

Shetland NHS Board

Minutes of the Public Shetland NHS Board Meeting held at 09.30am Tuesday 16th December at Isleburgh Community Centre and via Microsoft Teams

Present

Mr Gary Robinson	Chair
Mrs Natasha Cornick	Non-Executive Board Member (Vice-Chair)
Mr Colin Campbell	Non-Executive Board Member
Dr Brian Chittick	Chief Executive
Mr Joe Higgins	Non-Executive Board Member (Whistleblowing Champion)
Mrs Kathy Hubbard	Non-Executive Board Member
Dr Susan Laidlaw	Director of Public Health
Mrs Emma Macdonald	Local Authority Member
Mr Colin Marsland	Director of Finance
Mr Bruce McCulloch	Employee Director
Mrs Gaynor Jones	Non-Executive Board Member
Ms Jo Robinson	Director of Community Health & Social Care
Prof. Kathleen Carolan	Director of Nursing and Acute Services

In Attendance

Mr Karl Williamson	Head of Finance and Procurement
Mrs Carolyn Hand	Corporate Services Manager
Ms Millie Boulton	Board Business Manager (minute taker)
Mrs Lucy Flaws	Head of Planning and Performance
Mr David Wagstaff	Head of Estates and Medical Physics
Ms Amy Gallivan	Senior Communications Officer
Ms Laura Farrell	Communications Officer
Ms Susan Keay	Infant Feeding Lead and Integrated Midwife
Mr Michael Peterson	IT Manager
Mrs Pauline Moncrieff	Board Administrator
Ms Edna Mary Watson	Chief Nurse Corporate
Mr James McConnachie	Business Continuity and Resilience Officer
Mr Lawrence Green	Health and Safety Lead

Chair's Opening welcome

The Chair welcomed attendees to the final public Board Meeting of the year and noted that this was the first meeting to be held in a hybrid format. Although hybrid arrangements present logistical challenges due to venue capacity, the Board remained committed to improving public access and transparency in its decision-making.

The Chair highlighted the early rise in flu cases nationally and locally, encouraging all eligible individuals to receive the flu vaccine as the most effective protection against serious illness. Shetland's current uptake of 53.4% was above the Scottish average, and further increases were expected following recent clinics. The public was reminded to use NHS Inform, NHS 24 (111), and community pharmacies for non-urgent health concerns, and to follow good hygiene practices to reduce winter illness transmission.

The Chair reported the successful recruitment of a new Audiologist, who will take up post in the New Year, providing much-needed stability and supporting improvements in waiting times. Positive findings from the 2025 National Dental Inspection Programme were acknowledged, with 89.4% of Primary 7 pupils in Shetland recorded as decay-free, the second-highest rate in Scotland.

Warm thanks were extended to Dr Catriona Barr, Consultant Anaesthetist, on her retirement after 21 years of dedicated service, and congratulations were offered to Dr Margaret Johnston, GP Trainee of the Year (North of Scotland Faculty Grant and MacLeod Award).

In closing, the Chair expressed appreciation for the hard work of all NHS Shetland staff throughout 2025 and conveyed best wishes for a peaceful Christmas and New Year, noting in particular those who would be working over the festive period to support patient care.

2025/26/55 - Apologies for Absence

Apologies were received from Mr Lincoln Carroll, Mrs Lorraine Hall, Dr Kirsty Brightwell

2025/26/56 - Declarations of Interest

There were no declarations of interest.

2025/26/57 - Minutes of the Previous Meeting

DECISION: The Board approved the minutes.

2025/26/58 - Board Action Tracker

DECISION: There were no updates to the Board Action Tracker

2025/26/59 - Matters Arising

None to note.

2025/26/60 - Board Business Programme

Mrs Carolyn Hand presented the business programme for discussion and approval. Mr Joe Higgins asked if there should be a regular update coming to board from the newly created Strategic Change Oversight Group. Mrs Gaynor Jones responded with the suggestion that the group report through Finance and Performance Committee. Dr Chittick asked for the next Board Development Session to include discussion of the terms of reference.

DECISION: The Board Approved the Board Business Programme

Quality of Care

**2025/26/61 - Quality Report
(Board Paper 2025/26/43)**

Professor Carolan presented the report including the quality scored and report for feedback and complaints, and began by introducing Mrs Susan Keay, who took the board through a presentation regarding the Board's recent UNICEF UK Baby Friendly Initiative Gold Accreditation, highlighting the following points that were assessed and resulted in the accreditation:

1. **Leadership** – Strong governance and training, designated breastfeeding guardianship by Professor Carolan, and positive evaluation of support services.
2. **Culture** – Embedded staff training, mechanisms for feedback, and a supportive environment for responsive infant feeding. In one part of this theme the Board fell 1% short of the recommended percentage in the staff survey, but this was address by submitting an action plan which was accepted by the UNICEF board.
3. **Monitoring** – Regular, auditable data collection feeding into continuous improvement, including local and national benchmarking to support the Baby Friendly standards.

4. **Progression** – Ongoing programmes such as peer support, antenatal education, colostrum collection, bonding and attachment initiatives, and alignment with national schemes like Breastfeeding Friendly Scotland.

Mrs Keay reported that the Board had demonstrated substantial improvements in breastfeeding rates, with key indicators now among the highest in Scotland. The UNICEF assessment team highlighted the strength of Shetland's integrated, partnership-based approach, evidenced through collaborative working across maternity, health visiting, and the wider Children's Partnership. The Gold Award, achieved in August 2025, recognised not only service excellence but also the sustainability of these improvements. This followed progression over a ten year period from the bronze award, to silver, and Gold.

Discussion

Mr Colin Campbell complimented the positivity reaction in the report to some slight culture feedback from staff. Mr Higgins noted that the award was clearly hard earned and that it was reassuring to hear in the wider context of concerns that had been raised at a national level about maternity care. Dr Chittick raised that the leadership and improvement shown in the presentation and report linked into the board's strategic intent and therefore outcomes around building blocks of healthy communities and best starts in life.

For the wider report, Mrs Natasha Cornick asked if there was any reason why the Stage 1 complaints response time performance had increased to an average of nine working days, and if there was a mechanism for tracking that data, and any common themes. Mrs Hand responded that there was some frustration as many Stage 1 complaints were answered in time, but one or two could take 20-30 days to respond and that would skew the average. She noted that further training had been undertaken by the feedback and complaints team, and this raised that the Board needed to provide better guidance on when issues should be recorded as Stage 1, as many concerns were being resolved directly within the services and not formally recorded, therefore the remaining complaints tended to be more complex and take longer to resolve. Professor Carolan added that a further reason why it may have taken longer than the target five days could be that the team were trying to seek an outcome for the complainant, such as improving access to a service.

Mrs MacDonald asked for assurance as to why there was expected reduced capacity in 2026 when a new reporting system would be coming in. Mrs Hand responded that there would be a period of adjustment for the team and the new system, and the team itself was small, and was currently working with a system that was based mainly in spreadsheets and longhand. Ms Watson added that the new platform would allow more agile reporting and enable services to receive clearer, more timely insights into their quarterly data. Importantly, it would also integrate areas such as Healthcare Governance (formerly Healthcare Guardians), mortality and morbidity reviews, and risk management, offering broader organisational oversight. Although implementation would require staff to develop confidence and speed with the system, it represented a significant step forward in strengthening governance and enhancing the quality of information shared with the Board. The Chair said that the Board Chairs Group met with the new Patient Safety Commissioner the day previous, who had highlighted the need to act on complaints quickly, and the whistleblowing standard deadline for complaints to be dealt with promptly, recommending the training available on TURAS.

It was further noted that improving investigation capability would help managers complete investigations more effectively and take ownership of learning, rather than relying heavily on senior managers. Board Members agreed that both speed and quality were essential, and that meaningful, well-communicated responses were preferable to meeting targets at the expense of thoroughness. Clear and timely communication with complainants was also recognised as critical to maintaining trust and reducing frustration.

Positive feedback from medical students placed within services was also acknowledged, reflecting well on teams and potentially supporting future recruitment. The report was noted, and appreciation was expressed for the work presented, including the achievements shared earlier in the meeting.

DECISION: The Board noted the report.

**2025/26/62 - Winter Plan
(Board Paper 2025/26/44)**

Mrs Lucy Flaws introduced the Winter Plan for approval, explaining that it had been developed jointly with Shetland Islands Council to keep services safe and effective over the festive period and winter months. She noted ongoing system pressures and emphasised the importance of preventing avoidable admissions and supporting people to remain at home wherever possible. The plan built on previous years' work and aimed to strengthen whole-system coordination. She highlighted the following key points:

- The plan had been developed with input from hospital, community, communications and executive teams.
- Engagement across the system had been increased to improve coordination during periods of pressure. System capacity had already been stretched, and staff efforts to maintain safe services had been acknowledged.
- The plan had been organised around five areas: assessment, prevention, preparation, response and escalation, and recovery.
- Appendices provided operational details including rosters, escalation procedures, transport arrangements and outbreak management.
- The plan had been updated since submission, including clarified rosters, transport cover and discharge arrangements over the festive period.
- A post-festive workshop had been arranged to review early learning and support continuous improvement.
- Updated master copies and guidance were to be shared with managers shortly.

Discussion

Members expressed strong support for the Winter Plan and commended the clarity and strategic depth compared with previous years. The plan was recognised as clearly laying out how system-wide pressures would be managed and how individual teams contributed to the overall response.

The Board noted the significant work undertaken and the collaborative effort involved. During the discussion, several queries were raised, as follows:

Mr Campbell asked what the process would be to capture any learning from the season. Mr James McConnachie replied that the plan would be socialised in two stages, the first was in the diary for the 30th January 2026, with a second session later planned for community teams. Toward the end of winter, the organisation had historically experienced significant pressures, and a full debrief had previously been carried out at that point. This debrief process was expected to identify what had worked well, what had not, and which lessons could be carried forward into future planning. These reflections would then be incorporated into the next development cycle, with the intention of making the process more formalised for the following winter season. Following discussion, Board Members agreed that learning should apply across the full year, reflecting constant system pressures rather than being confined to the winter period.

Dr Laidlaw highlighted the seasonal prevention/vaccination programme as a key part of the winter response that operated on a defined seasonal cycle. The vaccination programme was therefore continually reviewed, with ongoing efforts made to increase uptake across all eligible groups.

Mr Higgins asked what support the Board was providing to unpaid carers, and what could be additionally supplied during the winter period? Ms Robinson responded that integrated working continued across care homes, community nursing, GPs, AHPs and social care, with vaccination programmes, respite provision and disability health checks supporting prevention and resilience. An unpaid carers strategy was also being developed, but other work that was being done such as around long term condition checks was helping to keep unpaid carers healthy longer term. Planned respite was also highlighted, with 1582 overnight stays for people with learning disabilities in Shetland delivered by the Board. Similarly planned respite was being planned for older people, but there was some capacity issue with the care centres.

Mrs Jones asked if the surge flow plan has been sense checked, and how it would work. Professor Carolan responded that Public Health Scotland had modelled expected inpatient occupancy using learning from the previous winter. This gave NHS Shetland an indication of likely surge capacity needs, though the main risk remained having enough workforce to staff non-standard care areas if required. The modelling showed that demand could vary widely, and using areas such as the maternity unit or day surgery for surge beds would impact elective activity.

The aim had been to remain within the existing bed base, with some care-home capacity available and the hospital operating at amber rather than red escalation going into winter. Business continuity measures were expected for at least two weeks, creating inevitable backlogs. Hospital-at-home activity had been included in the modelling, with capacity to support up to four patients at any one time if they meet the eligibility criteria, helping to reduce the length of hospital stays and contribute to overall system flow.

Mr Higgins asked whether the AHP and front-door initiatives were up and running, and if not, when they would become functional. In response, Mrs Flaws explained that staff were already in place to support the front-door function, and work had been ongoing to determine how the service should operate in practice and how best to balance activity between hospital-based and community-based care. Professor Carolan concluded that the service was expected to be operational during the winter period, though not in time for Christmas.

It was noted that some of this work had already begun at the hospital front door, helping to build on existing low admission-conversion rates. Members heard from Dr Chittick that a test-of-change had been introduced by Amanda McDermott, Chief Nurse (Acute), involving a daily multidisciplinary meeting to support rapid discharge, which appeared to be working well and offering some short-term relief from pressures.

The importance of geriatric risk assessments was raised, with members noting their effectiveness in reducing avoidable admissions. It was asked whether this work had now started, given its relevance to the frailty pathway. Ms Robinson responded by emphasising that avoiding hospital admission did not remove individuals from the system entirely. Those with high levels of need often remained in care homes, continuing to occupy system capacity.

DECISION: The Board approved the Winter Plan and noted that planning was a dynamic process. Any significant emerging issues or changes would be brought back to the Board.

Governance

**2025/26/63 - Board and Committee Schedule for 2026/27
(Board Paper 2025/26/45)**

Mrs Hand presented the paper, highlighting that wherever possible, scheduled dates should be maintained, as they were set for specific reporting reasons and could be difficult to move.

DECISION: The Board approved the paper and committee schedule.

**2025/26/64 - Blueprint for Good Governance Improvement Action Plan
(Board Paper 2025/26/46)**

Mrs Hand presented the paper for the Blueprint for Good Governance Improvement Action Plan. A self-assessment against the governance blueprint had been completed two years earlier, and a further assessment or external audit had been anticipated but had not yet taken place.

Progress had been made on many of the actions, though not all. The action which remained at red related to developing an assurance framework, jointly assigned to Mr Marsland and Mrs Hand. This had been delayed because a national “Once for Scotland” approach had initially been expected. As this now seemed less likely, Mr Marsland and Mrs Hand were shortly to attend a meeting to discuss that, with the intention of moving the action forward and ultimately closing the current action plan.

It was highlighted by Mr Marsland that external audit continued to provide valuable independent assurance on governance processes, including review of board papers and committee effectiveness.

Dr Chittick raised a point regarding the integrated governance operating system with a request for support to engage with the IJB to help progress development. He suggested this could be explored as part of a Board development session, subject to diary availability.

Mr Robinson noted that “Once for Scotland” work was still under discussion nationally, with recent conversations at the Board Chairs’ Group indicating a need to refresh communication and visibility of national policies.

DECISION: The Board noted the paper

**2025/26/65 – Counter Fraud Services
(Board Paper 2025/26/47)**

Mr Marsland presented the update on International Fraud Awareness Week from the paper. He advised that NHS organisations, like all public bodies, were susceptible to fraud and that NHS Scotland Counter Fraud Services provided national oversight and support. Their annual report summarised activity undertaken in the previous year and highlighted an increase in reported fraud cases, though under-reporting across the NHS continued to be likely.

Mr Marsland emphasised that fraud prevention was more effective than recovery, as any loss through fraud ultimately reduced resources available for patient care. He reminded members that fraud prevention and detection were national responsibilities under Turas standards, with board members and staff each having duties to report suspected fraud. He also highlighted ongoing fraud-prevention activity delivered locally, including awareness campaigns, mandatory training modules, and engagement with Counter Fraud Services. Communications during Fraud Awareness Week had been effective, with internal engagement exceeding targets.

Discussion

Mr Campbell asked what Mr Marsland’s views were on the new Economic Crime and Corporate Transparency Act 2023 from page 11 of the report, which came into effect in September 2025 that made it a corporate offense to not prevent fraud. Mr Marsland’s response was that accountability rested with senior officers, including the Accountable Officer and relevant managers. NHS Shetland’s fraud-prevention activity and training

through Turas provided evidence of compliance, with Mr Marsland noting that whilst fraud-awareness training compliance was not yet at 100%, it was acknowledged that uptake had increased but remained an area requiring continued focus.

Mr Robinson thanked the NHS Shetland Communications team alongside Mr Marsland for their highlighting of Fraud Week.

DECISION: The Board noted the paper.

**2025/26/66 – Shetland Public Protection Committee Annual Report
(Board Paper 2025/26/48)**

Dr Chittick presented the report, noting that it gave a full overview of work to safeguard vulnerable adults and children across Shetland. The Committee had launched a new three-year strategy focused on chronologies, lived experience, gender-based violence and safety. Key achievements included updated protection procedures, strengthened quality assurance, new training approaches, and greater inclusion of lived experience, particularly through engagement with young people and public-awareness campaigns on digital and community safety.

He highlighted ongoing work within NHS Shetland to review training compliance, with strong uptake at Levels 1 and 3, but challenges in capturing accurate Level 2 data. A training needs analysis was underway to ensure staff received appropriate, role-specific development. The NHS Shetland Protection Group, chaired by Professor Carolan, continued to provide governance oversight, and Dr Chittick confirmed he would raise public protection matters with Executive Management Team to ensure training and risk management were appropriately managed.

Discussion

Mr Higgins noted a significant drop in both the initial referral discussions and the joint investigation reviews over the period shown, were there assurances that the trend was real, and what was driving those reductions? Dr Chittick explained that new assessment criteria had been introduced following learning from the last adult protection inspection. Changes to referral sources and assessment processes had influenced the data. Social work colleagues, who oversaw these processes, were comfortable that the reduction reflected expected outcomes from the revised approach.

Mrs Hubbard noted an acknowledgment of the large amount of work that had gone into the report, highlighting the digital safety scope and the noted lived experience in the report. The Chair highlighted the report's openness about strengths, areas for improvement, and future actions was welcomed.

Professor Carolan noted that the NHS Protection Group had been re-established, with its first meeting held in September 2025. A self-assessment using the national NHS protection governance tool was underway. She highlighted that NHS Shetland currently had only one protection nurse, despite a growing level of safeguarding activity, and that protection resource and leadership capacity would need review. Discussions with other small boards (such as Orkney) were taking place to explore collaborative models. Any future proposals would return to the Board following the completion of the self-assessment.

DECISION: The Board noted the report.

**2025/26/67 – Shetland Integrated Children's Plan Annual Report 2425
(Board Paper 2025/26/49)**

Dr Susan Laidlaw presented the report as the annual update on the Children's Services Plan 2023–26. It was noted that leadership of the Children's Planning Partnership had changed in the summer, with joint chairing now shared between Dr Laidlaw and Jordan

Sutherland, from Children's Services and Lynn Tulloch as third-sector representation. A review of the partnership was underway to strengthen engagement, particularly from the third sector and from children and young people themselves, supported by work through the Open Project and care-experienced groups.

Mrs Flaw continued that the report covered progress from April 2024 to March 2025 across the plan's eight named priority areas, highlighting achievements in family support, poverty-reduction initiatives, trauma-informed practice, and strengthened youth engagement. Not all recent developments were included due to timing, though local work was progressing through the Corporate Parenting Board.

While improvements were evident, partners acknowledged ongoing challenges for some children and families. The partnership was also progressing the Fairer Futures programme locally, establishing a System Change Board and practitioner learning network to support more collaborative, proactive and sustainable ways of working. Further updates would be provided as development of the next Children's Services Plan continued.

Discussion

Mrs MacDonald thanked the Dr Laidlaw, saying that was a good example of different organisations working together. She queried what the cause was around the staffing challenges within the pre-conception services? Professor Carolan responded that service had stalled due to staffing gaps within the small healthcare support worker team in Maternity that were responsible for delivering it. These gaps meant the work had been deprioritised in order to maintain core services. Although the staffing picture was improving, meaningful progress was not expected until it was next reviewed in 2026–27, when senior leaders would review whether the service could be reintroduced into the next Children's Plan.

Mrs Jones referred to the table on child poverty on page 27 of the report, asked why there were gaps in the indicator about children going to bed hungry, and would this be explored further? Mrs Flaws responded that the data came from a national schools survey carried out a few years earlier, which had not been repeated. Re-running it locally would require significant resource, though the wider evidence base suggested that the overall picture had likely remained broadly similar. Work continued through other child-poverty initiatives to target those most at risk.

DECISION: The board approved the report.

2025/26/68 – Sub-national Planning Arrangement (Board Paper 2025/26/50)

Dr Chittick presented the paper, outlining significant recent changes in Scotland's strategic planning landscape. He explained that on 13 November 2025, the Scottish Government issued DL(2025)25, introducing a refreshed statutory approach to sub-national planning across NHS Scotland, which was included in the board pack as an appendix.

The directive provided health boards with a clear legal mandate for how population planning must be organised. As part of the structural change, two new Sub-national Planning and Delivery Committees, Scotland East and Scotland West, had been established. NHS Shetland had been placed within Scotland East, and the previous North Region planning structure had been discontinued. These changes were intended to streamline planning and strengthen cross-board collaboration.

The Board was advised that four priority planning areas had been identified for 2026–27:

- Orthopaedics
- Elective care

- Emergency care
- Once for Scotland business systems and digital front door

These were considered essential for service sustainability and improved outcomes both locally and nationally.

Dr Chittick noted that processes were underway to appoint national directors across key portfolios (medical, nursing, strategy, planning, public health, people, finance and operations) on a part-time secondment basis from existing directors within Scotland East. He emphasised that despite these structural changes, the Chief Executive's core accountabilities and the organisation's responsibilities to its island population remained unchanged. NHS Shetland would continue to deliver care at a local and island level while managing the opportunities and risks arising from the new planning model.

Given the recency of the directive, Dr Chittick noted that further clarification would emerge as implementation progressed.

Discussion

Mr McCulloch noted the importance of maintaining strong partnership working under the new arrangements and highlighted a lack of detailed national correspondence to date. Mrs MacDonald queried what this would mean for the public, and how the Board would be explaining the changes to them. Dr Chittick responded by outlining the positives, that the intention was to improve access and outcomes through nationally planned but locally delivered pathways, such as orthopaedics and the digital front door. The Board would advocate strongly to ensure any planning aligned with NHS Shetland's strategic intent to keep care as close to home as possible. Mrs MacDonald further asked for assurances as to how the Board, as a smaller island Board, would have its patients represented in a much larger system. Dr Chittick responded that NHS Shetland already had strong representation across professional groups (medical, nursing, COO networks) and had influenced early work on remote, rural and island healthcare, and that a paper was being written to scope out remote and rural areas. He accepted, however, that vigilance was needed to maintain equity of voice.

Professor Carolan continued that the impact could be felt the greatest in the specialist pathways that we share with other health boards. Mrs Flaws added that she felt the Board had good evidence and understanding for what they would be advocating as Shetland needs for in the future given the 1:1 connections with the local authority in comparison to other boards. Existing arrangements using a national treatment centre and the Golden Jubilee National Hospital were ostensibly in the west region. NHS Shetland was responsible for good governance and would need to set out a process to adapt to the new subnational planning arrangements.

Mrs Cornick enquired as to how this would fit with the Integrated Joint Board Governance landscape given that the IJB set the Health and Social Care Strategy, and directs the Health Board how to deliver that.. Dr Chittick confirmed that IJBs remained accountable for statutory strategic planning of health and social care. The detail of how local intelligence and IJB priorities would connect into sub-national planning was still emerging. Further clarity was expected as the model matured.

Mr Joe Higgins asked what is the financial impact might be and how the Board would protect its strong financial position, he also questioned what the proposal meant for the provision of the NRAC approach and capital allocations. The Board heard from Dr Chittick and Mr Marsland that financial plans remained board-specific and allocations were unchanged this year. Efficiency targets remained in place for all boards. Workforce sustainability was expected to be a key lever for future financial improvement. On capital, it

was noted that regional property and asset planning work would need to be realigned under the new structure and that a clear leadership role for capital within sub-national planning was required, however all changes will require consultation. Professor Carolan commented that the previous North structure had a Property and Asset Management Strategy, and that she would recommend that the new structure also have a lead on capital.

Mrs Jones asked how the Board would protect what it does well, and how could it safeguard progress on inequalities? Dr Chittick emphasised that NHS Shetland's evidence base and strong local partnerships placed it in a good position to advocate for the needs of its population. Tackling inequalities remained central to both local plans and national population health frameworks. Concerns about unnecessary travel or reduced local access would be advocated for and raised robustly.

Mrs Jones further enquired if there would be opportunities for Shetland to contribute to Scotland more widely? Professor Carolan confirmed that yes, Shetland's strong diagnostics, multi-professional teams, and digital capability could support national pathways. Opportunities existed particularly around remote delivery, education, and digital enablers. Dr Laidlaw added that the Board should be clear which services were best done locally and which would be best done nationally, it was important that the Board stand up for their patients and staff.

Mr Higgins asked when the implementation handbook would be developed and communicated, and when would the Board receive it? Dr Chittick responded that he had a meeting the following day and he would feed that back once it was available.

Mrs MacDonald queried how the Board would be kept informed, given the rapid timelines. Dr Chittick said that updates would be provided through Board Development Sessions, future Board meetings and incoming planning papers. Governance arrangements for oversight would also be clarified. Mr Robinson noted that there were four areas that had to be focused on in regard to subnational planning alongside the Board's own plans.

DECISION: The Board noted the paper.

Performance & Resources

2025/26/69 - Financial Monitoring Report at Month 07 (Board Paper 2025/26/51)

The Director of Finance presented the report which showed overspend of £1.6 million at Month 7 and noted that the underlying financial challenges remained unchanged.

Expenditure was 9.2% higher than at the same point last year, largely due to pay-award timing differences within NHS pay structures. For example, consultants received a 10.5% uplift last year and a 4% uplift this year, while junior doctors received their settlement only this year. These timing effects contributed to the year-on-year increase.

Ongoing cost pressures, particularly within the medical workforce and areas operating outwith standard NHS terms, continued to affect the position. Some of these pressures were being partially offset through non-recurring underspend and in-year savings.

Discussion

The Chair noted that the report was not vastly different from the previous month's report. He highlighted the two action points in the recommendation portion of the report.

DECISION: The Board noted the paper.

2025/26/70 – Performance Report (Q2) 2025/26 (Board Paper 2025/26/52)

Mrs Flaws presented the Quarter 2 Performance Report (covering July–September), noting it had already been reviewed by the Finance and Performance Committee. Overall performance remained broadly consistent with previous quarters, with some variation across indicators. She continued by highlighting the below areas:

Waiting Times & Capacity

- Progress continued on reducing waits over 52 weeks, though cancer and other mainland-dependent pathways remained pressured.
- Diagnostics performed strongly relative to other boards but still fell short of national targets due to capacity and reporting constraints.

Mental Health

- CAMHS consistently met the 18-week target.
- Psychological therapies performance dipped as the team prioritised the longest-waiting patients.
- A demand and capacity review with Public Health Scotland was underway.

Preventative Care

- Smoking-cessation performance remained below target, reflecting low local smoking prevalence.
- Significant behaviour-change support was provided but not captured in national data; work was underway to improve reporting.

Flow & Unscheduled Care

- Delayed discharges continued to cause system pressure, with further challenges expected over winter.
- A&E performance remained among the top three in Scotland but still below the 4-hour standard.
- Benchmarking with other island boards was ongoing to understand local process impacts (e.g., earlier triage clock-starts, full admission processes undertaken in ED).

Support Services

- Supplementary staffing spend remained high.
- FOI compliance had fallen to around 50% after introducing a new system; improvement work and training were planned.

Spotlight Areas

- MAT Standards: All 10 standards were now being met; significant joint working enabled adaptation to a rural context.
- Transport Review: System mapping and coordinated changes delivered early efficiencies and quality improvements.

Mrs Flaws concluded by noting that work continued to develop a more rounded view of performance against the Strategic Delivery Plan, while still meeting all national reporting requirements.

Discussion

Mr Higgins opened by noting that the performance results continued to demonstrate strong operational delivery and cautioned against complacency given the wider pressures on the system.

Mrs Cornick enquired regarding immunisation rates for MMR at age 2 which continued to sit below the Scottish average, and asked how the Board was engaging with parents and carers to improve uptake. Dr Laidlaw explained that MMR uptake in Shetland had been slightly below the Scottish average for many years, though it had improved over time. Due to the small population, even a few unvaccinated children could significantly affect the reported percentage. She noted that some earlier under-reporting had been due to data-recording delays between local and national systems, though this was improving. She highlighted that small pockets of the population remained reluctant to accept MMR, sometimes across extended family groups. These cases were recorded so families were not repeatedly contacted. For others, missed vaccinations were due to practical barriers or the need for reassurance, and monthly audits enabled practices and health visitors to follow up directly with parents.

Although local and national campaigns continued, the absence of measles cases in Shetland made the risk feel less immediate to families. Progress was therefore slow but steady. Finally, she noted that from 1 January, the second MMR dose would move to 18 months, which should strengthen full protection by nursery age.

Mr Marsland noted that the FOI commissioner would be visiting Shetland in January.

DECISION: The Board noted the report.

Workforce

2025/26/71 – Health and Care Staffing Act Internal Compliance Report Q2 (Board Paper 2025/26/53)

Ms Watson presented the paper, and reported that implementation work continued across the organisation, with strong progress on Health and Care Staffing (HCS) duties becoming increasingly important ahead of integration with e-Payroll from June 2026.

She highlighted the following:

SafeCare Implementation

- Overall organisational SafeCare implementation sat at 31%, including nearly 40% of nursing and 45% of AHPs.
- SafeCare was now embedded across acute wards, with 24/7 visibility supported by access for the night-shift site coordinator.
- Early discussions had taken place with primary care, with implementation expected from 1 April, aligning with changes to the working week.

Risk Management & Datix

- The Datix system continued to be used for reporting adverse events and risk.
- Work began on developing a local dashboard combining patient acuity, staffing levels, quality, safety and risk indicators.

Reporting & Management Tools

- Testing had taken place on a new rostering-based management report for all managers; refinement was ongoing.

- Quarterly compliance reporting continued to Staff Governance Committee, Clinical Governance Committee and the Board.
- The statutory annual report to Ministers was due by 30 April 2026, using a new national cloud-based template.

Agency Staffing

- Agency spend continued to be monitored against the 150% threshold, with consistent scrutiny.

HIS Oversight

- HIS monitoring shifted from “engagement calls” to “Board Review Calls”, reflecting a firmer assurance approach.
- NHS Shetland had completed its two scheduled calls for the year (May and October) with positive feedback.

DECISION: The Board noted the paper.

2025/26/72 – Whistleblowing Standard Report Q2 2025/26 (Board Paper 2025/26/54)

Ms Watson presented the Whistleblowing Standards Report, providing an update on activity up to September. She confirmed that one significant case previously discussed by the Board had progressed from Stage 1 to Stage 2 and had since been escalated to the Independent National Whistleblowing Officer (INWO), with the outcome still awaited. Two further contacts had been received through the whistleblowing inbox; neither met the whistleblowing threshold but both required advice and support.

She reported continued quarterly monitoring of the action plan arising from the 2024 case and highlighted the completion of the Short-Life Working Group on “raising concerns,” which had produced standardised templates for commissioning and conducting investigations. Speak Up Week activity in September included staff engagement sessions where awareness of whistleblowing processes was found to be improving. Training uptake remained low but was encouraged, and whistleblowing understanding continued to be checked during leadership induction.

Mr Higgins added in January the Whistleblowing Champions Group would meet with the new INWO lead, who started a few months ago, which may force some changes in some areas and that investigation templates would be being adapted specifically for whistleblowing cases.

DECISION: The board noted the report

2025/26/73 – Health and Safety Policy (Board Paper 2025/26/55)

Mr Lawrence Green attended to present the Health and Safety Policy, which had already been approved by the appropriate governance routes. Key updates included:

- Removing references to the Datix system in anticipation of a future transition to a new adverse-event reporting platform
- Deleting references to the health and safety officer post which had ended in April
- Updating the chairing arrangements for the Wellbeing Committee following the shift from the mental health lead to the spiritual care lead.

Mr Green also proposed a small amount of future-proofing ahead of the Once for Scotland health and safety-related policies due to go live in March. As national policies would be generic, NHS Shetland would convert its existing policies into local procedure documents that linked directly to the national policy framework. This approach was intended to avoid the need to revisit the document again in three months' time.

He confirmed that no further changes had been made and invited any questions.

Discussion

The Chair welcomed the approach, agreed that the changes represented an evolution rather than a significant revision of the policy, and were content to approve the updated document.

DECISION: The Board approved the updated policy.

2025/26/74 – Information and Noting

Approved committee minutes for noting

The Board noted the approved minutes of the following committees:

1. Clinical Governance Committee – 2 September 2025
2. Staff Governance Committee – 4 September 2025
3. Audit & Risk Committee – 30 September 2025
4. NHS Endowment Funds Scheme of Delegation – 2 October 2025
5. Finance & Performance Committee – 7 October 2025

Date of Next Meeting: 10th February 2026 at 09.30am