A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Primary Care

Clinical Governance Deep Dive

July 2026

Argyll and Bute Health and Social Care Partnership
NHS Highland

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Clinical governance assurance report

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Executive summary & assurance matrix

One-Page Primary Care Assurance Dashboard

Overall assurance: Governance arrangements are established and active across Primary Care. The collective position is positive but qualified: Standards 2, 3 and 7 are broadly green with amber direction of travel without further mitigation, while Standards 1, 4, 5 and 6 remain amber due to improvement requirements around staffing, escalation, learning, training, engagement and evidence visibility.

Visual Assurance Profile

Assurance category	Standards	Count	Visual bar
Green with amber direction of travel	Standards 2, 3 and 7	**3 / 7**	■■■□□□□
Amber	Standards 1, 4, 5 and 6	**4 / 7**	■■■■□□□
Red	None identified	**0 / 7**	□□□□□□□

HIS Standard	Assurance position	Key reason	Top action
1. Leadership and staffing	**Amber**	Established leadership, but resilience, role clarity and staffing baseline work require completion.	Complete staffing assessments and organisational mapping.
2. Quality management	**Green / Amber DoT**	Quality activity is active, but whole-system data and indicators are not yet mature.	Develop a Primary Care quality management system.
3. Clinical effectiveness	**Green / Amber DoT**	Active redesign and clinical review, but access and outcome measures need strengthening.	Define clinical effectiveness and variation measures.
4. Safety and risk	**Amber**	Controls exist but closed-loop learning and escalation visibility require improvement.	Implement risk review discipline and learning trackers.
5. Education and training	**Amber**	Training is active, but compliance, PDPs and competence evidence need recovery.	Agree recovery plan and competence matrix.
6. Patient involvement	**Amber**	Good examples exist, but engagement is not yet consistently early or standardised.	Create engagement framework and feedback loop.
7. Data and information	**Green / Amber DoT**	IG controls are in place, but data maturity and reporting consistency need development.	Develop data improvement plan and dashboards.

Cross-cutting priority	Relevant standards	Twelve-month focus
Data and evidence visibility	2, 3, 4, 7	Minimum datasets, dashboards, trend reporting and outcome measures.
Escalation and accountability	1, 2, 4, 6	Clear roles, escalation triggers, exception reporting and review discipline.
Workforce and competence	1, 3, 5	Safe staffing baseline work, competence matrix, training recovery and resilience planning.
Learning and improvement	2, 3, 4, 6	Learning tracker for complaints, incidents, audits, SAERs and engagement feedback.
Community involvement	6, 3, 4	Earlier engagement, impact assessment alignment and “you said, we did” feedback.

Dashboard conclusion: The next twelve months should focus on consolidating improvement activity into one monitored plan, with named owners, timescales, reporting routes, RAG status and escalation triggers. This will support a clearer shift from established but fragmented assurance to an integrated, evidence-led Primary Care governance framework.

1. Executive Summary

This paper presents a structured Primary Care deep dive aligned to the Healthcare Improvement Scotland Clinical Governance Standards. The assessment indicates that governance arrangements across Primary Care are established and functioning, with several areas of good practice. There is evidence of both strengths and areas that lack in maturity across the system with opportunities identified to strengthen our assurance systems in coming months.

The next phase should focus on consistency, visibility of evidence, stronger use of data, clearer escalation routes and a more systematic approach to learning from complaints, incidents, audits and engagement.

HIS Standard	What good looks like	Areas of strength	Areas for growth	Assurance
1. Leadership and staffing	Clear leadership, accountability, sustainable staffing and professional oversight.	Positive iMatter position, active organisational review and professional lead engagement.	Complete Health and Care Staffing Act baseline work; strengthen resilience, cross-cover and escalation clarity.	Amber
2. Quality management and continuous improvement	A whole-system approach to planning, improving, maintaining and assuring quality.	Cluster quality improvement activity and refreshed operational guidance.	Define minimum datasets and quality indicators across mixed delivery models.	Green
3. Clinical effectiveness	Timely, effective, personalised and evidence-based clinical care.	Service redesign in vaccinations, LARC, forensic medicine and enhanced services.	Dental workforce fragility and access inequalities require continued mitigation.	Green
4. Clinical safety and risk management	Risks, adverse events, complaints and safety concerns are identified, managed, learned from and escalated.	Established reporting routes through QPS and clinical governance structures.	Refresh overdue risk reviews and strengthen thematic learning trackers.	Amber
5. Education and training	Staff have the competencies, training and support needed for safe, effective and person-centred care.	Protected learning, GP appraisal capacity, BASICS training and NES dental feedback.	Improve statutory mandatory and PDP compliance; clarify nursing professional structures.	Amber
6. Service user and patient involvement	People and communities are meaningfully engaged in design, delivery and governance.	Jura engagement, sexual health scoping and emerging PPG approach.	Embed proactive engagement for future 2c and service-change proposals.	Amber
7. Data and information	Safe, secure information systems that support care, assurance and improvement.	DPIAs, information asset registers and programme board oversight of GPIT migration.	Improve consistency of data definitions and local reporting for assurance.	Green

2. Primary Care Services - Background

The Primary Care portfolio covers a broad range of services, including General Practice (GMS), Board-managed General Practice (2C), Public Dental Services, Community Treatment and Care (CTAC), Vaccinations, Forensic Medicine, Sexual Health and Community Optometry.

The developing GP walk-in service in Dunoon forms part of the wider Primary Care portfolio and should be considered a targeted access, prevention and service-redesign intervention rather than a standalone model of care. It aligns with the strategic direction set out in the Joint Strategic Plan by seeking to improve timely access, support care closer to home, reduce avoidable pressure on urgent and unscheduled care pathways, and test more responsive multidisciplinary models of primary care delivery. As the model develops, governance should be proportionate to its scale, complexity and risk profile, with clear accountability, agreed clinical parameters, operational performance reporting, risk and issue management, patient and staff feedback, equality and access considerations, and formal post-implementation review. Oversight should be routed through the relevant Primary Care Clinical and Care Governance, unscheduled care and programme-board arrangements, ensuring that emerging learning is visible, escalated where required and used to inform wider service transformation. Evaluation should consider not only activity and access, but also safety, equity, patient experience, workforce impact, sustainability, interface with existing services and contribution to the future Primary Care operating model across Argyll and Bute.

The service areas operate across a mixed governance environment, and this should be recognised when interpreting assurance, performance and escalation arrangements.

General Medical Services (GMS) practices are independent contractors delivering services under the national GMS contract, with NHS Boards and Integration Authorities retaining responsibilities for contract oversight, service planning, assurance and delivery of transferred services under the 2018 GMS contract reform and associated Memorandum of Understanding.

This differs from Primary Care Board Managed services, referred to as 2c practices, and directly employed multidisciplinary teams, where the Health Board and HSCP hold more direct operational, clinical, staff and financial governance responsibilities.

Vaccination and Community Treatment and Care services sit within the wider primary care reform programme and are predominantly NHS Board/HSCP responsibilities. Governance is focused on safe delivery models, workforce competence, clinical standards, access, audit and escalation. Some practices continue to provide remote, rural and island services directly, with HSCP funding; in these circumstances, governance is shared and assurance must be interpreted in the context of the local delivery model.

Public Dental Services are directly managed NHS services providing safety-net and specialist community dental provision, with HSCP accountability for quality, access, workforce, risk and clinical governance.

Forensic medical services have a specific statutory and standards-based framework, requiring NHS Boards to provide trauma-informed, person-centred and legally robust healthcare and forensic medical examination services. This includes clear governance, training, documentation, evidence handling and quality assurance requirements. Historically, services in Argyll and Bute were delivered through contracted models, with governance devolved through those arrangements. Following service review, some services have transitioned to managed provision under HSCP responsibility over the past six months. The current landscape remains mixed, with work underway to standardise provision in line with national standards over the next twelve months.

Community ophthalmology and optometry are delivered through a combination of national General Ophthalmic Services arrangements, community optometry contractors, Health Board ophthalmic lists and increasingly enhanced community eye

care pathways; governance therefore combines national contractual and clinical requirements with Board-level oversight of local schemes, referral pathways, quality, data and patient safety. These differences mean that assurance must be drawn from different sources across the portfolio, including contract monitoring, national returns, professional standards, statutory duties, locally managed service metrics, clinical governance reporting and exception-based escalation.

A visual summary is provided in appendix 1 to explain the differential delivery methods.

2.1 Primary Care Governance Assurance Programme

Within the past six months, Primary Care has commenced a structured Governance Assurance Programme aligned to the Healthcare Improvement Scotland Clinical Governance Standards. The programme provides a consistent and proportionate approach to assessing governance arrangements, evidencing assurance and identifying improvement priorities across the portfolio.

The programme is being delivered in phases across the seven standards. Each phase reviews current arrangements, identifies what good looks like, confirms areas of strength, defines areas for growth and agrees the evidence required to support ongoing assurance. This is supported by development of a central governance repository, clearer ownership and improved visibility of governance documentation.

As of July 2026, detailed review work has been completed for:

- Standard 1: Leadership and Staffing
- Standard 2: Quality Management and Continuous Improvement
- Standard 3: Clinical Effectiveness
- Standard 4: Clinical Safety and Risk Management

Work will continue across the remaining standards during 2026/27. Outputs will inform a single improvement plan and support a sustainable governance assurance framework for Primary Care.

2.2 Clinical Governance Standards Self-Assessment

As part of the Assurance Programme, a structured self-assessment has been undertaken to establish a baseline view of current governance arrangements across Primary Care. The assessment has been used to identify strengths, gaps and improvement priorities rather than to provide a static compliance statement.

The review confirms established assurance across several domains, particularly governance reporting, quality improvement activity, professional oversight and responsive risk management. It also highlights the need to improve consistency, evidence visibility, data quality and systematic learning across the portfolio.

The remaining standards will be assessed as the programme progresses. Findings will be consolidated into a single improvement plan with defined owners, timescales and reporting routes.

A summary of the self-assessment outcomes completed to date is provided in Appendix 2 with each pillar explored in depth throughout the body of this report.

Standard 1: Leadership and Staffing

Standard 1: Leadership and Staffing asks us to ensure that services have effective leadership and oversight, including staffing levels, to support the effective planning and delivery of services.

HIS Standard 1 requirement	Current assurance	RAG	Action required
Clear leadership and oversight of healthcare services.	Leadership structures are established, with bi-monthly senior management team meeting inclusive of multiprofessional oversight and engagement. Organisational review is underway to address portfolio complexity.	**Amber**	Complete organisational mapping, confirm responsibilities and strengthen escalation routes.
Appropriate and sustainable staffing and skills mix in line with the Health and Care (Staffing)(Scotland) Act 2019.	Workforce investment has strengthened capacity, but baseline assessments are required for CTAC, Vaccinations, 2C General Practice and Dental Nursing teams in line with the Act.	**Amber**	Complete baseline staffing assessments and agree reporting arrangements through professional governance routes.
Workforce resilience plans and monitoring.	Absence is monitored and mitigations are discussed through daily management arrangements, but dental staffing fragility continues to affect continuity.	**Amber**	Progress locum dental bank proposal and define contingency arrangements for high-risk services.
Values-based, person-centred and trauma-informed leadership.	iMatter results show a positive culture, with a 75% response rate and engagement index of 79. Further work is needed on involvement in decision-making.	**Green**	Use the iMatter action plan to strengthen staff involvement and monitor progress over twelve months.
Clearly communicated vision aligned to national priorities.	Service leadership is aligned to HSCP and national priorities, but clearer articulation of responsibilities and escalation routes is required across the portfolio, with intent to design a five-year delivery plan to achieve the wider vision of the Joint Strategic Plan.	**Amber**	Use organisational review outputs to agree and communicate a unified vision, responsibilities and escalation framework.

1.2 Leadership

A small senior management team, mostly AFC Band 7 and above, supports the portfolio. Limited administrative capacity creates risk given the breadth of services. Leadership focuses on strategic decisions, operational management and improvement, with bi-monthly SMT oversight aligned to HSCP and national priorities. Senior leaders work with clinical and administrative teams to maintain governance and safe, effective, person-centred care.

A key risk is the limited leadership and support structure for Sexual Health and Forensic Medical Examiner services. This, alongside siloed portfolios and service complexity, has prompted an organisational review focused on sustainability, development opportunities and role diversity. Discussions remain at an early stage and will progress through agreed policies, decision points and oversight arrangements.

APPENDIX 1

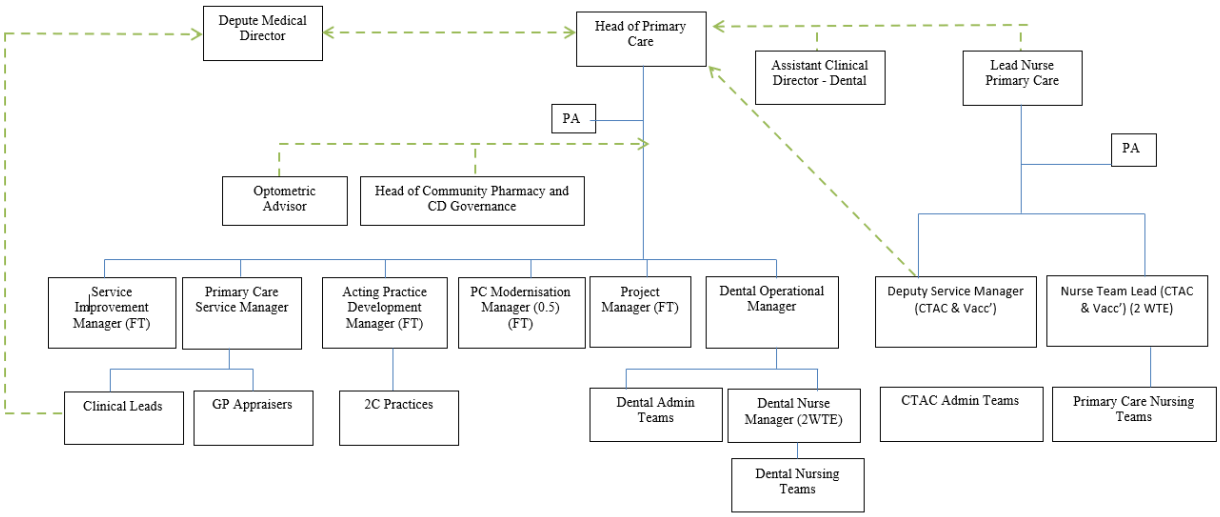


Figure 1: A&B Primary Care Organisational Structure (April 2026)
FT = Fixed Term

1.3 Staffing Levels

High-quality care depends on adequate staffing. Workforce growth since 2024 and 97% permanent employment provide assurance on stability and continuity, but small specialist teams remain vulnerable to absence, vacancies, single points of failure and limited cross-cover.

Primary Care: Headcount and WTE by date

While the workforce growth is encouraging, an oversight was identified in implementation of the Health and Care (Staffing)(Scotland) Act 2019, as Primary Care was initially treated as out of scope in A&B. CTAC, Vaccinations, 2C General Practice and Dental Nursing teams are in scope, requiring baseline assessments, clinical judgement tools and common staffing methods to be developed over the next twelve months.

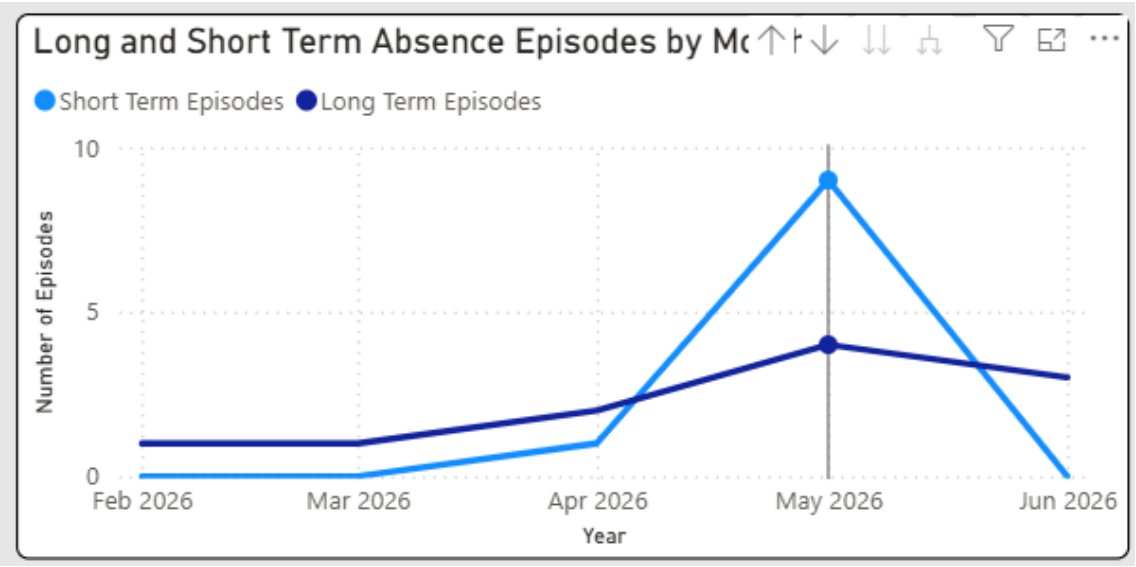
Supplementary staffing has totalled 2,178 hours since January 2026, mainly for vaccination campaigns. This appears appropriate for predictable peaks, but should be monitored to ensure it is not masking underlying capacity gaps in small teams.

Primary Care: Absence Statistics (1)

In 2026, sickness absence accounts for 36% of working days lost, or 540 days by June. Most absence is short term, and reduced long-term sickness in March is positive. The key issue is the operational impact on small teams, where even short-term absence can affect capacity, continuity and access. Absences continue to be managed within Once for Scotland Policies with reasonable adjustments applied to support staff to return to work when safe to do so.

Primary Care: Absence Statistics (2)

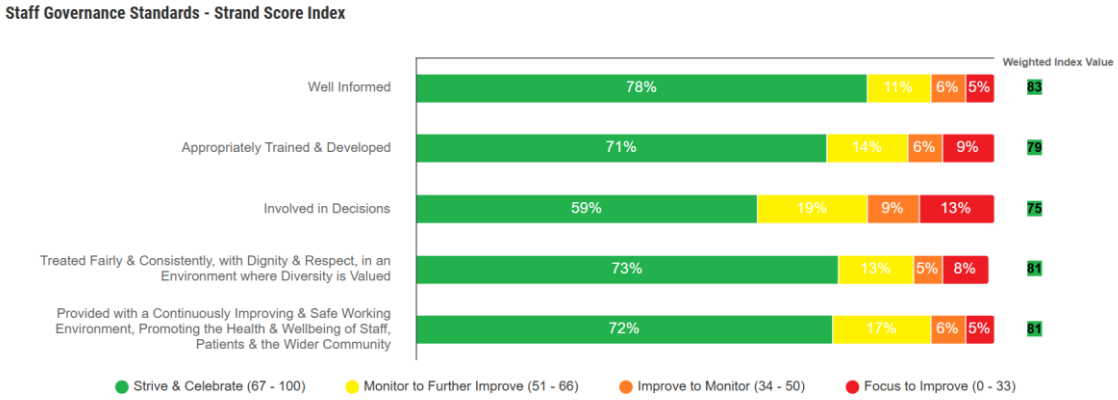
Dental services remain at particular risk from absence, with recent rates affecting clinical service delivery. The impact is amplified by a small workforce and limited cover. June trends are more reassuring, but continued oversight is needed due to the impact of short-notice cancellations on access, experience and equity. Mitigation is monitored through management processes and Datix.



Dental Services: Absence Statistics

1.4 Organisational Culture

Organisational culture is a strength. The iMatter response rate of 75% and engagement index of 79 indicate positive staff engagement during a period of redesign, workforce pressure and organisational review.



However, 13% of staff did not feel involved in decision-making, which is a material improvement signal. In small specialist teams, involvement supports psychological safety, change readiness, retention and early risk identification. The iMatter action plan, once developed with local teams, will likely focus on communication, involvement and feedback loops.

Local discussion has identified governance risks around continuity, cross-cover, managerial roles and escalation. These can delay decisions, reduce local autonomy and increase reliance on a small number of senior staff. Organisational mapping and change work is therefore being progressed to support risk mitigations.

Effectiveness will be measured by improved accountability, cross-cover, peer support and staff confidence, monitored through iMatter, risk review, SMT oversight and team feedback.

1.5 Vision and Values

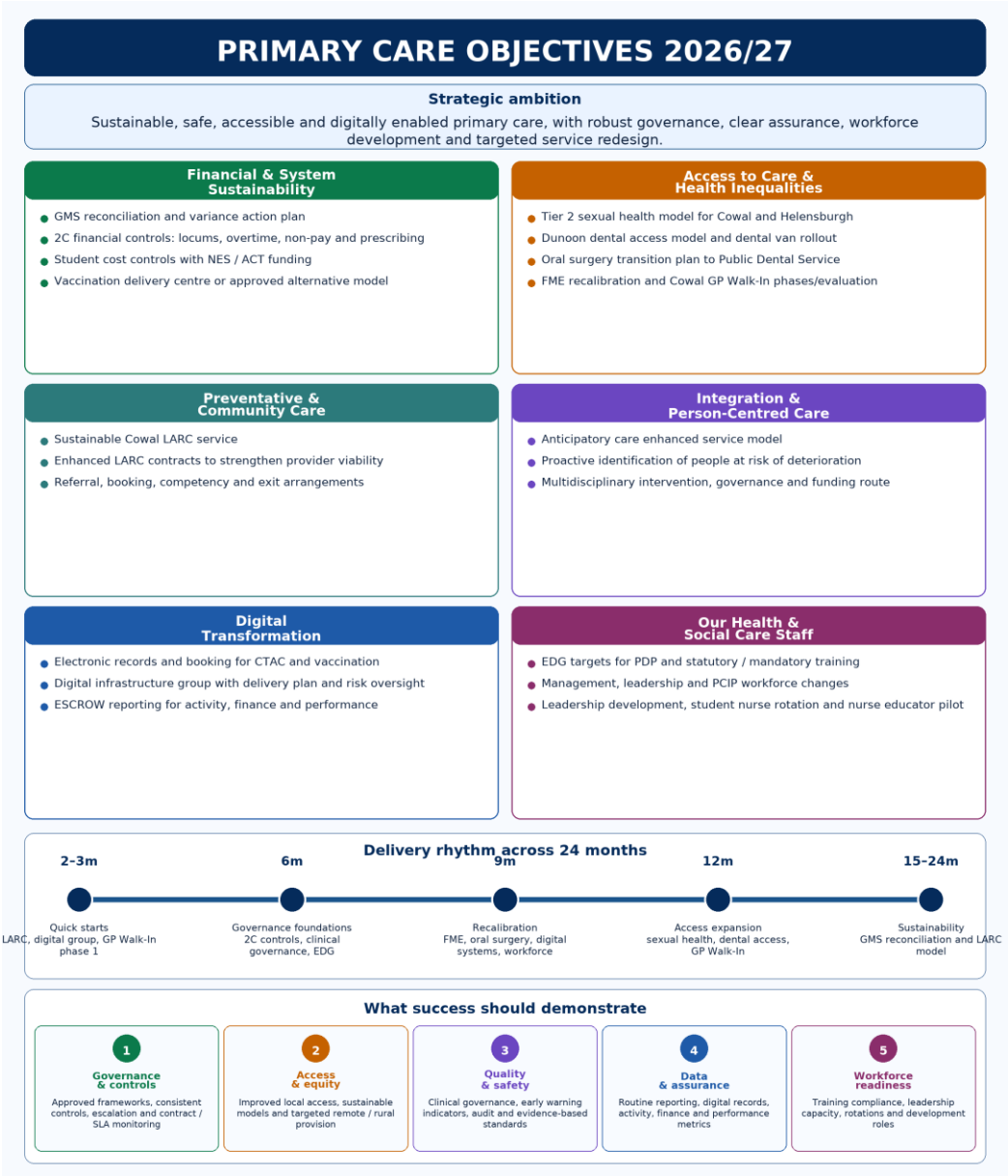
Primary Care's developing vision aligns with the Argyll and Bute HSCP Joint Strategic Plan 2026–2031, prevention, early intervention, person-centred care, improved access

and sustainable care closer to home. The key challenge is translating this intent into an operating model staff, partners and communities can recognise in practice.

Self-assessment shows a clear values-based direction: more collaborative, transparent and relationship-based working; stronger professional and operational leadership; active listening to staff, patients and communities; and better use of governance, data and learning. The critical dependency is embedding this consistently in decisions, priorities, engagement and escalation across all delivery models.

Draft objectives are set out below but still require Chief Officer review and senior management approval. Until confirmed, teams may continue to interpret priorities differently, particularly where service pressures, workforce constraints and contractual responsibilities compete.

The direction is well aligned to national and local priorities, but now needs clearer articulation across Primary Care, linked to team roles, professional responsibilities, escalation routes and the five-year Joint Strategic Plan delivery plan. Without this, the vision risks remaining aspirational rather than operational.



1.6 Current Assurance

Assurance for Standard 1 is proposed as amber. There is evidence of established leadership arrangements, positive organisational culture, active professional oversight and responsive management of emerging workforce risks. The amber rating reflects the scale and complexity of the portfolio, the need to complete baseline staffing assessments under the Health and Care (Staffing)(Scotland) Act 2019, and the requirement to strengthen clarity around roles, responsibilities, escalation routes and cross-cover arrangements.

The current position provides reasonable assurance that risks are known and being actively managed, but further work is required to move from responsive oversight to a more consistent, documented and sustainable leadership and staffing framework. The organisational review, iMatter action planning, professional nursing structure review and staffing act implementation work provide the key improvement routes over the next twelve months.

1.7 Areas for Growth and Next Steps

Area for growth	Why this matters	Next step	RAG
Health and Care Staffing Act implementation	Baseline assessments are required for in-scope services to evidence safe staffing and support statutory reporting.	Complete baseline assessments for CTAC, Vaccinations, 2C General Practice and Dental Nursing teams and agree reporting routes through professional governance.	**Amber**
Leadership structure and portfolio resilience	Current portfolios are complex and some specialist areas have limited leadership resilience and cross-cover.	Progress organisational review, clarify managerial and professional responsibilities, and define cross-cover arrangements for high-risk services.	**Amber**
Escalation routes and decision-making clarity	Staff need clear routes for operational, professional and clinical escalation to support timely decision-making and reduce ambiguity.	Develop an organisational map with responsibilities, escalation triggers and peer support networks, and communicate this across teams.	**Amber**
Staff involvement and culture	iMatter results are positive, but a proportion of staff reported limited involvement in decision-making.	Use the iMatter action plan and organisational change discussions to strengthen staff involvement, feedback loops and shared ownership.	**Green**
Vision and communication	The developing Primary Care vision is aligned to the Joint Strategic Plan, but requires clearer articulation across services and teams.	Agree and communicate the Primary Care vision, objectives and values through the organisational review and five-year delivery planning process.	**Amber**

Standard 2: Quality Management and Continuous Improvement

Healthcare Improvement Scotland defines Standard 2 as requiring clinical services to implement a whole-system approach to plan, improve, maintain and assure safety and quality. Within Primary Care, this must be interpreted through the mixed governance environment described in the opening section of this paper. As a result, quality management cannot rely on a single assurance route; it must draw together contract monitoring, cluster quality improvement, annual assurance returns, complaints and adverse event learning, operational performance, audit activity, professional oversight and programme board reporting.

HIS Standard 2 requirement	Current assurance	RAG	Action required
Actively monitor the quality of clinical care they deliver through established governance and oversight frameworks	Quality is monitored through HSCP performance arrangements, IPMF measures, clinical governance reporting, annual GMS assurance returns, payment verification visits, complaints returns, cluster activity and operational oversight.	**Green**	Continue to develop meaningful indicators, improve consistency of reporting and strengthen links between performance data, governance review and improvement action.
Have a system to receive applications for tests of change	Cluster quality improvement provides an established route for tests of change and local improvement activity within General Practice. A refreshed cluster operational guide supports roles, reporting routes and alignment with clinical governance.	**Green**	Finalise the protocol for non-engagement in cluster quality activity and ensure tests of change are recorded, monitored and shared through cluster and governance routes.
Use data and intelligence to monitor and improve the safety and quality of their clinical services	Data is used through IPMF reporting, GMS annual returns, assurance visits, complaints, audit activity and programme reporting. However, datasets remain fragmented across mixed delivery models and CTAC access and waiting-time data is not yet standardised. There is limited evidence of longitudinal data monitoring, which necessitates a cultural shift and restructuring of reporting frameworks.	**Amber**	Define minimum datasets and core quality indicators, modernise IPMF measures and develop a consistent approach to CTAC access and waiting time reporting.
Work collaboratively with other organisations to share learning and improve safety and quality of care	Collaborative improvement is evident through GP cluster working, LMC engagement, dispensing network development, prescribing improvement activity, cervical screening work and links to wider NHS Highland ITR scoping. There is less evidence of collaboration with research teams or quality improvement systems.	**Green**	Continue to use cluster, LMC, NHS Highland and programme board routes to share learning, reduce unwarranted variation and strengthen whole-system improvement.
Implement a whole-system evidence-based quality management system.	A developing quality management approach is in place through performance reporting, cluster improvement, assurance returns, audit, complaints learning and programme oversight, but it is not yet fully standardised across all portfolio areas.	**Amber**	Develop a more explicit quality management system for Primary Care, with agreed evidence requirements, reporting cycles, learning routes and escalation triggers across all services.

Current quality management provides reasonable assurance that improvement activity is active, visible and increasingly structured. Established routes include IPMF reporting, clinical governance, GP clusters, annual GMS returns, payment verification, complaints returns and programme oversight, demonstrating strengths in local improvement, collaboration and responsiveness.

The key assurance gap is that these arrangements are not yet a mature whole-system quality management system. IPMF performance in quarter 3 of 2025/26 was 67%, with four metrics on track and two off track; however, current indicators do not yet give a full view of quality, access, outcomes, equity, patient experience or sustainability. New indicators are therefore being progressed with the Planning Team for delivery within next twelve months.

STATUS at 2025/26 - Q3	
ON TRACK	4
OFF TRACK	2
AWAITING DATA	0

67%

							2025/26-Q3			2025/26-Q2			2025/26-Q1		
IPMF Service	Service Area	25/26 KPI No	Service	HoS	KPI	Variance	Target	Actual	Status	Target	Actual	Status	Target	Actual	Status
Primary Care	3	1	Dentistry	Eilidh Gallagher	80% of children who received Fluoride Varnish treatment did not require to be referred for further dental treatment	1%	80%	81%	G	80%	80%	G	80%	84%	G
Primary Care	3	2	Dentistry	Eilidh Gallagher	Percentage of planned activity carried out to deliver National Oral Health Improvement Programmes against Service Plan	16%	100%	89%	R	100%	73%	R	100%	85%	R
Primary Care	3	3	Primary Care	Eilidh Gallagher	Monitor vaccination delivery against National trends during autumn winter and spring booster programmes	62%	64%	65%	G	6%	2%	R	61%	61%	G
Primary Care	3	4	Primary Care	Eilidh Gallagher	Reduce the number of instances of HSCP run GP practices going into contingency measures	0%	14	0	G	14	0	G	14	0	G
Primary Care	3	5	Dentistry	Eilidh Gallagher	Monitor available appointments to increase the utilisation of HSCP Dental Clinic appointments	8%	75%	51%	R	75%	43%	R	75%	48%	R
Primary Care	3	6	Primary Care	Eilidh Gallagher	Achieve a minimum 95 percent uptake for 6 in 1 vaccination in children by the time they reach 1 year old	-1%	95%	97%	G	95%	97%	G	95%	100%	G

2.1 General Practice

General Practice quality improvement is delivered mainly through GP clusters, supported by the refreshed *Argyll and Bute GP Cluster Operational Guide*. This sets out roles, reporting and escalation, aligning cluster activity with Primary Care clinical governance and national priorities. It provides a key improvement infrastructure within a contractor-led environment where direct operational levers are limited.

Variable cluster engagement remains a governance risk because clusters are the main route for General Practice quality improvement, peer learning and tests of change. A non-engagement protocol has been developed and recently ratified which will provide a staged, supportive process with review periods and escalation routes where required.

The table below shows active improvement work across dispensing, prescribing, cervical screening, workload transfer and medical recall. The next step is to link each workstream to measurable aims, outcomes, learning routes and escalation where progress is delayed.

Topic	Lead	Remarks	Status
Dispensing Network	Dr Alida McGregor (Clinical Lead)	Reviewing practice, protocols, financial sustainability and governance arrangements for dispensing practices with the establishment of an A&B wide dispensing network to share learning, adverse event outcomes and best practice	In Development, administrative support allocated and stakeholders engaged
Prescribing Practices	Dr Brian McLaughlin (Clinical Lead)	2c prescribing audit and improvement project to deliver pharmacotherapy review, streamline prescribing practices within formulary and	In progress, key stakeholders engaged

		reduce unnecessary costs	
Cervical Screening	Dr Rob Waddingtong	Ongoing project with LMC to boost uptake rates across the localities	In Progress, data metrics to be reviewed
Secondary Care > Primary Care workload Transfer	Dr Rob Waddington	PQLs to collate and review common themes and workload impact associated with secondary care requests.	Engaged with NHSH ITR (Integrated Treatment Rooms) scoping work to consider scalability and funding options for A&B
Medical Recall Reviews	Dr Claire Harris	Review of recall system on EMIS and overriding med review by dispensing staff. Multiple systems issues identified and learning / improvement ongoing	80% of med reviews completed

Quality Improvement Programmes

Cluster working is a strong improvement mechanism, but contracted delivery limits routine access to comparable quality, access, outcome and patient experience data. This creates an assurance gap: the HSCP can evidence improvement infrastructure and contract compliance, but has a less complete view of comparative performance across practices. Developing national work to establish a minimum dataset should inform local learning and improvement and strengthen quality improvement programmes in the future.

GMS practices also provide assurance through annual returns, payment verification visits and complaint returns. These confirm core contractual requirements, including access, opening hours, equality and diversity, Disclosure/PVG compliance and GDPR assurance. They are important but largely self-assessed, annual and compliance-focused, so do not provide a full view of quality, outcomes, equity or improvement over time.

Annual Returns	Complaint Returns	Payment Verification
96%	**96%**	**3 visits concluded**

Assurance Returns : GMS 24/25

In 2024/25, one practice did not submit assurance documentation due to extenuating circumstances. Local communication provided sufficient assurance at the time; however, this highlights the need for a documented escalation and exception process when routine returns are incomplete.

The LMC and Primary Care Management Team are developing an annual review process between practices and the HSCP. This should better connect contract assurance with clinical governance. Until a formal framework is in place, there remains limited ability to take a consistent, evidence-based view of service delivery, experience, access, learning and improvement across practices.

For executive assurance, timeliness is the key issue. Annual returns are necessary but insufficient for in-year quality management, and self-reporting by practices limits independent scrutiny. Work is required to establish improvement metrics that should therefore be reported through clinical governance, cluster and management forums, with emphasis on trends, exceptions, impact and learning rather than activity alone.

2.2 CTAC and Vaccinations

CTAC quality management is supported by local governance, patient safety systems, workforce assurance, audit and learning. These arrangements provide assurance that quality issues are identified and managed, but wider limits in standardised primary care datasets mean local intelligence is not yet consistent or comparable enough for a mature quality management system.

There is no single mechanism for measuring CTAC access and waiting times because clinical and scheduling systems vary across sites. This limits assessment of effectiveness, equity and improvement opportunity. Pressures and delays are monitored operationally and reported through the Primary Care Modernisation Programme Board, but strategic assurance requires more consistent reporting on access, demand, capacity and outcomes.

The CTAC service specification has recently been reviewed and is pending final ratification via programme board, this is an opportunity to modernise delivery, align activity with prevention and long-term outcomes, and address recognised gaps. The revised specification defines service standards, data requirements, escalation triggers and reporting routes so quality can be assessed consistently across localities.

2.3 Public Dental Services

Public Dental Services are directly managed NHS services, providing a clearer line of operational, clinical, workforce and quality governance than independently contracted General Dental Services.

Quality management is supported through Public Dental Service management meetings, Datix, health and safety assurance, complaints review, team-lead escalation, QPS reporting and professional dental leadership.

The service contributes to prevention and population health through Oral Health Improvement, Caring for Smiles, Childsmile and the National Dental Inspection Programme. March 2026 reporting showed continued activity in care home training, fluoride varnish, health visitor referral follow-up and inspection outcomes, including 80% of inspected Primary 1 children and 79% of inspected Primary 7 children with no obvious decay experience.

The main quality risk is workforce fragility and its impact on access, continuity and utilisation. Prolonged staffing challenges, unplanned absence, vacancies in Oban and Campbeltown, and difficulty securing Dental Officer cover are affecting delivery. Mitigations are active, including a proposed dental locum model, a Dental Professional Oversight Group, regular service management oversight and service-model work for orthodontics, Tiree and mobile dental provision.

Mobile dental provision remains a significant equity issue, as the previous unit has been out of service since 2018, reducing local access for remote and island communities. A shared capital bid with Highland HSCP is progressing for a towable mobile dental trailer. Overall, governance routes are established and risks are known, but stronger capacity modelling, utilisation reporting, locality waiting-time data, workforce contingency and escalation thresholds are needed to move from reactive management to a more mature quality system.

2.4 Forensic Medicine and Sexual Health

Forensic Medicine and Sexual Health sit within a more specialised governance context, with particular requirements for clinical documentation, legal defensibility, trauma-

informed care, prescribing governance, pathway clarity, training, data quality and escalation. Both areas are moving through active service redesign, with quality management increasingly being strengthened through revised service specifications, standard operating procedures, clinical leadership, professional oversight and structured review. However, both areas also illustrate the wider challenge identified in this deep dive: quality assurance is improving, but it remains dependent on standardising documentation, data capture and reporting across mixed delivery arrangements.

In Forensic Medicine, the transition of Cowal custody healthcare from contracted arrangements to managed service provision has created a stronger quality management route. Provision of daytime services transitioned on 1 April 2026 and out-of-hours services from 1 June 2026, with training delivered to clinicians, further sessions planned, and service specifications being refreshed in line with Police Scotland changes. A final draft Forensic Medical Examiner service specification has also been developed to align provision with current policing arrangements, facilities, professional expectations and safe delivery requirements. This is a clear area of strength because it moves the service from historic contract-based provision towards a more standardised and clinically governed model.

The key quality gap is clinical records, auditability and inspection readiness, which has been captured on the service level risk register. The June 2026 Primary Care Risk Register notes variable Police Adastra use across custody healthcare, creating risks for inspection compliance, record access, documentation quality, audit, patient safety and Board assurance. Interim inspection-readiness processes, high-risk mitigations, standardised documentation and audit arrangements are planned, with full Police Adastra use targeted by December 2026 and Cowal/Oban implementation by August 2026. Assurance should remain amber until documentation and system alignment are complete.

Sexual Health quality management is developing through service redesign, with recognised long-term reduced provision affecting access and patient experience. Interim arrangements, including the Cowal LARC clinic model, have been implemented within the last month to maintain local access. Ratified SOPs for the Phase 1 soft launch set out eligibility, access, documentation, escalation, capacity management, data capture, prescribing queries and early review. This provides controlled clinical assurance, but a transitional plan is needed for a more sustainable and cost-effective future model.

Overall, Forensic Medicine and Sexual Health show active quality management and improvement momentum through refreshed specifications, managed-service development, SOPs, training, professional engagement and emerging data capture. Key areas for growth are documentation standards, Adastra implementation, audit capability, sexual health demand modelling, workforce planning and consistent governance reporting. These areas should remain amber within Standard 2 while systems to evidence quality across all sites and pathways mature.

2.5 Current Assurance

Assurance for Standard 2 is proposed as amber for data maturity and system consistency. There is evidence of established quality management and improvement activity across the portfolio, including GP cluster quality improvement, refreshed operational guidance, annual assurance returns, payment verification, complaints returns, collaborative improvement with the LMC, responsive operational oversight, programme board reporting and emerging service specification work across CTAC, Public Dental Services, Forensic Medicine and Sexual Health.

The current position provides reasonable assurance that quality and improvement activity is active, visible and increasingly structured. However, further work is required to move from multiple functioning assurance processes to a more integrated whole-system quality management approach. The key areas for growth relate to defining minimum datasets, improving timeliness and consistency of in-year intelligence, strengthening CTAC access and waiting-time reporting, improving outcome measurement for quality improvement workstreams, developing locality-level dental capacity and waiting-time data, completing Adastra implementation and audit readiness in Forensic Medicine, and embedding sustainable quality reporting for Sexual Health.

2.6 Areas for Growth and Next Steps

Limited longitudinal data monitoring shows the need to strengthen reporting culture, human factors awareness and reporting frameworks.

Area for growth	Why this matters	Next step	RAG
Whole-system quality management system	Quality activity is established but remains distributed across several assurance routes, which limits a single portfolio-wide view of quality, safety, access, outcomes and learning.	Develop an explicit Primary Care quality management system with agreed evidence requirements, reporting cycles, learning routes and escalation triggers across all services.	**Amber**
Minimum datasets and quality indicators	Fragmented data limits the ability to compare quality, access, outcomes, equity and patient experience across mixed delivery models.	Define minimum datasets, modernise IPMF indicators and agree core quality measures for directly managed, contracted and shared-delivery services.	**Amber**
GP cluster engagement and annual review framework	Cluster working is the main quality improvement mechanism in General Practice, but variable engagement and annual compliance-focused returns limit continuous assurance.	Finalise the non-engagement protocol and develop an annual practice review process with the LMC that links contract assurance, quality improvement and clinical governance.	**Amber**
CTAC access and waiting-time reporting	Different scheduling and clinical systems limit formal assessment of access, equity, demand, capacity and improvement opportunity.	Use the CTAC service specification review to define service standards, access measures, data requirements, escalation triggers and reporting routes.	**Amber**
Public Dental Services capacity and utilisation	Workforce fragility, absence, clinic cancellations and locality variation affect access, equity, continuity and patient experience.	Progress the dental locum bank proposal, strengthen capacity modelling, improve locality-level waiting-time and utilisation reporting, and agree escalation thresholds.	**Amber**
Forensic Medicine documentation and audit readiness	Variation in Police Adastra use creates risks to documentation quality, record accessibility, inspection compliance, audit capability, patient safety and Board assurance.	Complete interim inspection-readiness processes, standardise documentation and audit arrangements, and progress full Police Adastra implementation across custody healthcare areas.	**Amber**
Sexual Health sustainable quality model	Interim arrangements are clinically controlled, but reduced provision and changing access routes require a sustainable model with clear demand, workforce and outcome reporting.	Develop a transitional plan for a sustainable and cost-effective Sexual Health model, including demand data, referral routes, patient feedback, workforce requirements and governance reporting.	**Amber**

Standard 3: Clinical Effectiveness

Healthcare Improvement Scotland defines clinical effectiveness as timely, effective, person-centred and evidence-based care. In Primary Care, assurance must be drawn from multiple sources across independent contractor, directly managed, business-to-business and HSCP-led services, including contract review, service specifications, clinical guidance, audit, uptake data, complaints, adverse event learning, workforce capacity, professional oversight, access, redesign and measurable improvement.

Primary Care services are actively reviewing clinical effectiveness and responding to gaps, with strengths in service redesign, vaccination governance, enhanced service review, managed service development, forensic medicine improvement and use of audit and clinical guidance. The key gap is inconsistent evidence across services on outcomes, locality access, patient experience and formal audit cycles. The next step is to link redesign more clearly to outcomes, access equity, workforce resilience and patient experience.

HIS Standard 3 requirement	Current assurance	RAG	Action required
Deliver timely, effective, personalised and evidence-based care and treatment.	There is evidence of active clinical review, service redesign and use of clinical guidance across General Practice enhanced services, Vaccinations, CTAC, Public Dental Services, Forensic Medicine and Sexual Health. However, timeliness and equity are affected by workforce fragility, LARC provision gaps, dental access pressures and variable locality-level data.	**Amber**	Strengthen clinical outcome, access and patient experience measures across priority services, with clear escalation where access or effectiveness is compromised.
Ensure clinical services are delivered in line with current evidence, professional standards and national guidance.	Vaccination delivery is supported by PGDs, audit, training and national programme oversight. Forensic Medicine service specifications and documentation standards are being refreshed. Dental, LARC and enhanced service models are under review to improve alignment with current standards and local need.	**Green**	Continue service specification refresh, PGD audit, professional oversight and contract review, ensuring changes are reported through clinical governance routes.
Use clinical audit, quality improvement, adverse event learning and complaints to improve clinical outcomes.	Audit activity is evident in vaccination programmes, PGD compliance, prescribing, cervical screening, medication review and forensic documentation improvement. Complaints and adverse event learning inform service changes, but evidence of closed-loop clinical outcome improvement is not consistent across all services.	**Amber**	Develop a stronger clinical audit and outcomes tracker that records improvement aim, baseline, action, outcome, learning and reporting route.
Identify and address unwarranted variation in clinical care, access and outcomes.	Variation is recognised across LARC provision, dental access, vaccination uptake, CTAC access reporting, orthodontic provision in and forensic medicine documentation. Mitigations are active, but comparative data is not yet sufficiently mature to quantify and track variation consistently.	**Amber**	Define priority variation measures and report them through governance, including locality access, waiting time, uptake, cancellation and clinical outcome data where available.
Ensure service redesign improves effectiveness, quality, access and sustainability.	There is active redesign across Cowal LARC, managed forensic medicine, Public Dental Services, mobile dental provision, orthodontics, vaccinations and enhanced services. The direction of travel is positive, but some redesign remains dependent on workforce,	**Amber**	Ensure all redesign proposals include clinical effectiveness measures, workforce assumptions, patient impact, equality impact, sustainability assessment and post-implementation review.

	funding, system configuration and data maturity.		

3.1 General Practice

General Practice clinical effectiveness is supported through enhanced service review, LMC engagement, quality improvement, contract monitoring and new or revised service models. In quarter 4 of 2025/26, the Primary Care team reviewed enhanced service contracts and access equity, identifying opportunities to improve access, reporting, assurance and financial sustainability. Appendix 3 details the 25/26 enhanced service provision across Argyll and Bute. 26/27 provision will be reviewed following the cycle of annual contract renewal. Revised contracts are progressing to address gaps, including ring pessary and Long-Acting Reversible Contraception provision. New services have also been developed in recognition of access gaps and over reliance on secondary care pathways where primary care could offer a viable local alternative such as the provision of ring pessary services.

The key strength is that enhanced service review is being used to respond to clinical need and support care closer to home, particularly in remote, rural and island communities. Caution should be applied in expecting uniform access, as wider secondary care service provision creates resilience and influences the context of local community needs. Equally, clinical effectiveness cannot be assessed through contract existence alone; future contracts will include clear measures of access, activity, uptake, patient experience, equity, outcomes and escalation triggers where provision becomes fragile.

Cowal LARC provision is a specific risk following GP withdrawal from enhanced service contracts, creating a short-term local access gap and increased travel for some patients. While contractual access is recorded as 100% across the locality, enhanced service arrangements present limitations in how this translates into real-term access to care. A practice may opt in to a service, but the level of delivery required is not always determined within contracting arrangements. These limitations will also be considered as the enhanced service contract review progresses.

In relation to LARC access, interim signposting is in place and a managed service model has been developed at Cowal Community Hospital as a short-term intervention to maintain access. However, this model is not viable as a long-term service model from a financial or workforce perspective. Assurance remains amber until the model is implemented, evaluated and supported by demand, capacity, governance and patient feedback data.

3.2 CTAC and Vaccinations

The Vaccination Transformation Programme provides a strong example of clinical effectiveness across Argyll and Bute. The programme enables standardised delivery of national vaccination programmes through defined clinical models, approved Patient Group Directions, routine audit, infection prevention and control assurance, trained staff and dedicated data-quality monitoring. These arrangements provide assurance that vaccination delivery is aligned to national clinical guidance and that errors, trends and learning are identified and managed.

The critical issue is uptake and variation. National data shows declining vaccination uptake at several age points, and Argyll and Bute performance has been variable in the most recent reporting period, although it often reaches 95%. There has been a noted reduction in 12-month uptake across the HSCP. This does not indicate a failure of governance, but it does require active clinical effectiveness oversight because reduced

uptake can affect population health outcomes and health inequalities. Uptake rates should therefore continue to be monitored through vaccination oversight groups, with targeted improvement activity where variation or decline is identified.

CTAC clinical effectiveness is more difficult to evidence because access, waiting time and outcome data are not yet consistently captured across all localities. The service specification review provides an opportunity to define the clinical effectiveness measures that matter most, including access, demand, capacity, chronic disease monitoring, procedure completion, patient experience and escalation triggers.

Vaccine	Age administered	Age measured	2023	2024	2025
DTaP/IPV/Hib/HepB (6-in-1 or Hexavalent vaccine)	8, 12 and 16 weeks	12 months	96.1	94.4	95.4
DTaP/IPV/Hib/HepB (6-in-1 or Hexavalent vaccine)	8, 12 and 16 weeks	24 months	95.6	95.6	94.9
DTaP/IPV/Hib/HepB (6-in-1 or Hexavalent vaccine)	8, 12 and 16 weeks	5 years	95.5	95.6	95.7
Pneumococcal disease (PCV)	12 weeks	12 months	94.7	94.4	94.0
Rotavirus	8 and 12 weeks	12 months	94.4	92.4	92.7
Meningococcal group B (MenB)	8 and 16 weeks	12 months	95.6	93.7	94.7
Hib/MenC	1 year	24 months	93.4	92.7	92.1
Hib/MenC	1 year	5 years	94.5	93.7	93.9
Measles/mumps/rubella (MMR)	1 year	24 months	93.4	91.8	91.7
Measles/mumps/rubella (MMR)	1 year	5 years	95.1	94.4	94.3
Pneumococcal disease (PCV) booster	1 year	24 months	93.5	92.7	91.1
Meningococcal group B (MenB) booster	1 year	24 months	93.1	91.5	90.9
Diphtheria, tetanus, pertussis and polio (DTaP/IPV) booster	3 years and 4 months to 5 years	5 years	91.4	88.9	87.9
Measles/mumps/rubella (MMR) second dose	3 years and 4 months to 5 years	5 years	90.8	88.9	87.3

Table 4 : Argyll and Bute primary and booster immunisation uptake rates by financial year

Audit activity is undertaken where appropriate, including:

- Random audits of childhood and core vaccination programmes
- Patient Group Direction (PGD) audits to provide assurance of correct authorisation, use and compliance

These processes provide assurance of safe and effective practice and support continuous learning, rather than functioning as formal performance metrics.

3.3 Dental

Public Dental Services demonstrate clear clinical purpose, with safety-net and specialist community provision, oral health improvement encompassing national Reducing Inequalities programmes, inclusive of Childsmile, Caring for Smiles alongside the Dental Outreach Programme, delivered by means of Service Level Agreement in conjunction with NES and the University of Glasgow contributing to prevention, access and population health. The service has evidence of preventative impact, including oral health improvement activity and National Dental Inspection Programme results showing high proportions of inspected children with no obvious decay experience.

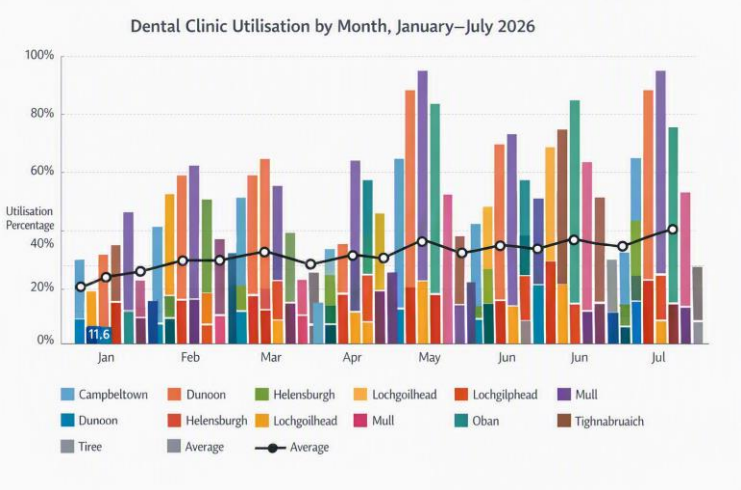
KPI	2025/26 Performance	Key Findings
Measure 1 – Delivery of National Oral Health Improvement Programmes	**85%** of planned activity delivered (1,529 of 1,800 activities). Quarterly performance: **Q1 85%**, **Q2 73%**, **Q3 88%**, **Q4 92%**.	Performance improved throughout the year, with the highest level of delivery achieved in Q4. Priority national programmes, particularly Childsmile, were maintained across Argyll & Bute despite operational pressures.
Measure 2 – Fluoride Varnish Follow-up	**3,983** children received fluoride varnish. **690 children (17.3%)** were identified as requiring follow-up dental appointments. Quarterly referral rates ranged from **14.8%–20%**.	Referral rates remained relatively stable throughout the year, demonstrating consistent identification of children requiring further dental care. Delivery of the fluoride varnish programme was maintained despite workforce challenges.

National Dental Inspection Programme latest figure. In 2025/26 caries experience overall has increased however, the percentage of children with untreated dental caries has decreased. This demonstrates a need to further improve prevention strategies and engagement but it does indicate access to dental services has increased.

Indicator	Outcome
P1 oral health	Increased from **73% (2023/24)** to **80% (2024/25)** (**+7 percentage points**).
P7 oral health	Increased from **76% (2023/24)** to **79% (2024/25)** (**+3 percentage points**).
Overall	**1,308 children** were inspected across Argyll & Bute, demonstrating continued improvement in children's oral health and providing valuable intelligence to target future Oral Health Improvement interventions.

Overall performance remained strong despite ongoing workforce and geographical challenges. The Oral Health Improvement Team delivered 85% of planned activity during 2025/26, with performance improving from 73% in Quarter 2 to 92% in Quarter 4 through effective prioritisation and collaborative working. National Childsmile programmes and fluoride varnish delivery were maintained across Argyll & Bute, ensuring continuity of key preventative services. These efforts have contributed to improved oral health outcomes, with the 2024/25 National Dental Inspection Programme reporting 80% of Primary 1 children and 79% of Primary 7 children free from obvious dental decay, demonstrating continued improvement from the previous year.

The principal clinical effectiveness risk is workforce fragility and its direct impact on access, continuity and utilisation. Recruitment challenges, unplanned absence, clinic cancellations, reduced clinical capacity and extended waiting times are affecting the ability of the service to convert available workforce and estate into reliable patient access. Clinic utilisation has fallen to around 50%, which is a significant clinical effectiveness concern because it indicates a mismatch between need, capacity, staffing resilience and appointment use.



There is evidence of active mitigation. A locum dental bank proposal is progressing, professional oversight has been strengthened, service-model reviews are underway in relation to orthodontics, Tiree and mobile dental provision, and a shared capital bid is progressing for a towable mobile dental trailer. These are appropriate responses, but the service will remain amber until workforce contingency, capacity modelling, utilisation reporting and locality-level waiting-time monitoring are sufficiently mature to demonstrate improved access and outcomes.

3.4 Forensic Medicine

Forensic Medicine has historically been delivered through business-to-business contracts with General Practitioners with specialist training. A comprehensive service review in 25/26 identified clinical risks relating to documentation, variation from national target operating models, training, oversight and auditability. In response, a targeted contract review and service redesign programme is underway.

The transition of Cowal custody healthcare from contracted provision to a managed service model provides positive assurance. The model improves clinical oversight, reporting capability, financial efficiency and consistency of governance. Refresher training in clinical practice and Police Adastra has been delivered to Cowal providers, with further training planned across the HSCP. Service specifications are being refreshed in line with Police Scotland changes and national expectations.

The critical assurance gap remains documentation and audit readiness. Variation in Police Adastra use creates risk to clinical record quality, inspection compliance, audit capability and Board assurance. The direction of travel is positive, with implementation and standardisation work planned, but clinical effectiveness should remain amber until documentation standards, audit processes, training compliance and system use are embedded across all custody healthcare areas.

3.5 Current Assurance

Assurance for Standard 3 is amber for access equity, outcome measures and workforce-sensitive services. There is clear evidence of clinical review, service redesign, professional oversight, vaccination governance, enhanced service review and forensic medicine improvement, with the portfolio responding to gaps through alternative delivery models.

Clinical effectiveness is actively managed, but evidence remains inconsistent across services and localities. Priorities include outcome measures, access equity, patient experience, locality variation, dental workforce resilience, LARC sustainability, CTAC reporting, vaccination uptake and forensic medicine documentation and audit readiness.

3.6 Areas for Growth and Next Steps

Area for growth	Why this matters	Next step	RAG
Clinical effectiveness measures	Current assurance is often based on activity, service redesign and professional judgement rather than consistent outcome, access and patient experience measures.	Define core clinical effectiveness measures for priority services, including access, uptake, outcomes, patient experience and escalation triggers.	**Amber**
LARC access and sustainability	Withdrawal from enhanced service contracts has created a local access gap in Cowal and increased travel burden for patients.	Implement and evaluate the Cowal managed service model, including demand, capacity, clinical governance, uptake, patient	**Amber**

		feedback and sustainability measures.	
Public Dental Services workforce and utilisation	Workforce fragility, absence and clinic cancellations reduce access, continuity and clinical capacity, with particular impact on remote and island communities.	Progress the locum dental bank, strengthen capacity modelling, monitor utilisation and waiting times, and agree escalation thresholds for access risk.	**Amber**
Mobile dental and island access	Loss of the mobile dental unit has reduced local NHS dental access for remote and island communities and contributes to inequity.	Progress the shared capital bid for a towable mobile dental trailer and define service model, staffing, governance and utilisation measures.	**Amber**
Vaccination uptake and variation	Declining or variable uptake may affect population health outcomes and widen inequalities if not actively monitored and addressed.	Continue uptake monitoring through vaccination oversight groups and develop targeted improvement activity where age-point, locality or population variation is identified.	**Amber**
CTAC clinical effectiveness reporting	Access, waiting time, demand, capacity and outcome data are not yet consistently captured across all sites.	Use the CTAC service specification review to define effectiveness measures and routine reporting for access, activity, outcomes and escalation.	**Amber**
Forensic Medicine documentation and audit readiness	Variation in clinical records and system use limits assurance on documentation quality, inspection readiness and clinical audit capability.	Complete Police Adastra implementation, standardise documentation and audit processes, and monitor training compliance across custody healthcare areas.	**Amber**
Enhanced service contract review	Enhanced services support care closer to home, but effectiveness is not always evidenced through consistent access, uptake, quality and outcome measures.	Ensure future enhanced service reviews include clinical effectiveness indicators, equity analysis, patient impact and post-implementation review.	**Amber**

Standard 4: Clinical Safety and Risk Management

Healthcare Improvement Scotland defines clinical safety and risk management as systems to identify, assess, manage, learn from and escalate risks, adverse events, complaints and safety concerns. In Primary Care, assurance is drawn from multiple routes, including Datix, complaints, SAERs, risk registers, IPC audits, service governance meetings, contractor assurance, programme boards and professional escalation. The key question is whether these processes operate as one coherent system that captures harm, embeds learning, reduces recurrence and escalates risk proportionately.

Current safety and risk arrangements are established and functioning, with strengths in complaints handling, adverse event review, IPC audit, QPS reporting, risk register review, dental governance, SMT oversight, clinical governance and emerging out-of-hours governance. However, learning and escalation are not yet consistently visible across the portfolio. Risks are known and managed, but thematic learning, overdue risk reviews, exception reporting and evidence of closed-loop improvement need further strengthening.

HIS Standard 4 requirement	Current assurance	RAG	Action required
Identify, assess and manage clinical safety risks across services.	Risks are captured through the Primary Care risk register, local team review, SMT oversight, Datix, complaints, SAER processes, QPS reporting and service-specific governance routes. However, some risk reviews have expired due to staff absence, and risk maturity varies between service areas.	**Amber**	Complete overdue risk reviews, strengthen routine review discipline and confirm escalation thresholds for high-risk services.
Learn from complaints, adverse events, incidents and near misses.	Complaints, Datix and SAER processes are active. Examples of learning include changes to 2C dispensing storage arrangements, follow-up arrangements for patients affected by locum provision, and dental extraction risk counselling. However, learning trackers are still developing and thematic learning is not consistently visible.	**Amber**	Implement portfolio-wide learning trackers that record theme, action, owner, timescale, outcome, evidence of improvement and route for shared learning.
Escalate safety concerns through appropriate clinical and governance routes.	Escalation routes exist through local management, Primary Care SMT, QPS, clinical governance, SLT and Board routes where required. Out-of-hours governance arrangements are being developed through a dedicated operational group aligned to Pan-Highland assurance.	**Amber**	Implement standardised exception reporting and ensure escalation routes are documented, understood and used consistently across directly managed, contracted and B2B services.
Maintain safe care environments through infection prevention and control arrangements.	Routine SICP audits are undertaken across services, with an annual audit schedule and monthly audit activity in line with national requirements. Findings and actions are followed up locally.	**Green**	Formalise IPC reporting metrics through clinical and care governance so that trends, exceptions and actions are visible at portfolio level.
Ensure significant adverse events are reviewed and learning is shared.	Two SAERs are ongoing in relation to primary care provision and are being managed in line with relevant A&B policies and frameworks. Learning will be shared through clusters and clinical governance once reviews are complete.	**Amber**	Track SAER actions through governance routes and ensure learning is shared across clusters, services and professional groups once reviews are concluded.

4.1 Complaints

Complaints provide an important safety and experience signal. Average monthly complaints are around two per service, or three for 2C practices. Volumes rose in February and March 2026, mainly linked to Skipness Satellite Surgery service changes, before returning to usual levels in April. The earlier increase should still be treated as an early warning on service change, communication and community confidence. It should be noted that the data presented below is reflective of the 25/26 data set, the process of pulling the information required manual extraction, further repeat of the exercise has been limited due to the transition to Healthcare Guardian although the active complaints position continues to be kept under review at operational level.

Primary Care performance broadly aligns with 2024/25 national complaints metrics. Upheld complaints can reflect transparent scrutiny and learning, but the higher upheld ratio in dental services needs further review. Only 8% of dental complaints were not upheld, with another 8% still open, which may indicate responsiveness or recurring issues in delivery, communication, expectations or documentation, active monitoring and oversight is ongoing to track any notable trends and ensure a proportionate response.

Two Primary Care SAERs are ongoing and being managed under Argyll and Bute policies. Learning should be shared beyond the service or locality involved, through clusters, clinical governance groups and relevant professional groups once reviews are complete.

Stage 1 /2 / MSP Enquiries	Mo																	
	2025									2025 Total	2026				2026 Total	Grand	Percentage of servic	April Trend (Vs 12 month
Row Labels	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr				
Dental Services - Public Dental Services		1	3		2		1	1	1	9	1	1	2		4	13	100%	
Not Upheld		1								1						1	8%	▼
Partially Upheld			2		2					4	1		2		3	7	54%	▼
Not allocated			1				1	1	1	4						4	31%	▼
Open												1			1	1	8%	▼
General Practice Services - General (non-salaried)			1				1		1	3						3	100%	
Partially Upheld			1							1						1	33%	▼
Not allocated							1			1						1	33%	▼
Open									1	1						1	33%	▼
General Practice Services - General (salaried)	1	2	1	1		2	7	3	3	20	1	9	6	2	18	38	100%	
Fully Upheld							2		1	3		4			4	7	18%	▼
Not Upheld				1		2	1		1	5		1			1	6	16%	▼
Partially Upheld	1	2	1				4	2	1	11		3	4	1	8	19	50%	▼
Not allocated								1		1	1	1	1		3	4	11%	▼
Open													1	1	2	2	5%	▲
Vaccination Service	3	1				1	2	1		8	2		2		4	12	100%	
Fully Upheld	1	1					1			3						3	25%	▼
Not Upheld	1							1		2			1		1	3	25%	▼
Partially Upheld	1									1	1				1	2	17%	▼
Not allocated						1	1			2						2	17%	▼
Open											1		1		2	2	17%	▼
Sexual Health Services - Family Planning						1				1	1	1		1	3	4	100%	
Fully Upheld												1			1	1	25%	▼
Partially Upheld						1				1						1	25%	▼
Not allocated											1				1	1	25%	▼
Open														1	1	1	25%	◀▶
Grand Total	4	4	5	1	2	4	11	5	5	41	5	11	10	3	29	70	100%	

Table 4: Primary Care 12 Month Complaint Position

Complaint Type	Fully Upheld (%)	Partially Upheld (%)
S1	39.6	13.8
S2	21.4	40.3
S2 escalated	27.8	32.2

Table 5: National Complaints Performance 24/25

Complaint themes mainly relate to resolution times, communication, quality of care, and attitude or manner. These reflect the interface between operational pressure, patient expectations, access constraints and communication quality. Remedial action is taken case by case, with staff supported to reflect on learning and improvement.

Complaints learning is informing operational change, including safer 2C dispensing storage, follow-up for patients affected by locum provision, movement toward a salaried GP workforce, and amended dental extraction risk counselling. These examples show learning is acted on, but a portfolio-wide learning tracker is needed to evidence completion, embedding and sustained impact.

4.2 Risk Management

The Primary Care risk register is the main portfolio route for recording and monitoring clinical, operational and service risks. It is reviewed bi-monthly at Primary Care SMT, with additional local team review and new risks added as identified. This provides visibility of risk and an established route for oversight and escalation. The programme of governance review has highlighted that while most areas hold their own local risk registers, not all operational services do, which is a gap. This is being addressed as a matter of urgency.

A risk register alone is not sufficient assurance. Key tests are timely review, current mitigations, completed actions, reassessed residual risk and escalation when risk appetite is exceeded. Two portfolio areas currently have expired reviews due to staff absence, creating an assurance gap until risks are updated and review discipline is restored which is being progressed actively via interim cover arrangements.

Cross-portfolio risks include dental workforce fragility, LARC access, forensic documentation and Adastra implementation, CTAC access data, GPIT migration, engagement and service-change communication. These risks are known and mitigated, but require consistent escalation triggers and exception reporting so service-level pressures are escalated when wider action is needed.

4.3 Infection Prevention and Control

Infection prevention and control assurance is supported through routine audit of Standard Infection Control Precautions across all Primary Care services. There is a defined annual audit schedule, with specific SICPs audited monthly in line with national requirements. Audit findings and actions are monitored and followed up where required, providing assurance of safe care environments.

This is a relative area of strength within Standard 4 because there is an established audit cycle and local follow-up. The area for growth is the visibility of this assurance at portfolio level with one 2c Practice having failed the most recent audit. An improvement plan with associated actions is in place to achieve the required standard in coming months with oversight in place via our professional nursing structure.

Formal reporting metrics through clinical and care governance would strengthen the ability to identify trends, outliers, recurring actions and service-level variation. This would also support the wider Standard 2 requirement for a more integrated quality management system. Adjustments are being made to the standard Primary Care Clinical and Care Governance agenda and paper templates to maximise reporting visibility which will be concluded within three months.

4.4 Clinical and Care Governance

All portfolio services have defined clinical governance reporting and escalation routes. General Practice, Dental Services, CTAC and Forensic Medicine quality and risk are overseen through Primary Care governance structures, with escalation to SLT and

Board routes where required. As Sexual Health develops, its clinical scrutiny and oversight route will be explicitly confirmed to ensure consistent assurance.

Out-of-hours governance is being strengthened through a dedicated Operational Group aligned to the Pan-Highland OOH Urgent and Unscheduled Care Assurance Framework. The group will oversee workforce capacity, rota performance, service pressures, risks and contractor engagement, with clearer escalation and exception reporting. This is important given contractor dependence, remote and rural fragility, and service continuity risks. Operationally, it should be noted that GP OOH does not sit within the primary care portfolio however reporting metrics are being routed via our governance for assurance and oversight, this is a developing picture and processes and reporting structures need to be strengthened through iterative improvement cycles.

4.5 Current Assurance

Assurance for Standard 4 is amber. Safety and risk arrangements are established through complaints handling, adverse event review, Datix, QPS reporting, IPC audit, clinical governance, SMT oversight, dental governance and emerging out-of-hours governance. These controls show that risks are known and actively managed.

The amber rating reflects system maturity, not absence of control. Further work is needed on risk review discipline, learning trackers, thematic analysis, IPC trend visibility, SAER action tracking, exception reporting and consistent escalation across all delivery models. Standard 4 is functioning but needs stronger evidence of closed-loop learning and risk escalation for full assurance.

4.6 Areas for Growth and Next Steps

Area for growth	Why this matters	Next step	RAG
Risk register review discipline	Expired risk reviews reduce confidence that scores, mitigations and escalation routes reflect the current position.	Complete overdue reviews, confirm risk owners and introduce routine exception reporting for overdue or high-scoring risks.	**Amber**
Portfolio-wide learning tracker	Complaints, Datix and SAER learning is active but not consistently visible, tracked or evidenced across the full portfolio.	Develop a learning tracker recording theme, action, owner, timescale, outcome, evidence of improvement and sharing route.	**Amber**
Thematic complaints analysis	Complaint themes provide important signals on communication, access, quality of care and service-change impact.	Introduce quarterly thematic review of complaints, including upheld dental complaints, Skipness service-change feedback and 2C locum-related concerns.	**Amber**
Significant adverse event review learning	SAER learning must be shared beyond the immediate service to reduce recurrence and support portfolio-wide improvement.	Track SAER action plans through governance routes and share learning through clusters, professional groups and clinical governance forums.	**Amber**
Infection prevention and control reporting	Local audit activity is established, but portfolio-level trend, exception and action visibility is limited.	Develop formal IPC reporting metrics for clinical and care governance, including trends, exceptions, completed actions and unresolved risks.	**Green**
Out-of-hours exception reporting	OOH services rely on business-to-business arrangements and require clear escalation for rota, workforce and service continuity pressures.	Establish the OOH Operational Group, agree standardised exception reporting and confirm escalation routes into Pan-Highland assurance structures.	**Amber**
Sexual Health governance route	Service redesign and interim provision require explicit clinical scrutiny, escalation and assurance arrangements.	Confirm the governance route for Sexual Health developments, including SOP review, clinical oversight, risk escalation and patient feedback.	**Amber**

Closed-loop improvement evidence	Actions are being taken, but evidence of completion, impact and sustained improvement is not consistently captured.	Require action logs for complaints, incidents, audits and risk actions to include completion evidence and post-action review.	**Amber**

Standard 5: Education and Training

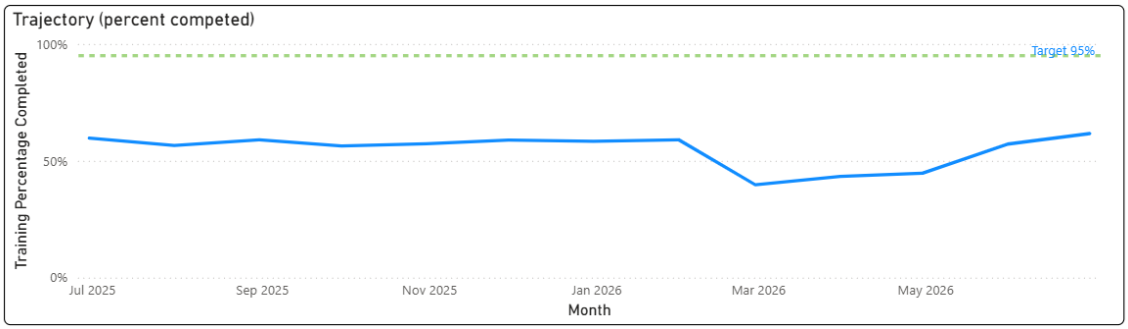
Healthcare Improvement Scotland defines education and training as ensuring staff have the knowledge, skills, competence, supervision and development support needed for safe, effective, person-centred care. In Primary Care, this applies across a mixed workforce, including directly employed teams, Board-managed practice staff, Public Dental Service staff, GPs, appraisers, trainees, advanced practitioners, contracted providers and business-to-business models. The key assurance question is whether learning needs are identified, recorded, delivered, monitored and linked to safe service delivery, governance and workforce sustainability.

The current position provides partial assurance. Strengths include protected learning, BASICS training, advanced practice assurance, Public Dental Service student training and SMT workforce governance reporting. However, statutory mandatory training and PDP compliance remain below the level expected for a mature system and there is a recognised risk in relation to GP appraisal capacity. There has been a reduction in mandatory training compliance following the Once for Scotland module refresh, which is understandable, but recovery plans, trajectories and exception reporting remain active to ensure full assurance can be achieved. Standard 5 should therefore remain amber.

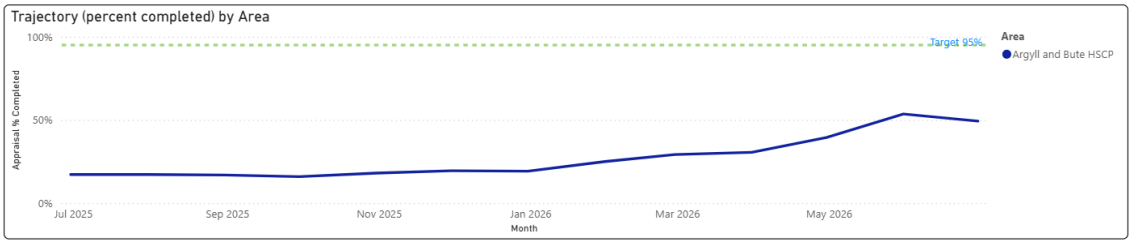
HIS Standard 5 requirement	Current assurance	RAG	Action required
Ensure staff have the knowledge, skills and competence required to deliver safe, effective and person-centred care.	Protected learning, BASICS training, advanced practice assurance, PGD training, professional oversight and local service-specific development activity provide evidence that learning is active across the portfolio. However, competence assurance is not yet consistently recorded across all teams and service models.	**Amber**	Develop a portfolio-wide training and competence matrix for directly managed services, including role-specific requirements, professional oversight and review frequency.
Identify and meet learning and development needs through appraisal, supervision and PDP processes.	PDP compliance is comparatively strong within the HSCP context but remains below desired levels, with Primary Care reported at 30.6% and Dental at 59.3%. This limits assurance that learning needs are consistently identified and followed up.	**Amber**	Set a PDP recovery trajectory, require exception reporting through SMT and ensure line managers use PDPs to identify development, wellbeing and service-risk themes.
Monitor statutory mandatory training compliance.	Statutory mandatory compliance reduced following the Once for Scotland nine-module refresh. Current compliance is 43% for Primary Care and 66% for Dental, compared with previous higher levels.	**Amber**	Agree a recovery plan for statutory mandatory training, including target dates, monthly monitoring, escalation for non-compliance and support for teams affected by workload pressure.
Support clinical and professional development across mixed workforce models.	GP protected learning funding, GP appraisal capacity, NES dental student training and advanced practice assurance are established. However, governance differs across independent contractor, directly managed and training-placement models.	**Amber**	Map professional development routes across GMS, 2C, CTAC, Vaccinations, Dental, Sexual Health and Forensic Medicine, identifying gaps in oversight and escalation.
Ensure education and training supports service resilience and safe delivery.	BASICS training has strengthened emergency response capability in 2C practices, and advanced practice assurance supports safe role scope. However, workforce fragility in small teams means training gaps can directly affect service continuity.	**Amber**	Link training risks to workforce resilience planning, cross-cover arrangements and the Primary Care risk register where competence gaps affect service delivery.

5.1 Mandatory Compliance – Primary Care

Primary Care is showing improvement in mandatory training and appraisal compliance. Since January 2026, focused work has supported staff and leaders to complete these core governance requirements. While meaningful appraisal and staff development should be embedded in day-to-day practice, the increase in formal compliance is encouraging. Local action plans are in place to sustain progress and meet the Executive Team's March 2026 compliance trajectory through to March 2027.



Primary Care Statutory Mandatory Compliance (June 2026)



Primary Care Appraisal Compliance (June 2026)

5.2 General Practice

Continuing Professional Development within GMS practices is supported through a designated protected learning fund, with practices guided to use available resources regularly. This provides an important development route within the independent contractor model and supports clinical learning, peer discussion and quality improvement. However, because allocation and prioritisation of funding are determined by individual practices, the HSCP has limited direct control over the consistency of learning uptake, themes or impact. The assurance opportunity is to strengthen the link between protected learning, cluster priorities, annual practice review, contract assurance and identified governance risks.

The HSCP employs several GP Appraisers with an allocated sessional commitment to deliver 132 appraisals per year. There are currently 142 GPs registered on the performers list who require appraisal, meaning that 10 are currently unallocated. Additional appraisal sessions are provided on an ad hoc basis, although there is a noted uncontrolled spend attached. This indicates a manageable but important capacity gap. Appraisal is a professional governance requirement and should be treated as a core assurance function rather than an optional development activity. A more controlled plan is required to match appraisal demand, capacity and cost.

Educational initiatives are advancing across Board-managed practices and the wider multidisciplinary workforce. Recent BASICS training within 2C practices has strengthened capacity to respond to emergencies and supports safe delivery in remote and rural localities. The Isle of Gigha will operate as a 24/7 BASICS Fixed Resource Model, while Muasdale and Southend has been operating as a fixed resource site

during core operating hours from 1 April. This is a clear strength because it links training directly to service resilience and urgent response capability. The critical requirement is to ensure that competence, refresher training, equipment readiness and operational learning are monitored through the relevant governance routes.

5.3 CTAC and Vaccinations

A risk relating to nursing management structure has been identified, prompting corrective measures to formally align employed practice nurses with the CTAC and Vaccinations professional nursing framework. Organisational change discussions will consider this risk and should establish profession-specific line management structures that secure appropriate CPD, leadership and oversight of staff training. This is an important governance issue because unclear professional lines can weaken competence assurance, supervision, role development and escalation.

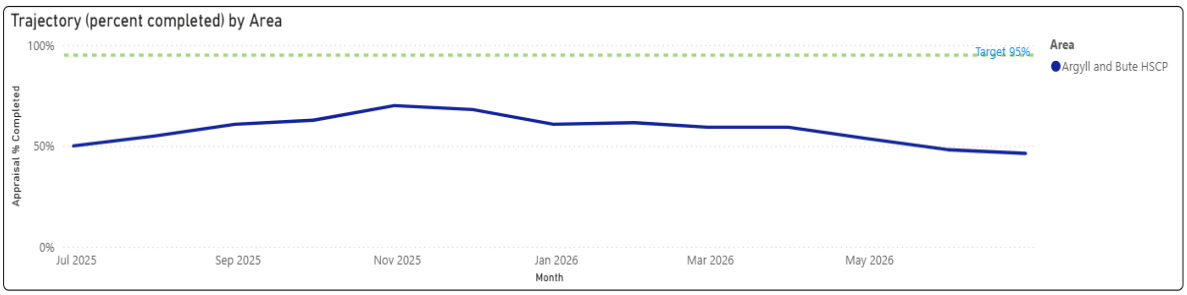
Targeted work has been undertaken to ensure Primary Care Advanced Nurse Practitioners are professionally compliant and competent across the four pillars of advanced practice. This includes assurance of postgraduate education, role scope and clinical competence, supported by appropriate governance and professional oversight arrangements. This provides positive assurance for advanced practice roles, but the same level of explicit competence mapping should be extended, proportionately, to other clinical roles where service delivery depends on defined skills, authorisation or clinical protocols.

Vaccination training and competence are supported through programme-specific requirements, PGDs, audit activity, infection prevention and control processes, and national programme guidance. This provides a strong assurance route for safe vaccination delivery. The area for growth is to ensure that evidence of training, authorisation, refresher requirements and audit learning is consistently visible within the wider Primary Care governance framework rather than held only within programme-level arrangements.

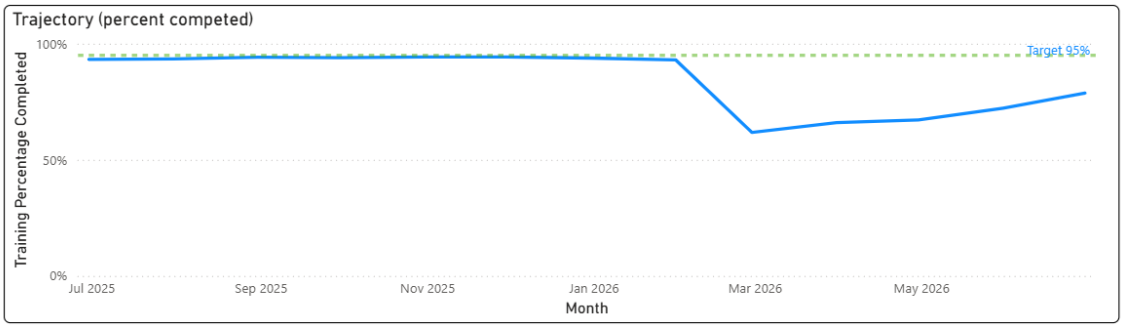
5.4 Dental

Dental workforce metrics are monitored separately and show partial recovery. Appraisal compliance has improved to 50%, but remains below the executive trajectory of 60% by September 2026, with further improvement required to reach the subsequent milestones of 80% by December 2026 and 95% by March 2027.

Statutory mandatory training compliance is also showing recovery following the reduction associated with the Once for Scotland module refresh, but the position remains an assurance gap until sustained improvement is evidenced. The key issue is not simply compliance performance, but whether local action plans, protected learning time, monitoring and escalation are sufficiently robust to deliver the agreed trajectory and ensure staff have the required development, competence and governance support.



Dental Appraisal Compliance



Dental Statutory Mandatory Compliance

Dental education is supported in collaboration with NHS Education for Scotland. A NES visit took place on 30 April 2026 to review the final year dental student Outreach Training Programme, delivered with the University of Glasgow Dental Hospital and School. The reviewers provided positive external assurance. No recommendations were raised, and feedback highlighted the safe working environment, clinical governance arrangements and student experience. This indicates that the training environment is well supported and provides an important contribution to workforce development.

The assessment should, however, be balanced against wider service pressures. The Public Dental Service remains affected by workforce fragility, reduced clinical capacity and access pressures, which may affect supervision capacity and the sustainability of training placements if not actively managed. Continued partnership with NES and the University should therefore focus not only on enhancing student experience and recruiting unregistered patients, but also on ensuring that training activity is aligned with workforce planning, clinic utilisation, patient access and service resilience.

5.5 Current Assurance

Assurance for Standard 5 is proposed as amber. There is evidence of active education and training arrangements across the portfolio, including protected learning, GP appraisal capacity, BASICS training, advanced practice assurance, vaccination training and audit, and positive external feedback from the dental student Outreach Training Programme. These arrangements demonstrate that education and training are valued and are supporting safe service delivery in several areas.

The amber rating reflects the inconsistency of evidence and compliance rather than the absence of training. Statutory mandatory and PDP compliance remain below desired levels, training and competence evidence is not consistently visible across all directly managed services, professional development routes vary across mixed delivery models, and workforce fragility increases the impact of training gaps. The executive assessment is that Standard 5 is functioning but requires stronger recovery planning, competence mapping, exception reporting and linkage between training risk and service resilience.

5.6 Areas for Growth and Next Steps

Area for growth	Why this matters	Next step	RAG
Statutory mandatory training recovery	Current compliance is below desired levels following the Once for Scotland module refresh, creating an assurance gap for safe and compliant service delivery.	Agree a recovery plan with targets, monthly monitoring, team-level exception reporting and escalation for persistent non-compliance.	**Amber**
PDP compliance and learning needs	PDP completion remains below desired levels, limiting assurance that learning, wellbeing and	Set a PDP improvement trajectory and require managers to report completion, themes, barriers and	**Amber**

	development needs are consistently identified and followed up.	actions through SMT workforce governance.	
Portfolio-wide competence matrix	Training and competence requirements vary across CTAC, Vaccinations, 2C, Dental, Sexual Health and Forensic Medicine, and are not yet consistently visible.	Develop a role-based competence matrix covering statutory, mandatory, clinical, professional and service-specific requirements.	**Amber**
GP appraisal capacity and cost control	Appraisal demand exceeds allocated capacity, creating a small but important gap and uncontrolled ad hoc spend.	Review GP appraisal demand, sessional capacity, allocation process and financial controls, with a clear plan to cover unallocated appraisals.	**Amber**
Nursing professional governance and CPD	Unclear nursing management and professional structures can weaken supervision, training oversight, role development and escalation.	Use organisational change work to confirm professional line management, CPD oversight and training escalation routes for practice nurses, CTAC and Vaccinations.	**Amber**
Training linked to service resilience	In small specialist teams, training gaps can directly affect continuity, cross-cover and patient access.	Link training risks to workforce resilience plans, the risk register and cross-cover arrangements for high-risk services.	**Amber**
Vaccination training visibility	Vaccination training, PGD authorisation and audit arrangements are active but may not be visible within the wider Primary Care governance framework.	Report programme-level training, PGD audit and learning through Primary Care governance routes at agreed intervals.	**Green**
Dental training sustainability	Dental student training is externally well assured, but workforce fragility may affect supervision capacity and service access.	Link dental training governance to workforce planning, recruitment, utilisation and access monitoring.	**Green**

Standard 6: Service User and Patient Involvement

Healthcare Improvement Scotland defines service user and patient involvement as systems that meaningfully involve people, carers and communities in designing, delivering, reviewing and improving clinical services. In Primary Care, this is particularly important because local service changes can significantly affect access, confidence, travel, continuity and perceived equity, especially in remote, rural and island communities. The key assurance question is whether involvement is early, proportionate, inclusive, linked to equality and human rights duties, and used to shape decisions before implementation.

The current position provides partial assurance. Strengths include targeted Jura engagement, Sexual Health scoping, emerging Patient Participation Group arrangements, complaints learning and use of Healthcare Improvement Scotland guidance. However, engagement is not yet consistently embedded early in service-change design. Recent engagement in Skipness demonstrates that, even where decisions are justified by safety or workforce issues, timing, framing and communication can materially affect community confidence and perceived legitimacy. Standard 6 should therefore remain amber until a clearer engagement framework, earlier impact assessment and stronger feedback loops are embedded.

HIS Standard 6 requirement	Current assurance	RAG	Action required
Involve people and communities in the design, delivery and improvement of services.	Engagement has informed the Jura out-of-hours model, Sexual Health scoping, Skipness discussions and emerging PPG arrangements. However, engagement is not yet consistently embedded at the earliest stage of service-change planning.	**Amber**	Develop a Primary Care engagement framework setting out when and how people, carers and communities should be involved in service design and review.
Ensure engagement is inclusive and proportionate to the impact of service change.	Public Health support has been secured for Sexual Health scoping to include young people, and Jura engagement reflected remote island need. However, service-change engagement has varied across localities and proposals.	**Amber**	Use proportionate engagement plans for all material service changes, including affected groups, equality impacts, island impacts and communication routes.
Use patient experience, complaints and feedback to inform improvement.	Complaints, community feedback and engagement events are used to inform service responses, including Skipness and 2C service-change learning. However, learning is not yet consistently captured in a portfolio-wide tracker.	**Amber**	Link engagement feedback and complaints themes to the proposed learning tracker and report actions through clinical governance routes.
Ensure children, young people and seldom-heard groups are considered where services affect them.	Sexual Health scoping includes Public Health support and funding to involve young people, aligning with UNCRC expectations. This is a clear strength, but it should become routine where service changes affect children or young people.	**Green**	Embed UNCRC, equality, island and Fairer Scotland considerations into engagement planning and Integrated Impact Assessment processes.
Provide clear communication and feedback to communities about decisions and changes.	Communications have been developed for Jura, Skipness and service-specific changes, but the Skipness experience shows that timing and perceived responsiveness can affect community trust.	**Amber**	Develop a standard communication and feedback approach for service change, including “you said, we did / we cannot because” feedback and escalation for community concern.

6.1 Community Engagement and Service Change

Meaningful community involvement is essential to quality, equity and clinical governance. Primary Care uses complaints, lived experience, local engagement and service-specific consultation to inform improvement, but engagement is not yet consistently embedded at the start of service-change planning.

On Jura, engagement shaped the revised GP Out-of-Hours model launched on 1 April 2026, informing access, pathways and communications. This is a strong example of proportionate, locality-specific engagement supporting safe and sustainable service redesign.

Sexual Health scoping in Cowal and Helensburgh includes Public Health support and funding to involve young people, helping align future service design with UNCRC expectations and local need.

Earlier engagement with some 2C practice communities may have reduced concern around potential changes and mergers. The key learning is that service changes affecting access, continuity or local identity should include an early engagement plan, even where the operational rationale is clear.

6.2 Skipness and Patient Participation Group Development

Skipness is the most significant recent engagement issue. The visiting clinic was paused immediately due to safety concerns, to meet employer responsibilities and ensure safe working arrangements. Although the decision was justified, the sudden pause caused significant community concern and highlighted the need for clear, compassionate and timely communication when local access changes.

Discussions with Healthcare Improvement Scotland and local councillors are ongoing, and a Skipness community engagement event has taken place. The learning is wider than one locality: service changes made for safety, workforce or sustainability reasons can still affect trust if communities cannot clearly understand the rationale, describe impact and influence future options.

The proposed Patient Participation Group for Skipness and the wider Carradale/Kintyre Medical Group population is a positive step from reactive engagement to continuous dialogue, and one which requires further thought to scale across wider areas. Its success will depend on clear remit, realistic expectations, inclusive membership, transparent communication and a route for feedback to influence planning and governance.

6.3 Current Assurance

Assurance for Standard 6 is proposed as amber. There is evidence of meaningful engagement in specific areas, including Jura out-of-hours redesign, Sexual Health scoping, Skipness engagement, complaints learning and emerging Patient Participation Group arrangements. These examples show that the portfolio recognises the importance of community voice and is able to adapt engagement approaches to local circumstances.

The amber rating reflects inconsistency and reactive rather than proactive plans, rather than absence of involvement. Engagement is not yet systematically embedded in all service-change proposals, feedback loops are not consistently documented, Integrated Impact Assessments are not yet routinely linked to engagement planning, and learning from Skipness needs to be translated into a standard approach for future service changes. The executive assessment is that Standard 6 is active but requires a more consistent, earlier and better-evidenced engagement framework to provide full assurance.

6.4 Areas for Growth and Next Steps

Area for growth	Why this matters	Next step	RAG
Primary Care engagement framework	Engagement is currently evident in some service changes but is not yet standardised across the portfolio.	Develop a Primary Care engagement framework setting out engagement triggers, impact levels, approval routes, communication expectations and governance reporting.	**Amber**

Early engagement in service change	Communities are more likely to understand and support change when they are involved before decisions are perceived as fixed.	Require every material service-change proposal to include an early engagement plan before implementation, unless immediate safety action is required.	**Amber**
Skipness learning	The Skipness experience highlights the impact of immediate service change on community trust, confidence and perceived access equity.	Complete a lessons-learned review and incorporate findings into the engagement framework, communication templates and service-change checklist.	**Amber**
Patient Participation Group development	PPG arrangements can support continuous dialogue but require clarity of remit and governance connection.	Establish the Skipness/Carradale/Kintyre PPG with terms of reference, inclusive membership, agreed communication routes and reporting links to service planning.	**Amber**
Integrated Impact Assessment alignment	Equality, island, socio-economic and children's rights considerations need to be embedded in engagement planning.	Align engagement plans with Integrated Impact Assessment requirements, including UNCRC, island impacts, Fairer Scotland duties and protected characteristics.	**Amber**
Young people's involvement in Sexual Health	Sexual Health service design affects young people and must reflect rights-based, accessible and confidential care expectations.	Continue Public Health-supported engagement with young people and use findings to inform the Sexual Health service model and SOP review.	**Green**
Feedback loops and "you said, we did" reporting	Communities need to see how feedback has been considered, including where requests cannot be met.	Introduce a standard feedback process for service-change engagement, including "you said, we did / we cannot because" summaries.	**Amber**
Portfolio-wide learning from engagement	Engagement learning is valuable but not yet consistently captured or shared across services.	Add engagement themes and actions to the portfolio learning tracker and report through clinical governance and SMT routes.	**Amber**

Standard 7: Data and Information

HIS defines data and information as the systems supporting safe, effective, person-centred care through accurate records, secure governance, reliable systems and meaningful reporting. In Primary Care, multiple clinical systems are used across services, so assurance must cover both safe information handling and whether data is accurate, accessible, comparable and useful for care, improvement, risk management and executive assurance.

There is reasonable assurance on information governance, with DPIAs, information asset registers, retention, archiving and GPIT oversight in place. However, data maturity is uneven: controls are stronger than routine use of data for quality, access, outcomes, equity and trend reporting. Standard 7 is green for core information governance, with amber direction of travel for data quality, interoperability and assurance reporting.

HIS Standard 7 requirement	Current assurance	RAG	Action required
Maintain accurate, accessible and secure clinical records.	Clinical systems are in place across services and DPIAs, information asset registers, retention and archiving arrangements support safe management of records. However, system variation creates inconsistency in record visibility, data extraction and reporting.	**Green**	Maintain DPIAs, information asset registers and retention processes, and strengthen standardisation of record-keeping expectations across service areas.
Use data and information to support safe, effective and person-centred care.	Data is used through IPMF, vaccination uptake, complaints, adverse events, GMS returns, workforce metrics, audit and programme reporting. However, data is not yet consistently available across all services to evidence access, outcomes, equity or improvement over time.	**Amber**	Define minimum datasets and dashboard requirements for priority services, with focus on access, outcomes, equity, demand, capacity, learning and improvement.
Ensure clinical systems are reliable and support continuity of care.	GPIT migration to nationally hosted Vision is being managed through NHS Highland eHealth and GPIT Programme Board oversight. Rollout was paused following concerns about degraded performance and loss of access, then resumed with improved user experience.	**Amber**	Continue GPIT migration oversight, ensure issues are escalated through Digital Governance and Programme Board routes, and capture service impact, downtime and learning.
Support appropriate information sharing across services and governance routes.	Information governance arrangements are in place across managed and contracted services, but data sharing remains complex across independent contractor, directly managed and business-to-business models.	**Amber**	Clarify information-sharing expectations across service models and ensure SOPs, service specifications and contracts include proportionate data and reporting requirements.
Use data to support assurance, improvement and decision-making.	Data supports some assurance reporting, but the paper identifies repeated gaps in CTAC access data, dental utilisation and waiting times, forensic Adastra use, clinical effectiveness metrics and engagement learning.	**Amber**	Develop a Primary Care data improvement plan linked to the Quality Management System, including data definitions, reporting frequency, owners and escalation triggers.

7.1 Information Governance and Clinical Systems

Several clinical record systems are used across the Primary Care portfolio. Data Protection Impact Assessments are in place for clinical systems within managed and

contracted services. Information asset registers, retention arrangements and archiving processes are in place in line with local policies. These arrangements support safe and appropriate storage, sharing and use of personal data and provide reasonable assurance that the core information governance infrastructure is established.

The critical issue is that safe data handling does not, by itself, provide assurance that data is sufficiently usable for clinical governance. Across the paper, several standards identify data gaps that affect assurance, including CTAC access and waiting-time reporting, dental utilisation and locality-level waiting-time data, forensic medicine documentation and audit readiness, clinical effectiveness outcome measures, training compliance recovery trajectories, and engagement learning. These gaps are not simply technical issues; they affect the ability of the system to identify variation, evidence impact, monitor improvement and escalate risk in a timely way.

A national reprovisioning exercise is underway across General Practice, with practices migrating to a nationally hosted Vision environment. NHS Highland eHealth is facilitating the migrations. Concerns about degraded performance and loss of access led to a temporary pause in rollout in February. The pause was agreed by the NHS Highland GPIT Programme Board following consultation with National Services Scotland, suppliers and local GP groups. The migration has subsequently resumed with improved user experience reported. Ongoing escalation will be provided to the Digital Governance Board and the Programme Board as required.

This is a positive example of system risk being identified, escalated and managed. However, GPIT migration remains an important assurance issue because clinical system performance directly affects continuity of care, data quality, prescribing, record access, workload and user confidence. Future reporting should therefore capture not only migration progress, but also service impact, downtime, issue resolution, practice experience and learning for future system changes.

7.2 Data Quality, Reporting and Assurance

Data is used across the portfolio for performance management, workforce governance, risk management, complaints, adverse events, vaccination uptake, audit activity, annual GMS assurance returns, programme reporting and service-specific review. This provides a broad evidence base for governance and assurance. However, the data is currently fragmented across multiple systems and service models, and it is not yet consistently structured around common definitions, reporting cycles or outcome measures.

The most significant assurance limitation is that the portfolio cannot yet consistently demonstrate trends over time across all priority services. This limits the ability to identify deterioration early, compare variation across localities, quantify the impact of service redesign, evidence improvement and provide concise executive assurance. The issue is particularly visible in CTAC access reporting, dental capacity and utilisation, forensic medicine documentation and audit readiness, Sexual Health demand modelling and clinical effectiveness measures.

A Primary Care data improvement plan should therefore be developed as part of the wider quality management system. This should define minimum datasets, common definitions, dashboard requirements, reporting frequency, owners, data sources, assurance routes and escalation triggers. The aim should be proportionate: not every service requires the same level of data collection, but high-risk or high-impact services should have clear, timely and reliable information to support decision-making.

7.3 Current Assurance

Assurance for Standard 7 is proposed as green for core information governance, with an amber direction of travel for data maturity and assurance reporting. Strengths include established DPIAs, information asset registers, retention arrangements, archiving processes, GPIT Programme Board oversight, Digital Governance Board escalation and evidence that system risks are identified and acted upon.

The green assurance position reflects the presence of core controls for safe and lawful information management. The amber direction of travel reflects the fact that data is not yet consistently used to support whole-system assurance, improvement and decision-making across all Primary Care services. The executive assessment is that Standard 7 is compliant and controlled from an information governance perspective, but requires a more systematic data improvement approach to support mature clinical governance.

7.4 Areas for Growth and Next Steps

Area for growth	Why this matters	Next step	RAG
Primary Care data improvement plan	Data gaps are recurring across Standards 2–6 and limit assurance on access, outcomes, equity, learning and improvement.	Develop a Primary Care data improvement plan linked to the Quality Management System and governance assurance programme.	**Amber**
Minimum datasets and definitions	Inconsistent definitions make it difficult to compare services, track variation or provide executive assurance.	Define minimum datasets and common definitions for priority services, including access, demand, capacity, outcomes, patient experience and learning.	**Amber**
Dashboard and reporting routes	Assurance is currently distributed across different returns, programme reports and local systems.	Develop proportionate dashboards for high-risk or high-impact services and agree reporting routes through SMT, clinical governance and programme boards.	**Amber**
GPIT migration oversight	System performance affects continuity of care, record access, prescribing, workload and user confidence.	Continue GPIT Programme Board oversight and report migration progress, downtime, issue resolution, service impact and learning through digital governance routes.	**Amber**
CTAC access and waiting-time data	Lack of standardised data limits assurance on equity, demand, capacity and effectiveness.	Use the CTAC service specification review to define access, waiting-time, demand, capacity and outcome reporting requirements.	**Amber**

8. Final Closing Statement

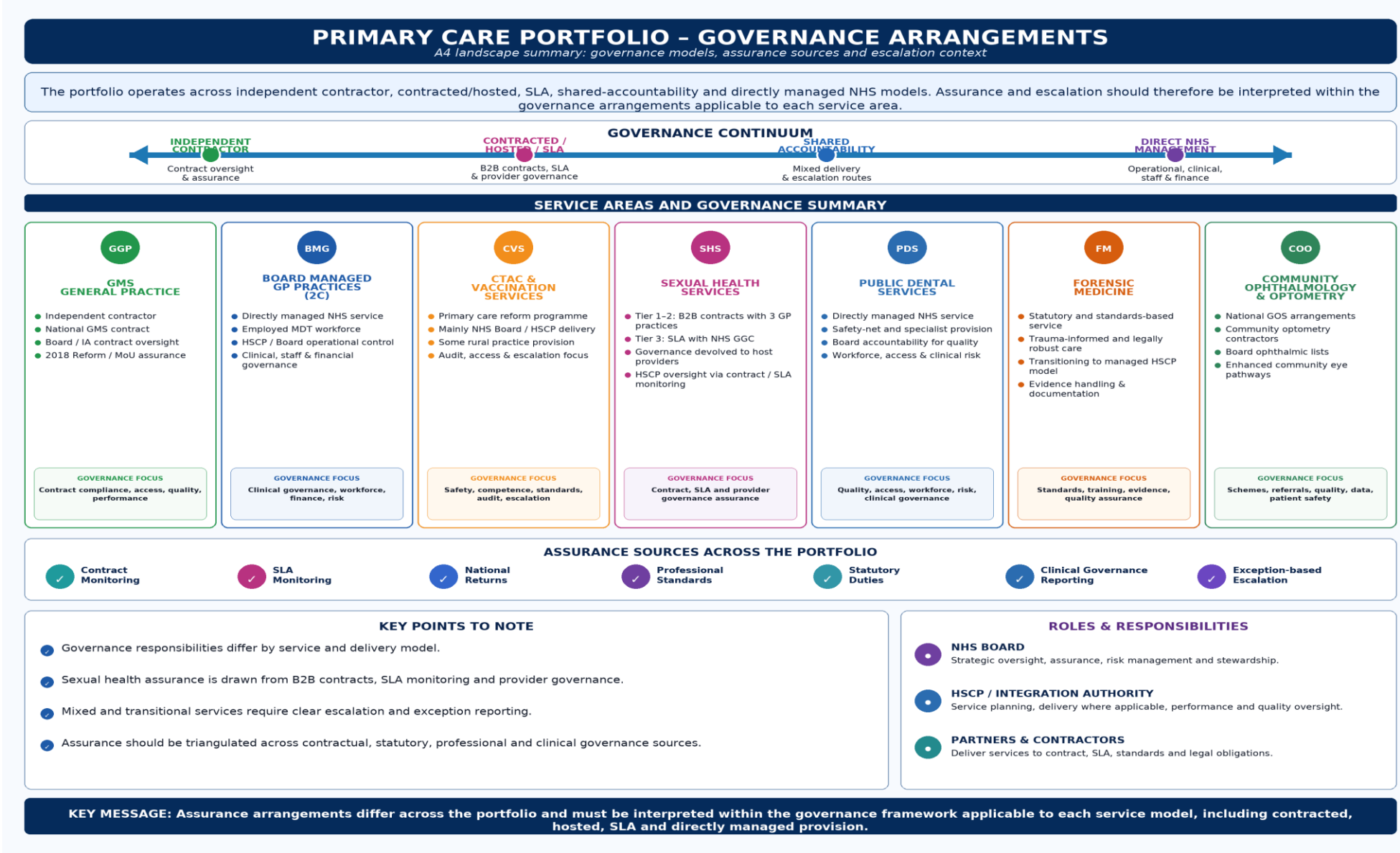
This deep dive provides collective assurance that Primary Care governance arrangements are established, active and broadly aligned to the Healthcare Improvement Scotland Clinical Governance Standards. The review identifies clear strengths across leadership and professional oversight, quality improvement infrastructure, clinical service redesign, risk management, education and training, patient and community engagement, and information governance. It also demonstrates that assurance is not uniform across the portfolio, reflecting the complexity of mixed delivery models, including independent contractor, directly managed, shared-delivery and business-to-business arrangements.

The overall assurance position is therefore reasonable but qualified. Standards 2, 3 and 7 provide broadly green assurance, with amber direction of travel where data maturity, system consistency, access equity and outcome measurement require further development. Standards 1, 4, 5 and 6 are assessed as amber, reflecting the need to strengthen safe staffing implementation, leadership resilience, escalation routes, closed-loop learning, training compliance, competence assurance, and earlier, more consistent service-user and community involvement. This does not indicate an absence of governance controls; rather, it highlights the need to move from established but sometimes fragmented arrangements to a more integrated, evidence-led and sustainable governance assurance framework.

Priority actions are being identified into a single improvement plan with named owners, timescales, reporting routes, RAG status and escalation triggers for delivery over the next twelve months. The key actions include completing Health and Care Staffing Act baseline assessments; finalising organisational mapping and escalation arrangements; developing a whole-system Primary Care quality management system; defining minimum datasets and dashboards; strengthening CTAC, dental, forensic medicine and sexual health reporting; implementing learning trackers for complaints, Datix, audits and SAERs; improving statutory mandatory training and PDP compliance; developing a portfolio-wide competence matrix; embedding early engagement and Integrated Impact Assessment requirements into service-change planning; and strengthening the use of data to evidence access, outcomes, equity, patient experience and improvement over time.

The Clinical and Care Governance Group is asked to note the assurance provided, endorse the proposed areas for growth, and support a twelve-month review of progress. This will allow the group to confirm that improvement actions are being delivered, risks are being escalated appropriately, and the Primary Care governance assurance framework is maturing in line with the HIS standards and the strategic ambition to deliver safe, effective, person-centred and sustainable care closer to home.

Appendix 1 : Visual Governance Summary



Appendix 2: Clinical Governance Standards Self-Assessment Summary

1. Overview

Standard	Position
Standard 1: Leadership and Staffing	Good
Standard 2: Quality Management and Continuous Improvement	Good
Standard 3: Clinical Effectiveness	Good
Standard 4: Clinical Safety and Risk Management	Good
Standards 5–7	In progress

2. Summary of Key Strengths

Established governance and reporting arrangements across Primary Care
Active management of risk, complaints, incidents and service performance
Ongoing quality improvement and service redesign activity
Alignment to national standards, contracts and clinical guidance
Positive organisational culture and staff engagement
Implementation of a structured Governance Assurance Programme

3. Key Themes Identified

Consistency
Variation in governance processes across services, including risk management, quality improvement and clinical documentation
Visibility of Evidence
Governance arrangements are in place but are not consistently documented or easily accessible
Data and Monitoring
Fragmented datasets and limited standardised indicators across services
Learning and Feedback
Learning from incidents, complaints and audits is not consistently captured, shared or tracked
Escalation and Assurance
Escalation routes are in place but require greater clarity and consistency across services

4. Priority Areas for Improvement

Development of a central governance repository
Standardisation of governance documentation, risk registers and SOPs
Definition of minimum datasets and core indicators
Strengthening thematic learning and feedback processes
Improved visibility and use of safety, quality and performance data
Clear escalation triggers and early warning indicators

5. Overall Position

The self-assessment indicates that governance arrangements across Primary Care are established and functioning. The Governance Assurance Programme provides a structured route to strengthen consistency, evidence visibility and sustainability of assurance. The current position should be treated as a baseline from which further improvement will be delivered as the programme progresses.

Appendix 3 : Enhanced Service Provision (25/26)

Area	List Size		Enhanced Service													
			Minor Surgery - Injections	Minor Surgery - Invasive	Minor Surgery - Varicose Veins & Piles	Extended Hours Access	Palliative Care	Drug Misuse	Anti-coagulation Monitoring	IUCD Fittings	IUCD Fittings – Non Patients	Implants – Non Patients	Basket of Services	Older Patients in Care Homes	Medicines Reconciliation	Minor Injury
Argyll and Bute	90,718.00	% Population with access	91%	91%	13%	31%	69%	61%	87%	100%	100%	100%	93%	82%	NA	11%
OLI	23,503	% Population with access	96%	95%	0%	36%	100%	91%	95%	100%	100%	100%	100%	91%	NA	20%
MAKI	21,078.00	% Population with access	97%	97%	6%	26%	57%	0%	99%	100%	100%	100%	92%	77%	NA	26%
Cowal & Bute	21,598.00	% Population with access	88%	88%	45%	17%	31%	69%	53%	100%	100%	100%	98%	81%	NA	0%
Helensburgh & Lomond	24,539.00	% Population with access	83%	83%	5%	43%	83%	78%	100%	100%	100%	100%	83%	78%	NA	0%