared.
3. In preparing a statement of accounts in accordance with paragraph 1, NHS Highland must adhere to any supplementary accounting requirements set out in the following documents which are applicable for the financial year for which the statement of accounts is prepared:
   a) The NHS Scotland Capital Accounting Manual,
   b) The Manual for the Annual Report and Accounts of NHS Boards and for Scottish Financial Returns, and
   c) The Scottish Public Finance Manual.
4. A statement of accounts prepared by NHS Highland in accordance with paragraphs 1, 2 and 3, must give a true and fair view of the income and expenditure and cash flows for that financial year, and of the state of affairs as at the end of the financial year.
5. NHS Highland must attach these directions as an appendix to the statement of accounts which it prepares for each financial year.
6. In these Directions:
   - "financial year" has the same meaning as that given by Schedule 1 of the Interpretation Act 1978,
   - "Government Financial Reporting Manual" means the technical accounting guide for the preparation of financial statements issued by HM Treasury,
   - "Manual for the Annual Report and Accounts of NHS Boards and for Scottish Financial Returns" means the guidance on preparing annual accounts issued to Health Boards by the Scottish Ministers,
   - "NI-1S Act 1978" means the National Health Service (Scotland) Act 1978 (c. 29),
   - "NHS Scotland Capital Accounting Manual" means the guidance on the application of accounting standards and practice to capital accounting transactions in the NHS issued by the Scottish Ministers,
   - NHS Highland is a Health Board established under section 2(1) of the National Health Service (Scotland) Act 1978
   - "NHS Highland Annual Accounts template" means the Excel spreadsheet issued to NHS Highland by the Scottish Ministers as a template for their statement of accounts, and
   - "Scottish Public Finance Manual" means the guidance on proper handling and reporting of public funds issued by the Scottish Ministers.
7. Any expressions or definitions, where relevant and unless otherwise specified, take the meaning which they have in section 108 of the NHS Act 1978.
8. This Direction will come into force on the day after the day on which it is signed.
9. This Direction will remain in force until such time that it is varied, amended or revoked by a further Direction of the Scottish Ministers under section 86 of the NHS Act 1978.



Signed by the authority of the Scottish Ministers
Dated 22 March 2022

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