A meeting of the **Forth Valley NHS Board** will be held on **Tuesday 25 March 2025** at **9.30am** in the **Boardroom, Carseview House, Castle Business Park, Stirling FK9 4SW**.

Neena Mahal
Chair

AGENDA

1.	**Welcome, Apologies and Confirmation of Quorum**		**09.30**
2.	**Declaration(s) of Interest(s)**		
3.	**Minute of Forth Valley NHS Board meeting held on 28 January 2025**	For Ratification **Pages 5 to 25**	
4.	**Matters Arising from the Minute / Action Log**	For Approval **Pages 26 to 30**	
5.	**Chair's Report** (Verbal update by Ms Neena Mahal, Board Chair)	For Discussion	
6.	**Board Executive Team Report** (Paper presented by Professor Ross McGuffie, Chief Executive)	For Discussion **Pages 31 to 35**	
7. COMMITTEE MINUTES AND AN OPPORTUNITY FOR COMMITTEE CHAIRS TO HIGHLIGHT MATERIAL ISSUES TO THE BOARD			
	Governance Committee Minutes		**09.45**
7.1	**Audit & Risk Committee – 24 January 2025** (Presented by Cllr Fiona Collie, Committee Chair)	For Noting **Pages 36 to 43**	
7.2	**Clinical Governance Committee – Minute of Meeting of 7 January 2025 and Verbal Update from Meeting of 11 March 2025** (Presented by Dr Michele McClung, Committee Chair)	For Noting **Pages 44 to 56**	
7.3	**Staff Governance Committee – Minute of Meeting of 13 December 2024 and Verbal Update from Meeting of 14 March 2025** (Presented by Mr Martin Fairbairn, Committee Chair)	For Noting **Pages 57 to 69**	
7.4	**Strategic Planning, Performance & Resources Committee – Minute of Meeting of 25 February 2025** (Presented by Ms Neena Mahal, Committee Chair)	For Noting **Pages 70 to 89**	
	Advisory Committee Minutes		
7.5	**Area Clinical Forum – 16 January 2025 and Verbal Update from Meeting of 13 March 2025** (Presented by Ms Kirstin Cassells, ACF Chair)	For Noting **Pages 90 to 95**	

7.6	**Area Partnership Forum Minute – 17 December 2024 and Verbal Update from Meeting of 25 February 2025** (Presented by Mr Robert Clark, APF Co-Chair)	For Noting **Pages 96 to 102**	
	FOR APPROVAL		
8.	**Strategic Risk Register Update – January – March 2025** (Paper presented by Ms Vicky Webb, Corporate Risk Manager)	For Approval **Pages 103 to 125**	**09.55**
9.	**Health and Care Staffing Act Annual Report** (Paper presented by Professor Frances Dodd, Executive Nurse Director)	For Approval **Pages 126 to 145**	**10.05**
10.	**a) Finance Report** (Paper presented by Mr Scott Urquhart, Director of Finance) **b) Draft Financial Plan 2025/26 to 2027/28** (Paper presented by Mr Scott Urquhart, Director of Finance)	For Approval **Pages 146 to 162** For Approval **Pages 163 to 190**	**10.15**
11.	**Draft NHS Forth Valley Corporate Objectives** (Paper presented by Professor Ross McGuffie, Chief Executive)	For Approval **Pages 191 to 196**	**10.35**
12.	**a) Update on Communication Priorities 2025/2026** (Paper presented by Mrs Elsbeth Campbell, Head of Communications) **b) Participation & Engagement Strategic Framework** (Paper presented by Mrs Elsbeth Campbell, Head of Communications)	For Approval **Pages 197 to 203** For Approval **Pages 204 to 242**	**10.45**
13.	**Board Assurance Framework** (Paper presented by Ms Kerry Mackenzie, Acting Director of Strategic Planning & Performance)	For Approval **Pages 243 to 259**	**11.00**
	BREAK 11.15 to 11.30		
14.	**Code of Corporate Governance – Annual Review** (Paper presented by Mr Jack Frawley, Board Secretary)	For Approval **Pages 260 to 474**	**11.30**
15.	**NHS Forth Valley Blueprint for Good Governance Board Development Plan:** **(a) Progress Against Actions from the 2024/25 Plan,** **(b) 2025/26 Board Development Plan** (Paper presented by Ms Neena Mahal, Board Chair)	For Approval **Pages 475 to 487**	
16.	**Board Schedule of Business 2025/26** (Paper presented by Mr Jack Frawley, Board Secretary)	For Approval **Pages 488 to 491**	
	FOR DISCUSSION AND ASSURANCE		
17.	**Population Health & Care Strategy Development** (Paper presented by Ms Kerry Mackenzie, Acting Director of Strategic Planning & Performance)	For Assurance **Pages 492 to 494**	**11.50**

18.	**Patient/Staff Story – Out of Hours Service** (Paper presented by Mr Andrew McCall, Out of Hours Service Manager)	For Assurance **Pages 495 to 504**	**12.00**
19.	**GP Primary Care Sustainability Update Report** (Paper presented by Ms Gail Woodcock, Chief Officer Falkirk Integration Joint Board)	For Assurance **Pages 505 to 511**	**12.20**
20.	**Power Outage – Forth Valley Royal Hospital 24 January 2025** (Paper presented by Mr Garry Fraser, Director of Acute Services and Mrs Nicola Watt, Emergency Planning & Resilience Manager)	For Assurance **Pages 512 to 517**	**12.45**
21.	**Update on Safety:** **(a)** **Quality Assurance and Improvement Report** (Paper presented by Mr Andrew Murray, Medical Director and Professor Frances Dodd, Executive Nursing Director) **(b)** **Healthcare Associated Infection (HAI) Reporting Template February 2025** (Paper presented by Mr Jonathan Horwood, Area Infection Control Manager)	For Assurance **Pages 518 to 536** **Pages 537 to 562**	**12.55**
22.	**Performance Report** (Paper presented by Ms Kerry Mackenzie, Acting Director of Strategic Planning & Performance)	For Assurance **Pages 563 to 582**	**13.10**
23. INTEGRATION JOINT BOARD MINUTES			
23.1	**Minute of Clackmannanshire & Stirling Integration Joint Board – 20 November 2024** (Paper presented by Cllr David Wilson, Clackmannanshire & Stirling IJB Chair)	For Information **Pages 583 to 598**	
23.2	**Minute of Falkirk Integration Joint Board – 29 November 2024** (Paper presented by Cllr Fiona Collie, Falkirk IJB Chair)	For Information **Pages 599 to 611**	
24. ANY OTHER COMPETENT BUSINESS			
25. RISKS AND REFLECTIONS			
26.	**Date and Time of Next Meeting** Tuesday 27 May, 9.30am	For Noting	

Forth Valley NHS Board
Record of Attendance: April 2024 to March 2025

MEMBERS	28 May	18 June	30 July	24 September	26 November	28 January	25 March
Neena Mahal (Chair)	✓	✓	✓	✓	✓	✓	
Kirstin Cassells	✓	✓	✓	✓	X	✓	
Robert Clark	✓	✓	✓	✓	✓	✓	
Fiona Collie	X	X	✓	✓	X	✓	
Amanda Croft (until 24 September 2024)	X	X	✓	✓			
Frances Dodd	✓	✓	✓	✓	✓	✓	
Martin Fairbairn	✓	✓	✓	✓	✓	✓	
Graham Foster	X	X	X	X	X	X	
Wendy Hamilton (until 7 March 2025)	✓	✓	X	✓	X	X	
Gordon Johnston	X	X	✓	✓	✓	✓	
Stephen McAllister	✓	✓	✓	✓	✓	✓	
Michele McClung	✓	✓	✓	✓	✓	✓	
Gerry McGarvey (until 30 July 2024)	✓	✓	✓				
Ross McGuffie (from 26 November 2024)					✓	✓	
Andrew Murray	✓	✓	✓	✓	✓	✓	
Allan Rennie	✓	✓	✓	✓	✓	✓	
John Stuart	✓	✓	✓	✓	✓	✓	
Scott Urquhart	✓	✓	X	✓	✓	✓	
David Wilson (from 26 November 2024)					✓	X	

Key:

✓ In attendance
X Apologies
O Non-attendance

FORTH VALLEY NHS BOARD

3. Minute of the Forth Valley NHS Board Meeting held on Tuesday 28 January 2025
For: Ratification

Minute of the Forth Valley NHS Board Meeting held on Tuesday 28 January 2025 at 9.35am in the Boardroom, Carseview House.

Present:
Ms Neena Mahal (Board Chair)
Ms Kirstin Cassells (Non-Executive Director)
Mr Robert Clark (Non-Executive Director)
Cllr Fiona Collie (Non-Executive Director)
Professor Frances Dodd (Executive Nurse Director)
Mr Martin Fairbairn (Non-Executive Director)
Mr Gordon Johnston (Non-Executive Director)
Mr Stephen McAllister (Non-Executive Director)
Dr Michele McClung (Non-Executive Director)
Professor Ross McGuffie (Chief Executive)
Mr Andrew Murray (Medical Director)
Mr Allan Rennie (Vice Chair)
Mr John Stuart (Non-Executive Director)
Mr Scott Urquhart (Director of Finance)

In Attendance:
Mrs Beth Allan (Corporate Services Assistant)
Ms Elsbeth Campbell (Head of Communications)
Dr Jennifer Champion (Acting Director of Public Health)
Mrs Morag Farquhar (Director of Facilities)
Mr Garry Fraser (Director of Acute Services)
Ms Janette Fraser (Head of Strategic Planning) (item 14)
Mr Jack Frawley (Board Secretary)
Professor Karen Goudie (Director of Nursing)
Mr Jonathan Horwood (Area Infection Control Manager) (item 11b)
Mr Scott Jaffray (Director of Digital)
Ms Sara Lacey (Chief Social Work Officer, Falkirk Council) (item 13.2)
Ms Joanna MacDonald (Interim Chief Officer, Clackmannanshire & Stirling HSCP)
Ms Kerry Mackenzie (Acting Director of Strategic Planning & Performance)
Ms Jackie McEwan (Corporate Business Manager)
Dr Julie Mardon (Clinical Director Scottish Centre Simulation and Clinical Human Factors) (item 10)
Mr Kevin Reith (Director of People)
Ms Tanya Somerville (Head of Service Medical Education) (item 10)
Mr Martin Thom (Head of Integration) (item 13.2)
Ms Jillian Thomson (Deputy Director of Finance)
Ms Jo Tolland (Programme Director - Culture Change & Compassionate Leadership Programme) (item 18)
Ms Vicky Webb (Corporate Risk Manager) (item 7)
Ms Gail Woodcock (Chief Officer, Falkirk HSCP)

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1. Welcome, Apologies for Absence and Confirmation of Quorum
The Chair welcomed all present to the meeting.

Apologies had been received from Cllr Wendy Hamilton and Cllr David Wilson. The Board meeting was quorate.

2. Declarations of Interest

There were no declarations of interest.

Statement on the Determination of the Fatal Accident Inquiry (FAI) Katie Allan and William Brown

The Board Chair addressed the Board in relation to the recent determination of the Fatal Accident Inquiry and again offered the Board's heartfelt condolences to the families of Katie Allan and William Brown and apologised for the failures relating to healthcare services highlighted in the recent FAI report. She indicated that a number of issues had been identified, and recommendations made in relation to the prison healthcare services provided. She invited the Chief Executive to set out the work which had taken place since 2018 and the ongoing work to improve and strengthen healthcare services across the three prisons.

The Chief Executive also apologised to the families of Katie Allan and William Brown. He assured the Board that NHS Forth Valley had not waited on the findings of the FAI to address the issues, and a number of actions were taken in 2018 with many other changes made over the last six years to improve and strengthen prison health services and support in all three national prisons in the Forth Valley area.

20 of the 21 healthcare related recommendations from the Expert Review on Mental Health Services for Young People at HMP YOI Polmont, which was published in May 2019, had been addressed with the final recommendation to be finalised for sign off. Work was now underway, supported by the Central Legal Office, to carefully consider the recommendations from the FAI to identify any additional actions required to further improve prison healthcare services and support the mental health and wellbeing of young people. An action plan would be submitted to the Clinical Governance Committee which would also monitor updates on progress made.

3. Minute of Forth Valley NHS Board Meeting held on Tuesday 26 November 2024

The minute of the meeting held on 26 November 2024, subject to previous electronic circulation and Board member approval, was **confirmed** as a correct record, subject to an amendment to item 11(a) to reflect Mr Johnston's term as Chair of the Falkirk IJB commences 1 May 2025.

4. Matters Arising from the Minute / Action Log

The Action Log was **reviewed** by the Board Chair and consideration was given to the actions still in progress. Board Members noted all updates and timeframes for actions 039, 048, 049, 055, 058, 059 and 060.

Board members noted that all other actions, 015, 053, 054, 056, 057, 061, 062 and 063, were marked as complete and would be removed from the Action Log.

The Forth Valley NHS Board noted the Action Log.

5. Chair's Report – Verbal Update by Ms Neena Mahal

The Board Chair highlighted the following:

(a) There had been two Ministerial visits to Forth Valley Royal Hospital. The First Minister, on 2 December 2024, had visited Planned Care and the National Treatment Centre service. The Cabinet Secretary for Health & Social Care

had, on 23 January 2025, visited the Emergency Department. The Board Chair noted her thanks to all staff who had showcased their excellent work and made these visits a success.

(b) There had been a Board Seminar on 3 December 2024, facilitated by colleagues from NES, on Active Governance. There was good learning from the session and the Board Assurance Framework would be presented to the Board in March. Upcoming Board Seminars would be held on Thursday 6 February regarding Value Based Health & Care, and on Tuesday 11 February regarding Equality, Diversity and Inclusion.

(c) The Board Chair had undertaken a number of very valuable visits including to the Sim Safety Club, local GP Practices and a Patient Safety Conversation Visit with the Director of People to Acute Dietetics. She had also attended a meeting of the Area Clinical Forum, visited Outpatients and met with the Public Health team.

(d) An update was given on Non-Executive Recruitment. Shortlisting had now been completed with interviews taking place in mid to late February.

(e) The Board Chair noted her thanks to all staff at Forth Valley Royal Hospital, across the Health and Social Care Partnerships and partners who had attended and worked in very challenging conditions with a Red Severe Weather Warning in place for Storm Eowyn and the power outrage at the hospital. The efforts of staff and partner organisations was outstanding and had kept patients safe from harm.

The Forth Valley NHS Board noted the update from the Board Chair.

6. Board Executive Team Report

The Forth Valley NHS Board considered the Board Executive Team report, presented by Professor McGuffie, which provided an update on service areas celebrating success, key areas of activity by the Senior Leadership Team, and upcoming issues.

The Chief Executive also provided a verbal update on the response to the Storm Eowyn Severe Weather event on Friday 24 January and into the weekend. As there was guidance to not travel a number of outpatient procedures had been cancelled which had limited the number of people travelling. There had been a power outage at Forth Valley Royal Hospital and a gap in the generators operating which required to be restarted manually while the further contingency of battery power kept key systems operational. An incident team was instituted onsite along with the presence of the Chief Executive and key senior colleagues. A full review of the incident would be undertaken by NHS Forth Valley and SERCO with debriefs scheduled for later in the week. It had been a significantly challenging circumstance and all learning from the resilience response would be sought and actioned. The Chief Executive highlighted the work of community-based staff who worked in very challenging circumstances across the weekend including delivering services to people who had no power during that whole period. He thanked all staff involved who had protected patients from harm.

Key messages in the report included:

(i) A number of areas of success including at the Scotland's Health Awards, the Adult Diabetes Team won Project of the year and the Community Pharmacy Team winning Hospital Pharmacy Team of the Year.

(ii) Forth Valley had joined the national Discharge Without Delay Collaborative. The collaborative, led by NHS Tayside, provided a strong framework for improving whole system flow and unscheduled care performance. Four key areas would be explored – integrated discharge planning; home first approaches; community bed model; and frailty at the front door. These components would be built into the Unscheduled Care /Delayed Discharge Improvement Plan.

(iii) The Draft Financial Plan, Review of Corporate Governance documents, draft Digital Plan and Corporate Objectives would all be presented to future meetings of the Board.

The following points were made in discussion:

(i) A question was asked on how the learning from Storm Eowyn would be reported to Board Members and the current status of damage to Cowie Health Centre and damage to any other premises. In response, the Director of Facilities advised that there had been some damage to the roof and windows at Cowie Health Centre and Bellsdyke Hospital and a fuller update would be provided outwith the meeting. The Service had primed the roofing contractor in advance and expected a quick resolution to the issues raised.

(ii) Members sought an update as to whether, in relation to winter pressures, 5 beds were now back in place in 4 bedded wards. The Chief Executive advised that on 6 January there had been 1 in 6 beds occupied by a patient with flu. The system impact had been extreme and Forth Valley saw the highest flu numbers in 15 seasons. There had been two weeks of good decompression on the site to quickly come out of 5 bedded areas. However, the impact of Storm Eowyn had impacted on progress and the Gold Command structure was in place to ensure a whole system response to the additional pressures. The additional beds would be removed as soon as possible.

(iii) There was a question on why there were issues with the generators at Forth Valley Royal Hospital despite recent tests. The Chief Executive noted that a full debrief would be presented to the Strategic Planning, Performance and Resources Committee along with an understanding of the resilience arrangements. Staff had responded in a very positive way to the challenges and had delivered services to ensure there was no patient harm.

The Forth Valley NHS Board noted the report and commended the response of staff across the system in dealing with the impact of Storm Eowyn.

Action:

(1) The outcomes of the investigation and debrief from Storm Eowyn to be reported to the Strategic Planning, Performance and Resources Committee. Ross McGuffie

7. Strategic Risk Register Update – October – January 2025

The Forth Valley NHS Board considered a report for approval, presented by Ms Webb which provided an update to the Strategic Risk Register for the period of October 2024 to January 2025.

Key messages in the report included:

(i) Over the reporting period all strategic risks remained static.

(ii) Two Focused Reviews had been conducted in the quarter on: SRR009 Workforce Planning, and SRR010 Estates & Supporting Infrastructure.

(iii) The closure of strategic risk SRR014 Healthcare Strategy had been endorsed by the Strategic Planning, Performance & Resources Committee at its meeting of 17 December 2024.

(iv) The closure of strategic risk SRR016 Out of Hours had been endorsed by the Clinical Governance Committee at its meeting of 7 January 2025.

(v) The Strategic Risk Register was appended to the report.

The following points were made in discussion:

(i) A question was asked on the overdue workforce plan and timeline for completion. The Director of People advised that an initial review had been

submitted to Scottish Government in the previous year. The actions would follow on from this. The workforce plan would be set for the next year.

(ii) Members asked if the Primary Care Improvement Plan item was still relevant. It was proposed that detail on the actions and date was updated and included in the focussed review.

(iii) A question was asked on whether there was merit in including the actions from the Fatal Accident Inquiry in the Strategic Risk Register, possibly on a short term basis. The Chief Executive advised that this could be looked at but confirmed that a number of controls had been implemented since the review in 2019. The actions would be picked up by the Senior Leadership Team. The Senior Leadership Team would also consider whether the FAI Findings should be added to the Strategic Risk Register. The Medical Director confirmed that there was an Organisational Risk on ligature points with a programme to remedy this including addressing issues within the prison estate.

(iv) The Board Chair noted that the Story item for the March Board meeting would be on the topic of Out of Hours and highlighted that Sir Lewis Ritchie had confirmed that the service had made good progress which had taken it out of enhanced monitoring.

The Forth Valley NHS Board:

(1) approved the changes to the Strategic Risk Register for the period October 2024 to January 2025;

(2) approved the closure of SRR014 (Healthcare Strategy) and SRR016 (Out of Hours) from the Strategic Risk Register, and

(3) noted the progression of the mitigating actions identified.

Action:

(1) The Senior Leadership Team to consider whether the FAI Findings should be included in the Strategic Risk Register. SLT

8. Strategic Planning, Performance & Resources Committee (SPPRC) – Terms of Reference

The Forth Valley NHS Board considered a report for approval, presented by Ms Mackenzie, which presented the draft Strategic Planning, Performance & Resources Committee Terms of Reference for approval.

Key messages in the report included:

(i) The Board established the Strategic Planning, Performance & Resources Committee at its meeting of 24 September 2024.

(ii) The SPPR Committee had considered draft Terms of Reference at its first meeting, held on 17 December 2024 and agreed, subject to further comments from Members, the submission of the Terms of Reference to the NHS Forth Valley Board.

The Forth Valley NHS Board approved the Terms of Reference for the Strategic Planning, Performance & Resources Committee.

9. Committee Minutes

9.1 Audit & Risk Committee – 24 January 2025

The Forth Valley NHS Board received a verbal update from Cllr Collie, Committee Chair, on the meeting of the Audit & Risk Committee held on 24 January 2025.

The Committee had considered the external audit plan and the Internal Control Evaluation (ICE) report. The Committee had agreed to the onward distribution of the ICE report to the other Governance Committees to pick up relevant actions.

The following points were made in discussion:

(i) The Director of Finance provided an update in relation to the Population Health Strategy internal audit action log entry. He noted that it was a key strategic priority for the Board and that further discussion would take place with internal audit around appropriate timing to ensure best value add.

(ii) The Acting Director of Strategic Planning & Performance advised that there had been some changes to the ICE report since the Audit & Risk Committee meeting and that the ICE report would be circulated electronically to Audit & Risk Committee members prior to its wider distribution.

The Forth Valley NHS Board noted the key issues highlighted from the Audit & Risk Committee meeting of 24 January 2025.

Action:

(1) Committee Chairs to note that the ICE report would be circulated to all Committees and follow up actions should be included on future agendas of their Committees. — Committee Chairs

9.2 Clinical Governance Committee - 12 November 2024

The Forth Valley NHS Board received the Clinical Governance Committee Minute of the meeting held on 12 November 2024. Key items had previously been highlighted at the November Board meeting. The minute was commended to the Board for noting. A verbal update was also provided on the meeting of 7 January 2025.

The Chair of the Committee, Dr McClung, provided an update on the recommended closure of the Strategic Risk on Out of Hours and the information considered by the Committee in relation to peri-natal services. Quality Assurance Improvement activities had also been considered by the Committee.

The following points were made in discussion:

(i) In relation to enhanced monitoring described in the Medical Education Report, the Medical Director highlighted that there had been a Deanery review with the consequent supportive action plan now concluded.

(ii) There was a question on the National Radiology Services and responsibility sitting with NHS Golden Jubilee. In terms of the higher incidence of clinical discrepancies described under emerging clinical issues, Mr Murray advised that the service was delivered by another Health Board. The Forth Valley NHS Board was assured that a process had been established to contact affected patients.

The Forth Valley NHS Board noted the minute of the Clinical Governance Committee meeting of 12 November 2024 and the verbal update on the meeting of 7 January 2025.

9.3 Staff Governance Committee – 13 December 2024

The Forth Valley NHS Board received a verbal update from Mr Rennie, Committee Chair, on the meeting of the Staff Governance Committee held on 13 December 2024.

The Committee had considered training compliance with particular focus on manual handling and violence & aggression training. The Committee had reached limited assurance and had requested follow up details at the next meeting on actions being taken to address the trajectory of uptake. The Committee had received information on the significant amount of work undertaken in regard to the Culture Change & Compassionate Leadership Programme and noted the excellent engagement levels. The next steps were around implementation of the plan and the Committee had requested more information on actions and outcomes. A key question was how to measure this performance for cultural improvements. The Committee had also noted a slight deterioration in the sickness absence position and the Chair highlighted their concerns on progress in this area.

The Forth Valley NHS Board noted the key issues highlighted from the Staff Governance Committee meeting of 13 December 2024.

9.4 Strategic Planning, Performance & Resources Committee - 17 December 2024

The Forth Valley NHS Board received the Strategic Planning, Performance & Resources Committee Minute of the meeting held on 17 December 2024. The minute was commended to the Board for noting.

The Chair of the Committee, Ms Mahal, highlighted consideration of issues around the IT provider of the Vision system and invited an update from the Director of Digital. He advised that the company's administrators had completed their invitation for potential buyers and were working through the bids. There would be continuity of service for those Health Boards who had moved over to Vision. Should there be any significant issues for Forth Valley these would be brought through the Committee. The Board Chair then noted the items which had been considered by the Committee prior to their onward submission to Board for decision.

The Forth Valley NHS Board noted the minute from the Strategic Planning, Performance & Resources Committee meeting of 17 December 2024.

Advisory Committee Minutes:

9.5 Area Clinical Forum (ACF) - 16 January 2025

The Forth Valley NHS Board received a verbal update from the Area Clinical Forum meeting held on 16 January 2025.

Ms Cassells, ACF Chair, highlighted that the Chair and Chief Executive had attended the meeting and highlighted the issues being raised by Independent Contractors on payments to allow them to attend and participate in the ACF.

The Forth Valley NHS Board noted the verbal update on the meeting of meeting of 16 January 2025.

9.6 Area Partnership Forum - 22 October 2024

The Forth Valley NHS Board received the Area Partnership Forum Minute of the meeting held on 22 October 2024, which was commended to the Board for noting, and a verbal update from Mr Clark, Committee Chair, on the meeting of 17 December 2024.

The following points were made in discussion:

(i) A question was asked on the target date for implementation of the reduced working week. Mr Clark advised that the arrangements with SERCO were

not finalised yet but that a proposal had been developed which was now subject to consideration by the Chief Executive.

The Forth Valley NHS Board noted the minute of the Area Partnership Forum meeting of 22 October 2024 and the verbal update on the meeting of 17 December 2024.

Quality & Safety

10 Patient/Staff Story – Clinical Simulation Centre NHS Forth Valley a Patient Safety and Cultural Transformational Service

The Forth Valley NHS Board considered a report for assurance, presented by Dr Mardon, Clinical Director Scottish Centre Simulation and Clinical Human Factors, and video presentation providing information on the impact of Transformational Simulation.

Key messages in the report included:

(i) The transformative simulation service allowed real time responsiveness to patient safety, service design and developmental needs across the whole of Forth Valley.

(ii) There had been thirty-eight contemporary peer reviewed publications from authors working within the simulation centre.

(iii) The work crossed traditional working boundaries and enabled whole system working, including:

- ordering small pieces of equipment in the home care setting saving 175 years of waiting in the first year of the project,
- supporting international graduates in a successful transition into the NHS allowing early integration into full shift patterns.
- working collaboratively with our education authorities, councils, and the national youth academy to bring values-based simulation into our local schools to aid with recruitment into social care.

The following points were made in discussion:

(i) No other Board in Scotland had this facility which facilitated safe and positive work and also involved social care. The Clinical Director Scottish Centre Simulation advised that the Centre was about to take its first social care faculty member on sabbatical.

(ii) The rent arrangements which applied to the Centre were highlighted.

(iii) Members commented that it was important to raise the profile of the Simulation Centre and noted the importance of Human Factors.

(iv) Questions were asked on encouraging uptake from other Boards and what plans there were for the use of artificial intelligence. The Clinical Director Scottish Centre Simulation advised that artificial intelligence projects were ongoing in relation to virtual reality and the interface with AI. This could be particularly valuable for groups who did not traditionally affiliate with the immersive model.

(v) The enthusiasm of the team was commented on and the impact this has on staff development and the quality and safety practice of those using the Centre.

(vi) The Board noted that the Centre could assist in communications work and asked about cost savings delivered and any modelling undertaken. The Clinical Director Scottish Centre Simulation noted that she would like to further develop the understanding of the economic benefits derived from the

Centre's work. Members suggested links could be strengthened through the University Partnership in this area.

(vii) Members also commented on the Centre's ability to release capacity and be a key resource for transformation as an enabler.

The Forth Valley NHS Board:

(1) noted and celebrated the innovative work of transformational simulation;

(2) noted the vast number and quality of peer reviewed publications originating from the simulation centre;

(3) commended the local, national and international reputation of the Forth Valley simulation centre especially with regards to transformative simulation;

(4) agreed to visit the simulation centre, and

(5) continued support of the transformative simulation programme to enable board strategic priorities and enable sustainability spread.

Action:

(1) Opportunities to visit the Simulation Centre to be arranged for Board Members. — Jack Frawley & Julie Mardon

11 Update on Safety

(a) Quality Assurance and Improvement Report

The Forth Valley NHS Board considered a report for assurance, presented by Professor Dodd, which described the Board's quality assurance position, progress with key quality improvements and use of evidence to plan for quality. There was also an update on implementation of the NHS Forth Valley Board Quality Strategy.

Key messages in the report included:

(i) The Clinical Governance Working Group approved recommendations for updated Safeguard reporting, operational definitions for the key measures and moving cardiac arrest reporting to Safeguard, in preparation for robust use of data as part of the Safer Together Collaborative.

(ii) The key performance indicators (KPI) within the framework for completing the SAER reviews were highlighted:

- Time to Commissioning the SAER - 10 working days from reporting on incident management System.
- SAER report submission due 90 working days from date SAE was commissioned.
- Final approval of SAER report no later than 30 working days from report submission.
- Develop an improvement plan within 10 working days from report being approved.

A review of current performance in relation to each of the measures had been undertaken, and an improvement plan and supporting measures drafted for implementation.

The following points were made in discussion:

(i) A question was asked on resource level for SAERs and the number of review leaders needed. The Executive Nurse Director stated that there were sufficient staff to undertake SAERs. Individuals were being identified who clinically wanted to be involved but also those who should be involved by level of role. The Medical Director noted that in the implementation of the Quality Management Strategy there were yearly evaluation reports to the

Clinical Governance Committee on progress. The Executive Nurse Director advised that the SAER concern was around timelines for completion. She assured the Board that the quality of SAERs and the learning gained was extremely high and robust.

(ii) Members commented that the report needed to distil whether the quality and safety of services was good enough to provide assurance to the Board and highlight any areas of risk, while preserving the role of the Clinical Governance Committee in doing the detailed work.

(iii) Further comments highlighted members' desire to see information on what areas of concern there were and suggested utilising benchmarking to assist in this. The Executive Nurse Director noted that this was a newer report and was evolving through its presentation to the Board each cycle. There was also a need to avoid duplication of reporting in multiple forums, noting that much of the detail was also discussed at the Clinical Governance Committee and Clinical Governance Working Group.

(iv) The Board Chair noted that further comments on the shape of the report were welcome directly to the authors and that Board Members were able to attend the Clinical Governance Committee even if they were not members of the Committee. The Chief Executive confirmed that the report going forward would focus on exception reporting of which the wider Board needed to be made aware of.

The Forth Valley NHS Board:

(1) noted overall delivery of quality assurance, quality improvement and using evidence to plan for quality;

(2) noted the current quality assurance position and quality improvements being made in relation to specific quality measures and compliance with national safety standards and targets, and

(3) supported the progress and further development of the quality management system.

Actions

(1) Directors to consider how the report could be strengthened to provide assurance around areas of risk and exception reporting. — Frances Dodd/Andrew Murray

(2) Board Members to be advised of Clinical Governance Committee dates for anyone who wished to attend this Committee. — Jack Frawley

(b) Healthcare Associated Infection (HAI) Reporting Template December 2024

The Forth Valley NHS Board considered the Healthcare Associated Infection Report Template (HAIRT) for assurance, presented by Mr Horwood.

Key messages in the report included:

(i) Total SABS remained within control limits. There were two hospital acquired SABs in December.

(ii) Total DABs remained within control limits. There was one hospital acquired DAB in December.

(iii) Total CDIs remained within control limits. There were two hospital acquired CDIs in December.

(iv) Total ECBs remained within control limits. There were 8 hospital acquired ECBs in December.

(v) There had been no deaths with MRSA or C.difficile recorded on the death certificate.

(vi) There were three mandatory surgical site infections in December. There was one breast SSI recorded outwith the mandatory surveillance period.

(vii) There were no outbreaks reported in December.

(viii) Influenza cases increased significantly in December.

The following points were made in discussion:

(i) A question was asked on whether there was a particular issue with ECBs and UTIs. The Executive Nurse Director noted that ECBs had been outwith control limits but that this was an exception and that levels were back within limits. She also noted that improvement work was underway in this area.

The Forth Valley NHS Board noted the:

(1) HAIRT report;
(2) performance in respect of SABs, DABs, CDIs & ECBs, and
(3) detailed activity in support of the prevention and control of Health Associated Infection.

12 Whistleblowing Standards and Activity Report

The Forth Valley NHS Board considered a report for assurance, presented by Professor Dodd, which provided an update on whistleblowing activity in NHS Forth Valley. The Board's Whistleblowing Champion, Mr Johnston, noted that the numbers were relatively low and in line nationally. There were good learning and themes which were used to make system improvements. Opportunities to use simulation in training were being explored.

Key messages in the report included:

(i) NHS Forth Valley had investigated or were investigating a total number of 23 concerns since the development of the whistleblowing arrangements. This included 9 under Stage 1 and 14 under Stage 2 of the Whistleblowing Procedure.
(ii) The Whistleblowing Network continued to meet bi-monthly and gave opportunities for learning to be shared from the process of whistleblowing, particularly in relation to strengthening the processes, communication with reporters, the process of investigation, as well as the organisational learning from whistleblowing investigations.
(iii) There were future plans underway to deliver simulation training to the Confidential Contacts and Lead Investigators. The purpose of the training was to give exposure to realistic investigation scenarios to enhance investigation skills and to support decision making abilities as part of the Whistleblowing process.

The following points were made in discussion:

(i) Members discussed the wording used in the report to ensure confidentiality of specific areas where actions were not organisation wide.
(ii) A question was asked on whether there were issues with referrals which were not suitable for consideration as whistleblowing. The Executive Nurse Director advised that there was lots of publicity work around the Whistleblowing process and she was happy as long as staff felt comfortable to raise issues, whether they met the Whistleblowing criteria or needed redirected into another process or not. Whistleblowing and Speak Up provided a person to deal with who had been trained appropriately. It was most important to ensure any concerns were heard and addressed.

The Forth Valley NHS Board noted the Whistleblowing performance in Quarters 2 and 3 2024/25.

The Forth Valley NHS Board adjourned at 11.30am and reconvened at 11.40am with all members present as per the attendance list.

13. Integration Joint Board Minutes & HSCP Updates

13.1 Minute of Clackmannanshire & Stirling Integration Joint Board – 2 October 2024

The Forth Valley NHS Board received the Clackmannanshire & Stirling Integration Joint Board Minute of meeting held 2 October 2024.

The Forth Valley NHS Board noted the Clackmannanshire & Stirling Integration Joint Board minute of meeting of 2 October 2024.

13.2 Proposed Integration of Children's and Justice Social Work Services into the Falkirk Health and Social Care Partnership

The Forth Valley NHS Board considered a report for endorsement, presented by Ms Woodcock, supported by Martin Thom, Head of Integration and Sara Lacey, Chief Social Work Officer which provided an update on actions taken following a decision by Falkirk Council on 27 September 2023 to consider whether the Council's Children's and Justice Social Work should be integrated into the Health and Social Care Partnership (HSCP) and included in the revised Integration Scheme.

Key messages in the report included:

(i) The Council and HSCP established an Integration Programme Board to consider how Children's Social Work Services were delivered and managed at a local level. The programme board comprised senior staff from Falkirk Council, NHSFV and Falkirk HSCP.

(ii) Engagement events provided a high-level overview of the work being taken forward by the Integration Programme Board and subgroups and set out a proposed timeline for integration.

(iii) Subject to the decision being taken to integrate Children's and Justice Social Work services into the HSCP as a delegated service of the IJB, it was intended that the Programme Board would continue to monitor benefits being realised.

The following points were made in discussion:

(i) Board members had received previous briefings, including at Board Seminars, on the proposed integration and the proposal had been considered at the SPPR Committee with a number of opportunities for discussion and points of clarification.

(ii) A question was asked on the impact for service users of this change. The Chief Officer advised that there would be continued excellent quality care and continuous improvement of services. The Head of Integration stated that there would be quick wins in relation to a smoother transition for children with disabilities. Currently there was a requirement to refer into Adult Services and join a waiting list, this would be smoothed out through a combined referral process. There would be a single point of contact for families who could work with the family over a longer period. Staff would be trained to provide support to the whole family and broaden the skillset of the workforce.

(iii) Members asked if management capacity was sufficient to make the transition a success. The Chief Officer noted that the current Children's and Justice Social Work management structure would lift and shift into the partnership.

(iv) Board members requested clarification on what the position was with NHS Children's Health Services. The Chief Officer noted that there was no requirement to transfer Children's Health Services but that it was timely to ask if where the services sit currently was best for service users. The Programme Board would seek to understand the potential benefits of a transfer in the future but this was not a matter for decision as part of this proposal.

(v) Members noted that children do not live in isolation but rather within family settings so taking a whole family approach was positive.
(vi) There was a question on governance and the timing of the transfer. The Chief Officer advised that until the revised Integration Scheme had been formally approved by Scottish Ministers, an initial transfer of only operational management could proceed with delegation of functions following. Once the functions were delegated, the Integration Joint Board would be the decision maker in relation to these services.

The Forth Valley NHS Board endorsed the direction of travel as set out in the report in relation to the delegation of Children's and Justice Social Work Services, noting formal approval was sought within the Integration Scheme report at Item 13.3 on the agenda.

13.3 Integration Schemes

The Forth Valley NHS Board considered a report for approval, presented by Ms Thomson, which set out the outcome of a review of the Falkirk and Clackmannanshire & Stirling Integration Schemes.

Key messages in the report included:
(i) In accordance with the Public Bodies (Joint Working) (Scotland) Act 2014, Local Authorities and Health Boards are required to jointly prepare an integration scheme. Each integration scheme should be reviewed every 5 years.
(ii) A project team, led by an external facilitator/project manager, together with key representatives from the NHS Board and all three Local Authorities was established in January 2024 to take forward the review of both integration schemes.
(iii) The most extensive revisions were made to the finance section in a bid to improve the level of detail provided on financial governance and financial management, including risk sharing arrangements.
(iv) The Falkirk scheme included a change in the voting membership from 3 to 4 for each partner. The Falkirk scheme had also been updated to extend the functions delegated by Falkirk Council to include Children's and Justice Social Work services.
(v) Dedicated NHS Board seminars were held on 5th and 11th November to consider all changes to both documents in more detail, together with any outstanding issues to be resolved. This was followed by further discussion and clarification at the Strategic Planning, Performance Resources Committee on held on 17 December 2024.
(vi) Public consultation had been undertaken on the revised Schemes and no changes had been required in light of the responses received.
(vii) Following formal approval by the NHS Board and Local Authorities, both schemes were expected to be submitted to the Scottish Government for ministerial approval in late February 2025. A further update would be provided to the Board in March 2025 to confirm the ministerial feedback and decision.

The following points were made in discussion:
(i) Members considered how the changes would be communicated once approved. The Board Chair suggested that an update report to the March Board include any Ministerial feedback and a Communications Plan.
(ii) Board members discussed turnover in Chief Officers and the need to avoid duplication in the system.

(iii) A question was asked on when the approved Schemes would take effect. The Deputy Director of Finance noted that approval may take until financial year 2025/26 and the Schemes were in effect immediately upon approval.

The Forth Valley NHS Board:

(1) noted the work undertaken by the project team to review and update the Integration Schemes;

(2) noted that the Integration Schemes were subject to collective formal agreement by all partners in advance of submission to the Scottish Government for Ministerial approval, and

(3) approved the revised Integration Schemes for Falkirk and Clackmannanshire & Stirling.

Action:

(1) The 25 March 2025 Board should receive an update on any Ministerial feedback received and a communications plan for when the Schemes are approved for implementation. — Jillian Thomson/Elsbeth Campbell

13.4 IJB Directions

The Forth Valley NHS Board considered a report for noting, presented by Mr Urquhart, which provided a high-level summary of the Directions received from both IJBs to date during the 2024/25 financial year.

The key messages in the report included:

(i) Directions are a key aspect of an IJB's governance framework and form the mechanism and legal basis by which the IJB's commissioning role and strategic plans are enacted.

(ii) Clackmannanshire and Stirling IJB had issued 13 Directions: 7 of which were issued jointly to NHS Forth Valley, Clackmannanshire Council and Stirling Council to confirm 2024/25 revenue budgets and to take forward development of strategic commissioning plans for Mental Health and Wellbeing and Palliative Care and End of Life services; 3 were issued to Clackmannanshire Council and Stirling Council to implement the Local Government finance settlement as it applied to integration and to implement various policy initiatives relating to Self-Directed Support, and 3 were issued to NHS Forth Valley in relation to implementation of financial recovery plans.

(iii) Falkirk IJB had issued 28 Directions relating exclusively to year to date budget amendments at individual service level.

(iv) Falkirk IJB had also issued 4 non-financial Directions during 2024/25: 1 was issued jointly to NHS Forth Valley and Falkirk Council relating to the development of a Mental Health and Wellbeing strategic commissioning plan, and 3 were issued to NHS Forth Valley relating to the development of locality plans, an extension to a block contract for interim care beds and development of the Palliative Care and End of Life strategic commissioning plan.

The following points were made in discussion:

(i) Members asked how the Board was assured services were delivering against the Directions. The Chief Executive stated that reporting would be through SPPR Committee and be reflected in performance framework changes.

(ii) It was highlighted that one Direction was shown which had not been approved or issued.

The Forth Valley NHS Board noted the Directions received from both IJBs to date.

Action

(1) The Board agreed that future Directions reporting would be aligned with changes to the Performance Framework being implemented by the Chief Executive. Ross McGuffie

13.5 Clackmannanshire and Stirling IJB Inspection Improvement Plan

The Forth Valley NHS Board considered a report for approval, presented by Ms MacDonald, which provided the Improvement Plan for approval.

The key messages in the report included:

(i) The Joint Inspection of Clackmannanshire & Stirling HSCP took place between April and September 2024.

(ii) The improvement plan was approved by Chief Executives from all partner bodies and Interim Chief Officer on 24 January 2025 for submission to the inspection team by 28 January 2025 to meet the deadline.

(iii) The plan had been developed in partnership with services in mental health across the spectrum but would apply to all integrated services in the HSCP as principles were the same regardless of condition. An event was held in early December to go through the draft and discuss what needed to change and what could be built upon.

The following points were made in discussion:

(i) Members noted that governance oversight of the Plan would be through the Integration Joint Board and asked how the Health Board would be kept up to date. The Interim Chief Officer confirmed that governance sat with the IJB but recognised the interest of constituent parties in progress with the Plan. Professor McGuffie emphasised the importance of the NHS Board having ownership and oversight of delivery of the improvement actions.

(ii) A question was asked on the rating of limited assurance in the report and processes for robust data. The Interim Chief Officer noted that the action plan had been agreed on 17 December 2024 with timescales that were appropriate to drive forward the work at pace. There was a plethora of data available and the service was considering what was needed to effectively monitor progress. The work in terms of the data action was on track to complete in March.

The Forth Valley NHS Board approved the Improvement Plan.

Strategy & Performance Updates

14 Population Health & Care Strategy 2025 – 2035 Development

The Forth Valley NHS Board considered a report for approval, presented by Ms Fraser, which set out the proposed plan and associated timeline for developing the Forth Valley Population Health and Care Strategy 2025-2035. It was expected that the Population Health and Care Strategy would be published by the end of August 2025 and would set the direction of travel for the next ten years.

The key messages in the report included:

(i) The engagement plan would build on the significant previous engagement with patients, the public, partner organisations and staff.

(ii) The Steering Group would ensure that the Strategy aligned to the national strategy including the Population Health Framework and the two Health and Social Care Partnership Strategic Commissioning Plans.

(iii) The report also provided details on:

- The Engagement Timeline
- Staff and Patient Feedback and Engagement

- What was learned from engagement to date
- Initial outline of Proposed Further Engagement

The following points were made in discussion:

(i) The Terms of Reference for the Task and Finish Group were being developed.

(ii) Members discussed the benefits of aligning with work in the Health & Social Care Partnership over engagement. Comments included that the Communications Plan should be explicit about what was wanted from the exercise and how seldom heard groups would be reached.

(iii) It was highlighted that it was important to build the Equality Impact Assessment into the development of the Strategy from the start.

(iv) Further feedback on the plans to take the Strategy forward were welcome outwith the meeting.

The Forth Valley NHS Board:

(1) approved the governance arrangements for the development of the Population Health and Care Strategy, the timeline for the Strategy, and the timeline for the proposed engagement;

(2) noted the initial outline of the proposed engagement on the Strategy;

(3) noted the extensive engagement which had been undertaken to date, and

(4) agreed that the draft Population Health and Care Strategy and engagement plan are brought to the March 2025 Board for approval, prior to further engagement as outlined in section 5 of the report.

15 Finance Report

The Forth Valley NHS Board considered a report for noting, presented by Mr Urquhart, which provided an update on the 2024/25 financial position, which remained exceptionally challenging due to a range of ongoing operational service and financial pressures.

Key messages in the report included:

(i) Following an in-depth review of the latest financial results, together with a reassessment of projected savings delivery, funding allocations, and changes in planning assumptions, the projected outturn deficit had been revised downwards to £14.9m.

(ii) The forecast position was subject to a number of outstanding assumptions and risks including the finalisation of Service Level Agreements with other NHS Boards, updates to planned funding arrangements, and confirmation of IJB outturns (an estimate of £5m was included in respect of Clackmannanshire and Stirling IJB, and nil in respect of Falkirk IJB).

(iii) The non-recurring nature of improvements did not address the underlying recurring financial gap which would roll forward into 2025/26.

The following points were made in discussion:

(i) Discussion included the ongoing challenge of the financial position. Focus was required on initiatives which would make a difference to the position on a recurring basis. Members recommended that Executives consider how to make the shift toward primary care with appropriate resources.

(ii) Through implementation of the Value Based Health and Care approach, Financial and Population Health and Care Strategies, more services would move upstream into prevention where best value for money could be achieved.

(iii) It was important to show traction and that services would be sustainable for the longer term. Discussions had taken place with Scottish Government on

transformation. Local work on hip fracture and falls prevention work was highlighted. There was a challenge in supporting transformative activity while existing resource was locked in to areas of service delivery.

(iv) Members considered the First Minister's recent announcement on Improving public services and NHS renewal. The actions outlined to deliver a more accessible, more person-centred NHS had three aims:
- to reduce the immediate pressures across the NHS.
- to shift the balance of care from acute services to the community.
- to use innovation – digital and technological – to improve access to care.

(v) Members highlighted the excellent work undertaken in regard to Nurse agency spend where the position was £8m better than the previous year. If this progress could be maintained and extended out to other staff groups good returns would be achieved.

(vi) It was confirmed that the purchase of the Killin Medical Practice building had been progressed.

(vii) The final Financial Plan would come to Board in March for sign off and the timescale was aligned with consideration of the Delivery Plan, however this could not be signed off by Board until Scottish Government feedback was received.

The Forth Valley NHS Board noted:

(1) that a £14.9m revenue deficit was projected for 2024/25, which reflected an improvement on the previously reported position;

(2) the significant level of ongoing service and financial pressure across the whole health and care system and the requirement for an ongoing focus on cost improvement to reduce the deficit as far as possible in-year;

(3) a balanced capital position as at 31 December 2024 with a break even position forecast for capital at year-end, and

(4) that the draft three-year financial plan would be presented to SPPR Committee in February.

Action

(1) The Financial Plan to be considered at the 25 March 2025 Board meeting. Scott Urquhart

16 Capital Business Continuity Plan Submission 2025/26

The Forth Valley NHS Board considered a report for approval, presented by Mrs Farquhar, which provided a draft Capital Business Continuity Plan Submission in response to a new approach to strategic infrastructure planning and investment across NHS Scotland.

Key messages in the report included:

(i) The first planning phase has been to develop a Business Continuity Plan based on a risk-based assessment of the Board's existing infrastructure and was a maintenance only plan. This is required to be submitted to Scottish Government by 31 January 2025.

(ii) The submission has some proposed investment which is phased over more than one Financial Year, due to scale and complexity.

(iii) A summary of the submission, including risk ratings, were included as appendices to the report.

The following points were made in discussion:

(i) A question was asked on the flexibility in the plan to deal with emerging issues. The Director of Facilities noted that in-year issues would need to be

met through the local budgets and that the next iteration of the Business Continuity Plan would be due in November as the cycle was changing.

(ii) The financial risk around anti-ligature points work was raised. The estimated remedial costs exceeded the resource available. This would require re-prioritisation in the next two to three years in recognition of the safety risks to patients.

(iii) As there were other Boards in a similar situation, with anti-ligature improvements required, a question was asked on whether national support would be forthcoming. The Director of Finance noted that the issue had been raised with Scottish Government and as Forth Valley had a Health & Safety Executive Improvement Notice, had sought further capital funding to support compliance more quickly. There were other mitigating actions being taken including enhanced observations and additional staffing.

(iv) Discussion highlighted that while Forth Valley was not the only Board with a HSE Improvement Notice for anti-ligature points there had been a change where the Forth Valley Notice covered the whole estate. Previous notices had been facility or ward specific. The Chief Executive had raised this in national forums. The Deputy Director of Finance advised that modelling had been undertaken through the Capital Plan to consider different scenarios and how the actions would be delivered.

(v) Following a point on the Plan being maintenance only, a question was asked if there were any steps being taken to strategically improve the estate. The Director of Facilities advised that the Whole System Infrastructure Plan was changing and Scottish Government would work with Boards to establish a baseline position. There could also be consequential works required as the Population Health & Care Strategy developed.

The Forth Valley NHS Board:

(1) noted the update provided on anti-ligature point actions and possible mitigations;

(2) noted the position in relation to the Business Continuity Plan submission and the proposed investment contained therein, and

(3) approved the Business Continuity Plan for submission to Scottish Government for consideration.

17 Radiology Information System Business Case

The Forth Valley NHS Board considered a report for noting, presented by Mr Jaffray, which presents the Business Case for a replacement Radiology Information System (RIS). This report had also been considered at the SPPR Committee on 17 December 2024 with the opportunity for discussion and points of clarification to be raised and incorporated into the report presented to the Board for decision.

Key messages in the report included:

(i) The key discussions at SPPR Committee related to the difference between option 4 (Non-Cloud Hosted) and option 5 (Cloud hosted), the core difference being the significantly increased cost implication (& complexity) of cloud hosting.

(ii) An End of Service notice had been served by the provider of the current RIS system which would be unsupported from December 2025. At that point, the system would have no further updates and if the system failed, there would be no service team to make any necessary changes or developments to fix the system.

(i) The Business Case was provided as an appendix to the report.

The following point was made in discussion:

(i) Clarity was sought on the rationale to not progress with Option 5. The Director of Digital highlighted that a replacement solution was required in advance of the availability of the Cloud based system in Option 5 and that the financial costs were significantly higher. The system would move to the Cloud based model when the national solution was implemented.

The Forth Valley NHS Board approved the Radiology Information System Replacement Business Case.

18. Culture Change & Compassionate Leadership Programme Update

The Forth Valley NHS Board considered a report for noting, presented by Mr Reith, supported by Ms Tolland, Programme Director - Culture Change & Compassionate Leadership Programme which provided an update on the work of the Culture Change & Compassionate Leadership Programme including the planned launch of 8 project teams with supporting workstreams.

Key messages in the report included:

(i) The Phase 1 workstream projects were:
- Invest & Celebrate
- Safe, Well & Heard
- Great Communication
- Live the Values

(ii) The Phase 2 workstream projects were:
- Develop Our Leaders
- Attract & Retain
- Learning & Continuous Improvement
- Get Connected

(iii) The main assurance reporting would continue to be through the Staff Governance Committee. Organisational commitment to the CC&CL programme would be reflected in updates to the Board as the work progressed, with specific engagement work planned with the Board on proposals arising from the first phase of the Living our Values workstream.

The following points were made in discussion:

(i) A question was asked on the methodology for assessment of the impact made. Work would continue to be undertaken on what the measures would look like. The Director of People advised that there were a number of different cultural measure models. Value would be added by using diagnostics from as many sources as possible. The Programme Director - Culture Change & Compassionate Leadership Programme noted that modelling had started. The traditional indicators included metrics including absence and grievances which could be condensed to a cultural score. How the individual components were weighted was an important factor. The cultural score could then be used across the organisation to compare areas. The involvement of staff side had added significant value.

(ii) Comments were made on the value of the Programme and the importance of embedding the changes for the longer term. The Programme was felt to meet the needs of staff having been based on their feedback.

(iii) Members discussed the Values Group and the large volume of feedback from staff, which was honest and hard hitting. It was important to ensure that with a new direction that there was staff ownership of matters. There were links to the development of the corporate objectives, aims and vision. The Corporate

Objectives would be presented to the February SPPR Committee for discussion.

The Forth Valley NHS Board noted the:

(1) activity and progress of the Culture Change & Compassionate Leadership Programme, and

(2) internal governance arrangements in place for progress reporting, including the assurance role of the Staff Governance Committee.

Action

(1) Future reports should incorporate progress on evaluation metrics. Kevin Reith

19. Performance Report

The Forth Valley NHS Board considered a report for noting, presented by Ms Mackenzie, which provided key performance information which had been reviewed in support of effective monitoring of system-wide performance.

Key messages in the report included:

(i) Included within the metrics were the eight key standards that were most important to patients: 12-week outpatient target, diagnostics, 12-week treatment time guarantee, cancer targets, access to Psychological Therapies, access to Child & Adolescent Mental Health Services and Accident & Emergency 4-hour waits.

(ii) Overall compliance with the 4-hour emergency access standard (EAS) in November 2024 was 51.6%; Minor Injuries Unit 100%, Emergency Department 43.4%.

(iii) Cancer target compliance in October 2024:
- 62-day target – 77.9% of patients waited less than 62 days from urgent suspicion of cancer referral to first cancer treatment, compared with the October 2023 position of 77.1%.
- 31-day target – 98.2%

(iv) The new outpatient Did Not Attend rate across acute services in November 2024 was 4.4%, an improvement from November 2023's 6.0%. The return outpatient DNA rate across acute services in November 2024 was 5.3%.

(v) The sickness absence target was 4.0%. Absence remained above the target at 7.60% in October2024.

The following points were made in discussion:

(i) Board members discussed the sickness absence rates and access to supports including counselling. Members considered that to tackle absence rates there needed to be a culture which supported wellbeing and resourced this appropriately. It was suggested that applications to the NHS Forth Valley Endowment Funds could perhaps be used to support staff wellbeing, as long as the request was for non-core provision. For every percentage improvement in sickness absence, it was acknowledged that a significant impact was made in relation to staffing and service provision. The Director of People advised that all options were being considered. Resource from occupational health and peer support had worked well and he was happy to explore matters further. He noted that culturally things were moving in the right direction and highlighted the work of the Promoting Attendance Group.

(ii) It was important to target a realistic improvement trajectory and focus on how to deliver improvements with absence. The Director of People noted that the winter months will have been hard and had an impact on rates. Leading into winter the absence position had been held but this winter had been particularly challenging, with exceptionally high flu levels.

The Forth Valley NHS Board noted the:

(1) current key performance issues, and

(2) detail within the Performance Report.

Actions:

(1) Executive Directors to consider encouraging applications to the Endowment Funds, where appropriate, to support staff wellbeing, and

(2) The Staff Governance Committee to continue close monitoring of sickness absence levels.

Cllr Collie left the meeting during consideration of the previous item.

20. Any Other Competent Business

There was no other business.

21. Risks and Reflections

The Forth Valley NHS Board resolved, consistent with its earlier decision on item 7, to recommend that the Senior Leadership Team consider whether FAI Findings should be included in the Strategic Risk Register.

22. Date and Time of Next Meeting: Tuesday 25 March 2025 at 9.30am.

4. Action Log
Forth Valley NHS Board – 25 March 2025

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
039	30.07.24	Strategic Risk Register Update	An update on Primary Care Sustainability to be provided to the Staff Governance Committee and the Board meeting of 26 November 2024.	David Williams/Gail Woodcock	28.01.25	The Update on Primary Care Sustainability is provided at item 19 of this agenda.	Complete
048	24.09.24	Update on Level 4 Escalation	That the alignment of Committees monitoring actions against the Assurance and Improvement Plan is recirculated and committee workplans reviewed accordingly.	Kerry Mackenzie & Jack Frawley	25.03.25	The Assurance & Improvement Plan was recirculated as requested. Committee workplans have taken account of thematic actions.	Complete
049	24.09.24	Realistic Medicine and Value Based Health & Care Update	That information on how Realistic Medicine will be embedded in all aspects of reporting is provided to a future meeting.	Andrew Murray & Jack Frawley	27.05.25	A revised Board report template is being developed with the Board Chair. Embedding Realistic Medicine/Value Based Health & Care will be a consideration in this process.	In progress

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
055	26.11.24	Audit & Risk Committee Minute	The Audit & Risk Committee to consider the appropriateness of an Internal Audit on the Population Health Strategy.	Scott Urquhart & Cllr Collie	25.03.25	The Director of Finance provided an update to the Board at its January meeting, further to consideration by Committee.	Complete
058	26.11.24	Falkirk Health & Social Care Partnership Assurance Report	Consideration of the reporting and assurance of HSCP delivery to the Board as part of its new performance framework.	Ross McGuffie	27.05.25	The new performance framework will include reporting and assurance of the HSCPs delivery to the Board.	In Progress
059	26.11.24	Strategic Risk Update – July-September 2024	Clear timelines to be set against overdue actions, with these to be added and followed through to Committee workplans.	Vicky Webb	25.03.25	The detail of timelines and, where necessary, follow through to Committee workplans, has been added to the March 2025 paper. An interim update was provided at the Board in January 2025.	Complete
060	26.11.24	Purchase of Killin Medical Practice Premises	Confirmation on the number of GP Premises owned by NHS Forth Valley to be included in the paper to the March Board on Primary Care.	Scott Urquhart/Gail Woodcock	25.03.25	The detail requested is provided in the report on today's agenda at item 19.	Complete
064	28.01.25	Board Executive Team Report	Present the outcomes of the investigation and debrief from the severe weather event to Strategic Planning, Performance and Resources Committee.	Ross McGuffie	25.02.25	A report was considered by the SPPR Committee on 25 February 2025, with a further report included on today's agenda.	Complete
065	28.01.25	Strategic Risk Register Update – October – January 2025	Senior Leadership Team to consider whether FAI Findings should be included in the SRR.	Ross McGuffie	25.03.25	As requested in the action, SLT considered the inclusion of FAI Findings in the SRR and resolved that this was	Complete

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
						not required due to the progress made and other routes of monitoring and oversight that are in place.	
066	28.01.25	Audit & Risk Committee – 24 January 2025	Committee Chairs to note that the ICE report would be circulated to all Committees and follow up actions should be included on future agendas of their Committees.	Committee Chairs	25.03.25	ICE Report included on Committee agendas.	Complete
067	28.01.25	Clinical Simulation Centre NHS Forth Valley a Patient Safety and Cultural Transformational Service	Opportunities to visit the Simulation Centre to be arranged for Board Members.	Julie Mardon & Jack Frawley	25.03.25	Invitations to attend the Simulation Centre were issued for Board Members and Senior Leadership Team.	Complete
068	28.01.25	Quality Assurance & Improvement Report	Consider how the report could be strengthened to provide assurance around areas of risk and exception reporting.	Frances Dodd/Andrew Murray	25.03.25	Key authors involved in the preparation of this report have worked together to further consider how to strengthen assurance around risk and exception reporting. The development of this report is iterative and will continue to evolve going forward.	Complete
069	28.01.25	Quality Assurance &	Board Members to be advised of Clinical Governance	Jack Frawley	25.03.25	All members received Clinical Governance Committee	Complete

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
		Improvement Report	Committee dates for anyone who wished to attend this Committee.			dates through the November 2024 Board report. Dates were circulated separately to Board Members.	
070	28.01.25	Integration Schemes	An update on any Ministerial feedback received and a communications plan for when the Schemes are approved for implementation.	Jillian Thomson	25.03.25	The Falkirk Integration Scheme was approved by Board on 28 January and subsequently by Falkirk Council at its meeting on 30 January 2025. The Clackmannanshire & Stirling Integration Scheme was approved by Board on 28 January and subsequently Stirling Council at its meeting on 6 February 2025. Communication to NHS Forth Valley staff confirmed, in light of the transfer of Children's & Justice Social Work, that there was no change to the current management arrangements for children's healthcare services. Any Ministerial feedback and updates on the approval of	In Progress

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
						the Schemes will be reported to Board in due course.	
071	28.01.25	IJB Directions	Future Directions reporting would be aligned with changes to the Performance Framework being implemented by the Chief Executive.	Ross McGuffie	25.03.25	As requested, future reporting of IJB Directions will be aligned with the Performance Framework.	Complete
072	28.01.25	Finance Report	The Financial Plan to be considered at the 25 March 2025 Board meeting.	Scott Urquhart	25.03.25	The Draft Financial Plan report is included on this agenda.	Complete
073	28.01.25	Culture Change & Compassionate Leadership Programme Update	Future reports should incorporate progress on evaluation metrics.	Kevin Reith	25.03.25	Evaluation metrics are being reviewed as part of the Programme Board oversight and will be incorporated into Staff Governance Committee updates, which will also be included in future reporting to the Board.	Complete

STATUS:
Overdue
In progress
Complete

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

6. Board Executive Team Report
For: Information

Executive Sponsor: Professor Ross McGuffie, Chief Executive
Author: Mr Jack Frawley, Board Secretary

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1. Executive Summary

1.1 This report provides an opportunity to deliver a wide update from the Board's Executive Team, covering celebrating success; general updates; inspection activity; visible leadership; and horizon scanning.

2. Recommendation

2.1 The Forth Valley NHS Board is asked to **note** the report.

3. Key Issues to be Considered

3.1 Celebrating Success

3.1.1 Celebrating success is an essential part of reinforcing positive outcomes, enhancing staff morale and strengthening commitment to our organisational values. Recognising the great achievements of our dedicated workforce helps foster a positive culture, encourage collaboration and remind both staff and Board Members of the great impact we have on the population of Forth Valley.

3.1.2 Since the last Board meeting, there have been a number of positive areas of success, including:

- A local Emergency Nurse Practitioner who helped build a leading emergency medicine unit for patients in one of the world's poorest countries has been nominated for the prestigious '**People's Choice' title in the Royal College of Nursing Scotland awards**. Charlie McCarthy, who works in FVRH, has been instrumental in developing lifesaving treatment for children and adults in Malawi.
- Kay Mair, NHS Forth Valley Lead Nurse for Parkinson's, and one of Scotland's longest serving Parkinson's Nurse Specialists, attended an afternoon tea reception hosted by the Duchess of Gloucester, Patron of Parkinson's UK at St James's Palace, London to celebrate and recognise **the 35th anniversary of the Parkinson's Nurse**.
- The latest cohort of graduates on NHS Forth Valley's **THRIVE to Keep Well programme** - designed to build confidence, motivation and self-esteem amongst women - celebrated receiving their certificates at the end of a 16-week learning session.
- **Children and Young People's Speech and Language Therapy** service has received national recognition as the first in Scotland to deliver a whole systems approach to improving children and young people's communication, delivered within education settings. Against a national average of 13-month waits, over 90% of children in NHSFV are accessing support within 12wks and over 40% seen within seven days of referral.

Glenn Carter, Head of the Royal College of Speech and Language Therapists in Scotland, has called for the approach to be spread across Scotland.

- NHS Forth Valley gained national recognition for the **improvements in waiting times** for diagnostic scans and urology treatment, through investment and the development of Advanced Practice roles. Urology waiting times dropped by 22% in the first half of the financial year alone and waiting lists for CT and ultrasound have reduced by 6,000, with current waiting times now under 12wks.
- A successful information day took place at the Bellfield on 18 February to support **unpaid carers**. In attendance was 20 providers from across Clackmannanshire & Stirling as table hosts, with the event on the day being attended by 78 people. The event was another fantastic example of collaborative working with some attendees commenting on the high level of interest at the event, and the beneficial networking opportunity created, as well as being grateful for the opportunity to engage with the public and other services.
- The **State Hospital** has been collaborating with NHS Forth Valley around Care Assurance, due to recognition from Healthcare Improvement Scotland around the work done locally within prisons. The State Hospital team are undertaking shadowing visits to support learning, which is great recognition of the work being undertaken by the Prisoner healthcare team, Practice Development Unit and Care Assurance team.

3.2 General Updates

3.2.1 Since the last Board meeting, there have been a number of developments of note:

- The **third CT scanner** to be installed at FVRH arrived on site on Sunday 2nd March following extensive preparatory work. The scanner is due to be fully functional by the end of the month, creating capacity for an additional 6,500 scans per year and reducing the need for patients to travel to other sites for imaging services.
- Our latest **MP/MSP briefing session** took place on Friday 28th February, covering key topics including performance, 25/26 financial plan and Value Based Health and Care.
- A **Discharge Without Delay** development day was held on 27th February, bringing together staff from across the system to discuss some of the key components of the approach and participate in simulation sessions to bring it all to life. As part of the national collaborative, local leaders have been agreed for each of the national workstreams and FV continues to be one of the best represented Boards at each of the national sessions.
- A whole system **Moving On Policy** has been developed to support the flow of adults who are being supported through hospital discharge and choosing a care home placement, returning home with support or moving to an interim care arrangements. The policy is currently going through final governance sign off prior to an anticipated implementation from April 20205.
- The first round of our new **quarterly performance reviews** has commenced, with Finance, Facilities and Procurement, Acute and Falkirk HSCP reviews already completed, and Clacks and Stirling HSCP and HR, Digital and Communications taking place imminently.
- The first meeting of the **Shadow Regional Anchor Board** was held on 5th March, with positive agreement to focus on a small number of ‘pillars’ as priorities. It was agreed that task and finish groups will be developed to support progress with great buy in from local partners.
- A **FV Leadership Group** is being formed to bring together public sector leaders in the FV area to discuss common priorities, issues and opportunities. The group aims to hold its first meeting in April and will meet six-monthly thereafter, providing another vehicle for joint working and shared efficiencies across the FV area.
- The NHSFV Corporate Headquarters at **Carseview House** has now condensed onto one floor, providing a positive flexible workspace, which will be supported by an online

desk booking system, whilst also delivering an ongoing cost saving for the organisation.

- The public consultation in relation to the **Falkirk IJB budget** to address a £20m gap was launched on 17th January and closed on 26th February 2025. The consultation has gathered feedback on the potential impacts on our stakeholders including our staff, providers, third and voluntary sector partners and the people of Falkirk. At the time of writing 251 online submissions have been received and a further 600 people have been engaged via a number of online or in person sessions. The feedback has been used to inform equalities impact assessments to support decisions that IJB will be asked to make on 21 March
- Following publication of the **Charter of Rights for People Affected by Substance Use**, Clackmannanshire and Stirling Alcohol and Drugs Partnership has been considering how partners can collectively implement a Human Rights Based Approach to substance use care and support. The upcoming Commissioning Consortium activity will be informed by lived and living experience reflection and learning from the ongoing process of MAT Standards implementation. This is complemented by ongoing work in the Clackmannanshire and Stirling Health Improvement Service on antiracist practice and human rights approaches.
- The **NHS Forth Valley Public Health team** has been invited to provide local support to the soon to be established Grangemouth Town Team, as part of the £80m Falkirk and Grangemouth Growth Deal. The deal will support the area to achieve the ambition of a transition to net-zero, improving local skills, growing innovation and improving culture and tourism in the area.

3.3 Inspection Activity

3.3.1 Since the last Board meeting, there has been ongoing activity around:

- High level feedback has been received following the HIS inspection of HMP Glenochil. Overall, the feedback was very positive, with the draft report due at the end of April, the final report to be published in June and any action plans to be in place by mid-September.
- The Mental Welfare Commission visited HMP Glenochil on 6th February 2025 to review mental health services provided to prisoners and their experience of using these services. The MEC visit was promoted to all prisoners prior to the visit and we expect their report in 12 weeks' time.

3.4 Visible Leadership

3.4.1 In line with the Board's culture programme, the Executive Team are programming regular walk rounds and visits to provide an opportunity for positive engagement with staff. This programme aims to make it easier for staff to raise concerns or ideas with senior staff, foster a culture of collaboration and allow leaders to set a positive example, demonstrating commitment to our organisational goals and values.

3.4.2 Since the last Board meeting, members of the senior team have visited:

- The Forth Valley Quality Team at Falkirk Community Hospital
- Outpatients Department at FVRH
- Adult Diabetes Service
- Paediatric Diabetes Service
- HMP Stirling
- Laboratories at FVRH
- Forth Valley Neuro Rehabilitation Team at Falkirk Community Hospital
- Richmond GP Practice at Bo'ness Health Centre
- Strathcarron Hospice
- HSCP workshops to engage with all frontline staff

3.5 Horizon scanning

3.5.1 Moving forward, Board members can anticipate further updates around the following areas of activity:

- The development of the Digital Plan.
- The Scottish Government are currently developing three plans, which will set the immediate and longer-term priorities for the NHS in Scotland. The Operational Delivery Plan will focus on the immediate priorities; the Population Health plan will focus on the need to change towards a much more preventative and population health focus moving forwards; and the Reform plan will set out the aims of creating a much more NHS Scotland centred approach through collaboration between Boards and a new methodology around the Scottish Approach to Change.

4. Implications

4.1 Financial Implications

There are no financial implications within this update report.

4.2 Workforce Implications

The report details a range of positive development for staff wellbeing, including celebrating success, staff engagement and visible senior leadership.

4.3 Infrastructure Implications including Digital

There are no infrastructure implications within this update report.

4.4 Sustainability Implications

There are no sustainability implications within this update report.

4.5 Sustainability Declaration

Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process. (A policy for NHS Scotland on the climate emergency and sustainable development) (please tick relevant box)

☐ *Yes*

☒ *N/A*

Where applicable, the climate change, environmental and sustainability impacts and any mitigating measures are noted above/contained in the supporting papers.

4.6 Quality / Patient Care Implications

This report outlines inspection activity currently underway within the Board but has no implications around quality of care.

4.7 Information Governance Implications

There are no information governance implications within this update report.

4.8 Risk Assessment / Management

No risk assessment has been undertaken on this update report.

4.9 Relevance to Strategic Priorities

This update report demonstrates coherence with our organisational goals and values, highlighting staff engagement, celebrating success and providing transparency around inspection activity and future developments.

4.10 Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process. Further to an evaluation it is noted that: (please tick relevant box)

☒ *Paper is not relevant to Equality and Diversity*

☐ *Screening completed - no discrimination noted*

☐ *Full Equality Impact Assessment completed – report available on request*

4.11 Communication, involvement, engagement and consultation

There has been no engagement activity around the completion of this update report, though it does outline ongoing walk rounds and staff engagement.

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

7.1 Minute of the Audit & Risk Committee held on 24 January 2025

For: Noting

Minute of the Forth Valley Audit & Risk Committee held on Friday 24 January 2024 via MS Teams

Present:	Fiona Collie (Chair)	Robert Clark	John Stuart

In Attendance:
Jack Frawley, Board Secretary
Iain Howse, Deloitte
Joceyln Lyall, Chief Internal Auditor
Ross McGuffie, Chief Executive
Anne Marie Machan, Regional Audit Manager
Kerry Mackenzie, Acting Director of Strategic Planning & Performance
Neena Mahal, Board Chair
Sarah Smith (Minute taker)
Scott Urquhart, Director of Finance
Vicky Webb, Head of Risk
Gordon Young, Head of Service, Counter Fraud Services

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1. COUNTER FRAUD SERVICES UPDATE

The Audit & Risk Committee received a Counter Fraud Services Presentation, led by Mr Gordon Young, Head of Service for NHS Counter Fraud Services.

The presentation outlined the significant money being lost to fraud within the public sector. This was made stark by the increasing financial challenges being experienced within the Public Sector.

Mr Young outlined the role and purpose of the Counter Fraud Strategy 2023-26 and detailed the four strategic pillars.

The NHSS Counter Fraud Standard was also discussed, recognising this was an ideal framework with self assessment and method statement submission. Assurance was provided to the Committee that for 2023/24, NHS Forth Valley had met 9 out of the 12 components, with the remaining 3 partially completed. This was positive and work to progress would continue.

The referral position for 2024/25 was provided for NHS Forth Valley, with main topics highlighted. Assurance was provided this was in line with the National position.

In terms of new, emerging and continuing threats, an increase was being seen around the areas of digital and mandate fraud. Concern was also noted around expanding AI usage. The significant number of people now working from home was also being seen as a contributing factor to the fraud increase being seen in a number of areas. Colleagues recognised the need for workforce policies to be more explicit around these areas.

Fraud Awareness month took place in November 2024 with thanks expressed for the significant involvement from colleagues.

Promotion of Fraud within the Board was discussed, with agreement information around the Strategy would be recirculated to staff to enhance awareness. Ms Machan provided assurance

that all CFS communications were added to the NHS Forth Valley Intranet. Awareness of fraud was recognised as a key issue with a need to ensure staff felt empowered to raise any concerns.

For NHS Forth Valley, the Fraud Policy was contained within the Code of Corporate Governance with key information provided. It was agreed this could be refreshed in line with this discussion, providing greater reflection of the changing environment. Linkage with the Prevention Team within CFS was proposed to provide simplified examples.

Colleagues were also advised that CFS would take the lead on ensuring the National Training Modules were reflective of the new and emerging issues.

The Audit and Risk Committee thereafter noted the presentation led by Mr Young.

2. APOLOGIES FOR ABSENCE

There were no formal apologies for absence noted.

3. DECLARATION(S) OF INTEREST(S)

There were no declarations of interest.

4. MINUTE OF FORTH VALLEY AUDIT & RISK COMMITTEE MEETING

4.1 Minute of NHS Forth Valley Audit Committee meeting held on 25 October 2024

The note of the meeting held on 25 October 2024 was approved as an accurate record.

Mr Stuart advised in the chat that he had provided virtual approval for the minutes from the meeting on 22 March 2024.

Page 2, Item 5.1, Paragraph 7 Complex Care - Assurance was provided that further discussion had taken place at the Senior Leadership Team. At this time it was agreed this be added to the Audit Plan, with Ms Machan confirming this was now included within the 2024/25 Plan.

5. ACTION LOG & MATTERS ARISING

5.1 ACTION LOG

All items on the action log were now complete.

The NHS Forth Valley Audit and Risk Committee:

- **Noted the update to the Action Log.**

6. INTERNAL AUDIT

6.1 Internal Audit Progress Report

The Audit and Risk Committee received the Internal Audit Progress Report presented by Anne Marie Machan, Regional Audit Manager.

Positive progress was noted since the last meeting with two finalised reports. A10/24 was noted as a separate Agenda item for this meeting. Work had continued to focus around ICE Report which would be discussed at Item 6.2 on the Agenda.

A draft of the Savings Report had been circulated to Mr Scott Urquhart, with confirmation of reasonable assurance. Final drafting of the Management of Sickness Absence report ongoing with aim to issue to management week commencing 27 January 2025.

Scoping work for the next phase of audits was underway with detail provided within the paper. The potential to incorporate Complex Care within this phase was discussed

Following the External Quality Assessment of the Internal Audit Service, the initial draft of the report findings had been received, with presentation to the March Committee. This had been a robust process, with assurance provided there were no areas of non conformance. Also, no areas of concern were noted.

The Audit of Adverse Events Management was discussed, recognising delivery against expected timelines for events was a challenge being seen in a number of Boards. Clarification was sought around the scope, recognising the need to also look at quality of outcomes.

Recruitment for the final vacant auditor post was approaching completion with aim to have person in post by February 2025. This would provide much needed additional capacity to the Audit Team.

The Audit and Risk Committee thereafter:

- **Noted the report provided Reasonable Assurance on the progress with the remaining 2024/25 Annual Internal Audit Plan**
- **Noted the update on the Internal Audit External Quality Assessment (EQA)**

6.2 Internal Control Evaluation Report

The Audit Committee received a paper titled Internal Control Evaluation 2024/25 presented by Ms Jocelyn Lyall, Chief Internal Auditor.

The purpose of the report was outlined, noting the aim of early identification of any significant issues, allowing time for resolution.

Assurance was provided around the process undertaken, with all officers thanked for their input with excellent engagement noted.

The report provided 11 recommendations for improvement, 3 significant and 8 moderate. At time of paper publication, agreed management responses were outstanding for 3 recommendations focussed around Clinical Governance. This was due to leave and responses were received yesterday 23 January 2025 and would be incorporated within the report.

The challenging position of all Health Boards was recognised, with a recognition of the de-escalation of the position. This was a reflection of the Governance, Leadership and Culture work undertaken, with recognition of the need for ongoing work.

A recommendation had been made around the Strategic Planning and Performance Resources Committee, with monitoring to continue around its effectiveness, reflecting the significant change in process. The Board Chair, Neena Mahal, provided assurance around the role of the Committee with the Committee recognising the opportunities around Board engagement for complex decisions.

Overarching themes within the report were detailed within the paper and these were outlined and discussed. The challenge around the financial position was recognised.

Key developments were recognised within the report which reflected the continuous improvement and strong assurance reporting through Committee structures.

The timeline for the Healthcare Strategy was discussed, noting further change following the preparation of this paper. Contributing factors were noted and the paper would be updated. The expectation was to provide a programme of work that would clearly establish all components for delivery and clarity around how this would be taken through the Governance process.

Recommendations were outlined, with a focus on coherence between all key areas. Professor Ross McGuffie, Chief Executive, provided assurance of ongoing pieces of work for each of the identified areas. Assurance around broader governance was noted, with focus on alignment in flow through Committee and management structure. Audit actions and risks were being included within this work. Advancing work was noted around workplans for each of the Board Committees.

The need to ensure connectivity between the Board and both IJB's was recognised. This would include a focus around monitoring of service delivery to ensure maintenance of standards. Professor McGuffie outlined the new Performance Framework advising regular Performance Reviews were in place for all key areas, including both IJBs. This process would evolve and develop as required. Each operational division would report to the SPPRC twice each year, which would provide a wider position update on the broader range of service. Vicky Webb, Risk Manager, outlined a recently established group that would look specifically at the area of risk sharing.

Ms Lyall confirmed the report acknowledged significant improvement around Clinical and Care Governance assurances. All reports were very transparent around highlighting any issues.

The Committee were also assured that the report highlighted no items of fundamental risk.

The Audit and Risk Committee thereafter: -

- **Discussed and confirmed assurance from the Internal Control Evaluation 2024/25**
- **Agreed for the ICE to be presented to each Governance Committee**

6.3 Audit Follow-up report

The Audit and Risk Committee considered a paper 'Internal Audit follow up report' presented by Ms Anne Marie Machan, Regional Audit Manager.

The report noted the implementation and position of internal audit recommendations to 31 December 2024. There had been 28 recommendations followed up, with the paper outlined the updated position for each.

One extended recommendation from audit A17/20 (Job Planning) had been risk assessed as significant with a red status. Anne Marie Machan provided clarity around the position and actions in place which provided assurance around progress. Further confidence was provided by Ms Kerry Mackenzie, who noted the contributing factors to the delay. This remained a key focus within the Directorate Reviews with direction being led by Clinical Director colleagues. Assurance was provided around an expectation of meeting the March 2025 deadline.

It was noted each of the standing Committees was taking an audit follow up report to address any areas within their remit. As a result of the embedding of these reports and improvement in processes, it was proposed the Audit Committee review their audit follow up process. This would be brought back as part of the 2025/26 reporting. It was also agreed that a clear flow chart would be created that would provide clarity around the full process for Audit recommendations. The Audit follow up report would also be returned to the next meeting with an update around this area, with wider circulation. **Action: Ms Mackenzie/Internal Audit**

Colleagues agreed the need for clearer narrative around the surrounding factors that were contributing to any delays. It was agreed

The Audit and Risk Committee thereafter:

- Noted the implementation status of Internal Audit recommendations.
- Considered the proposed level of assurance related to the actions to address identified control weaknesses is being implemented as expected.
- Noted the Internal Audit opinion that agreed extended action by dates are reasonable, subject to the one action which is risk assessed as red (two at October 2024).
- Noted where control weaknesses are not being addressed promptly this is escalated to the Director of Finance who ensures Senior Leadership Team (SLT) scrutiny of outstanding actions.
- Concluded that overall progress and any residual risk was considered acceptable.

7. FRAUD

7.1 Counter Fraud Services Quarterly Report

The Audit and Risk Committee received an paper Counter Fraud Services Quarterly Report led by Anne Marie Machan, Regional Audit Manager.

The Committee were advised the report summarised the most recently available Report which was to September 2024. This was presented with Reasonable Assurance.

The report noted 152 national referrals and allegations for the quarter, of these 13 related to NHS Forth Valley. The topics of these aligned to those highlighted during the earlier Counter Fraud Presentation. In terms of formal investigations, there were 3 active investigations and 4 live criminal investigations ongoing.

The report noted the position around recoveries with a small increase being seen within NHS Forth Valley.

The Audit & Risk Committee noted the report.

7.2 Fraud Action Plan

The Audit & Risk Committee received a paper 'Fraud Action Plan' presented by Anne Marie Machan, Regional Audit Manager.

The Plan provided reasonable assurance and detail was provided around it's purpose, noting linkage with the elements highlighted during the previously led Presentation by Mr Young. Detail was provided around the identification of focus areas, noting the consideration given to the achievements from the previous years plan.

NHS Forth Valley were praised for the high achievement around general fraud awareness training, noting they were the highest performing Board in Scotland. However, an additional action was recommended for the plan to promote additional related training within relevant staff groups.

Following the earlier presentation, it was also agreed an action would be added around circulation of the Fraud Strategy.

The positive work undertaken within NHS Forth Valley was recognised, however ongoing focus was required around the unmet activities aligned to the three partially met standards. Ms Machan and Mr Urquhart would meet to discuss expectation and timelines. This would then be reflected within the next iteration of the document.

The Audit and Risk Committee: -

- Approved the Fraud Annual Action Plan for 2024/25
- Agreed inclusion of an action around promotion of training and additional training for relevant staff groups
- Further discussion to take place around expectation and timeliness for partially met standards
- Recirculation of the Fraud Strategy.

8. EXTERNAL AUDIT

8.1 External Audit Progress Update

The Audit & Risk Committee received a verbal update on 'External Audit Progress Update' presented by Iain Howse, Deloitte LLP, External Auditors.

It was noted the preparatory work was ongoing with the plan to be presented to the next Committee meeting.

Mr Urquhart confirmed collaborative work would continue with Internal and External Audit colleagues to progress the timetable. A final date was in place for consideration of sign off for the Annual Accounts and associated External and Internal Audit Reports.

The Audit Committee thereafter noted the update on External Audit.

8.2 Audit Scotland: NHS in Scotland 2024 Report

The Audit Committee received a report "NHS in Scotland 2024" presented by Mr Scott Urquhart, Director of Finance.

Colleagues were advised the report was being presented for information, following its publication at the end of 2024.

The report covered finance and performance for 2024 with three key messages noted:

1. Fundamental change was required around how services were provided in order for the NHS to remain sustainable. A clear vision and strategy was required.
2. Waiting times and delayed discharges remained challenged with initiatives not having required impact.
3. Need to improve population health across Scotland, recognising a stalling and reducing life expectancy across Scotland. Scottish burden of disease was expected to increase by 20% over the next 10 years despite reducing population.

Three areas of recommendation were noted within the report, with one recommendation for NHS Boards around financial sustainability. Specifically, this focussed around a need to achieve balanced financial sustainability within 3 years. Consideration was required around more fundamental changes can be made locally to services and their provision to increase sustainability. This aligned with previously highlighted recommendations within the ICE Report and in terms of the Population Health and Care Strategy and Value Based Health and Care.

In terms of ongoing work, Mr Urquhart noted the return for the financial plan would be submitted to Scottish Government 27 January 2025 with a fuller updated to the Strategic Planning and Performance Resources Committee in February 2025.

The report also provided an additional recommendation for both Scottish Government and NHS Boards around a review of services of limited clinical value, with potential disinvestment and reinvestment into services with better clinical outcomes.

Mr Urquhart highlighted a case study within the report around CAMHS Performance. This noted a positive change in performance for NHS Forth Valley which was reflection of the significant work undertaken.

The Audit and Risk Committee noted the report as presented.

9. RISK MANAGEMENT

9.1 Strategic Risk Update (October 2024 - January 2025)

The Audit and Risk Committee received a Strategic Risk Update presented by Miss Vicky Webb, Risk Manager.

A change in timing was noted, with an extension of the report timeline noted to enable inclusion of the recent Clinical Governance Committee, recognising some key actions from this.

Miss Webb advised there were no changes to the risk position since the last quarter.

A proposal was being brought to the Committee to close two risks that related to Strategic Risk 4 Healthcare Strategy and SRR16 Out of Hours with details included within the report. Assurance was provided that these changes had been endorsed by the relevant Committees.

Section 3 provided an update on the actions related to the Strategic Risk Profile, with 8 actions completed in the last quarter, with 55 actions progressing to further mitigate. 10 were overdue with full detail within the appendix. Assurance was provided that these were all being picked up within the focussed review process. A further update would be provided to the next Committee.

The appetite profile this remained static, however change was anticipated once the above noted actions were completed.

Detail was provided around the focussed reviews undertaken in the last quarter, with specific details provided within the report. By March 2025 a focussed review should have been completed on all current strategic risks.

In terms of general risk management, formal reporting of the strategic risks to Urgent and Unscheduled Care and for Scheduled Care would move from the Clinical Governance Committee to the Strategic Planning and Performance Review Committee.

Review of the risk framework was required with anticipated presentation to the Committee in early 2026. Risk Appetite statements would then be undertaken within Quarter 3.

Governance around risk management reporting to the Board would be changed with a bi-monthly update to Board from the standing assurance committees. Audit and Risk would receive a quarterly update to support these updates.

In terms of Strategic Risk 16 Out of Hours, Ms Mahal provided confirmation from Sir Lewis Ritchie that NHS Forth Valley were no longer being monitored around this area. Further update would be provided to the NHS Board in March around Out of Hours to provide assurance around the work undertaken.

Ms Mahal also sought assurance around timelines for one of the overdue action relating to Innovative Portfolio roles, noting this had been outstanding since 31 December 2023. Miss Webb confirmed work was ongoing to determine if this action was still appropriate. It was agreed the narrative should be updated to reflect this.

Clarity was sought around the establishment of a Strategic Workforce Group with Miss Webb provided detail around the background of the action. This work was at an early stage and being led by Mr Kevin Reith, Director of People. Professor McGuffie confirmed he would follow up with Mr Reith to determine reporting arrangements. **Action: Professor McGuffie**

The Audit and Risk Committee endorsed the proposed changes to the Strategic Risk Register for the period for onward reporting and approval by the NHS Board.

10. ANY OTHER COMPETENT BUSINESS

Mr Urquhart advised the terms of reference for the Audit and Risk Committee were under review as part of the Code of Corporate Governance. Presentation would be taken to the March NHS Board. These would be circulated virtually in advance of this meeting. **Action: Mr Urquhart/Mr Frawley**

11. FUTURE COMMITTEE MEETING DATES

The next meeting of the Audit and Risk Committee would be held on Friday 28 March 2025, commencing at 9.00am

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

7.2 Minute of the Clinical Governance Committee Meeting held on Tuesday 7 January 2025

For: Noting

Minute of the Clinical Governance Committee Meeting held on Tuesday 7 January 2025 at 9.00am in the Boardroom, Carseview House.

Present:
Mrs Kirstin Cassells (Non-Executive Director)
Mr Robert Clark (Non-Executive Director)
Mr Gordon Johnston (Non-Executive Director)
Dr Michele McClung (Committee Chair)
Ms Helen McGuire (Public Involvement Network Member)
Ms Neena Mahal (Board Chair)
Mr John Stuart (Non-Executive Director)

In Attendance:
Miss Jennifer Brisbane (Corporate Services Assistant) Minute
Ms Laura Byrne (Director of Pharmacy)
Mr Ashley Calvert (Head of Clinical Governance)
Dr Aileen Cope (Clinical Director for Obstetrics & Gynaecology) Item 8.4
Prof Frances Dodd (Executive Nurse Director)
Mr Jack Frawley (Board Secretary)
Mrs Eilidh Gallagher (Head of Person Centred Care) Item 10.1
Mr Jonathan Horwood (Infection Control Manager)
Ms Joanna Macdonald (Interim Chief Officer Clackmannanshire & Stirling Health & Social Care Partnership)
Prof Ross McGuffie (Chief Executive)
Ms Helena Marshall (Head of Women, Children & Sexual Health) Item 8.4
Dr Jennifer Rodgers (Dental Public Health Consultant)
Mr David Watson (Chief of Acute Nursing Services) Item 8.1
Miss Vicky Webb (Corporate Risk Manager)

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1. Welcome, Apologies for Absence and Confirmation of Quorum
There were no apologies noted on behalf of committee members.

An apology was received on behalf of Mr Andrew Murray.

The Chair confirmed the meeting was quorate.

2. Declarations of Interest
There were no declarations of interest.

3. Minute of Clinical Governance Committee held on 12 November 2024
The minute of the meeting held on 12 November 2024, subject to previous electronic circulation and committee member approval, was **confirmed** as an accurate record subject to the addition of Mr John Stuart's attendance.

4. Matters Arising from the Minute / Action Log
The Clinical Governance Committee reviewed the action log and noted the complete actions, and below updates from the action log:

- Actions 36: It was agreed that Dr Oliver Milling-Smith and Ms Karen Bonner would be reminded of the action so the action could be closed off.
- Action 37: It was agreed an Oncology Workforce recommendation paper would be added to the 2025/2026 committee planner and the action closed.
- Action 39: Committee members were assured that further detail on the Out of Hours Improvement Plan would be included in the Patient/ Staff Story at the 28 January 2025 NHS Forth Valley Board therefore it was agreed that the action would be closed.
- Actions 41 & 42: Mr Ashley Calvert to liaise with Mr David Watson regarding the actions therefore it was agreed that the actions would be closed.
- Action 43: Assurance was provided that a review was undertaken, and complaints regarding general surgery were related to bariatric and scheduled surgery. Reassurance was provided that the staff member associated with such complaints had left their position, and therefore there was no further concern, action noted as complete.
- Action 45: Following discussion, it was agreed that the action would be amended to reflect 'Discuss capturing concerns from PSCVs within the relevant operational risk registers', and an update regarding risks captured from Patient Safety Conversation Visits would be provided as a report at the 11 March 2025 meeting. Action noted as complete.

The Clinical Governance Committee noted the Action Log.

Action:

(1) Provide a paper outlining the risks captured from Patient Safety Conversation Visits.

4.1 Clinical Governance Committee Terms of Reference

The Clinical Governance Committee received the committee Terms of Reference presented by Mr Ashley Calvert.

Following discussion, it was agreed that committee members would provide comments to the Board Secretary to allow the development of a further iteration for approval at the 11 March 2025 committee meeting and 25 March 2025 NHS Forth Valley Board.

The Clinical Governance Committee noted the Terms of Reference and actions agreed.

Action:

(1) Committee members to provide comments to the Board Secretary prior to 11 March 2025 committee meeting. All

5. Clinical Governance Committee Planner

The Clinical Governance Committee noted the Committee Planner presented by Mr Ashlely Calvert.

Committee members were advised of the below additional items added to the committee planner for the 11 March 2025 meeting: -

(i) Child to Adult Services Transition Age Agreement was added to the planner following discussion at the Senior Leadership Team.

(ii) Electronic Medicines System for Emergency Department: Options Appraisal.

The following points were made in discussion: -

(i) As a result of the removal of the Out of Hours risk (SRR016) from the Strategic Risk Register, no strategic risks would be aligned to Clinical Governance committee going forward. Therefore, it was proposed that following the NHS Forth Valley Board's approval to remove SRR016, that no focussed reviews would be provided at future Clinical Governance Committee meetings. Committee members queried the ability to flag risks at committee meetings and noted the requirement for a risk section within the agenda. Reassurance was provided that risk updates could still be provided, where it was suggested that a risk specific to Quality and Safety risk may be of benefit. It was agreed that Prof Frances Dodd and Miss Vicky Webb would further discuss risk update arrangements.

(ii) Clarity was sought on the reporting of Care Opinion data, where it was noted that work was ongoing to ensure that staff had access to Care Opinion reports or were notified of Excellence Reports submitted to Safeguard.

The Clinical Governance Committee noted the Committee Planner.

Action: -

(1) Undertake further discussion on future risk update arrangements at Clinical Governance Committee, if the removal of SRR016 is approved at the 28 January 2025 NHS Forth Valley Board. — Frances Dodd & Vicky Webb

6. For Approval

There were no items taken for approval.

7. In Our Services, Was Care Safe in the Past?

7.1 Emerging Clinical Issues

The Clinical Governance Committee received 'Emerging Clinical Issues' paper presented by Prof Frances Dodd.

The purpose of the paper was to provide a conclusion and response from NHS Forth Valley of the Scottish National Radiology Reporting Service (SNRRS) incident previously discussed at the Clinical Governance Committee.

Key messages in the report included: -

(i) In response to the SNRRS incident where significant discrepancies were higher than deemed acceptable, correlated to a single reporter within NHS Golden Jubilee National Hospital, NHS Forth Valley undertook an SBAR to review the level and extent of impact of the 104 scans subject to review.

(ii) Committee members were assured that organisational duty of candour had been agreed as sitting with SNRRS due to the incident being identified as a national risk.

The following points were made in discussion: -

(1) Following a question regarding previous discussions on the potential risk of future commissioning issues, it was agreed that Prof Frances Dodd would liaise with Mr Andrew Murray to discuss mitigations.

(2) The committee Chair sought assurance from executive colleagues regarding their confidence in systems in place to mitigate similar incidents. Committee members were advised that full assurance could not be provided as the challenge sat within the Golden Jubilee, however assurance would

be advised to health boards on a national basis. It was agreed that further assurance would be provided at the 11 March 2025 committee meeting.

The Clinical Governance Committee noted the conclusion of the incident and the response from NHS Forth Valley.

Action:

(1) Discuss mitigations to prevent potential commissioning incidents, and provide further assurance to committee at 11 March 2025 meeting. Frances Dodd & Andrew Murray

8. In Our Services, Was Care Safe in the Past?

8.1 Acute Directorate Safety and Assurance Report

The Clinical Governance Committee received the 'Acute Directorate Safety and Assurance Report' presented by Mr David Watson.

The purpose of the report was to support discussion, provide assurance of robust clinical governance within the Acute Services Department (ASD) and appropriate scrutiny at the Clinical Governance Working Group (CGWG) for the Clinical Governance Committee.

Key messages in the report included: -

(i) Hospital Standardised Mortality Rate (HSMR) remained stable at 0.94, with a fifth consecutive reported period below 1.
(ii) Adult Cardiac Arrest rate from September to October 2024 saw an improved position with a reduction in rate from July 2024.
(iii) Overall Stroke Bundle compliance increased from 42% in July 2024 to 42.86% in October 2024. Access to the stroke unit remained variable with the most recent performance at 58%, lower than the previous month of 61.22%, however assurance was provided that the access rate was above the average of 53% over the previous 23 months.
(iv) Hospital Acquired Pressure Ulcers within the Acute Directorate was 2.7 per 1000 occupied bed days for Grades 2 to 4.
(v) Committee members were advised of the ongoing work to improve compliance.

The following points were made in discussion: -

(i) Prof Frances Dood gave recognition to the significant work undertaken within the acute directorate and noted a level of confidence in the directorate's ability to identify and respond to issues due to the improvements and plans in place.
(ii) Further detail was sought on the crossover and development of pressure ulcers within community and acute care. Committee members were advised that data presented within the dashboard did not identify specific trends, however, were advised that work was ongoing to promote robust briefing notes to increase recognition of pressure ulcers at the front door.
(iii) Following discussion on the data presented within the report, committee members requested further detail in reference to the stroke bundle compliance, specifically requesting trajectory data in order to provide assurance. Furthermore, colleagues sought further narrative on the overdue completion dates to provide further detail on delays. Committee members were advised that the gap in stroke data was as a result of a vacancy for a Clinical Risk Manager however it was agreed that such suggestions would be undertaken as actions.

(iv) A question was raised on the measurement of the impact of data obtained from the Electronic Observation System (eObs). Assurance was provided that a variety of measurements were in place such as identifying deteriorating patients during patient safety huddles, recording of admissions to the Intensive Care Unit, cardiac arrest data, hospital at night reports and Transforming Care at Bedside audits.

The Clinical Governance Committee noted the current position, challenges, and quality improvements being made in relation to the specific Scottish Patient Safety Programme (SPSP) measures and compliance with national targets.

Action: -

(1) Ensure further trajectory data, timelines and narrative is incorporated into future reports. Ashley Calvert

8.2 Whole System Assurance Report

The Clinical Governance Committee received the 'Whole System Assurance Report' presented by Mr Ashley Calvert.

The purpose of the report was to provide assurance that the clinical governance processes within each of the directorates was working as intended.

Key messages in the report included: -

(i) Committee members were provided an overview of the continued improved format of the report and were advised that an additional section specific to clinical risks and mitigations was added to the report.

(ii) Overdue clinical guidelines and policies were identified as a risk to the Acute Services Directorate where it was noted that such delays in addressing overdue guidelines was correlated with the Clinical Governance Manager vacancy, which was being progressed through the recruitment processes.

The following points were made in discussion: -

(i) Committee members were assured that work was ongoing to address gaps within the Clackmannanshire & Stirling Health & Social Care Partnership (HSCP) governance arrangements.

(ii) Recognition of the improved report format was provided, where colleagues were content with the level of assurance provided.

(iii) Following discussion, the below amendments were sought to provide further clarity in future reports:

- Remove the use of acronyms.
- Provide further assurance of the plans in place following an issue raised within the escalation section of the report. Assurance was provided that such discussions were undertaken at the Clinical Governance Working Group such detail would be articulated in future reports.

The Clinical Governance Committee noted the: -

(1) agenda items discussed and presented at the Directorate Clinical Governance meetings with exception of Clackmannanshire & Stirling HSCP; Ashley Calvert

(2) and data sources provided within the report.

Action: -

(1) Implement the agreed amendments to future reports to provide further clarity and assurance.

8.3 Healthcare Associated Infection (HAI) Report

The Clinical Governance Committee received the 'Healthcare Associated Infection (HAI)' report presentation by Mr Jonathan Horwood.

The purpose of the report was to provide oversight of the HAI targets, Staph aureus bacteraemias (SABs), Clostridioides difficile infections (CDIs), device associated bacteraemias (DABs), incidents, outbreaks and all other HAI activities across NHS Forth Valley.

Key messages in the report included: -

(i) Committee members were advised that the Annual Operational Plan (AOP) targets remained to be established by the Scottish Government.

(ii) Total SABs, DABs, CDIs and ECBs reported cases remained within controlled limits.

(iii) Within the reported month of November 2024, there were:

- 4 hospital acquired DABs.
- 3 hospital acquired DABs.
- 4 hospital acquired ECBs.
- 1 hospital acquired SAB.
- No MRSA or c.difficile recorded deaths.
- No outbreaks.
- 1 surgical site infection reported through mandatory reporting. Committee members were informed of the ongoing work to expand the surgical site infection surveillance.

(iv) Work was ongoing as part of the safety collaborative to address ECB recorded cases correlated with urinary catheters and raise awareness within the primary and community care sectors.

(v) Assurance was provided that influenza cases had peaked within NHS Forth Valley and a reduction in cases was anticipated. Ms Laura Byrne noted the work ongoing within the pharmacy directorate to test the appropriateness of the use of anti-viral stock for potential learning regarding the impacts of testing for influenza.

The following points were made in discussion: -

(i) A question was raised on the certainty of influenza cases peaking, where it was advised that such predictions were in relation to inpatient and Emergency Department activity where it was advised that data showed a downward curve in cases. Committee members were informed that immunisation rates had decreased to pre-Covid 19 numbers however reassurance was provided that the uptake of those identified within the vulnerable group remained high.

The Clinical Governance Committee noted the: -

(1) performance in respect of the AOP Standards for SABs, DABs, CDIs and ECBs;

(2) and detailed activity in support of the prevention and control of HAI.

8.4 Scottish Patient Safety Programme (SPSP) Perinatal Update

The Clinical Governance Committee received the 'Scottish Patient Safety Programme (SPSP) Perinatal' paper presented by Dr Aileen Cope and Ms Helena Marshall.

The purpose of the paper was to provide an overview of the aims of the SPSP Perinatal Programme which was co-designed to improve outcomes for women, birthing people, babies and families across Scotland.

Key messages in the report included: -

(i) Committee members were provided with an overview of the programme aims, it was noted that the project team would review the programme aims and establish smaller sub working groups to facilitate delivery and implementation.
(ii) A review of the SPSP stillbirth change package identified the reduction of birthing people identified as smoking at booking as an area of improvement. Assurance was provided that collaborative work was being undertaken with the smoking cessation service.

The following points were made in discussion: -

(i) A question was raised on the preparedness of the service with regard to an unannounced inspectorate visit. Assurance was provided that a regular meetings were undertaken within the department to explore implications and prepare the site in preparation for a visit. Furthermore, it was noted that peer review initiative with NHS Dumfries & Galloway would be undertaken to facilitate shared learning, and local governance arrangements were in place to understand the work being undertaken.
(ii) Detail was sought on further areas of improvement, where it was advised that early intervention work was ongoing to facilitate the recognition of patient deterioration, supported by the eObs system once implemented. Furthermore, a one system collaborative approach was ongoing to support gestational diabetic mothers.

The Clinical Governance Committee noted the aims of the SPSP Perinatal Programme.

9. In Our Service, Will Care Be Safe in the future?

9.1 Public Health Update

The Clinical Governance Committee received the 'Public Health Update' paper presented by Dr Jennifer Rodgers.

The purpose of the paper was to provide assurance that all principles and standards of clinical governance were applied to the Public Health Directorate.

Key messages in the report included: -

(i) Assurance was provided that the principles and standards of clinical governance continued to be applied to the Public Health Directorate as a result of the recent established governance arrangements.
(ii) The Public Health Directorate Clinical Governance Group Terms of Reference was confirmed on 11 November 2024, informing bi-monthly meetings where flash reports are reviewed, and deep dives are discussed and escalated to the Clinical Governance Working Group and Clinical Governance Committee, as appropriate.
(iii) Committee members were advised of the Public Health Directorate's focus on aligning to national strategies and priorities.

The following points were made in discussion: -

(i) Dr Jennifer Rodgers sought further direction on the desired reporting from the committee. Committee members noted the significant universal approach undertaken by the directorate to strengthen governance arrangements.

The Clinical Governance Committee noted the clinical governance arrangements implemented and established in the Public Health Directorate.

9.2 Strategic Risk Register

The Clinical Governance Committee received the 'Strategic Risk Register- Update to Clinical Governance Risks' paper presented by Miss Vicky Webb.

The purpose of the paper was to provide an update on the Strategic Risk Register, with a focus on Clinical Governance Risks.

Key messages in the report included: -

(i) All three strategic risks aligned to the Clinical Governance Committee were reviewed, where it was noted that there was no change to the scoring of the Strategic Risk Profile.

(ii) At the 12 November 2024 committee meeting the closure of SRR016: Out of Hours risk was proposed, where it was agreed that confirmation from Sir Lewis Ritchie was sought prior to approving the risks closure. Assurance was provided that a formal letter was received from Sir Lewis Ritchie confirming discontinuation of any further scrutiny of NHS Forth Valley Out of Hours services, and therefore SRR016 was being proposed for closure from the Strategic Risk Register.

(iii) Following a committee structure review from the NHS Forth Valley Board Chair and Chief Executive, consideration of strategic risks and the alignment to assurance committees was undertaken, where it was found that the below risks would be reported into the Strategic Planning, Performance & Resources Committee:

- SRR002: Urgent & Unscheduled Care
- SRR004: Scheduled Care

(iv) Within the reporting period, there were:

- 25 controls mitigating the strategic risks.
- 5 actions identified to mitigate the strategic risk profile.
- no overdue actions.

(v) NHS Forth Valley's risk appetite profile of the strategic risks remained static in quarter 3.

The following points were made in discussion: -

(i) In light of the proposal for there to be no focused risk review updates provided to future Clinical Governance Committee meetings, concern was raised over the opportunity to capture quality and safety of care risks. It was agreed that a further discussion regarding future risk arrangement would be undertaken.

The Clinical Governance Committee: -

(1) endorsed the Clinical Governance strategic risks for the period of November 2024 to January 2025 for onward reporting to the NHS Forth Valley Board; and closure of the SRR016 from the Strategic Risk Register for approval at the NHS Forth Valley Board.

(2) noted the assurance provided regarding the effective management and escalation of risks aligned to the committee; and changes to the reporting requirements for the strategic risks aligned to the committee.

Action: -

(i) Discuss future risk update arrangements to the Clinical Governance Committee, with consideration of quality and safety of care risks. — Frances Dodd, Vicky Webb & Michele McClung

10. Is Our Care Person Centred?

10.1 Person Centred Care Report

The Clinical Governance Committee received the 'Person Centred Care Report: December 2024' presented by Mrs Eilidh Gallagher.

The purpose of the report was to assess feedback mechanisms in place across NHS Forth Valley and performance in line with national key indicators.

Key messages in the report included: -

(i) Committee members were advised that performance in 2024/2025 had demonstrated improvements in comparison to 2023/2024, however, the challenge on the service remained with significant backlog.

(ii) Following concern raised in relation to General Surgery complaints levels at the 11 November 2024 committee meeting, assurance was provided that a deep dive was undertaken where it was highlighted that such complaints were correlated to waiting times as opposed to patient safety concerns. Reassurance was provided that discussions were ongoing to explore mitigations and improvements in patient engagement in their care plans.

(iii) It was advised that 2 band 5 posts were to commence within the service to support the complaint backlogs.

(iv) NHS Forth Valley received the FutureScot grant programme to consider how AI can support the organisation to improve performance and triangulate learning.

(v) A risk matrix was established in Summer 2024, developed in correlation with the National Risk Matrix, and formally implemented on Safeguard to recognise previous missed harms.

The following points were made in discussion: -

(i) Committee members noted the service's positive direction of travel, however noted the work required to enhance complaints information on the organisation's public website and explore additional resources and capacity to support improvements.

(ii) It was advised that a review of the service's skill-mix was undertaken to maximise resource, however it was noted that the service remained under resourced to meet the demands.

(iii) Ms Laura Byrne provided assurance that work was ongoing to upskill volunteers to support a patient's discharge journey following complaints regarding medication.

(iv) Further detail was sought on the overdue actions outlined within the action log, where it was agreed that updated narratives would be incorporated into the next report.

(v) A question was raised on the mitigations in place to support staff wellbeing within the service, where it was advised that work was ongoing to explore all opportunities, with a focus on initial impressions and early resolution work within wards. Furthermore, a business case was being devised with the hope of obtaining short-term non-recurring funding to address the complaints back log, and the development of a model to outline how to manage complaints with workloads. Reassurance was provided that the service's staff wellbeing concerns were identified as a risk at the Staff Governance Committee.

(vi) Following discussion on staff wellbeing, it was proposed that clinical staff on sick leave could be redeployed on a short-term basis to support workload. However, committee members were advised that such efforts were trialled and were not considered as effective. Committee members were advised that work was ongoing to scope redeployment opportunities where it noted that there weas potential support from consultants.

The Clinical Governance Committee:
(1) noted the ongoing organisational risk associated with current position;
(2) noted the mitigating steps undertaken and improvements demonstrated;
(3) noted variance in demand and capacity within patient relations.
(4) endorsed the ongoing performance monitoring with escalation through Clinical Governance Groups.

Action:
(1) Provide further narrative on the overdue actions outlined within the Person Centred Care action log. Frances Dodd/ Eilidh Gallagher

11. Are We Learning and Improving?

11.1 Significant Adverse Event Report

The Clinical Governance Committee received the 'Significant Adverse Event Report' presented by Mr Ashley Calvert.

The purpose of report was to provide the Clinical Governance Committee with information on Significant Adverse Events (SAEs) in relation to the requirements specified by the Scottish Government.

Key messages in the report included: -
(i) Limited assurance was provided due the performance being outwith key performance indicators from the Healthcare Improvement Scotland (HIS) Framework. However, committee members were informed of the work undertaken to improve performance.
(ii) Work was ongoing to develop an improvement plan to capture SAE data on Safeguard.
(iii) Further analysis was undertaken to enhance measures however it was noted that challenges remained within the commissioning space.
(iv) Committee members were advised that the outcome codes for SAERs were identified as 3 or 4, which indicated that no inappropriate SAERs were being commissioned.

The following points were made in discussion: -
(i) Following a query on local and operational performance monitoring matrixes, committee members were advised of the ongoing work to make performance available to teams to provide a better understanding of SAER processes and promote local ownership. Furthermore, noting the newly established care groups within the acute directorate which facilitated the accountability of teams in relation to SAERs.
(ii) Further clarity was sought on the timescale and journey of SAER 102, where it was agreed that further narratives on SAER timescale would be incorporated into future reports to understand delays and risks.

(iii) A concern was raised over SAERs without an assigned lead reviewer. Reassurance was provided that a significant number of staff were trained to undertake SAERs and were undertaking shadowing opportunities, therefore future improvements were anticipated.
(iv) In reference to the target of 90% of all SAERs being commissioned being completed within 140 days by December 2026, outlined within Appendix 2. Assurance was sought on the oversight and monitoring of work to achieve the target where it was noted that a variety of detailed plans were devised and discussed at the Clinical Governance Working Group for assurance.

The Clinical Governance Committee noted NHS Forth Valley's position on current SAERs with specific regard to compliance of the commissioning, completion, acceptance of SAERs and development of an improvement plan, within the timescales of the national framework.

Action:
(1) Provide further narratives on SAER timescales in future reports to understand delays and risks. Ashley Calvert

12. Are Our Systems Reliable?

12.1 Internal Audit Follow Up Actions

The Clinical Governance Committee received the 'Internal Audit Actions Follow Up' report presented by Mr Ashley Calvert.

The purpose of the report was to provide oversight of the audit actions aligned to the remit of the Clinical Governance Committee.

Key messages in the report included: -
(i) As of 27 December 2024 there were:
- 2 overdue actions:
  - Departmental Review: Out of Hours Service.
  - Medicines Management Controlled Drugs Policy Ref 6.
- 3 actions with a status of 'check progress':
  - Annual Internal Audit Report 2023/24 Ref 3.
  - A15/21 Resilience Planning- in progress.
  - A18/24 Medicines Management Controlled Drugs Policy Ref 4- in progress.

The following points were made in discussion: -
(i) An update was provided on the Annual Internal Audit Report Ref 3, where it was noted that Ms Laura Byrne has commenced as Chair of the Clinical Policies Review Group, and a bow tie analysis was undertaken to understand the risk and implementations. It was noted that the outcome of the bow tie analysis would be presented to the Clinical Governance Working Group. Committee members sought further narrative on the work undertaken to address overdue policies and guidelines, recognising the requirement to consider inappropriate and outdated documents.
(ii) Assurance was provided that work was undertaken to address the Medicines Management Controlled Drugs Policy Ref 6, such as training staff to raise awareness. Committee members were advised that the action was complete and would be closed off following an update to Internal Audit and Pentana.

(iii) Committee members were advised that the Medicines Management Controlled Drugs Policy Ref 4 remained outstanding however the level of risk to the organisation had reduced due to a decrease in agency and bank staff usage.
(iv) In reference to Departmental Review: Out of Hours (OOH) Service Ref 2, Miss Vicky Webb advised committee members that performance indicated service improvement therefore it was proposed that the action was noted as complete and closed. Committee members sought further detail on performance indicators linked to OOH to provide assurance prior to endorsing the closure of SRR016: Out of Hours.

The Clinical Governance Committee: -
(1) noted the status of the six internal audits follow up actions aligned to the Clinical Governance Committee.
(2) considered the two overdue actions and the progress update provided.
(3) noted the proposed level of assurance.

Actions:
(1) Incorporate further narrative regarding the work undertaken to address overdue policies and guidelines, recognising the requirement to consider inappropriate and outdated documents. Laura Byrne
(2) Provide further detail on the performance indicators linked to the OOH service prior to endorsing the risk closure of SRR016. Vicky Webb

12.2 Professional Assurance Framework

The Clinical Governance Committee received the 'Professional Assurance Framework' presented by Prof Frances Dodd.

The purpose of the paper was to provide the committee with oversight of a draft Professional Assurance Framework which proposed a comprehensive system for NHS Forth Valley to adopt to be assured in relation to their clinical Staff's qualifications, registration and ongoing fitness to practice.

Key messages in the report included: -
(i) An overview of the draft Professional Assurance Framework was provided, and committee members were assured of the quality of the framework, where it was noted that work was being undertaken to further develop the document.

The following points were made in discussion: -
(i) It was agreed that any comments were to be submitted to Prof Frances Dodd and Mr Andrew Murray.

The Clinical Governance Committee: -
(1) noted the proposed Professional Assurance Framework and;
(2) approved engagement with staff side and the Senior Leadership Team.

12.3 Clinical Governance Working Group Update

The Clinical Governance Committee received the 'Clinical Governance Working Group Update' paper presented by Mr Ashley Calvert.

The purpose of the paper was to provide the committee with an update from the Clinical Governance Working Group in relation to key items discussed, noted and approved.

Key messages in the report included: -

(i) An overview of the new reports format and purpose was provided, where it was noted that work would continue to refine future updates presented.

The following points were made in discussion: -

(i) Committee members were content with the format of the new report and asked for further detail on the next steps of issues raised within the paper in order to provide further assurance.

(ii) It was suggested that the Clinical Governance Working Group Update could be moved to the beginning of future agendas to provide oversight of issues prior to detailed discussion within items.

The Clinical Governance Committee endorsed the Clinical Governance Working Group Update and noted key issues outlined within the paper.

Action:

(1) Provide further detail on the actions and mitigations implemented following discussion of issues at the Clinical Governance Working Group. Ashley Calvert

13. For Noting

13.1 Reports from Associated Clinical Governance Groups

13.1.1 The Clinical Governance Committee noted the Clinical Governance Working Group Minute from 10 October 2024.

13.2 Standards and Reviews

13.2.1 The Clinical Governance Committee noted the Standards and Reviews Report October 2024.

13.3 Scottish National Audit Programme (SNAP) Update

13.3.1 The Clinical Governance Committee noted the Scottish Intensive Care Society Audit Group paper. Committee members were advised that issues within the Intensive Care Service were experienced nationally, and were informed that due to operational challenges, an improvement was not anticipated however assurance was provided that concerns were being monitored.

13.3.2 The Clinical Governance Committee noted the Scottish Electroconvulsive Therapy Aduit Network paper.

14. Any Other Competent Business

An update was sought on the progress of procurement of a third CT Scanner to support cancer diagnostics. It was agreed that Prof Ross McGuffie would liaise with the Director of Acute Services to provide an update with timelines at the next meeting.

Action:

(1) Ross McGuffie to liaise with the Director of Acute Services to provide an update with timescales on the procurement of a third CT Scanner. Ross McGuffie

15. Date and Time of Next Meeting

Tuesday 11 March 2025 at 9:00am, in the Boardroom, Carseview House.

7.3. Minute of the Staff Governance Committee Meeting held on Friday 13 December 2024
For: Noting

Minute of the Staff Governance Committee Meeting held on Friday 13 December 2024 at 9.00am in the Boardroom, Carseview House and via MS Teams.

Present:	Mr Robert Clark	Mrs Karren Morrison
	Mr Nicholas Hill	Mr Allan Rennie (Chair)
	Mr Gordon Johnston	Ms Janet Sneddon
	Mr Stephen McAllister	
In Attendance:	Mrs Beth Allan (Minute)	Mrs Neena Mahal
	Mrs Pauline Beirne	Mr Cameron Raeburn
	Ms Elaine Bell	Mr Kevin Reith
	Mr Michael Brown	Mrs Linda Robertson
	Mr Martin Fairbairn	Ms Rachel Tardito
	Ms Morag Farquhar	Mrs Jo Tolland
	Mr Garry Fraser	Mr Scott Urquhart
	Mr Jack Frawley	Ms Vicky Webb

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1. Welcome, Apologies for Absence and Confirmation of Quorum
The Chair welcomed all present to the meeting. There were no apologies from members.

Apologies were noted on behalf of Mr Tom Cowan, Professor Frances Dodd, Ms Jackie McEwan, Ms Kerry Mackenzie and Ms Linda McGovern.

It was confirmed the meeting was quorate.

The chair welcomed Mr Martin Fairbairn to the meeting and congratulated his appointment as new chair of the Staff Governance Committee.

2. Declarations of Interest
There were no declarations of interest made.

3. Draft Minute of Staff Governance Committee Meeting held on Friday 13 September 2024.
The note of the meeting held on Friday 13 September 2024 was approved as an accurate record.

4. Matters Arising from the Minute / Action Log
In terms of matters arising, the Chair advised the actions relating to the Staff Governance Report would be discussed.

Item 1 - *Assurance & Improvement Update: Leadership and Culture* – Mr Kevin Reith provided the group with a verbal update and stated that an in-depth discussion has taken place on the agenda and amended as appropriate. Mr Kevin Reith confirmed the action is still ongoing and the Staff Governance Report has been adapted and developed, informed by the Action Log. It was agreed that Item 1 would be brought back to the Staff Governance Committee on Friday 14 March 2025.

Item 2– *Staff Governance Report* – Mr Kevin Reith stated that the completion date for this item should be updated to Friday 14 March 2025, so that it is in line with the audit completion date.

Item 4 – *Staff Governance Report* – Mr Kevin Reith confirmed that this item will remain on the Action Log and a further update will be provided at the next meeting on Friday 14 March 2025.

The Staff Governance Committee noted the Action Log Progress and clarified that no other matters arising were declared.

5. Staff Governance Committee Workplan

The Staff Governance Committee noted the following points in relation to the Workplan:

(i) Mr Kevin Reith highlighted that the Workplan will be a standing item on the meeting agenda, and this will be discussed at the meeting taking place on Friday 14 March 2025.

(ii) Mr Kevin Reith confirmed a draft 2025/2026 workplan will be established to reflect the plan for the next year's Staff Governance Committee meetings. Mr Kevin Reith reminded committee members that there are six Staff Governance Committee meetings scheduled and the new cycle and workplan will be adjusted to reflect these changes. A draft is in progress and an update will be provided at the next meeting in March 2025.

(iii) It was also highlighted that the meeting being held on Friday 14 March 2025 ties in with work on Performance Reporting. Update on Culture Change & Compassionate Leadership Programme (CC&CLP) will be shared with committee members in line with internal programme reporting through the Programme Board to the Senior Leadership Team (SLT).

(iv) Mr Kevin Reith confirmed that PDP training updates will be part of the workplan as part of routine performance reporting and discussions would inform proposals for specific reporting on this theme as part of the new workplan.

(v) Committee members were informed that the Primary Care Sustainability update will now be provided at the March 2025 Board.

The Staff Governance Committee:

- **noted** the update and rationale for changes to the workplan and the intention to present a new workplan for 2025/2026 at the 14 March 2025 meeting.

Actions:

(1) Staff Governance Committee draft workplan for 2025/26 to be developed for presentation to the 14 March 2025 meeting reflecting the discussions on specific workplan items. **Kevin Reith**

The Chair of the Committee **noted** no other matters arising and all Committee Members **noted** the Staff Governance Committee Workplan updates.

6. FOR APPROVAL

6.1 Staff Governance Report – Including Workforce Performance Reporting

The Staff Governance Committee received the Staff Governance Report.

The report provided the Committee with an update on a range of Staff Governance and Partnership priorities with focus on developing performance metrics against our aims.

Key messages in the report included: -

(i) Mr Kevin Reith highlighted the latest position on Employee Health & Wellbeing including Staff Absence, Employee Relations, Development and Resourcing activity. Mr Kevin Reith noted that work continues to focus on development of Performance Reporting. He noted updated reporting on specific elements of the report including Staff Turnover and Bullying and Harassment Cases which were in response to previous Committee discussions.

The following points were made in discussion: -

(i) Mr Robert Clark brought attention to Appendix 1 of the Staff Governance Committee Report and raised a point on the reference to 'unknown/other' on the reasons for staff leaving. Ms Elaine Bell agreed to speak to the HR Service Manager to investigate this issue.

(ii) Discussion took place around undiagnosed absence issues. Mr Stephen McAllister suggested that pro-active signposting would help to capture early undiagnosed absence issues. On this point, Mr Robert Clark confirmed this is part of a national sub-group work which will be undertaken with National Colleagues in early New Year.

(iii) The Staff Governance Committee noted the waiting times for Counselling, Psychology and Mental Health with concern that although there has been an improvement in waiting times for initial referral this still stood at an average of 25 weeks. This will be considered as part of the Occupational Health ongoing improvement work and further updates provided in future reporting.

(iv) Mr Kevin Reith highlighted that the Occupational Health Team with the support of our new Head of Service Aileen Love are assessing all support services to consider effectiveness and access issues. It was noted that every Board is looking at the Mental Health agenda as Anxiety, Stress and Depression remains the largest reason for absence. Ms Elaine Bell confirmed waiting times and referrals are moving in the right direction. It was noted that Mr Garry Fraser as chair of the Promoting Attendance group is considering additional support through "Able Futures" around Mental Health Issues and work on this will be part of future updates.

(v) Mr Allan Rennie noted updates on Reduction in Working Week and acknowledged the importance of completing work on the first phase as national update was awaited about the approach to the next phase of the reduction to 36 hours. Mr Kevin Reith confirmed that once this was received the Staff Governance Committee would be advised of next steps.

The Staff Governance Committee:

- **noted** updates to be provided on improving the 'unknown/other' reason for leaving as part of the information capture during exit interview process.
- **noted** exploration of alternative solutions for the health board to support undiagnosed absence issues.
- **noted** waiting times for Counselling, Psychology and Mental Health and support which is in place to develop and improve waiting lists**.**

Actions:

(1) Review figures for referrals and waiting times and work on undiagnosed absence issues to be included in future updates. **Kevin Reith/ Elaine Bell**

(2) Further update to the Committee on the next phase of the Reduction in Working Week when national guidance is shared. **Kevin Reith**

7. STAFF GOVERNANCE STANDARD ACTIVITY

7.1 Safe Staffing Report

The Staff Governance Committee received a 'Safe Staffing' update.

Key messages in the report included: -

(i) Mrs Pauline Bernie took lead in presenting the paper in Prof Frances Dodd's absence. It was stated that the report aimed to provide a briefing focusing on assurance. In this respect the Safe Staffing Pro-forma has been included to show the compliance report due to be submitted by 31 January 2025. The report identified that further assurance is required to ensure colleagues are compliant and Occupation Leads were identified for quarterly updates.

The following points were made in discussion: -

(i) The Committee **noted** the policies around support staffing and the implementation of E-rostering.

(ii) Mrs Pauline Bernie highlighted 98% of compliance was logged with daily reporting of Safe Staffing. Mrs Neena Mahal, Board Chair, expressed concerns around risk and areas of work to focus on to reach timelines. It was suggested that the cover paper should pull out areas of risk and Committee members concurred that reporting these risks in the Safe Staffing cover paper would provide the Board with assurance.

(iii) Mr Michael Brown provided an update to the committee around quarterly meetings taking place with government which address the risks and associated mitigation.

(iv) The Committee are to note that the 1-year report for Safe Staffing will be taken to the Staff Governance Committee Meeting in March 2025. Mr Michael Brown confirmed Prof Frances Dodd as Executive lead is provided with assurance of progress through our internal reporting. Mr Scott Urquhart provided the committee with an update that the Safe Staffing Paper supports Financial Risk. It was noted that this will be highlighted to Strategic Planning, Performance and Resources Committee on Tuesday 17 December 2024.

The Staff Governance Committee:

- **noted** the request for risks and mitigation to be highlighted as part of future reporting.

Actions:

(1) Safe Staffing reporting to cover risks and mitigations in future updates. **Frances Dodd**

7.2 Speak Up/Whistleblowing Report

The Staff Governance Committee received a "Speak Up/Whistleblowing Report" update.

Key messages in the report included: -

(i) The report identified that NHS Forth Valley had investigated 23 Concerns, 9 Stage 1 and 14 Stage 2 around Whistleblowing. A copy of the table has been included in the report which details Stage 1, Stage 2 and closed complaints.

(ii) It was highlighted that training completion is at 70% which is an increase from the last report.

The following points were made in discussion: -

(i) Mrs Pauline Bernie identified the main key areas to highlight were that bimonthly meetings were scheduled, and work is progressing to ensure processes are strengthened. The committee were asked to note National Speak Up Week will be taking place for all Whistleblowing Leads/Champions and all content will be shared widely.

(ii) Future plans are put in place to provide more support including simulation training.

(iii) The Staff Governance Committee were informed that Speak Up Ambassadors being engaged with and activity will continue to be incorporated into this report.

(iv) It was confirmed that additional stages have been added to processes and include ensuring contact with all whistleblowers as part of the updating process. Feedback letters are being implemented to capture the nature of the issues. It was also suggested that new templates will help to clarify actions which have been agreed in response to complaints.

The Staff Governance Committee: -

- **noted** future training plans including use of Simulation training
- **noted** the plans for National Speak Up Week
- **noted** conversations which will take place to ensure the effective operation of the roles of Speak Up ambassadors

7.3 Culture Change and Compassionate Leadership Programme Updates

The Staff Governance Committee received a “Culture Change and Compassionate Leadership Programme” update.

Mr Kevin Reith and Ms Jo Tolland presented the paper.

Key messages in the report included: -

(i) The report identified a wide programme of work which is progressing and that there will be further reporting to the NHS Board in January 2025. Ms Jo Tolland provided all Committee Members with a presentation on the workstream activity as part of the implementation phase which commenced in December 2024. It was identified that all 8 project workstream are set for launch in the next 6 months with the focus on delivering on the key issues identified through our extensive staff engagement activity.

The following points were made in discussion: -

(i) Committee Members were given an update on the Culture Change and Compassionate Leadership Action Plan. It was noted that the first 3 project workstreams have been defined and aim to complete initial work by Spring 2025.

(ii) Committee Members were also informed that the programme will have a 'plan on a page' developed for sharing to the Committee and presenting to the Board to provide a overarching understanding of the work ambitions.

(iii) An updated paper for the Board will be circulated to all committee members with the additional content in advance of its presentation in January 2025 additional assurance.

The Staff Governance Committee: -

- **noted** the actions to provide more insight to the Board on the Culture Change & Compassionate Leadership Programme which will be presented at the NHS Board meeting in January 2025
- **noted** that proposals for NHS Forth Valley values will be presented to the Board as part of setting our strategic direction
- **noted** the intent to present highlight reports to Staff Governance Committee which will track programme delivery noting work will progress on developing methodology on outcome measurement as part of our performance reporting work.

Action:

(1) The updated Culture Change and Compassionate Leadership Programme Paper will be circulated to all Staff Governance Committee members. **Kevin Reith**

7.4 Organisational Development Report including Learning and Education

The Staff Governance Committee received a "Organisational Development Report including Learning and Education" update.

Mr Kevin Reith presented the paper in Ms Linda McGovern's absence.

Key messages in the report included: -

(i) Mr Kevin Reith highlighted the update on a range of current Organisational Development updates in the report noting the update on the iMatter report for 2024 would be covered later on the agenda.

(ii) The Protected Learning Time for Agenda for Change staff partnership work now has 3 core work streams. One of these themes which is being focused on is the capture of activity on our systems to ensure consistency of reporting across Scotland.

(iii) The report highlighted some of the work which related to the Culture Change and Compassionate Leadership programme. In the work related to 'Getting Connected' Mr Kevin Reith referred to "Step into my Shoes" which is now being supported by the Organisational Development Team following a decision by Senior Leadership Team to further develop this programme.

(iv) The report identified the demand for coaching, mentoring support and the extended range of development activities. Mr Kevin Reith informed the Committee that all items in the report will be influenced by our culture change activity and the new Head of OD will review the portfolio of work on appointment later this year.

(v) The report highlighted current work at a national level in relation to standardisation of Statutory and Mandatory training across NHS Scotland. The committee was also asked to note work within NHS Forth Valley to standardise induction.

The following points were made in discussion: -

(i) Mr Robert Clark referred to the Statutory and Mandatory training and consistency across all Boards in Scotland. Mr Kevin Reith indicated that this was the intent behind the present national work and advised Committee Members that updates would be provided on new developments and assurance around how we would

adjust current practice. It was noted that Ms Linda McGovern is currently working on this area until the Head of OD is appointed.

(ii) Work was also highlighted around Equality and Diversity; Mr Kevin Reith indicated that this will be a focus in the coming months starting with a Board development session. Further work is anticipated in relation to building into our future reporting to Staff Governance Committee.

(iii) Ms Neena Mahal identified the value of being clear around areas of risk in relation to meeting targets and ambitions. This was accepted as a general area of focus for building into future reporting. Ms Neena Mahal also highlighted our need to consider work experience changes we may need to make to support progression in certain career paths. Mr Kevin Reith advised that the team are currently working on plans as part of our Employability agenda.

The Staff Governance Committee: -

- **noted** the sector wide plans for Statutory and Mandatory Training standardisation with updates to be provided as these progress
- **noted** the focus of work around Equality and Diversity
- **noted** the development of plans to support Work Experience as part of our Employability agenda.

7.5 iMatter Update

The Staff Governance Committee received an “iMatter” update.

Mr Kevin Reith presented the paper in Ms Linda McGovern’s absence.

Key messages in the report included: -

(i) Mr Kevin Reith highlighted to all Committee Members that reflections from the experience in 2024 are being built into iMatter cycle 2025. Committee members were asked to note that our local experience has now been assessed in the context of the national report recently received and shared with the Committee.

(ii) The report identified that our Employee Indicator Score has remained at 76 which has remained static from our past two years. The response rate is down 3% to 58% from the previous year.

(iii) Mr Kevin Reith informed committee members action plan completion has been positive with an increase of 1% from last year for performance indicator for completions within the 8-week window, noting that this remains an ongoing process.

(iv) It was identified that Reporting of Concerns question responses were positive (Confident to Raise Concerns – 78; Confident they Would be Followed Up 72) and were close to the national average.

(v) The focus for our future work is NHS Forth Valley continues to Build and Grow noting the iMatter programme has been 10 years in evolution and there are challenges acknowledged nationally how it continues to remain meaningful to staff. The Committee were asked to note that there are plans to complete a national review during 2025/26.

The following points were made in discussion: -

(i) Mr Gordon Johnston referred to the limitations with iMatter and how visibility responses remain slightly low, requiring board members to continue to focus on how to rectify. Mr Robert Clark added that visibility of outcomes at team level might impact on 2025 responses with actions required including increasing engagement and updating the system.

(ii) Ms Neena Mahal, Board Chair, addressed issues around Board visibility and the need for culture work to include actions for the Board. Clarity was sought around linking iMatter into the report and focusing on the evidence around the Culture Programme.

(iii) Ms Jo Tolland confirmed that iMatter data was used from the start of the programme and there was a commonality with themes.

(iv) Discussion took place around staffing pressures to complete iMatter. Themes noted in the discussion included the questionnaire being a point in time assessment based on how staff felt at that point and challenges in relation to work life/balance. It was agreed that we will continue to monitor the national review but that opportunity for different types of local engagement would continue to be explored.

The Staff Governance Committee: -

- **noted** the local outputs in the context of the national report
- **noted** comments and concerns raised on the iMatter
- **noted** the need for communications of outcomes going forward

7.6 Workforce Planning Update Report

The Staff Governance Committee received a "Workforce Planning Report" update which confirmed national changes proposed by Scottish Government in relation to workforce planning expectations for NHS Boards and Health & Social Care Partnerships.

Key messages in the report included: -

(i) Mrs Linda Robertson identified that a Workforce Planning update was due to be submitted to Scottish Government on 17 March 2025 and will be brought back to Staff Governance Committee at the next meeting on Friday 14 March 2025.

(ii) It was confirmed that a review was taking place of the Workforce Planning Processes and a would inform future reporting to the Staff Governance Committee in 2025/26.

The Staff Governance Committee: -

- **noted** the update on the draft Workforce Planning Report paper
- **noted** further updates proposed on Workforce Planning in 2025/26 as a result of the review of activity to inform our governance arrangements

7.7 Staff Governance National Monitoring Return

The Staff Governance Committee received a "Staff Governance National Monitoring Return" update.

It was identified that the provision of an Annual Return has been paused from 2023/2024 to facilitate a review, although NHS Boards are expected to maintain monitoring locally.

Key messages in the report included: -

(i) Mrs Linda Robertson confirmed that during the national pause our local focus is on developing our performance reporting to monitor action plans. Committee members were advised that SG monitoring information is being populated onto the Pentana System by services and will support any future Scottish Government requests for monitoring information in the future.

The Staff Governance Committee: -

- **noted** commitment to continue to provide assurance that work continues to uphold the Staff Governance Standard
- **noted** the focus on performance reporting in the Pentana System to populate Action Plans
- **noted** the board data requested by Scottish Government.

7.8 Internal Audit Actions Update

The Staff Governance Committee received a "Staff Governance Internal Audit Actions" update.

Key messages in the report included: -

(i) The report identified that a reasonable level of assurance was provided. Target dates had been signed off and a few were proposed for extension with an appropriate rationale. The report noted new actions arising from relevant audits since the previous update.

The following points were made in discussion: -

(i) Mr Kevin Reith informed the Staff Governance Committee the eESS System has an action outstanding, and an audit recommendation extension was required

(ii) Mr Scott Urquhart identified that the Annual Control Evaluation Report was due to be approved at the January 2025 SLT meeting with management to update comments and then issue to all committees

(iii) Ms Neena Mahal addressed concerns around Primary Care Sustainability, Risks and risk work must be undertaken. Ms Vicky Webb will follow this up

The Staff Governance Committee: -

- **noted** the current status of outstanding actions and supported the level of assurance proposed

7.9 Staff Support & Wellbeing Update Report

The Staff Governance Committee received a "Staff Support & Wellbeing Report" update.

A presentation was shared by Rachel Tardito to all Committee members.

Key messages in the report included: -

(i) The Committee was provided with an update on support to staff being given on our Financial wellbeing platform.

(ii) It was noted that the work on Protected Learning Time and the "Celebrating Success" workstream of Culture Change and Compassionate Leadership programme were positive aspects of our Staff Support and Wellbeing activity.

(iii) It was noted that input on Wellbeing was being provided to the "Safe, Well and Heard" workstream of the Culture Change and Compassionate Leadership programme which is in progress for work around relationships

(iv) Neurodiversity Training video will soon be available on the intranet for all staff

(v) The report indicated that a new plan will be submitted in August 2025 and to cover the period up to 2029

The following points were made in discussion: -

(i) Discussion took place around staff support and how this will be a huge component of culture change.

(ii) Additional training and resources are being identified to support potential changes

The Staff Governance Committee:-

- **noted** a new plan will be submitted in August 2025
- **noted** the work to support staff through the Financial wellbeing platform
- **noted** the connections between the Staff Support and Wellbeing and Culture Change and Compassionate Leadership programmes
- **noted** the Neurodiversity Training resources being made available on intranet Net for all staff

8. RISK MANAGEMENT

8.1 Strategic Risk Register

The Staff Governance Committee received the 'Strategic Risk Register'.

Key messages in the report included:-

(i) All risks associated with the Staff Governance Committee remain static and all actions are progressing as expected

(ii) There was one action that is overdue, which relates to Primary Care Sustainability. The Staff Governance Committee were informed that the wording has been changed around the risk description and a lot of time has been spent on the Focus Review which will allow more in-depth actions to be changed to focus on risk

(iii) The report indicated that Quarter 2 will have an appetite of 21% of Board Tolerance

The Staff Governance Committee:

- **considered** the assurance provided regarding the effective management and escalation of Staff Governance risks
- **noted** the ongoing actions around risk management
- **endorsed** the Staff Governance Strategic risks for onward reporting to the Audit and Risk Committee and NHS Board.
- **noted** several risks were to be reviewed under Primary Care Sustainability and will be brought to NHS Board for further discussion

Actions:

(1) Review of Primary Care Sustainability Risk to be taken to Board for discussion. **Vicky Webb**

8.2 SRR009: Workforce Plans Focused Review

The Staff Governance Committee received the 'Workforce Plans Strategic Risk Focused Review'.

Key messages in the report included: -

(i) The report identified some strengthening was required around Workforce Planning

(ii) Miss Vicky Webb highlighted the work around a 1:1 Bow-tie analysis and that a slight change in the score has been identified

(iii) Section 2 of the report stated that there are other controls which need to be worked on including, control 1, 3, 6 and 7

(iv) Miss Vicky Webb also highlighted gaps around Section 3 of the report and gaps within the assurance map. An overarching plan and routine monitoring would take place to help create processing and improve these gaps

The following points were made in discussion: -

(i) A limited assurance assessment for risk gaps in the overall insurance map presentation highlighted the following:

(ii) Mr Gordon Johnston highlighted concerns around text under section 2.2 in the report. A better understanding of this was required for all Staff Governance Committee members to understand

(iii) Mr Kevin Reith suggested some of the work was progressing in relation to workforce establishment review through the Nursing & Midwifery Workforce Group. The committee were asked to note the understanding of a sustainable a workforce establishment was required for all staff groups to assess the challenges faced

(iv) The impact of Attendance Management was outlined, noting the impact this had on assurance levels for workforce planning. Committee members were asked to note the connection with the work on Promoting Attendance previously discussed.

(v) The Committee noted the importance of management ensuring the right level of support for staff who are off sick. Ms Elaine Bell noted that development of our culture of support for long-term sickness absence was part of the Promoting Attendance Group's workplan.

The Staff Governance Committee:

- **noted** the strengthening requirements around Workforce Planning and Prof Frances Dodd, Mr Michael Brown and team are capturing these actions
- **noted** the understanding of sustaining a workforce establishment and the challenges faced
- **noted** the bow-tie analysis in place to support Attendance Management
- **endorsed** the proposed assurance level for Audit and Risk Committee

8.3 Health & Safety Quarterly Report

The Staff Governance Committee received the 'Health & Safety Quarterly Report'.

Key messages in the report included: -

(i) Sections 5.1 and 5.2 on Adverse Events noted an overall increase in numbers reported over the last couple of years but that no significant spikes were identified within the data.

(ii) 5.4 identified the review of events and there was a reduction in events being reviewed in the target period which was causing concern. Assurance was given to the monthly focus on work within Acute Servies to address this problem. It was noted that support was being provided across services to improve reporting given the increase in events.

(iii) Quarter 2 Reports identified Health and Safety issues around Health Records Department., reporting a case note injury and a weight limit requirement for health notes

(iv) The report also highlighted the continuing requirement for a focus on improving training compliance levels.

The following points were made in discussion: -

(i) Mr Robert Clark raised concerns with the decrease in training compliance, noting the 14% increase in Violence and Aggression events since the previous quarter.

(ii) Concerns were raised regarding the issues detailed within the report and the health and safety concerns. It was agreed that the report needs assurance that appropriate actions are being taken to address these issues. Several concerns have been raised as significant which required urgent attention. The Staff Governance Committee suggested that if improvements are not achieved these should be escalated to the NHS Forth Valley Board. Mr Kevin Reith acknowledged concerns and noted that this report will be brought back to SLT and progressed through the Performance Review cycle.

(iii) Concerns were also raised against the level of investment required in Mental Health services in relation to windows and doors. Mr Cameron Raeburn will follow up to provide additional assurance

(iv) Miss Vicky Webb noted that risk associated with Health and Safety compliance would be discussed further with Mr Cameron Raeburn

The Staff Governance Committee:

- **noted** compliance reports will be available for managers on the Intranet Portal and through email updates
- **noted** Acute Services needs to provide further assurance on work being undertaken to mitigate risks
- **considered** the update on Violence, Aggression and Manual Handling training which has limited assurance
- **noted** the proposal for additional assurance from the Senior Leadership Team to the Committee
- **noted** the contents of the report which provided appropriate assurance regarding Health and Safety Issues within NHS Forth Valley

Action:

(1) The next Health & Safety report to provide additional information relating to improvement actions as part of the update at the next SGC meeting in March 2025 — **Cameron Raeburn**

(2) Develop an Action Plan/ Recovery Plan for all key performance metrics over the next 12 months — **Ross McGuffie**

9. For Noting

9.1 Area Partnership Forum Minute from 270824

The Staff Governance Committee **noted** the Area Partnership Forum Minute.

9.2 Acute Services Partnership Forum Minute from 250724
The Staff Governance Committee **noted** the Acute Servies Partnership Forum Minute.

9.3 Facilities and Infrastructure Partnership Forum Minute 290824
The Staff Governance Committee **noted** the Facilities and Infrastructure Partnership Forum Minute.

9.4 Health and Safety Committee Minute from 130824
The Staff Governance Committee **noted** the Health and Safety Committee Forum Minute.

9.5 Joint Staff Forum Clackmannanshire & Stirling HSCP Minute from 300424
The Staff Governance Committee **noted** the Joint Staff Forum Clackmannanshire and Stirling HSCP Minute.

9.6 Joint Staff Forum Clackmannanshire & Stirling HSCP Minute from 190924
The Staff Governance Committee **noted** the Joint Staff Forum Clackmannanshire & Stirling HSCP Minute.

10. ANY OTHER COMPETENT BUSINESS

The Staff Governance Committee was asked to note the appointment of Mr Martin Fairbairn in taking over as Chair of the Staff Governance Committee.

A thank you was given to Mr Allan Rennie for his chairmanship of Staff Governance Committee.

11. DATE OF NEXT MEETING

Friday 14 March 2025 at 09:00am, Boardroom Carseview, Stirling

STRATEGIC PLANNING, PERFORMANCE & RESOURCES COMMITTEE

7.4 Minute of the Strategic Planning, Performance & Resources Committee Meeting held on Tuesday 25 February 2025.

For: Ratification

Minute of the Strategic Planning, Performance & Resources Committee Meeting held on Tuesday 25 February 2025 at 9.30am in the Boardroom, Carseview House.

Present:
Ms Neena Mahal (Chair)
Mr Robert Clark (Non-Executive Director)
Ms Fiona Collie (Non-Executive Director)
Mr Martin Fairbairn (Non-Executive Director)
Mr Gordon Johnston (Non-Executive Director)
Mr Stephen McAllister (Non-Executive Director)
Dr Michele McClung (Non-Executive Director)
Mr Allan Rennie (Non-Executive Director)
Mr John Stuart (Non-Executive Director)

In Attendance:
Dr Jennifer Borthwick (Director of Psychological Services, Mental Health & Learning Disability) Item 11
Miss Jennifer Brisbane (Corporate Services Assistant) Minute
Ms Elsbeth Campbell (Head of Communications)
Dr Jennifer Champion (Acting Director of Public Health)
Professor Frances Dodd (Executive Nurse Director)
Mr Garry Fraser (Director of Acute Services)
Mrs Janette Fraser (Head of Strategic Planning)
Mr Jack Frawley (Board Secretary)
Ms Claire Giddings (Corporate Performance Manager)
Ms Laura Henderson (Senior Performance Management Officer)
Ms Sarah Hughes-Jones (Head of Information Governance)
Mr Scott Jaffray (Director of Digital)
Ms Joanna Macdonald (Interim Chief Officer, Clackmannanshire & Stirling IJB)
Ms Kerry Mackenzie (Acting Director of Strategic Planning & Performance)
Ms Jackie McEwan (Corporate Business Manager)
Professor Ross McGuffie (Chief Executive)
Mr Andrew Murray (Executive Medical Director)
Mr Mark O'Hear (Serco Contracts Manager) Item 7
Mr Kevin Reith (Director of People)
Mr Iain Shaw (Serco SPV Manager) Item 7
Mrs Jillian Thomson (Deputy Director of Finance)
Mr Scott Urquhart (Director of Finance)
Mrs Nicola Watt (Emergency Planning & Resilience Manager) Item 7
Miss Vicky Webb (Corporate Risk Manager)
Ms Gail Woodcock (Chief Officer, Falkirk IJB)

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1. Welcome, Apologies for Absence and Confirmation of Quorum
Apologies were noted on behalf of Ms Kirstin Cassells, Cllr Wendy Hamilton, and Cllr David Wilson. The Chair confirmed the meeting was quorate.

2. Declarations of Interest

There were no declarations of interest.

Item 7 was taken at this point in the meeting.

7. Update on the Impact of Storm Eowyn

The Strategic Planning, Performance & Resources Committee received the 'Update on Impact of Storm Eowyn' Paper presented by Mr Garry Fraser, Mr Iain Shaw, Mr Mark O'Hear and Mrs Nicola Watt. The paper provided detail on the power loss experienced within Forth Valley Royal Hospital on 24 January 2025 during Storm Eowyn, resulting in a Major Infrastructure Failure being declared.

Key messages in the report included:

(i) A Major Infrastructure Failure was declared due to full loss of power to Forth Valley Royal Hospital (FVRH) as result of a power surge through the national grid. Due to weather conditions experienced the telephone exchange went offline which resulted in complete loss of communication, lighting and running water in areas which required electrical power to function (e.g. wave taps).

(ii) The power outage within FVRH lasted approximately an hour.

(iii) Contingency plans were implemented on site to maintain care for patients and staff. A command structure was in place due to the red weather warning and within minutes a structure was in place to manage the power outage situation.

(iv) There was no recorded harm to patients due to the exceptional response of staff teams on site. Critical medical equipment is powered by a separate battery-operated Uninterruptible Power Supply.

(v) An on-site staff survey and debrief was undertaken to identify successes and understand areas of improvement.

The following points were made in discussion:

(i) It was noted that an update report would be presented at the March meeting of Forth Valley NHS Board.

(ii) In a response to a question raised on patient complaints, it was advised that no complaints were raised in relation to the events of 24 January 2025. It was noted that a positive letter had been received, commending NHS Forth Valley for their response and care.

(iii) Following a query raised regarding damage sustained to NHS Forth Valley estate in Cowie, assurance was provided that the Estates department responded immediately to reports, however detailed information would be sought and provided to Committee members.

(iv) Following discussion on business continuity, it was advised that standing operating procedures outlined the requirement to ensure that unused medical equipment maintained a charged battery in preparation for potential power outages.

(v) A Black Start test took place on 26 November 2024 and at that time everything was tested and working as normal.

(vi) Discussion highlighted the issues experienced with telecommunications and communication onsite. Assurance was provided that the Scottish Ambulance Service was able to cascade FVRH's position to partners and arrange diversion arrangements with surrounding health boards. Committee members were informed of two Airwave phones held within FVRH, however were advised that the signal onsite was not sufficient and improvements to the Airwave contract were being reviewed at a national level. Following discussion, it was noted that consideration would be given to what improvements could be put in place to ensure the phone systems within FVRH were protected.

Committee members gave a note of thanks to the staff across the whole system for the significant work undertaken to maintain patient safety during Storm Eowyn.

The Strategic Planning, Performance & Resources Committee:

(1) considered the detail provided in the report and took assurance that plans were in place to mitigate against recurrence of a similar event;

(2) considered the feedback from the staff survey and debrief note and took assurance that lessons learned would enhance the response to any future major incidents, and

(3) noted that the completion of any resultant actions would be overseen by the Emergency Planning & Resilience Group.

Actions:

(1) Schedule Power Outage Response Report for presentation at NHS Forth Valley Board. Jack Frawley

(2) The Director of Facilitates to provide further assurance on the response to damage of estate in Cowie and feedback to the committee. Morag Farquhar

Scott Jaffray

(3) Consider improvement options for telecommunications within Forth Valley Royal Hospital.

3. Minute of Strategic Planning, Performance & Resources Committee on 17 December 2024

The minute of the meeting held on 17 December 2024, subject to previous electronic circulation and committee member approval, was **confirmed** as an accurate record.

4. Matters Arising from the Minute / Action Log

The Strategic Planning, Performance & Resources Committee reviewed the action log and noted all actions that were complete.

Mr Scott Urquhart provided an update on action 94 in regard to the National Treatment Centre (NTC), advising that continued delays were due to the previously identified fire safety concerns. Discussions with Portakabin and Falkirk Council's Building Control were ongoing to consider a proposed building design solution. Following a question raised on the timescale and solutions, assurance was provided that NHS Forth Valley continued to provide regular updates on progress to Scottish Government, however Committee members were advised that a clear completion date could not be confirmed until a determination was reached on the building design proposals currently being considered by Falkirk Council and subsequently ratified by NHS Assure.

Further clarity was sought on the foil wrapping defect, where it was noted that once a fire safety resolution was agreed, NHS Forth Valley would instruct Portakabin to address the foil wrapping issue.

In response to a question around external media interest specific to the NTC, Mrs Elsbeth Campbell highlighted that there had been steady interest in this regard. It was noted however that as a result of the interim arrangements currently in place, NHS Forth Valley NTC was recognised as operational and there had been no specific requests around its status.

The Strategic Planning, Performance & Resources Committee noted the Action Log and NTC update aligned to action 94.

5. Strategic Planning, Performance & Resources Committee Terms of Reference

The Strategic Planning, Performance & Resources Committee received the committee Terms of Reference (ToR) presented by Ms Kerry Mackenzie, where it was noted that the ToR had been approved by the NHS Forth Valley Board. Committee members were advised of amendments to the format to align all Assurance Committees, however, were reassured that the content remained the same.

The Strategic Planning, Performance & Resources Committee noted the Terms of Reference.

6. Strategic Planning, Performance & Resources Committee Planner

The Strategic Planning, Performance & Resources Committee received the proposed Committee Planner for 2025-26 presented by Mrs Kerry Mackenzie.

Committee members were advised that the Planner would be developed throughout the year to ensure all items scheduled for Committee were reflected in the planner.

The Strategic Planning, Performance & Resources Committee noted the Committee Planner.

8. Finance

(a) Financial Sustainability Focused Risk Review

The Strategic Planning, Performance & Resources Committee received the 'SRR005: Financial Sustainability Focused Risk Review' presented by Mr Scott Urquhart. The purpose of the paper was to provide an assurance assessment on SR005: Financial Sustainability Focused Review.

Key messages in the report included:

(i) Committee members were advised of the two dimensions of the Financial Sustainability risk which resulted in it being regarded the highest risk for NHS Forth Valley with a score of 25.

(ii) There were 6 controls in place to mitigate the Strategic Risk, which saw a reduction from the previous 11 controls reported due to the amalgamation of controls. Of the 6 controls:
- 1 received a yellow status.
- 5 received an amber status.

(iii) The overall assurance recommendations were noted as 'Reasonable' in terms of the financial systems of control within the internal scope of NHS Forth Valley, and 'Limited' in terms of the external financial environment outwith the control of NHS Forth Valley.

The following points were made in discussion:

(i) A question was raised on the oversight of the control to optimise medicines spending, where it was advised that detailed review of such controls was undertaken at the Finance Sustainability Oversight Board.

(ii) Following concern raised over the understanding of risks across the system, assurance was provided that a whole system approach was adopted when implementing controls.

The Strategic Planning, Performance & Resources Committee considered and noted the evaluation of assurance provided for SRR005 for reporting to the Audit & Risk Committee.

Action:

(1) Consider if further oversight and assurance is required for the Optimise Medicines Spending control. — Scott Urquhart

It was agreed that Items 8b and 8c would be taken in conjunction.

(b) Finance Report

The Strategic Planning, Performance & Resources Committee received the 'Finance Report' presented by Mr Scott Urquhart. The purpose of the report was to provide an update on NHS Forth Valley's 2024- 2025 financial position.

(c) Financial Sustainability Oversight

The Strategic Planning, Performance & Resources Committee received the 'Financial Sustainability Oversight' paper presented by Mr Scott Urquhart. The purpose of the paper was to provide a progress update on the work of the Financial Sustainability Oversight Board (FSOB) during mid-December to early February and summarise the savings progress reports reviewed.

Key messages in the reports included:

(i) The in-year financial position continued to move in a positive direction with a steadily reducing projected deficit. However, it was noted that the non-recurring nature of improvements did not address the underlying recurring financial gap transferring into 2025-2026 therefore sustainable cost improvement and continued application of enhance internal financial controls were required.
(ii) Additional unplanned non-recurring funding from the Scottish Government was confirmed.
(iii) Following in-depth review of financial results, in conjunction with reassessment of projected savings delivery, funding allocations and changes in planning assumptions, the projected outturn deficit for year end was identified as £6.1m, with a potential for further improvement towards a break-even position.
(iv) NHS Forth Valley were on Level 1 of the national Scottish Government Support and Intervention Framework for finance.
(v) Approximately £26m of savings were achieved by the end of December 2024, which was £7.6m behind the planned savings trajectory.

The following points were made in discussion:

(i) Concern was raised over the significant increase in prisoners being transferred to Forth Valley Prisons and the associated financial impact. It was noted that such increases in prison population posed a key financial issue, with over 20% of Scotland's prison population situated in Forth Valley. Assurance was provided that such concerns were being raised at Scottish Government meetings. However, it was advised that additional funding was required to meet demand. Further assurance was provided that this issue would be raised at the national ministerial group. It was agreed that an update on Prisoner Healthcare should be added to the 2025-2026 planner.
(ii) Following discussion, committee members noted the importance of the messaging to be delivered to staff when considering financial pressures experienced within teams and that although good progress was being made and gratitude should be expressed to staff for their efforts, there is no room for complacency as we look ahead with pressures on finding recurring cost savings.
(iii) Committee members asked about NHS Forth Valley's position nationally and were informed of the Scottish Government's desire to support Value Based Health & Care work in order to drive a national move towards such approaches to finances.
(iv) Discussion also took place with reference to NHS Reform and Renewal and the requirement for greater Collaboration across Boards. Committee members were

informed of Scottish Government's expectation for Health Boards to support other Boards. Committee members raised concerns on the potential impact such expectations would have on the organisation and the population of Forth Valley.

The Strategic Planning, Performance & Resources Committee noted the contents of the Finance Report and Financial Sustainability Oversight Paper.

Actions:

(1) add Prisoner Healthcare to the Committee workplan. Jack Frawley

(2) consider messages of thanks to staff in relation to their support around financial pressures and uncertainty of non-recurring funding. Scott Urquhart & Elsbeth Campbell

(d) Draft Financial Plan 2025-26 to 2027-28

The Strategic Planning, Performance & Resources Committee received the 'Draft 3 Year Financial Plan 2025-25 to 2027-28' presented by Mr Scott Urquhart. The purpose of the paper was to provide comment on the draft financial plan for the 3-year period of 2025-2026 to 2027-2028 prior to it being received at the March Board for approval.

Key messages in the report included:

(i) The draft plan outlined a 3-year strategy to restore recurring financial balance through whole system reform and innovation, guided by the principles of Value Based Health Care.

(ii) The Scottish Government advised that payments to Integration Joint Boards (IJBs) in respect of delegated health functions during 2025-2026 must deliver an uplift of 3% over 2024-2025 recurring budgets.

(iii) A programme of service redesign and reform based on the principles of Value Based Health & Care (VBHC) will be implemented, aiming to support all services to operate within their available budget, whilst maximising value to the local population, by the end of the 3-year term of the financial plan.

(iv) A draft Scottish Government settlement letter for 2025-2026 was issued on 4 December 2024, highlighting the need for NHS Scotland to work collaboratively across organisational boundaries.

(v) In consideration of financial planning assumptions in conjunction with the impact of recurring pressures and unachieved recurring savings carried forward from prior years, the opening deficit was estimated at £51.8m for 2025-2026, reducing to £17.8m residual deficit after planned savings. Committee members were advised of the Scottish Government's plans to allocate non-recurring sustainability funding on a national basis to reduce the residual gap.

(vi) Stewardship & Culture was noted as a key priority underpinning the financial plan where the requirement of ensuring clear lines of financial accountability was highlighted.

(vii) Following submission of the draft plan, positive feedback regarding the approach taken to address longer-term financial sustainability had been provided from the Scottish Government.

The following points were made in discussion:

(i) Assurance was sought on the capacity and confidence of staff to take ownership of clinical budgets, where it was noted that work was required to find finance resource to invest time and commitment to ensure effective implementation of the approach. However, reassurance was provided that analysis of data was being undertaken at triumvirate level to facilitate the appropriate level of stewardship and encourage autonomy of budget decisions.

(ii) Concern was raised over the financial implications of staff absence. It was agreed that it would be beneficial to present such information to the Area Partnership

Forum to facilitate a robust discussion on actions which need to be taken to reduce staff absence.

(iii) In response to a question on contracts, Committee members were made aware of the increased percentage uplifts to contracts due to a lack of historical uplifts being implemented.

(iv) Members asked about the implementation and oversight of the VBHC approach. In response, the significant contribution required for the VBHC programme was noted, where emphasis would be placed on the importance of ensuring good governance across the system.

(v) Further detail and assurance was sought on the position and risk-share of deficits associated with funding allocated to IJBs and the need to have clarity on savings against the 15 box grid.

(vi) It was agreed that any additional comments on the draft plan should be directly submitted to the Director of Finance.

The Strategic Planning, Performance & Resources Committee:

(1) noted the Draft 3 Year Financial Plan.

(2) endorsed the approval of proposed payments to IJBs for the financial year 2025-2026 to the NHS Forth Valley Board.

Actions:

(1)	**Provide Area Partnership Forum with the financial implications associated with staff absences.**	Scott Urquhart
(2)	**Incorporate further detail on the deficits associated with funding allocated to IJBs.**	Scott Urquhart
(3)	**Members to feed in any comments on the plan and any areas that they would like covered at the Board Seminar on Finance, scheduled for April, to Mr Urquhart.**	All

9. Forward Look

The Strategic Planning, Performance & Resources Committee received a verbal update from the Chief Executive.

Key messages in the verbal report included:

(i) National work was being undertaken to achieve an NHS Scotland wide Planned Care approach, with the aim of rebalancing the number of patients waiting over 52 weeks for treatment across Scotland. Committee members were advised of the potential requirement to reprofile activity to support other Health Boards which could potentially impact on the population of NHS Forth Valley.

(ii) Discharge without delay work was progressing at pace as a result of NHS Forth Valley joining the Discharge without Delay collaborative with a positive response across the Forth Valley system.

(iii) Committee members were informed of the plan to investigate the feasibility of repurposing the unfunded ward A11, holding 32 patients and costing £2.2m per year, into a National Treatment Centre (NTC) ward by June 2025. This would involve the transfer of funds into the community supporting the movement of patients delayed in their discharge to the community.

(iv) A decision to pause the Adult Autism service to undertake service redesign had been made following significant increase in demand and lack of staff. It was acknowledged that the communications distributed to patients that suggested cessation of the service should have been clearer in the reasons for the steps being taken.

The following points were made in discussion:

(i) Committee members discussed the need for more information and a clearer understanding of the implications of and potential changes to planned care, following significant work that had been undertaken to maintain Planned Care during Covid and the benefits this had brought to Forth Valley waiting times.

(ii) Members sought assurance that an updated communication regarding the Adult Autism Service would be shared with stakeholders to ensure clear messaging.

(iii) Assurance was sought on the repurposing of ward A11, specifically in relation to the need for further work on the Urgent and Unscheduled Care (UUC) Plan. Assurance was provided that UUC pressures were being considered in plans and were anticipated to lead to improvements.

The Strategic Planning, Performance & Resources Committee noted the key updates provided.

Action:

(1) Share updated Adult Autism service communications with stakeholders and Committee members. — Joanna Macdonald

The Committee adjourned at 11.35am and reconvened at 11.45am with all members present as per the attendance list.

Item 11 was taken at this point in the meeting.

11. Psychological Therapies Update

The Strategic Planning, Performance & Resources Committee received the Psychological Therapies Update presented by Dr Jennifer Borthwick. The purpose of the presentation was to provide an update on the performance, demand and capacity of the Psychological Therapies directorate, aligned to national specifications.

Key messages in the presentation included:

(i) The Local Delivery Plan (LDP) standard was for 90% of patients to commence treatment within 18 weeks, where it was advised that NHS Forth Valley was below the Scottish average of 80% at 73.3%. Assurance was provided that despite NHS Forth Valley being below the national average, performance had begun to stabilise and steady improvements had been made.

(ii) Committee members were advised of the increased demand on Adult Psychological Therapies and the challenge experienced representing such demand in Referral to Treatment (RTT) data due to six specialities within the directorate achieving performance targets. Significant waits in Adult Psychological Therapies were noted, with 1859 patients waiting for 1 to 1 treatment, of which patients were waiting over 104 weeks. Processes were in place to keep in contact with patients.

(iii) Activity had increased however it was noted that due to continued rise in demand and a recent decrease in workforce, there was not enough resource to meet the level of demand. It was indicated that an additional 8 to 10 posts was required within the directorate to meet demand.

(iv) Health & Social Care Partnership budget pressures resulted in services being asked to identify a 5% budget reduction subsequently limiting future resource.

(v) Committee members were made aware of the improvement work undertaken specific to Adult Psychological Therapies and effective time-limited interventions.

(vi) The National Specification for the Delivery of Psychological Therapies and Interventions in Scotland outlined 7 key outcomes required by Health Boards. Committee members were advised of the work undertaken within NHS Forth Valley to achieve such targets and areas that required further development.

The following points were made in discussion:

(i) Questions were raised on maximising the use of Third Sector organisations and the commissioning of services to provide support and resource to areas of high demand. It was noted that more work was required to utilise stakeholder resource and that the Mental Health & Wellbeing Strategy would outline alignment with the Third Sector.

(ii) Members also asked if demand profiling was taking place so that support could be provided to those who need it most. Assurance was given that this took place.

(iii) Following a question raised on the reason behind Forth Valley having a significant unmet need, due to higher referral rates, in comparison with other national health boards, it was noted that increased demand was correlated to having better communication with Primary Care colleagues therefore resulting in increased referrals which were appropriate. It was suggested by Members that more work could be undertaken to consider health inequalities and the impact of this on referrals.

The Strategic Planning, Performance & Resources Committee noted the Psychological Therapies Update and recognised the ongoing work carried out within the directorate.

Action:

(1) Ensure the Mental Health and Wellbeing Strategy is contained within the workplan for consideration by Members. — Kerry Mackenzie

10. Risk Management

(a) Strategic Risk Register Update

The Strategic Planning, Performance & Resources Committee received the 'Strategic Risk Register' report presented by Miss Vicky Webb. The purpose of the report was to provide an update on the Strategic Risk Register as of February 2025, with a focus on the risks aligned to the Strategic Planning, Performance and Resources Committee.

Key messages in the report included:

(i) All 10 risks aligned to Strategic Planning, Performance and Resources Committee were reviewed and remained static. The following risks were subject to a focused review:
- SRR003: Information Governance
- SRR005: Financial Sustainability
- Update to SRR015: Cyber Resilience

(ii) At the 28 January 2025 NHS Forth Valley Board meeting, it was agreed that the below risks would be closed:
- SRR014: Healthcare Strategy
- SRR016: Out of Hours Service

(iii) Control SRR015.10: Review of cyber roles to support recruitment of vacant post and retention was noted as overdue, however assurance was provided that review of the action would be included in the update to SRR015.

The following points were made in discussion:

(i) Consideration was sought on the effectiveness of actions in place for SRR002: Urgent & Unscheduled Care, following the limited progress against actions with a due date of March 2025. Further clarity on progress was requested.

(ii) Members also asked that future reports should contain more detail on why certain actions were overdue.

The Strategic Planning, Performance & Resources Committee:

(1) noted the assurance provided in relation to the effective management and escalation of risks aligned to the committee.

(2) endorsed the risks for the period of January to February 2025 for onward reporting to the NHS Forth Valley Board.

Action:

(1) Provide further clarity and assurance on the progress of actions in relation to SRR002: Urgent & Unscheduled Care. Vicky Webb

(b) GP IT Reprovisioning Update

The Strategic Planning, Performance & Resources Committee received the 'GP IT Reprovisioning Update' paper presented by Mr Scott Jaffray. The purpose of the paper was to provide reasonable assurance that NHS Forth Valley continued to prepare the rollout of the GP IT Reprovisioning project, where possible, following the In Practice Services Limited (INPS) administrator's outcome.

Key messages in the report included:

(i) Contracts for the supply and support of GP Clinical Systems within Scotland were coming to end of life in summer 2026 and therefore required a replacement system.

(ii) The implementation of Docman 7 to Docman 10 had overlapped with the GP IT Reprovisioning project, reassurance was provided that timescales would be revised following the INPS administration outcome.

(iii) National delays were experienced due the readiness of the EMIS to Vision migration tool, Stalis, resulting in uncertainty. However, assurance was provided that the risk had substantially reduced as 2 national EMIS pilot practices in Tayside and Greater Glasgow & Clyde had successfully gone live with a similar data set to NHS Forth Valley.

The following points were made in discussion:

(i) Following a query on the process for the procurement of a new system, assurance was provided that it was a national solution lead by the Scottish Government and National Services Scotland.

The Strategic Planning, Performance & Resources Committee noted the report and change to risk profile.

12. Board Assurance Framework

The Strategic Planning, Performance & Resources Committee received a verbal update on the Board Assurance Framework provided by Mrs Neena Mahal and Ms Kerry Mackenzie.

Key messages in the verbal update included:

(i) Committee members were advised that work was underway in developing the Board Assurance Framework, taking cognisance of comments and feedback from the Board Development session on Active Governance held in December 2024. A draft paper would be circulated for comment prior to presentation at the 25 March 2025 NHS Forth Valley Board.

(ii) The Board Assurance Framework would be an iterative paper that would be used as a dynamic tool.

(iii) Assurance was provided that benchmarking with other Boards had taken place to develop the Board Assurance Framework.

(iv) The Board Assurance Framework would be aligned with the Code of Corporate Governance refresh and the ongoing governance improvement work.

The following points were made in discussion:

(1) Members noted that this work would support the refresh of Governance and the working of Committees. It was agreed that the draft framework would be circulated to colleagues for comment prior to final submission for the NHS Forth Valley Board on 25 March 2025 for approval.

The Strategic Planning, Performance & Resources Committee noted the Board Assurance Framework Update.

Action:

(1) Circulate the draft Board Assurance Framework paper to committee members for comment. — Kerry Mackenzie

13(a) Internal Audit Actions Follow Up

The Strategic Planning, Performance & Resources Committee received the 'Internal Audit Actions Follow Up' report presented by Ms Kerry Mackenzie. The purpose of the paper was to provide oversight of the audit actions aligned to the remit of the committee.

Key messages in the report included:

(i) Internal Audit Actions Follow Up was scheduled as a standing item for all NHS Forth Valley Assurance Committees.

(ii) Of the 16 reported actions aligned to the Strategic Planning, Performance & Resources Committee, the below updates were provided:

- Financial Compliance Ref 5 was noted as overdue. Assurance was provided that the action was in progress and was anticipated to be completed within 2 to 3 months.
- Internal Control Evaluation 2024/25 Ref 10 had a due date of 28 February 2025 and would be closed following discussion within Item 8a, Financial Sustainability Strategic Focused Risk Review.

The following points were made in discussion:

(i) Further understanding and oversight of overdue actions was sought by the Committee. It was noted that discussions regarding the monitoring of such actions would be undertaken at the Senior Leadership Team and for future reporting, where there were overdue actions, a clear explanation would be provided.

The Strategic Planning, Performance & Resources Committee noted the status of the audit follow up actions aligned to the committee.

Action:

(1) Ensure that future reports to Committee contain clear explanations of overdue actions and the rationale for any decision to extend the due date. — Kerry Mackenzie

13(b) Internal Control Evaluation Report

The Strategic Planning, Performance & Resources Committee 'Internal Control Evaluation' Report was presented Ms Kerry Mackenzie. The purpose of the report was to highlight the key sections of the Internal Control Evaluation report relevant to the Strategic Planning, Performance & Resources Committee Terms of Reference.

Key messages in the report included:

(i) The Internal Control Evaluation report 2024- 2025 contained 11 recommendations, intended to embed good governance principles and to ensure coherence between Governance Structures, Performance Management, Risk Management and Assurance. Of the 11 recommendations, the below sections were highlighted for consideration by the committee:

- Corporate Governance
  - Action Point Reference 1 – SPPRC Assessment
  - Action Point Reference 2 – Levels of Assurance
  - Action Point Reference 3 – Performance Reporting
  - Action Point Reference 4 – Risk Management
- Financial Governance
  - Action Point Reference 10 – Focused Risk Review
  - Action Point Reference 11 – Financial Sustainability
- An action from the Clinical Governance section was aligned to the Strategic Planning, Performance & Resources Committee as a result of changes in the reporting structures.
  - Action Point Reference 7 – SRR002: Urgent and Unscheduled Care

The Strategic Planning, Performance & Resources Committee noted the report

14. Information Governance

(a) Information Governance Annual Report

The Strategic Planning, Performance & Resources Committee received the 'Information Governance Annual Report' presented by Mrs Sarah Hughes-Jones. The purpose of the report was to provide assurance assessments on Governance & Accountability, Disclosure, Compliance and Assurance and to provide insight into the relative strengths and weaknesses of NHS Forth Valley's information governance arrangements.

Key messages in the report included:

(i) NHS Forth Valley's Governance & Accountability arrangements continued to be an area of strength with a number of controls in place.

(ii) Significant challenges were experienced with Disclosure workstreams, specifically in relation to the NHS Forth Valley's compliance with freedom of information laws. An upward trend in compliance was not sustained due to capacity challenges within the Information Governance Unit (IGU) following significant absence. Committee members were advised that the Office of the Scottish Information Commissioner (OSIC) was actively engaged in NHS Forth Valley's performance and had implemented a targeted remediation project.

(iii) Despite gaps in information governance compliance, reasonable assurance was provided that issues were being actively addressed with robust processes implemented.

(iv) In order to encourage Cyber awareness across the organisation, monthly communications were circulated to emphasise the threat caused by phishing to staff members.

(v) Committee members were advised of next year's focus on improving compliance of Information Governance training modules.

The following points were made in discussion:

(i) Concern was raised over OSIC escalating its open intervention from Level 1 to Level 3, citing NHS Forth Valley's inability to maintain consistent compliance. Further information and assurances on the processes and action required was sought. Assurance was provided that an agreed action plan with the OSIC was being put in place to respond to the Commissioner. Committee members were

advised that the jump from Level 1 to Level 3 was due to performance issues over prolonged period of time and that no discussions had taken place with the Commissioner's office about going to Level 2.

(ii) Members raised concerns that NHS Forth Valley had low performance in comparison to other Scottish Health Boards. In response, to provide further assurance, it was agreed that a further update following the meeting with the OSIC would be provided to the Committee.

(iii) Following a question raised on staff absence within the team, assurance was provided that there was no systemic issue experienced.

The Strategic Planning, Performance & Resources Committee noted assurance activity referenced in the report.

Action:

(1) Provide an update on the output of the meeting with the Office of the Scottish Information Commissioner at the April SPPR Committee. — Sarah Hughes-Jones & Andrew Murray

(b) SR003: Information Governance Focused Risk Review

The Strategic Planning, Performance & Resources Committee received the 'SRR003: Information Governance Focused Risk Review' paper presented by Mrs Sarah Hughes-Jones. The purpose of the paper was to provide an assurance assessment on SRR003.

Key messages in the report included:

(i) Of the 13 controls in place mitigating the strategic risk, there was: -
- 1 identified as a green status
- 2 identified as yellow status
- 6 identified as amber status
- 4 identified as red status

(ii) In reference to the assurance map outlined within the report, it was noted that there were 25 processes and individuals implementing controls, with 8 monitoring bodies reporting into the Strategic Planning, Performance & Resources Committee.

(iii) Committee members were advised of the further control of moving to SharePoint therefore providing an opportunity to review records management.

(iv) In order to progress with SRR003 mitigations and cyber risks, it was noted that work was required to maintain specialist staff due to issues experienced with the competitive nature of salaries within cyber. Assurance was provided that discussions were ongoing with Human Resources to review the banding assigned to specialist staff within the cyber team.

The Strategic Planning, Performance & Resources Committee:

(1) noted the evaluation of assurance provided for SRR003.

(2) noted the issues experienced with retaining staff within the cyber team due to competing salaries out with NHS Forth Valley and the actions being taken to address this.

(c) Cyber Security & Controls

The Strategic Planning, Performance & Resources Committee received the 'Cyber Security & Controls' paper presented by Mr Scott Jaffray. The purpose of the paper was to provide an update on the progress in relation to Cyber Security and Controls within NHS Forth Valley following the last Strategic Risk Review in December 2023.

Key messages in the report included:

(i) NHS Forth Valley tracked good progress in Cyber Security and Controls throughout 2024, where the below key developments were noted:
- A positive assessment of Network Information Services (NIS) controls was received in March 2024, and such progress continued against outstanding actions with all Back and Amber controls progressed ahead of the 2025 re-assessment.
- Following consultation with the Corporate Risk team, the Cyber risk was separated into SRR015 Cyber Resilience, with the additional of the organisational risk ORG 36 Internal Cyber Risk, with the intention of providing a better focus on actions and controls. Assurance was provided that such arrangements remained under review.

(ii) Concern was raised over the cyber resilience arrangements, specifically the emerging risk of the organisation's ability to attract and retain appropriate levels of skills in the competitive cyber market. Committee members were informed of the lack of coverage of cyber roles by national job profiles, with the standard Agenda for Change process not evaluating specialist roles at a level that would attract the necessary skillset. Assurance was provided that discussions were ongoing to explore resolutions.

The following points were made in discussion:

(i) Following proposal, it was agreed that a further Cyber Security & Controls deep dive would be added to the committee planner.

(ii) A question was raised on the discrepancy of job evaluation of cyber roles across health boards, where it was advised that such difference may have been related to the health board's design of jobs. Assurance was provided that job evaluation for such roles was under review.

(iii) Members sought assurance around the timing of the implementation of the Fairwarning System and asked for a further update to be provided.

The Strategic Planning, Performance & Resources Committee:

(1) noted the progress made in managing Cyber Security and Controls across NHS Forth Valley.

(2) noted the issue pertaining to the review of cyber security job roles and the review which was underway.

Action:

(1) Amend the date of the next Cyber Security & Control focussed review on the Committee Planner to enable oversight earlier than planned. — Jack Frawley

(2) Provide an update on the timeline for the implementation of the Fairwarning system — Scott Jaffray

(d) Information Governance Group Minute

The Strategic Planning, Performance & Resources received the Information Governance Group Minute from the meeting held on 3 October 2024.

The Strategic Planning, Performance & Resources Committee noted the Information Governance Group Minute.

It was agreed that Items 14a and 14b would be taken in conjunction.

15. Population Health

(a) Draft Population Health & Care Strategy

The Strategic Planning, Performance & Resources Committee received the 'Population Health and Care Strategy 2025- 2025 Development' paper presented by Mrs Janette Fraser. The purpose of the paper was to present the draft Population Health and Care Strategy for comment and feedback by the committee prior to further consideration by the Task and Finish Short Life Working Group and presentation to the 25 March 2025 NHS Forth Valley.

Key messages in the report included:

(i) The draft Strategy outlined the plan and priorities for the next 10 years for NHS Forth Valley, and aimed to respond to key national health plans, health information and trends which highlight the scale of the anticipated future challenges.

(ii) The draft Population Health & Care Strategy was built on previous extensive engagement with members of the public, staff, patients, partner organisations and other stakeholder groups.

(iii) Committee members were advised of the 5 priority areas with proposed actions for NHS Forth Valley, some of which would require the support and commitment of partner organisations.

(b) Population Health & Care Strategy Engagement Plan

The Strategic Planning, Performance & Resources Committee received the Population Health & Care Strategy Draft Engagement Plan' presented by Mrs Janette Fraser. The purpose of the paper was to present the draft Population Health and Care Strategy Engagement Plan to the committee for comment and feedback prior to further consideration by the Task and Finish Short Life Working Group and presentation to the 25 March 2025 NHS Forth Valley Board.

Key messages in the report included:

(i) The draft Engagement Plan provided an overview of the extensive engagement which had already been undertaken prior to developing the draft Population Health, and summarised learning gained from previous engagement. The plan outlined the proposed arrangements for further engagement over a 6-week period from 1 April to 13 May 2025.

(ii) The Strategy Steering Group were to lead and facilitate the engagement process.

(iii) Engagement would be underpinned by and aligned to the NHS Forth Valley communications, engagement and participation arrangements.

The following points were made in discussion about both documents:

(i) Committee members made comments about the need to amend the format and language within the document and provide further explanation of Population Health to increase accessibility of the document and facilitate understanding, without oversimplifying the strategic nature of the document.

(ii) Members asked for more detail on the Equality Impact Assessment (EQIA) which was being undertaken and assurance about how any issues and mitigating actions would be reflected within the Strategy and Plan.

(iii) Suggestions were made on the ways in which questions could be presented to members of the public, with a request that we needed to ensure they were meaningful to the stakeholders we want to engage with. It was also suggested that external advice could be sought on the questions from those who work closely with communities to ensure they were appropriate.

(iv) Members commented on the requirement to streamline the messaging and provide further clarity on actions which would be undertaken.

(v) Clarity was also needed on the section on outcome measures and the section on Value Based Health and Care, particularly on Allocative Value.

(vi) Following discussion, it was agreed that further comments were to be submitted electronically to Mrs Janette Fraser. Thereafter, the Task and Finish Group would consider the comments and a revised version of the Strategy and refinements required to the engagement plan. A second iteration would be circulated to committee members for comment prior to consideration at the March NHS Forth Valley Board.

(vii) It was recognised and agreed that due to the limited timeframe, if more time was required to develop the Strategy further, in light of comments received, a review of the timeline for the Strategy would be undertaken.

The Strategic Planning, Performance & Resources Committee did not endorse the Strategy or the Engagement Plan at this stage as further work was required in light of comments received.

Actions:

(1)	**Provide further comments on the Population Health & Care Strategy and Engagement Plan to Mrs Janette Fraser.**	All
(2)	**Amend the Population Health & Care Strategy and Engagement Plan in line with the received comments for further review at the Task and Finish Group on 6 March.**	Janette Fraser
(3)	**Review the timeline for the Board approval process for the strategy and engagement if required.**	Jennifer Champion

16(a) Update on Communication Priorities April 2025- March 2026

The Strategic Planning, Performance & Resources Committee received the 'Update on Communication Priorities: April 2025- March 2026' paper presented by Mrs Elsbeth Campbell. The purpose of the paper was to provide an update on the key communication plans and priorities in place over the financial next year.

Key messages in the report included:

(i) A key communication priority was to support the NHS Scotland Reform agenda and highlight progress in delivering national key priorities locally in NHS Forth Valley.

(ii) Further communication priority areas included:
- Population Health & Care Strategy
- Value Based Health & Care
- Culture Change & Compassionate Leadership Programme
- Equality & Inclusion
- National Treatment Centre

The following points were made in discussion:

(i) It was proposed that there was read across and alignment from the paper ensuring relevant detail within was captured in the Population Health and Care Strategy.

(ii) A member also raised the need to ensure there was alignment with communication priorities within the Health and Social Care Partnerships

(iii) Committee members were asked to consider the priorities outlined within the paper and provide comments directly to Mrs Elsbeth Campbell.

The Strategic Planning, Performance & Resources Committee noted the key plans and priorities.

Action

(1) Provide comments on the 2025 - 2026 communication priorities to Mrs Elsbeth Campbell prior to consideration at the March 2025 Board meeting. All

16(b) Participation & Engagement Framework

The Strategic Planning, Performance & Resources Committee received the 'Participation & Engagement Framework' paper presented by Mrs Elsbeth Campbell.

The purpose of the paper was to provide an oversight of NHS Forth Valley's commitment to work collaboratively with staff, patients, service users, partner organisations, local communities and other stakeholders to plan, develop and improve local health services. The paper also highlighted relevant legislative requirements and national standards to ensure best practice, and engagement underway across the organisation. Members were being asked for comments on the Framework so that this could be taken to the Board for approval in March 2025.

Key messages in the report included:

(i) The framework provided an approach to engagement, and would benefit the Health Board, local patients, staff and communities by:
- Informing key plans and priorities.
- Identifying individual and community healthcare needs, preferences and issues.
- Highlighting potential barriers and solutions.
- Strengthening and influencing decision making.

The following points were made in discussion:

(i) Committee members commended the work to align the engagement framework correlated to partnership work, not exclusive to NHS Forth Valley.

(ii) Members asked about an easy read version of the framework as a public facing document and were advised this would be considered.

(iii) Feedback was sought on any gaps or areas which required strengthening and it was agree that this should be done directly to Mrs Campbell.

The Strategic Planning, Performance & Resources Committee noted the Participation and Engagement Framework and the key plans and priorities highlighted.

Action

(1) Provide comments on the Participation & Engagement Framework to Mrs Elsbeth Campbell prior to consideration at the March 2025 Board meeting. All

17. Draft NHS Forth Valley Corporate Objectives

The Strategic Planning, Performance & Resources Committee received the 'Draft NHS Forth Valley Corporate Objectives' paper presented Professor Ross McGuffie. The purpose of the paper was to provide an overview of the NHS Forth Valley draft corporate objectives which reaffirmed the Health Board's ambition and function as an organisation, describing the response to key priorities in 2025- 2026.
Feedback was being sought on the draft to inform a final paper for consideration at the March 2025 Board meeting.

Key messages in the report included:

(i) The Corporate Objectives had been refined and simplified to streamline NHS Forth Valley's approach and focus on the below 4 key deliverables through an Executive Team workshop:
- Collaboration
- Transformation
- Stewardship
- Outcomes

(ii) Committee members were advised that the work on values was ongoing due to through one of the workstreams within the Culture and Compassionate Leadership Programme. This was considering what the values mean to staff, and consideration of how the organisation would know if staff were adhering to such values.

The following points were made in discussion:

(i) Committee members commended the process around the work which had taken place and agreed that comments would be provided directly to Mr Kevin Reith

(ii) A request was made to ensure there was alignment and read across to the Population Health and Care Strategy, which was being developed, with particular reference to clarity on the proposed Vision statement.

The Strategic Planning, Performance & Resources Committee noted the NHS Forth Valley Corporate Plan 2025-2026 which set out the Health Board's corporate objectives and agreed to provide feedback on any refinements required.

Action

(1) Provide comments on the Draft Corporate Objectives to Mr Kevin Reith prior to consideration of a revised paper at the March 2025 Board meeting. All

18. Delivery Plan Overview 2025- 2026

The Strategic Planning, Performance & Resources Committee 'Delivery Plan Overview' Paper was presented by Mrs Janette Fraser. The purpose of the paper was to set out the process and requirements for completing the Board's Annual Delivery Plan 2025-2026.

Key messages in the report included:

(i) The ongoing work to finalise the Delivery Plan, due for submission on 17 March 2025. The Delivery Plan was to incorporate national and local priorities, and align to the Finance Plan, the Workforce Plan, Anchor work, Planned Care and Urgent & Unscheduled Care requirements.

(ii) It was noted that the Delivery Plan was a responsive and dynamic document which would be adapted and amended throughout the year, in response to internal and external factors.

The following points were made in discussion:

(i) Members asked that a relevant read across to the developing Population Health and Care Strategy and the Value Based Health & Care Programme should be undertaken with a consistency of approach and language. It was felt that the explanations provided within the Delivery Plan were easy to understand and could be adapted for the developing Population Health and Care Strategy.

(ii) Members also acknowledged that the Plan was iterative and reports on delivery would be provided through the Performance Framework being reviewed by the Chief Executive.

The Strategic Planning, Performance & Resources Committee noted the Delivery Plan Overview 2025- 2026.

Action

(1) Further consideration to be given to read across of the content with other key priorities such as the developing Population Health and Care Strategy and the work on Values Based Health and Care. — Mrs Janette Fraser

19. Performance

(a) Urgent & Unscheduled Care Progress Report

The Strategic Planning, Performance & Resources Committee received the 'Urgent & Unscheduled Care Progress Report' presented by Mr Garry Fraser. The purpose of the report was to provide an overview of the whole system working being undertaken to meet the obligation of NHS Forth Valley Board to improve patient experience and aims to reduce the number of people in hospital ready to be discharged.

Key messages in the report included:

(i) From 1 February, national reporting began to include minor injury performance into reports against the emergency 4-hour access standard. This saw a 9% increase in the performance for the health board.

(ii) Collaborative work undertaken to achieve compliance and work towards timely access, treatment, admission or discharge within 4 hours of presentation to the emergency department was recognised.

The following point was made in discussion:

(i) Following discussion on the improvements in performance, with the addition of the data on Minor Injuries now included within the 4 hour performance reports, it was agreed that further detail was needed in future reports to provide oversight of the difference being made by specific actions within the Plan and where actions needed to be reviewed or further actions were needed.

The Strategic Planning, Performance & Resources Committee noted the Urgent and Unscheduled Care Progress Report.

Action:

(1) Review future reports to enable oversight against the delivery of specific actions and highlight where further actions are required. — Garry Fraser

(b) Performance Report

The Strategic Planning, Performance & Resources Committee received the 'Performance Report' presented by Ms Kerry Mackenzie. The purpose of the report was to provide the committee with key performance information to support effective monitoring of system-wide performance.

Key messages in the report included:

(i) Following a change in national reporting the overall 12-week performance included mutual aid and National Treatment Centre (NTC) data. Work was undertaken to provide additional data within NHS Forth Valley Performance Reports to highlight the performance excluding mutual aid and NTC due to variance in compliance.

(ii) Assurance was provided that performance continued to improve in a number of areas and patients were being seen within a timely manner, although there were still challenges within the system.

The Strategic Planning, Performance & Resources Committee noted the Performance Report.

20. Any Other Competent Business
There was no other competent business.

21. Risks, Reflection & Areas to Highlight to the NHS Forth Valley Board
There were no further comments provided.

22. Date and Time of Next Meeting
Tuesday 29 April 2025 at 9.30am, in the Boardroom, Carseview House.

The Chair closed the meeting at 1.40pm.

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

7.5 Minute of the **Area Clinical Forum** meeting held on **Thursday 16 January 2025 a**t **6.15pm** via MS Teams

For: Noting

Present:	Kirstin Cassells (Chair)	Oliver Harding	Elizabeth Kilgour
	Gillian Lennox	Wendy Nimmo	Lucie Risk

In Attendance: Ross McGuffie (Chief Executive)
Neena Mahal (Board Chair)
Scott Urquhart (Director of Finance)
Sarah Smith, Corporate Services Assistant/PA *(Minute Taker)*

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1. Apologies for Absence/Confirmation of Quorum

Apologies were noted on behalf of: Andrew Murray and Pamela Scott.

2. Declaration(s) of Interest(s)

There were no declarations of interest made.

3. Draft minute of Area Clinical Forum meeting held on 12 September 2024

The Area Clinical Forum approved the minute from 12 September 2024.

4. Action Log

The action log was presented and would be updated to reflect discussions.

Specific note was made of Action 3, with the following update provided:

3. PAC Terms of Reference – Lucie Risk noted work had been undertaken to review and update. Neena Mahal advised colleagues that a template was being compiled for Board Committees and proposed this could also be utilised for Advisory Committees. This was welcomed by colleagues.

Kirstin Cassells agreed that a review would be undertaken of all Terms of Reference to ensure alignment. Clarity would be sought from Kerry Mackenzie, Director of Planning and Performance to establish best process.

5. Matters arising

There were no matters arising.

6. FOR DISCUSSION

6.1 Introduction and reflections from new Chief Executive, Ross McGuffie (taken first on the Agenda)

Ross McGuffie provided an introduction and reflections from his time since taking up post on 1 October 2024. He noted his enjoyment in visiting services and meeting staff within the organisation.

Year 1 priorities were outlined noting a focus on escalation and governance structures. The Culture Programme was outlined noting commencement of the first 2 workstreams. The third and fourth would commence tomorrow, 17 January 2025. Each workstream would enable open and honest feedback with the values and culture of staff being fundamental.

A Clinical Governance meeting had taken place earlier today (16/01/25) which outlined the significant work being undertaken within Committees.

Incident Management would also be a key focus, particularly around ensuring the appropriate tracking of report recommendations, with positive progress being made.

Work would be undertaken to set future direction of the organisation, with the Population Health and Care Strategy providing a different way of working. This reflected the criticality of introducing a new organisational vision and values.

The Value Based Health and Care Programme would be commencing, with 6 different expert groups established to take forward key areas of work. This approach provided a significant change, with NHS Forth Valley taking the initiative amongst Board's in Scotland.

Financial challenges within Boards were significant across Scotland with recognition of the need for transformational work. Ensuring best value for the individuals within existing resource would be a key requirement.

The empowerment of front-line teams was recognised with a bottom-up approach being taken. Work was ongoing with the Healthcare Institute Scotland to create an organisational culture to drive change. Clinical engagement was vital, with the pivotal role of the ACF recognised.

Kirstin Cassells provided assurance that the Population Health & Care Strategy would be brought to the ACF meeting in March 2025. This would enable colleagues to take the Strategy to their individual Groups and ensure the provision of full feedback.

The establishment of a Consultation and Engagement Strategy was noted with learning from IJBs around ensuring wider use of engagement.

Neena Mahal recognised the ACF's role as an advisory Committee of the NHS Board. Their role was clear in influencing the shape of key strategies and providing a clinical voice for the organisation.

In terms of the culture programme, it was recognised that the level of engagement was a culture change in itself. Scott Urquhart noted the culture work was a critical strand of work for the organisation. Inclusion of learning and feedback was key in ensuring a tangible different in the organisation's way of working.

The Forum thanked Ross McGuffie for attending and for his informative update.

6.2 Finance update (taken second on the Agenda)

The Area Clinical Forum received a Presentation providing a Finance Overview led by Scott Urquhart, Director of Finance.

The Presentation covered the following key areas

- Key financial parameters for the organisation
- NHSFV position amongst all Scottish Boards
- Draft Scottish Budget 2025/26
- Financial Planning Approach

It was recognised that NHS Forth Valley had a good financial record in achieving financial balance and had never required brokerage. The organisation was also not escalated for finance.

The financial year 2024/25 had commenced with a significant challenge of £58m financial gap. A savings plan of £44m had been established which targeted key areas. A Financial Sustainability Oversight Board had also been established and continued to meet fortnightly to take this work forward.

The current financial position was noted as a £28m gap with a path to achieve balance by end of March 2025. Areas of uncertainty were recognised.

During discussions, clarity was sought around whether the National Insurance increases had been factored into the financial plan. Scott noted the impact of threshold and rate change, with further clarity awaited around financial contributions from Scottish Government. There was acknowledgement of pressures across the system.

Waste was recognised as a key area of focus, with the need for understanding around the costs of products within each area. Empowerment of staff through stewardship was a key focus going forward.

Agenda for Change was discussed, recognising some initial additionality in overtime costs. These had reduced monthly and was now effectively at 0.

Elizabeth Kilgour highlighted challenges within Labs, particularly around multiplicity of samples from the same patient. Key areas were diagnostics and radiology. Investment in a new Order Comms system was forthcoming, with the huge opportunity noted. Scott Urquhart recognised the benefit of investment in systems, if there was confidence in the return. The need for good reliable data was recognised in enabling these decisions to be made.

The ACF thanked Scott Urquhart for the presentation and welcomed the information around budgets. Potential attendance at individual groups was requested, noting the benefit of each area having understanding around their budgets. Scott welcomed this proposing linkage with Chief Financial Officers within the 2 Partnerships, Ewan Murray and Marie Keris as the majority of these services were delegated to the Health and Social Care Partnerships.

6.3 Agenda for Change – reduction in the working week

Kirstin Cassells provided colleagues with a verbal update confirming comms had been issued. Clarity however was still awaited around further implementation and whether this would be done in ½ hour increments or the full 1-hour reduction. Impact on service provision was recognised.

Protected learning time was also discussed noting the importance of this area for staff wellbeing. A disparity throughout the organisation was noted, with some areas having this as part of their job roles, or revalidation requirements.

6.4 Pharmaceutical Care Service Plan 2024-2027

The Area Clinical Forum received the Pharmaceutical Care Service Plan 2024-2027 presented by Kirstin Cassells. The Medical Director, Andrew Murray had requested review and update of the document.

It was confirmed that all NHS Boards required to have this Plan which outlined available services within their area. Sensitivity in updating was noted.

The ACF were receiving a copy of this report for noting and support. Approval had been provided by the Area Pharmaceutical Committee and presentation would also be made to the Senior Leadership Team for formal sign off.

It was requested that colleagues review the document and feedback any comments within the next 2 weeks. **Action: ALL**

7. FOR NOTING

7.1 Psychology Advisory Committee 26/09/24

Lucie Risk advised that the Psychology Advisory Committee had not met since the last the last Forum meeting. Work however had been undertaken to review and refresh the Terms of Reference. This was currently with the Psychological Services Management Group for contribution. The potential for a template for the Terms of Reference was welcomed.

7.2 Area Nursing & Midwifery Advisory Committee 16/09/24

Wendy Nimmo advised the last meeting had taken place on 25 November 2024 and noted the Terms of Reference had also been reviewed and again a template would be helpful.

As with other committees it was noted that membership remained a challenge with a number of proposals undertaken, including ‘bring a buddy’ to next meeting in March.

It was confirmed that all ANMAC Chairs had met with the Chief Nursing Officer in October 2024 and this would be a regular meeting going forward. Discussion had included an understanding of how the ANMAC Committees operated and input to ACF. It was recognised that similar challenges were being experienced throughout all Committees.

Contact had also been made with the West of Scotland ANMAC Chairs, with shared learning.

Kirstin Cassells also noted the update on the ANMAC progress provided to the recent Non-Ministerial Review.

7.3 Area Dental Committee 26/11/24

ACF colleagues were advised of the circulated minutes from the meeting in November 2024. Recruitment and retention remained a significant challenge, including the areas of hospital services and Community Dental Services which were previously coveted roles.

All services were working well with waiting lists reduced, however the impact of any sickness or maternity leave would be significant due to posts not being filled.

Dental Technicians were also becoming hard to fill posts, noting a change in training. A degree was now required with only Aberdeen University providing. For the recent Vocational Training Year, it was noted that 22 trainers did not get a trainee. These unfilled places had a significant impact on Practices. In order to try and address, the Vocational Year in Scotland was being amended to align with England,

7.4 Healthcare Science 03/12/24

A National update was provided noting engagement challenges, especially within smaller specialities. A Healthcare Sciences Lead job description had been circulated, with the benefit of session provision. Liz Kilgour advised she had changed post so continuing to lead on this area was a challenge.

7.5 Pharmaceutical Committee 02/10/24

Colleagues were advised there were no new ratified minutes to be presented to ACF.

Area Optical Committee

Rhona King confirmed no meeting had taken place since the last Area Clinical Forum. An in-person session had been held with a CPD focus. The next meeting would take place on 27 January 2025.

Area Medical Committee

The Area Clinical Forum were advised of similar challenges around attendance with no meeting held since the last Forum. Oliver Harding outlined a proposal from Andrew Murray for the Committee to be put into abeyance. A meeting would take place at the end of January 2025 to discuss options.

Contributing factors around attendance were noted including that Primary Care attendees received remuneration, however Hospital Doctors did not. Potential learning from the work undertaken around ANMAC was proposed. It was agreed an update around this work would be brought to the new ACF meeting in March 2025. **Action: Wendy Nimmo**

7.6 Comms

A verbal update was provided by Kirstin Cassells following discussion with Elsbeth Campbell, Head of Communications. Elsbeth had been unable to attend the January 2025 or March 2025 meeting.

The origins of the discussion were noted as challenges highlighted by a number of Committees around using Comms within the Organisation.

The issue of national concerns was highlighted around the use of certain social media platforms.

The work undertaken within Innovation was noted, with benefit of Wendy Nimmo meeting with Kirstin Cassells. Neena Mahal advised that she would wish further clarity around the specific issues and proposed discussion with Kirstin Cassells following this.

8 AOCB

8.6 Proposed 2025 dates

The proposed 2025 dates were discussed with a request for the July date to be moved back one week. It was requested attendees review the proposed dates and advise of any challenges.
Action: All

8.7 Non-Ministerial Annual Review

The Area Clinical Forum received verbal feedback on the Non-Ministerial Annual Review held on 28 November 2024. Kirstin Cassells advised colleagues of the opportunity to showcase the work undertaken within the Forum. Areas presented were:

MARG – David Herron
Polypharmacy – Community Hospital Team
ANMAC role – Wendy Nimmo

Kirstin Cassells expressed her thanks to all for attending and contributing.

Reflections

Neena Mahal noted she had been unaware of some of the challenges highlighted within the meeting. It was suggested an addition could be made to the Agenda around discussion of any items to be escalated to the Chair/Chief Executive. This was agreed by all present as an extremely positive recommendation.

There being no other competent business, the Chair closed the meeting at 8 pm.

9 DATE OF NEXT MEETING

The next meeting would be held on Thursday 16 March 2025 at 6.15 pm via MS Teams.

7.6 DRAFT Minute of the Area Partnership Forum meeting held on Tuesday 17 December 2024 at 2pm, within the Boardroom, Carseview and via MS Teams.

Present:
Ross McGuffie, Chief Executive (Chair)
Robert Clark, Employee Director (Co-Chair)
Elaine Bell, Associate Director of HR
Elaine MacDonald, HR Service Manager
Frances Dodd, Executive Nurse Director
Garry Fraser, Director of Acute
Janet Sneddon, Royal College of Midwives
Karen Leonard, Regional Organiser, GMB
Karren Morrison, Unison Branch Secretary
Kevin Bye, Royal College of Nursing
Kevin Reith, Director of People
Laura Byrne, Director of Pharmacy
Linda McGovern, Associate Director of Human Resources
Linda Robertson, HR Service Manager
Morag Farquhar, Director of Facilities
Pamela Bowman, CSP Rep
Nick Hill, GMB Rep

In Attendance:
Mark Craske, Waste and Travel Planning Manager (Item 7.2)
Karen Goudie, Director of Nursing
Ailsa Russell, Professional Lead Nurse, Forth Valley Prison Healthcare (Item 7.1)
Sarah Smith, Corporate Services Assistant/PA (minute)

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1. Apologies for Absence/Confirmation of Quorum

Apologies for absence were noted on behalf of: Carole Murray; Emma Currer; Gillian Morton; Tom Cowan; Yvonne Myler.

2. Declaration(s) of Interest(s)

There were no declarations of interest made.

3. Draft Minute of Area Partnership Forum meeting held on 22 October 2024

The note of the meeting held on 22 October 2024 was approved as an accurate record.

4. Action Log

44 Delegated Authority for Dismissal Hearings - This item would be returned to the February 2025 meeting.

49 Job Evaluation - Figures were provided, noting 13 jobs were awaiting approval. There were 93 new jobs, with 78 of these submitted within 2021/2023. These would be returned to Managers to confirmed continued requirement. This would then leave 28 jobs in total. A 6-week lead time was noted, with weekly panels to be held from January – April 2025. Nick Hill confirmed Panels for the Band 5 review had commenced. 18 forms had been submitted with a number returned for additional information. Low uptake was noted across all Boards with monitoring to continue. Local publicity had been undertaken with a number of sessions held. Union colleagues were also regularly attending clinical areas.

51 Band 2/3 - It was confirmed the job descriptions had been amended with constant enhanced obs not included within the Band 2 job description. Work was also ongoing to review Bank staff at Band 2 to ensure appropriate options. COMPLETE

54 Annex 21 - This item would be returned to the February 2025 meeting.
63 Partnership Working on Intranet – On Agenda
64 Session on Partnership Working - This item would be returned to the February 2025 meeting.
70 Vacancy Management - Discussion around vacancy control process and feedback from panel members at Financial Sustainability Programme Board. Then return to APF.
73 Absence Management Review Group actions - Review of data ongoing with minutes to be brought to next meeting.
74 Phase 2.2. NHS Scotland Workforce Policies - Robert provided staff side update and implementation would be brought to the next meeting.

5. Matters arising from the minute/action log

There were no matters arising.

6. Assurance & Improvement Plan Escalation Update

The APF received a verbal update from Ross McGuffie, Chief Executive.

Colleagues were reminded that the Board was de-escalated to Level 3 on 1 October 2024. A paper taken to the September 2024 Board meeting outlined progress to that date. Following the de-escalation, there had been ongoing proactive discussions with Scottish Government with recognition of the ongoing improvements.

A further update would be taken to the March 2025 Board and then shared with Scottish Government for their presentation to the National Planning Oversight Group.

The positive progress being made was recognised, particularly around the commencement of the Culture Change Programme and ongoing Internal Assurance Plan and Self-Assessment, with actions due for completion by March 2025.

Challenge remained around Unscheduled Care which could impact on the further de-escalation of the Board.

Staff side colleagues reflected that this level of improvement was not being seen by staff at all levels within the organisation. Ross McGuffie outlined the Culture Change Programme, noting the recent launch of the first two workstreams. All present recognised this was a long-term and ongoing focus for the Board, with a need for ongoing engagement with staff.

Laura Byrne highlighted a short TED talk around ‘Civility Saves Lives’. This would be shared with APF colleagues. **Action: Laura Byrne**

7. FOR APPROVAL

7.1 HMP & YOI Polmont Change to shift pattern

The Area Partnership Forum considered a paper presented by Ailsa Russell, Professional Lead Nurse, Forth Valley Prison Healthcare.

A brief background was provided noting the shift pattern of the Scottish Prison Service had changed as of 2 December 2024. This had been instituted as part of the reduction of the working week to 35 hours and brought forward lock up from 9.30 pm to 8.30 pm, Monday to Friday. NHS staff were required to also vacate the premises at this time. Resultantly, the shift pattern for NHS staff had been changed to 8.00 am to 8.30 pm and this had been received well by staff. There were no other contractual changes.

The issue highlighted within the paper was around staff suffering financial detriment through the loss of unsociable pay. The request was for this pay to be protected, recognising an element of back pay would be required.

Implications across the Prison estate was discussed, with assurance provided that this change impacted on HMY & YOI Polmont only. The other prisons within the Forth Valley Estate, Glenochil and Stirling, already had a lock up time of 8.30 pm. A paper had been submitted to APF at the time of this change.

An impact of this change was recognised around patients who arrived late and required mental health screening. The deadline for this would be 7.45 pm with any admissions after this not seen by Healthcare staff. Assessment was undertaken on a patient by patient basis recognising a variety in the level of review required. The APF recognised the clinical risk around this which was outwith their remit.

The APF approved the change to the shift pattern and approval of the unsocial hour protection as set out within the paper. It was recognised further work was required around the clinical aspect, with further discussion to take place with Ailsa Russell.

7.2 Cycle to Work Scheme, increase in limit

The Area Partnership Forum received a paper presented by Mark Craske, Waste and Travel Planning Manager.

The success of the scheme was noted, with 603 staff redeeming a certificate for a bike and equipment since 2014. The significant staff wellbeing benefit was also recognised. In reflection of the increase in electric bike usage, an increase was being sought to increase the financial limit available to £4,000, which would greatly increase the options available. There would be no extension to the repayment period.

The APF recognised the wider opportunities around salary sacrifice schemes which were being explored and utilised in other Boards. The work being undertaken by Linda McGovern in this area was noted. As a result of this work, there was a need and obligation for the organisation to ensure staff were fully aware of all implications and that appropriate controls were in place. For the cycle scheme, Mark Craske provided assurance that staff were fully informed of the implications if they left the scheme. Checks were also undertaken to ensure repayments would not take staff below the minimum wage.

The APF agreed their support for the increase in value to £4000, with a proposal that repayment time be graduated on the amount borrowed. This would minimise the risk of financial hardship.

The need for an impact assessment on the impact of salary sacrifice was recognised. This would be taken forward as a separate piece of work.

7.3 2025 Area Partnership Forum dates

The 2025 dates had been circulated to colleagues with holds issued to diaries. No challenge was noted and these dates would be confirmed.

8. BETTER VALUE

8.1 Finance Report

The Area Partnership Forum received a Finance Report that was presented to the Strategic Planning and Performance Resource Committee (SPPRC) earlier today.

Scott Urquhart, Director of Finance, then led a short presentation titled “2024/25 Financial Projection”. He outlined the current financial position for November 2024 was a £30m overspend, with an improved saving position of £6m. Work was ongoing to reduce this overspend, recognising the risk that a lot of this pressure was non-recurring and would be brought into the new financial year. Positive areas of cost improvement were noted, particularly around the area of medicines spend.

The Draft Scottish Budget was issued on 4 December 2024 and the main points were outlined. This included a risk around the Agenda for Change funding which had reduced by £50m to £150m. However, this was now recurring and Scottish Government confirmed they would continue to monitor the position. It was also confirmed there would be no brokerage provision for the next financial year.

The Audit Scotland Report was issued on 3 December 2024 and detail was provided around the key points. This included the need to withdraw from services with limited clinical value. Ross McGuffie noted a number of national discussions ongoing, which recognised a focus around transformation work. A reform group had been established with Jennifer Champion, Interim Director of Public Health, representing Forth Valley. The focus on a local Value Based Health and Care approach was recognised as key, with Scottish Government keen to work with Forth Valley as an early adopter of the methodology.

The preparation of a financial plan was underway with a timeline for presentation noted.

The APF noted the update.

8.2 Carseview Update

The Area Partnership Forum received a paper around ‘Carseview Relocation’ presented by Scott Jaffray, Director of Digital.

The paper outlined the fast-paced approach noting origins were around achieving financial savings through more efficient utilisation of accommodation.

Detail was provided around the work undertaken to date, with final agreement awaited around Carronbank. The proposed moves were detailed, noting good engagement from staff with several sessions held and a number of questions asked. The aim was to present an initial ground floor map at the next session on 20/12/24.

Scott Jaffray confirmed the work also focussed on a culture change, noting the introduction of a desk booking system and sharing of space. The complexities around this were noted, however it was recognised a number of other organisations were already operating a similar approach. The example of Falkirk Council was noted who were operating a 40% desk ratio.

Ross McGuffie advised a Forth Valley Leadership Forum was being established. Attendees would include Chief Executives from all public bodies, including Stirling University and the 2 Chief Officers. Topics for discussion would include a sharing of resources, both physical and in areas such as Comms functions to, for example, coordinate shared campaigns around energy efficiency and sustainability due to the decreasing national funding available to support this.

Carseview was noted as the first stage of this work on moving to a more hybrid desk-sharng approach, with potential expansion of the approach into other areas. The option to review front line services was also highlighted recognising testing would be required to fully understand requirements.

The 40% desk ration may be appropriate for 'back-room' services but would need to be tested with frontline clinical services to understand if this would work.

The APF praised the approach with staff side noting this review of accommodation had been requested for some time. The initial 'small scale' approach was also noted, which provided the opportunity for learning. The benefit of saving money on buildings, rather than on services or people was a preferred option, noting that despite the ground floor being maintained, significant savings were still anticipated of around £200,000 recurring. Some one-off costs were expected, recognising the need for staff to be provided with suitable and professional accommodation. The potential identification of monies within the Capital Plan was noted. A full layout of costs would be provided to APF once definitive costs were obtained.

The need to avoid creation of a 2-tier absence management system was recognised. Kevin Reith advised exploration would be undertaken around how to monitor working patterns to enable triangulation of data. Scott Jaffray recognised there were currently 2000 staff per day logging in remotely. **Action: Kevin Reith**

The need for Quality Impact Assessments (QIA) was recognised with assessments still ongoing with individuals. An Equality and Diversity Board Seminar was being held in February 2025. Appropriate completion of QIA for areas of significant change would be a key aspect.

9. BETTER WORKFORCE

9.1 Agenda for Change Pay Review – Update

The Area Partnership Forum received a verbal update led by Elaine Bell, Associate Director of HR.

It was noted that since the last update there was now 95% implementation for Rostered Staff. 4 areas had not implemented with 3 in acute and 1 in the Clackmannanshire and Stirling Health and Social Care Partnership.

An options paper had been discussed with staff side colleagues, Ross Cheape and Human Resources. Actions had been agreed and taken forward and would be discussed at a further meeting to be held in January 2025 with a wider attendance to enable progression.

In terms of Serco, concern was highlighted around implementation in the reduction in the working week as there appeared to be no agreement. Back pay was being paid but concern was noted as these were some of the lowest paid staff and were being treated differently to NHS employees. Nick Hill confirmed the GMB Union had spoken with Acas (Advisory, Conciliation and Arbitration Service) Morag Farquhar confirmed it had been made clear to Serco that it was their responsibility to implement the reduced working week. It was agreed she would follow up to obtain clarity on the position. **Action: Morag Farquhar**

Protected Learning

The Area Partnership Forum received a verbal update on Protected Learning led by Linda McGovern, Associate Director of Human Resources.

Sessions had been led by Karen Gormal, with around 130 people attended to date and helpful discussions had been generated. The main issue was noted around staff that had a significant number of people reporting to them and time required to log information on SSTS and eRostering system. Discussions were ongoing with NES and other Boards around logging and obtaining evidence.

9.2 Nursing Workforce Review Update

The Area Partnership Forum received a paper and presentation on the NHS Forth Valley Nursing Workforce Review, led by Karen Goudie, Director of Nursing.

A brief background was providing, noting the aim of reducing and then ceasing Agency usage across all areas within NHS Forth Valley. Stabilisation of recruitment was key driver. The work was being undertaken in a 4-phase approach, with current status being commencement of phase 4.

Karen outlined the primary and secondary drivers, along with change ideas and enablers. The phasing of the Workforce Review was then detailed:

- Phase 1- Baseline Measurement - COMPLETE
- Phase 2 – Improvement Aim setting & supplementary staffing controls - COMPLETE
- Phase 3 – Measurement and blueprint completion - COMPLETE
- Phase 4 – Bank Utilisation Improvements 2024/25

Data was provided around the overall usage of Registered Nurses and Health Care Support Workers (HCSW), noting the new governance controls had showed a clear reduction across the system. The target of HCSW usage cessation had been achieved. Spend reduction of £5.8m was noted to date. There was a variety of trend data provided and explained. In particular Prisons were highlighted, noting Registered Nurse Bank Usage had been reduced by 50%. The key focus areas were outlined.

In terms of ED, it was noted there had been a reduction in Registered Nurse Agency usage, however Bank Usage had increased. Further analysis would be undertaken to understand this data.

Significant work had been undertaken to improve Pentana reporting, noting previously Health Care Support Workers and Registered Nurses had been reported jointly, which created challenge in understanding and identifying risks in particular areas. These have now been separated which provided a clarity and enabled a drill down to team level.

In terms of Healthcare Support Workers, vacancies remained a challenge with an excess of 50 currently within the system. Evidence confirmed that stabilisation of the baseline staffing was the right action, so there was exploration of opportunities around employing bank staff in substantive roles with Comms being planned.

Nick Hill questioned the partnership engagement within this area of work. Frances Dodd noted that it had been developed through the Professional NMAHP Workforce Governance Group, which includes staff side representation. Karen Goudie agreed to work with partnership in full exploration of the phase 4 work in quarter 4.

Next stage of work would focus on review of non-patient and inpatient areas as well as advanced practice; clinical nurse specialities and theatres. Key areas being addressed would be around stabilising base staffing and ensuring appropriate governance around recruitment planning.

Frances Dodd recognised the improvement work undertaken around Blueprints and funded establishments. This would provide a solid foundation and enable progression. Work would be undertaken with the Workforce Planning Team to prepare an annual cycle of the tool run outputs. This would then be brought to NMAP Workforce Governance and then the Senior Leadership Team.

For areas of over recruitment, clarity was provided this was in place solely to deal with turnover and focus was required to ensure this did not become the new funded establishment. Recalibration of expectations around staffing requirements was recognised.

Ross McGuffie noted the review work has been recognised nationally as best practice.

The APF praised the work undertaken and noted that due to the size of the work, there was a need to ensure staff side were involved fully. To avoid duplication of conversations, Frances Dodd confirmed she would welcome additional staff side colleagues at the NMAP Workforce Governance Group.

10. FOR NOTING

10.1 Circulars and Policies

The Area Partnership Forum noted the circulars and policies as presented.

Kevin Reith, Director of People, confirmed he would recirculate the Workforce Planning National Guidance that was released today, 17 December 2024. **Action: Kevin Reith**

10.2 APF Partnership Agreement

The Area Partnership Forum received the APF Partnership Agreement presented by Robert Clark, Employee Director.

It was recognised that significant update was required and staff side agreed they would undertake a review of the document, with comments to be fed into Caroline Smith Caroline.Smith11@nhs.scot. A session would then be arranged to discuss. All present confirmed the need for this document to appropriately reflect all aspects of Partnership working. **Action: Robert Clark**

11. ANY OTHER COMPETENT BUSINESS

Nick Hill raised the issue of car parking recognising this remained an ongoing issue with significant staff impact. A review of the permit process was requested, with recognition this required a digital overhaul. Morag Farquhar advised colleagues of ongoing work at FVRH with input of Consultancy time provided following the recent benchmarking exercise. It was agreed that suggestions would be gathered and brought to the Senior Leadership Team, with this being the appropriate Governance route for approval.

12. DATE OF NEXT MEETING: Tuesday 25 February 2024 at 2pm, in the Boardroom, Carseview

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

8. Strategic Risk Register Update – January – March 2025
For: Approval

Executive Sponsor: Ms Kerry Mackenzie, Interim Director of Strategic Planning & Performance
Author: Miss Vicky Webb, Corporate Risk Manager

Executive Summary
The appended report presents an update to the Strategic Risk Register for the period of January 2025 through to March 2025.

Recommendations
The Forth Valley NHS Board is asked to:

- **approve** the changes to the Strategic Risk Register for this reporting period (January'25-March'25).
- **note** the progression of the mitigating actions identified.

Key Issues to be Considered
Over this reporting period (January'25-March'25), all strategic risks have been reviewed and the profile remains static. Details on the specific risks have been included in appendix 1.

To coincide with the standard review process, two Focused Reviews have been conducted in this quarter. Section five of appendix one highlights specific details around:

- SRR003: Information Governance
- SRR005: Financial Sustainability

Financial Implications
Financial implications are included in the body of the paper where relevant to risk.

Workforce Implications
Workforce implications are included in the body of the paper where relevant to risk.

Infrastructure Implications including Digital
Infrastructure including Digital implications are included in the body of the paper where relevant to risk.

Sustainability Implications
Environmental Sustainability and Climate Change implications are included in the body of the paper where relevant to risk.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process. *(A policy for NHS Scotland on the climate emergency and sustainable development) (please tick relevant box)*

☐ *Yes*
☒ *N/A*

Where applicable, the climate change, environmental and sustainability impacts and any mitigating measures are noted above/contained in the supporting papers.

Quality / Patient Care Implications
Patient Harm and Patient Experience implications are included in the body of the paper where relevant to risk.

Information Governance Implications
Information Governance implications are included in the body of the paper where relevant to risk.

Risk Assessment / Management
Risk is the subject of the paper.

Relevance to Strategic Priorities
Risk Management is an essential tool in supporting the organisation to achieve its strategic objectives and implement management arrangements to mitigate threats to those objectives.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:
☒ Paper is not relevant to Equality and Diversity
☐ Screening completed - no discrimination noted
☐ Full Equality Impact Assessment completed – report available on request

Communication, involvement, engagement and consultation
Risk reviews were conducted with Risk Owners and/or Risk Leads.

- Staff Governance Committee – 14 March 2025
- Strategic Planning, Performance & Resources Committee – 25 February 2025

Additional Information
N/A

Appendices
- Appendix 1: Strategic Risk Register Update – January'25-March'25
- Appendix 2: Strategic Risk Register

Appendix 1 - Strategic Risk Review – January - March 2025

Contents

1. Summary and Key Messages
2. Strategic Risks in Focus
    2.1 Strategic Risk Dashboard
    2.2 Strategic Risk in Focus
3. Risk Controls Progress Update
4. Risk Trend Analysis
5. Strategic Risk Focused Reviews

1.Summary and Key Messages

During this reporting period, all twelve of the current strategic risks have been reviewed and remain static. Further detail on these risks can be found in section two of this report.

To coincide with the standard review process, two Focused Reviews have been conducted in this quarter. Section five of appendix one highlights specific details around:

- SRR003: Information Governance
- SRR005: Financial Sustainability

Following the closure of, SRR014 (Healthcare Strategy) and SRR016 (Out of Hours), as agreed at the last NHS FV Board, the risk appetite profile has changed. As it stands, there are currently 0% of risks within the Boards appetite, 25% are within the Boards tolerance and 75% are out with the Boards appetite and tolerance. Section 4 of the report provides further details on this.

Emerging Risks/Hotspots:

There are no emerging risks/hotspots to note during this reporting period.

2.Strategic Risks in Focus

2.1 Strategic Risk Dashboard

Ref	Risk Title	Untreated Score	Current Score	Last Assessment	Score History	Risk Trend	Target Score	Owned By	Governance Committee	Lead Impact Category
SRR 002	Urgent & Unscheduled Care	25	25	14-Feb-2025	25; 25; 25		10	Garry Fraser	Strategic Planning, Performance and Resources Committee	Patient Harm
SRR 005	Financial Sustainability	25	25	05-Feb-2025	25; 25; 25		15	Scott Urquhart	Strategic Planning, Performance and Resources Committee	Financial
SRR 009	Workforce Plans	25	20	14-Feb-2025	20; 20; 20		10	Kevin Reith	Staff Governance Committee	Financial
SRR 015	Cyber Resilience	25	20	14-Feb-2025	20; 20; 20		16	Andrew Murray	Strategic Planning, Performance and Resources Committee	Service Delivery
SRR 017	Environmental Sustainability & Climate Change	25	20	12-Feb-2025	20; 20; 20		15	Morag Farquhar	Strategic Planning, Performance and Resources Committee	Environmental Sustainability
SRR 020	Health Inequalities	25	20	10-Feb-2025	20; 25; 20		10	Jennifer Champion	Strategic Planning, Performance and Resources Committee	Health Inequalities
SRR 010	Estates & Supporting Infrastructure	25	16	12-Feb-2025	16; 16; 16		6	Morag Farquhar	Strategic Planning, Performance and Resources Committee	Service Delivery
SRR 004	Scheduled Care	20	15	22-Jan-2025	15; 15; 15		5	Garry Fraser	Strategic Planning, Performance and Resources Committee	Patient Experience
SRR 011	Digital & eHealth - Infrastructure & Strategy	16	15	17-Feb-2025	15; 15; 15		6	Scott Jaffray	Strategic Planning, Performance and Resources Committee	Service Delivery
SRR 018	Primary Care Sustainability	20	15	14-Feb-2025	15; 15; 15		10	Gail Woodcock	Strategic Planning, Performance and Resources Committee	Service Delivery
SRR 019	Culture & Leadership	25	15	14-Feb-2025	15; 15; 15		10	Kevin Reith	Staff Governance Committee	Inspection/ Audit
SRR 003	Information Governance	20	12	14-Feb-2025	12; 12; 12		8	Andrew Murray	Strategic Planning, Performance and Resources Committee	Inspection/ Audit

2.2 Strategic Risks in Focus

SRR 002 Urgent & Unscheduled Care		Current Score	Managed By	Assigned To
Risk Description	If we do not have enough whole system capacity and flow to address key areas of improvement, there is a risk that we will be unable to deliver safe, effective, and person-centred unscheduled care resulting in a potential for patient harm, increases in length of stay, placement of patients in unsuitable places, and a negative impact on patient & staff experience.	25	Garry Fraser	Fiona Murray
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Patient Harm	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		14-Feb-2025		Zero

Latest Update
This risk was reviewed by the U&USC Programme Board and there is no change to the current position of this risk. Work continues to be progressed around the implementation of the U&USC Programme with a focus on Discharge Without Delay (DWD). A national DWD collaborative is being established, with four key workstreams, and NHS FV has been included in this piece of work. Work also continues on the establishment of a Frailty Unit at our front door.

Internal Controls Description
Flow Navigation Centre Workstream
Hospital at Home
Front Door Workstream
Optimising Flow Workstream
Conducted a Firebreak Exercise to identify key actions to improve performance.
Conducted a Firebreak to transform UUSC performance.
Dynamically using resources to reduce and mitigate risk of patient harm.
Your Home First Strategy developed to document our highest priorities for UUSC.

Further Controls Required	Action Owner	Due Date	Progress
Development of RACU working with undifferentiated pathways	Fiona Murray	31-Mar-2025	35%
Develop Adults With Incapacity (AWI) Process.	Joanna Macdonald; Gail Woodcock	31-Mar-2025	5%
Establishment of Frailty Unit at front door.	Fiona Murray	31-Mar-2025	80%
Implement learning from the National DWD Collaborative.	Fiona Murray	28-Feb-2026	0%
Review of the Target Operating Model.	Fiona Murray	31-Mar-2025	25%

SRR 003 Information Governance		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley fails to implement and embed effective and consistent Information Governance arrangements, there is a risk we would experience systemic compliance issues and inability to use our information assets effectively, resulting in reputational damage and potential legal breaches leading to financial penalties.	12	Andrew Murray	Sarah Hughes-Jones
		Target Score	**Lead Impact Category**	**Appetite Level**
		8	Inspection/Audit	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		17-Feb-2025		Moderate (12-16)

Latest Update
This risk has been reviewed as part of the focused review process and the output of these discussions is now reflected in the below detail.

Internal Controls Description
Robust, and regularly reviewed, procedures which address information handling available to all staff involved in the activity.
Adherence to IG assurance processes & documentation (Information Assets, DPIA, ISA, Contracts, Risk Assessments, Privacy notices).
Use of approved devices, systems, and channels.
Active supplier management (as required).
Routine review and disposal processes. Ensuring regular deletion of redundant, obsolete, trivial material.
Annual information governance training & awareness
Technical & Physical Security controls to manage access & audit.
Secure & backed up storage arrangements which avoid use of moveable media.
Effective and consistent use of filing systems, structured on Business Classification Scheme.
Identifying records for permanent preservation.
Identifying critical records within local business continuity plans
Information Governance Security Incident Management process
Routine processes to check & update information over time.

Further Controls Required	Action Owner	Due Date	Progress
Assess presence of Business Continuity Plans within DPA and SSA process. Include in recommendations as required.	Sarah Hughes-Jones	30-April-2025	90%
Co-ordinate SLWG to review and develop mechanisms to assess information governance compliance within supplier management processes.	Sarah Hughes-Jones	30-Jun-2025	50%

Develop a process for registering ‘shadow IT’ within the Information Asset Register.	Sarah Hughes-Jones	30-June-2025	20%
Develop arrangements to assure accuracy of joiners, movers, leavers data across the organisation.	Sarah Hughes-Jones	30-Jun-2025	10%
Develop mechanisms to support routine testing of back-ups as part of business as usual arrangements.	Sarah Hughes-Jones	30-Apr-2025	70%
Introduce and embed routine assurance audit process to test compliance with DPA and SSA actions.	Sarah Hughes-Jones	30-Apr-2025	90%
Review frequency of mandatory information governance training, and mechanisms for delivery	Sarah Hughes-Jones	30-Jun-2025	20%
Roll out of DPIA process to support implementation of OneTrust - DPIA management.	Sarah Hughes-Jones	31-Mar-2024	50%
SharePoint roll out (dependent on National O365 delivery)	Sarah Hughes-Jones	31-Dec-2025	0%
Capture presence of procedures for the handling of assets through the information asset logging process.	Sarah Hughes-Jones	30-Jun-2025	0%
Provide Information Risk Reports to all services who have logged critical assets but which do not have a business continuity plan recorded.	Sarah Hughes-Jones	31-Dec-2025	0%
Options paper to be presented to Information Governance Group outlining findings and recommendations from the SLWG.	Sarah Hughes-Jones	30-Jun-2025	0%
The IGU will analyse the data available from the dashboard and engage with services to identify targeted training solutions.	Sarah Hughes-Jones	31-Dec-2025	0%
Finalise the onboarding of TrakCare with FairWarning.	Sarah Hughes-Jones	30-Sep-2025	0%
Ensure USB device management software enforces user-specific policies rather than allowing blanket access for specific USB models, preventing unauthorised or unintended use.	Sarah Hughes-Jones	31-Dec-2025	0%

SRR 004 Scheduled Care		Current Score	Managed By	Assigned To
Risk Description	If NHS FV does not consider and plan for current and future changes to population and associated demand/case-mix, there is a risk that the model for delivery of planned care will not meet demand or prioritise effectively, resulting in poorer patient outcomes, avoidable harm and failure to meet targets.	15	Garry Fraser	Marie Gardiner
		Target Score	**Lead Impact Category**	**Appetite Level**
		5	Patient Experience	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		22-Jan-2025		Moderate (12-16)

Latest Update

This risk has been reviewed by the Head of Scheduled Care and there is no current change to the current position of this risk. Work is being progressed by the services to complete the actions listed against the risk. It is felt that once the actions have been progressed that the service will have a better understanding of their baselines to inform the position for 2025/2026.

Internal Controls

Scheduled Care Performance Management process in place - identification of performance issues allowing interventions to be applied.

All urgent and suspected cancer pathways are maintained via tracking and reporting carried out by Cancer Service Manager.

Annual Delivery Plan to maximise scheduled care services.

Approval given by NHS Board to invest NRAC monies recurrently on a sustainable solution

NHS Forth Valley, in line with the rest of NHS Scotland, continues to prioritise and treat those patients - two levels - urgent and routine.

Consultant Job Plans.

Non-medical staff delivering clinic and surgical based interventions releasing consultant time to do complex cases.

Further Controls Required	Owner	Due Date	Progress
Implementation of a 3rd CT Scanner within acute.	Jennifer Gilchrist	28-Mar-2025	70%
Enhance the sign off of consultant job plans in Scheduled Care.	Chris Cairns; Sara Else	31-Jul-2025	80%
Assessment of the effectiveness of the non-consultant model of care.	Marie Gardiner	31-Mar-2025	95%
Implementation of a 24-month plan to improve efficiency and to address the impact of NTC.	Marie Gardiner	30-Apr-2025	75%
Complete the theatre efficiencies programme of work to try and increase capacity within our theatres.	Marie Gardiner	31-Mar-2025	75%
Orthopaedics recovery plan to review. Plan will be complete and submitted in January.	Marie Gardiner	31-Mar-2025	75%

SRR 005 Financial Sustainability		Current Score	Managed By	Assigned To
Risk Description	If our recurring budget is not sufficient to meet the recurring cost base there is a risk there will be an increasing recurring gap in our finances, resulting in an inability to achieve and maintain financial sustainability, a detrimental impact on current/future service provision and an impact on our reputation.	25	Scott Urquhart	Jillian Thomson
		Target Score	**Lead Impact Category**	**Appetite Level**
		15	Financial	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		17-Feb-2025		Moderate (12-16)

Latest Update
At this review there has been no change to the scoring of the risk. The internal controls and actions have been updated to reflect the output from the Focused Review.

Internal Controls Description
Optimise Medicines Spending
Maximise the Value from Workforce Spend
Financial Sustainability Action Plan
Communications Programme
Cost Awareness Programme
Systems and controls in place to maximise income generation.

Further Controls Required	Action Owner	Due Date	Progress
Medium Term: Develop a plan which allows services to re-design within available resources.	Scott Urquhart	30-Jun-2025	0%
Completion of the Population Health & Care Strategy.	Kerry Mackenzie	31-Jul-2025	0%
Review savings programme in line with revised 15 box grid.	Scott Urquhart	31-Mar-2025	70%
Develop a plan for the further roll out of the nursing blueprint to other staff groups.	Scott Urquhart	31-Mar-2025	0%
Finalise decisions around unfunded services.	Scott Urquhart	31-Mar-2025	0%

SRR 009 Workforce Plans		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley does not implement effective, fully costed strategic workforce planning based on projected demand there is a risk that we will not have a sustainable workforce that is the right size, with the right skills and competencies, within an affordable budget, resulting in significant pressures on staff health and wellbeing, sub-optimal service delivery to the public and increasing pressure on our financial sustainability.	20	Kevin Reith	Elaine Bell; Linda Robertson
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Financial	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		14-Feb-2025		Moderate (12-16)

Latest Update
This risk has been reviewed and there is no change to the scoring of this risk. The risk description and controls have been updated to reflect the output from the Focused Review. Progress is being made against the actions identified.

Internal Controls Description
Overarching workforce plan in line with annual plan to Scottish Government.
Detailed demographic profiling completed due to age range of medical workforce to inform recruitment.
Directorate "risk-based" workforce action plans with measurable objectives.
Wellbeing Controls in place;
Sustainable Workforce Initiatives in place.
e-Rostering Solution implemented.
Attendance Management Action Plan.
Nursing, Midwifery & Allied Health Professional (NMAHP) Workforce Tools.
Safe Staffing Legislation.

Further Controls Required	Action Owner	Due Date	Progress
Increasing employability through Anchor Institution Work.	Kevin Reith	31-Mar-2025	40%
Exploration of Regional Workforce Solutions.	Kevin Reith	31-Mar-2025	30%
Action Plan will be developed to address identified staffing gaps.	Linda Robertson	31-Mar-2025	30%
Completion of the workforce actions in relation to the financial sustainability plan.	Kevin Reith	31-Mar-2025	25%

SRR 010 Estates & Supporting Infrastructure		Current Score	Managed By	Assigned To
Risk Description	If a whole system, multidisciplinary approach is not applied, there is a risk that we will not make best use of available capital and revenue funding, via prioritisation and allocation, to fully proceed with existing Estates and Infrastructure plans, make new development plans, or maintain and enhance the existing estate. This will result in an inability to maintain and develop a suitable environment for modern and sustainable services.	16	Morag Farquhar	Andrew McGown
		Target Score	**Lead Impact Category**	**Appetite Level**
		6	Service Delivery/Business Interruption	Averse (1-6)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		12-Feb-2025		Cautious (8-10)

Latest Update
This risk has been reviewed by the Director of Facilities and there is no change to the scoring of this risk at this review. The Business Continuity Plan was submitted to Government on the 29th of January, and we are awaiting feedback from this. It is thought that the whole-system infrastructure plan, once completed, will be a critical mitigation for this risk.

Internal Controls
NHS Board capital plan outlining prioritisation and funding for Infrastructure developments
Operational condition of estate regularly assessed and monitored through the Strategic Asset Management System.
Rolling estate survey programme carried out within 5-year cycle
Regular reviews with PPP partners for FVRH, SHCV, CCHC and planned preventative maintenance programmes in force including ‘Black Start’.
Prioritisation of Revenue and Capital budget planning process in place for Estates
Horizon scanning – keeping on top of latest developments in Estates Management, changes in guidance, awareness of national position re capital funding (through membership of national groups).
SCART - Statutory Compliance Audit and Risk Tool
Estates and Capital Planning Service Delivery
Facilities Management Tool.

Further Controls Required	Owner	Due Date	Progress
Development of whole system infrastructure plan.	Morag Farquhar	31-Jan-2026	5%

SRR 011 Digital & eHealth - Infrastructure & Strategy		Current Score	Managed By	Assigned To
Risk Description	If NHS FV does not develop and effectively implement a Digital and eHealth strategy which enables transformation and improvement as well as minimising technical vulnerabilities, there is a risk that other key organisational strategies cannot fully deliver the intended benefits, or the IT infrastructure could fail, impacting on long-term sustainability and efficient and effective service delivery.	15	Scott Jaffray	Rachel Marshall
		Target Score	**Lead Impact Category**	**Appetite Level**
		6	Service Delivery	Averse (1-6)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		19-Dec-2024		Cautious (8-10)

Latest Update
This risk has been reviewed by Scott Jaffray and there is no change to the current position of this risk at this review. Work continues to be progressed to further mitigate this risk into the Boards appetite.

Internal Controls
Annual Digital and eHealth delivery plan - 23/24 plan approved at March Digital and eHealth Programme Board.
Lifecycle System matrix reviewed annually by the Digital and eHealth Programme Board to shape future investment plans
Cyber security objectives and initiatives included in the annual programme of work
Windows/Office Programme team in place.
Programme of work to upgrade ICT infrastructure at FVRH as part of 20/21 delivery commenced and on track for completion this FY
Disaster Recovery and Business Continuity Plans are in place to improve the overall infrastructure and contingency plans. Linkages made with Business Continuity and Risk Management teams to support resilience work.
Digital Directorate Workforce Plan.
Ensure alignment of new digital & eHealth proposals are linked to local and national Strategies.
Accredited by the Service Desk Institute Standard.

Further Controls Required	Owner	Due Date	Progress
Implementation of the PC/ Server & System asset management system.	Scott Jaffray	30-Jun-2025	30%
Raise awareness and obtain clinical support throughout the organisation to understand the Delivery Plan objectives and support roll-out of the 66 projects held within.	Scott Jaffray	30-Apr-2025	80%
Increase the number of digital champions across the organisation to enhance digital/clinical partnership working.	Scott Jaffray	30-Apr-2025	0%
Establish a benefits realisation process to document and report on all identified benefits within digital projects and report these to the Digital & eHealth Programme Board.	Scott Jaffray	30-Apr-2025	0%

SRR 015 Cyber Resilience		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley do not maintain the effectiveness of current cyber security controls and implement improvements to security controls where possible. There is a risk that the cyber security of the organisation may be compromised Resulting in a significant disruption to the services delivered by the organisation and an impact to the confidentiality, integrity, and availability of systems and data.	20	Andrew Murray	Sarah Hughes-Jones; Scott Jaffray
		Target Score	**Lead Impact Category**	**Appetite Level**
		16	Service Delivery/Business Interruption	Averse (1-6)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		24-Feb-2025		Cautious (8-10)

Latest Update

Impact and likelihood remain the same, the Action around review of Cyber roles has not been achieved due to difficulties with the Job Evaluation process.

Internal Controls Description

Cyber Resilience Framework.

Digital and eHealth Strategy.

Previously implemented NIS Audit Recommendations are specific recommendations from the auditor to help the Health Board prioritise based on risk exposure.

Change Management within the organisation is supported through rigorous process and scrutiny.

Further Controls Required	Action Owner	Due Date	Progress
Cyber Security Awareness and Training.	Sarah Hughes-Jones; Scott Jaffray	31-Mar-2025	60%
Our reliance on suppliers is better understood with a degree of assurance especially around our critical suppliers processes, policies and people.	Sarah Hughes-Jones; Scott Jaffray	31-Mar-2025	40%
Business Continuity Plans – Embedding and testing - BCPs should be widely known, understood, and regularly tested for effectiveness.	Sarah Hughes-Jones; Scott Jaffray	31-Mar-2025	75%
Gatekeeping process for third party access.	Scott Jaffray	31-Mar-2025	20%
Review of cyber roles to support recruitment and retention.	Sarah Hughes-Jones; Scott Jaffray	31-Jan-2025	50%
Implementation of the new NIS audit recommendations for 2024/25.	Sarah Hughes-Jones	01-Apr-2025	0%

SRR 017 Environmental Sustainability & Climate Change		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley does not maximise our available resources to implement our Climate Emergency & Sustainability Strategy, there is a risk that we will be unable to comply with DL38 and not meet requirements of the Scottish Government Climate Emergency & Sustainability Strategy resulting in an inability to operate in an environmentally sustainable manor, an inability to meet objectives, and damaging stakeholder/public confidence.	20	Morag Farquhar	Derek Jarvie
		Target Score	**Lead Impact Category**	**Appetite Level**
		15	Environmental Sustainability/Climate Change	Moderate (12-16)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		12-Feb-2025		Open (20-25)

Latest Update

This risk has been reviewed with the Director of Facilities and the Head of Climate Change & Sustainability, and the risk position remains high at this review. The funding from Scottish Government around this is still limited which in turn limits the amount of progress which can be made to comply with DL38.

Internal Controls

Climate Emergency Response and Sustainability Team
This relates to the secondary roles of key members of staff within the organisation who have taken on extra responsibility to assist in the delivery of the action plan.

Climate Change & Sustainability Team

All Board and Committee meeting papers contain a section requiring the author to highlight any sustainability implications and to complete the sustainability declaration confirming that due regard has been given to compliance with DL38. Note: This needs to be built on as this was going to be taken forward buy previous Chief Exec.

Climate Emergency & Sustainability Strategy and Action Plan, detailing the activities to be undertaken by each of the operational workstreams.

Continual review and identification of funding sources.

Further Controls Required	Owner	Due Date	Progress
Successful Implementation of the Environmental Management System.	Derek Jarvie	31-Mar-2026	10%
Communications Strategy and action plan to be developed - Both public facing and internal for staff.	Derek Jarvie	30-Jun-2025	80%
Recruit the Waste and Compliance Support Officer role.	Derek Jarvie	31-Dec-2025	0%
Create a process to random sample the papers presented to the Standing Assurance Committees.	Derek Jarvie	31-Aug-2025	0%

SRR 018 Primary Care Sustainability		Current Score	Managed By	Assigned To
Risk Description	If we do not have adequate resources to support and implement a Primary Care framework, there is a risk that we don't have effective measures to ensure delivery of primary care across Forth Valley, resulting in a failure to meet our statutory responsibilities.	15	Gail Woodcock	Scott Williams
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Service Delivery/Business Interruption	Averse (1-6)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		14-Feb-2025		Cautious (8-10)

Latest Update
Risk is currently subject to a focused review and therefore there is no immediate progress to note on this risk.

Internal Controls
GP Sustainability loans in place.
Primary Care Improvement Plan being delivered - proactively supporting recruitment etc. iteration 3 substantively delivered in March 2022
Expansion of community pharmacy services. Further development of pharmacy first service.
Capital Investment Programme in PC premises initial agreement completion Dec 21.
Premises Improvement funding in place capital budget available each year.
Investment in quality clusters and leads to ensure GPs and multidisciplinary teams (MDT) are informed and involved in key developments.
Strong and regular engagement with SG and BMA in place regarding national MOU funding.
GP Sub-committee developed a paper outlining actions to improve recruitment and retention in FV.
Directly appointed GPs where there are issues such as rural practices or practices under 2c contractual arrangements
Targeted recruitment to build GP and MDT capacity and capability - promoted NHS FV as an employer of choice for PC role.

Further Controls Required	Owner	Due Date	Progress
New Innovative portfolio roles and career pathways. Further investment in PCIP and roles of most value.	Tom Cowan	31-Dec-2023	64%
Development of Governance routes and escalation procedures following the delegation of PC to FHSCP	Scott Williams	31-Mar-2025	75%
Development of a whole-system General Practice/Primary Care Transformation Programme.	Tom Cowan	31-Mar-2025	0%

SRR 019 Culture & Leadership		Current Score	Managed By	Assigned To
Risk Description	If NHS FV do not foster a cohesive culture with strong leadership, there is a risk that our people will not feel valued in their roles and understand how they feed into organisational success, resulting in a negative impact on staff morale, and an inability for FV to be resilient, agile and achieve long-term success.	15	Kevin Reith	Margaret Kerr
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Inspection/Audit	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		17-Feb-2025		Moderate (12-16)

Latest Update
This risk has been reviewed by the Director of People and there is no change to the scoring. Work has continued to be progressed around this risk and the mobilisation of phase one is continuing.

Internal Controls Description
Whistleblowing procedures including “Speak Up” service.
Communication - Resources supporting development of culture are available on the intranet.
Personal Development Reviews
Promotion of yearly iMatter surveys across the organisation.
Recognising Our People (e.g., staff awards).
Culture Change and Compassionate Leadership Programme - Phase 1 (scoping) and Phase 2 Diagnostics and Discovery are complete.
ELT co-produced Organisational Development Programme - scoping and agreement.
Leadership Programme.
Peer Support and Wellbeing Teams in place to support staff.
Induction Processes
Step into my Shoes Initiative.

Further Controls Required	Action Owner	Due Date	Progress
Building on staff awards, work is progressing on other staff recognition opportunities.	Kevin Reith	30-Jun-2025	30%
Review arrangements for annual iMatter staff experience survey to ensure effective organisational engagement	Kevin Reith	31-May-2025	50%
Implementation of the mobilisation phase one.	Kevin Reith	31-May-2025	25%
Implementation of the mobilisation phase two.	Kevin Reith	31-May-2025	0%

SRR 020 Health Inequalities		Current Score	Managed By	Assigned To
Risk Description	If NHS FV does not work with partners to influence the social determinants of health and the NHS does not create a healthcare system which can be accessed by all the people of Forth Valley, there is a risk that health outcomes do not improve, and health inequalities do not reduce or may even widen. This could result in reduced healthy life expectancy for the population, or for individual population groups, and a significant financial cost through increased need and demands on services.	20	Jennifer Champion	Andrew Murray
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Health Inequalities	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		10-Feb-2025		Moderate (12-16)

Latest Update

This risk has been reviewed by the Interim Director of Public Health and there is no change to the position of this risk at this review. Work has been progressed on the creation and the development of the Population Health & Care Strategy.

Internal Controls

NHS Forth Valley is an Anchor Institution, working with other partner organisations in their role as Anchor Institutions, to improve the social determinants of health.

Director of PH work collaboratively across the local population health system with CPPs to embed tackling inequalities as a principal theme.

NHS Forth Valley senior planners and managers contribute to multiple Community Planning Partnership theme groups to plan for improved health outcomes and reduced inequalities.

Anchor NHS service design planning commenced with strategic leads and service managers to improve reach and benefit of services and programmes.

Directors of Public Health are working with Heads of Population Health at the Scottish Government with a view to intelligence performance management around Health Inequalities.

Commenced work with HR re revamped EQIA with a poverty/health inequalities focus.

Healthcare PH Consultant understanding health inequalities and barriers to paediatric outpatients.

Further Controls Required	Owner	Due Date	Progress
Development of a comprehensive healthcare inequalities delivery plan.	Jennifer Champion	31-May-2025	0%
Embed mitigating Health Inequalities as a workstream within all the NHS Forth Valley programme boards.	Jennifer Champion	31-May-2025	0%
Health Inequalities delivery plan should be aligned with partnership plans.	Jennifer Champion	30-Sep-2025	0%
Develop staff training plan to understand responsibilities around health inequalities.	Jennifer Champion	31-Oct-2025	0%
Develop a systematic way to assess and monitor health inequalities.	Jennifer Champion	31-Aug-2025	0%
Review NHS Forth Valley contribution to community planning partnerships.	Jennifer Champion	30-Sep-2025	5%
Development of the Population Health & Care Strategy.	Jennifer Champion	30-Jun-2025	30%

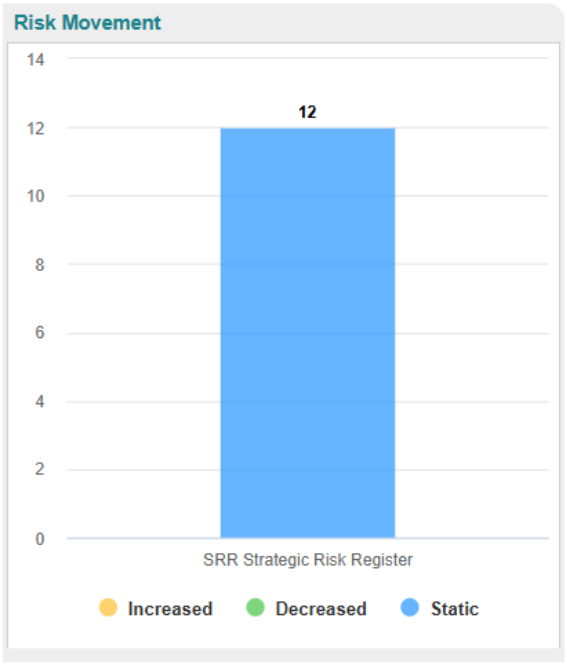
3.Risk Controls Progress Update

In this reporting period, there were 8 actions completed to mitigate the strategic risk profile. At the end of this reporting period there is 1 overdue action reported. This is in relation to SRR015: Cyber Resilience. Detail on this control is included in the below table. There are 33 controls which are due to be completed by Quarter 4 24/25.

Action Code	Action Title	Due Date	Status	Owned By
SRR015.10	Review of cyber roles to support recruitment of vacant post and retention	31-Jan-2025	Overdue	Sarah Hughes-Jones; Scott Jaffray

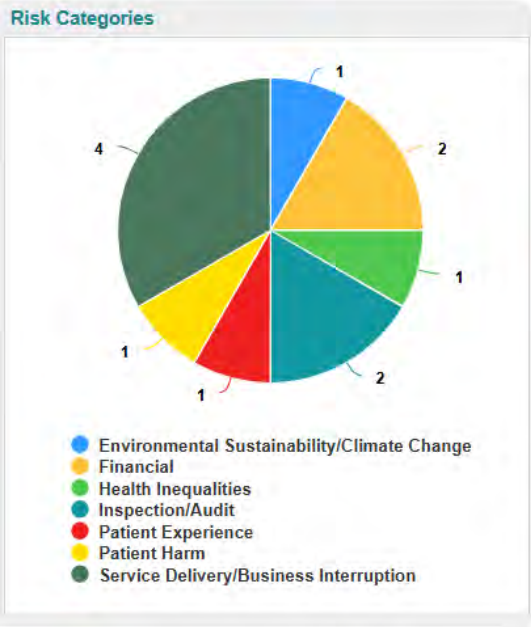
4.Risk Trend Analysis

Table 4.1 Risk Register Activity



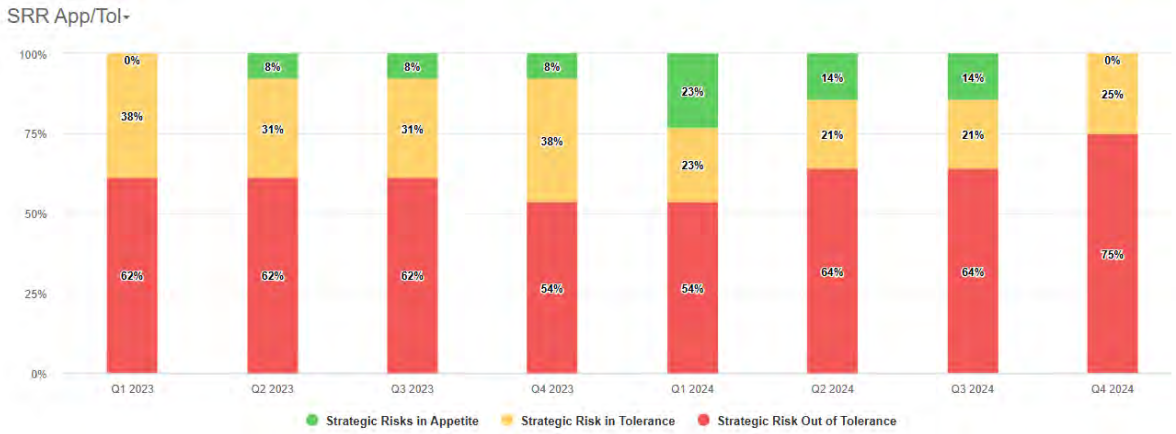
The chart to the left shows that across the Strategic Risk Register, twelve of the Strategic Risks remain static at this reporting period. This is a reduction of two risks at last report due to the closure of SRR014 & SRR016.

Table 4.2 Risk Category Breakdown



When risks are assessed, a lead impact category is selected, which sets the appetite/tolerance level for the risk. The chart to the left shows that Service Interruption is the most common category, followed by Finance & Inspection/Audit. The remaining risks are split between Patient Experience, Patient Harm, Public Confidence, Environmental Sustainability and Climate Change and Health Inequalities.
There is a reduction in the number of risks within Service Delivery & Inspection/Audit due to the two risks that were closed in January 2025: SRR014 (Healthcare Strategy) & SRR016 (Out of Hours).

Table 4.3 Strategic Appetite and Tolerance



A graph depicting the risk appetite profile of the strategic risks across the previous financial year:

- Quarter 2 (24/25) is starting to show a deterioration in the risks that are highlighted as out with appetite and tolerance for the Board. This will have increased to 64% from 54%.
- Quarter 3 (24/25) as it currently stands remains static at this point in time.
- Quarter 4 (24/25) is showing a deteriorating position as there are no risks within the Boards appetite, 25% of risks within tolerance and 75% out with the Boards appetite and tolerance.

Note that the colours in the chart represent status (In appetite, In Tolerance, Out of Tolerance) rather than score.

5. Strategic Risk Assurance Focused Review

During this period, two Focused Reviews were conducted on:

- **SRR003: Information Governance –** This was presented to the February 2025 Strategic Planning, Performance & Resources Committee, with an approved assurance level of **Reasonable Assurance**.
- **SRR005: Financial Sustainability -** This was presented to the February 2025 Strategic Planning, Performance & Resources Committee, with an approved assurance level of **Reasonable Assurance** for internal controls and **Limited Assurance** for external influence on the risk.

SRR003: Information Governance

Commentary

During the focused review process, there was no change to the overall description of the risk and the current score remains static. A review of the current and further controls was undertaken and highlighted a variety of criticality across these controls. Ten of the identified current controls were given a rating of red & amber which prompted a gap analysis. The below graph highlights the amount of assurance activity applied to the current control environment mitigating the strategic risk. As depicted, there are numerous assurance functions monitoring compliance with these current controls. The final assurance assessment was assessed as reasonable as progress is being made to strengthen these controls.

BETTER VALUE								
5. Demonstrate best value using our resources								
SRR003	**Information Governance** If NHS Forth Valley fails to implement and embed effective and consistent Information Governance arrangements, there is a risk we would experience systemic compliance issues and inability to use our information assets effectively, resulting in reputational damage and potential legal breaches leading to financial penalties.	12	Robust proceudres in place.	X	X	X	X	Reasonable
			Adherence to IG assurance processes and documentation.	X		X	X	
			Use of approved devices, systems, and channels.	X	X	X	X	
			Active supplier management.		X	X	X	
			Routine review and disposal processes.	X	X		X	
			Information governance training & awareness.	X	X		X	
			Technical & Physical security controls to manage access & audits.	X	X	X	X	
			Secure & backed up storage arrangements.	X	X	X	X	
			Effective and consistent use of filing systems.	X	X	X	X	
			Identifying records form permanent presevation.	X		X	X	
			Idntifying critical records wih local business continuity plans.	X	X	X	X	
			Information Governance Security Incident Management Process.	X	X	X	X	
			Routine processes to check & update information over time.	X	X	X	X	

SRR005: Financial Sustainability

Commentary

During this focused review process, there was no change to the overall description of the risk, and the overall risk score remains the same.
A review of the current and further controls was conducted, highlighting that across all mitigation measures, there is a variety of criticality. Within the current controls, five controls were given an overall status of amber, prompting a gap analysis. The below graph highlights the amount of assurance activity applied to the current control environment mitigating the strategic risk. As depicted, there are numerous assurance functions monitoring compliance with these current controls. The final assurance assessment was assessed as reasonable for our internal control and limited for external circumstances.

BETTER VALUE								
5. Demonstrate best value using our resources								
SRR005	**Financial Sustainability** If our recurring budget is not sufficient to meet the recurring cost base there is a risk there will be an increasing recurring gap in our finances, resulting in an inability to achieve and maintain financial sustainability, and a detrimental impact on current/future service	25	Optimise Medicines Spending	x	X	X	X	Reasonable/ Limited
			Maximise the Value from Workforce Spend	X	X	X	X	
			Financial Sustainability Action Plan	X	X	X	X	
			Communications Programme.	X	X	X		
			Cost Awareness Programme.	X	X	X		
			Systems and controls in place to maximise income generation.	X	X	X		

Strategic Risk Register

Generated on: 11 March 2025

NHS Forth Valley

Ref	Risk Owner	Risk Lead	Risk Description	Risk Category Description	Untreated Likelihood	Untreated Impact	Untreated Score	Current Controls In Place	Current Likelihood	Current Impact	Current Score	Current Risk Trend	Further Controls Required	Linked Actions Author	Original Due Date	Further Controls Target Date	Progress %	Target Likelihood	Target Impact	Target Score	Last Review Date	Review Notes	Risk Owner	Risk Lead
SRR 002		Urgent & Unscheduled Care	If we do not have enough whole system capacity and flow to address key areas of improvement, there is a risk that we will be unable to deliver safe, effective, and person-centred unscheduled care resulting in a potential for patient harm, increases in length of stay, placement of patients in unsuitable places, and a negative impact on patient & staff experience.	Patient Harm	5	5	25	Flow Navigation Centre Workstream Hospital at Home Front Door Workstream Optimising Flow Workstream Conducted a Firebreak Exercise to identify key actions to improve performance. Conducted a Firebreak to transform ULSC performance. Dynamically using resources to reduce and mitigate risk of patient harm. Your Home First Strategy developed to document our highest priorities for ULSC.	4	5	20		Development of RACU working with Lead/Escalated Ambulance Develop Adults With Incapacity (AWI) Process Establishment of Frailty Unit at front door Implement learning from the National DWD Collaborative. Review of the Target Operating Model.	Fiona Murray Joanna Macdonald; David Williamet; Gail Woodcock Fiona Murray Fiona Murray	30-Jun-22 31-Jan-24 31-Jan-24 29-Feb-24 31-Dec-24	31-Mar-25 31-Mar-25 31-Mar-25 29-Feb-24 31-Mar-25	35% 5% 60% 0% 25%	2	5	10	14-Feb-25	This risk was reviewed by the ULSSC Governance Board and there is no change to the scoring of this risk. The risk description was updated to reflect the current position.	Gerry Fraser	Fiona Murray
SRR 005		Financial Sustainability	If our recurring budget is not sufficient to meet the recurring cost base there is a risk that we will not maintain sustainability in our finances, resulting in an inability to achieve and maintain financial sustainability, a detrimental impact on current/future service provision and an impact on our reputation.	Financial	5	5	25	Minimise Medicines Spending: - Savings Plan for Primary Care Medicines - Savings Plan for Acute Medicines Minimise Premium Spending (Bank/Agency): - Align Financial Plans with Workforce Plans. - Off-framework contract usage for supplementary staff has ceased - Reduce: - Absences - Vacancies Reduce usage of Contingency Beds Structured Savings Plans Communications programme around "spending well" - staff suggestions on cost improvement schemes submitted via the intranet. Cost Awareness Programme – Finance team engaging with clinical teams, running clinically led sessions to raise financial awareness. Aim is to educate clinicians around how much things cost in their area to increase understanding of their cost base, and that they understand the level of financial pressure that we are going in to. Financial Recovery Plan - this is mainly focused on the Acute directorate budget which is continually overspent - Plan sets out clear targets, rationale for actions and a week by week plan to demonstrate progress. Assurance and Improvement Plan - Financial section to be added to Cost Improvement and Value, in addition to Culture, Governance and Leadership. System is in place for recharging overseas residents (recharge portion to individual or their insurance company) Financial Sustainability Action Plan developed, with a Financial Sustainability Oversight Board in Place to monitor this. Increased communications throughout the organisation to ensure organisational awareness and buy-in to financial sustainability actions. Increased briefings to the Area Partnership Forum.	5	5	25		Medium Term: Develop a plan which allows services to re-design within available resources. Completion of the Population Health & Care Strategy.	Kerry Mackenzie	30-Jun-25 31-Mar-25	30-Jun-25 31-Jul-25	0% 0%	3	5	15	05-Feb-25	This risk has been subject to a Focused Review this month and the risk is updated to reflect these changes.	Scott Urquhart	Jillian Thomson
SRR 009		Workforce Plans	If NHS Forth Valley does not implement effective, fully costed strategic workforce plans that are aligned to service delivery there is a risk that we will not have a sustainable workforce that is the right size, with the right skills and competencies, within an affordable budget, resulting in significant pressures on staff health and wellbeing, sub-optimal service delivery to the public and increasing pressure on our financial sustainability.	Financial	5	5	25	Submission of costed overarching workforce plan in line with annual plan to Scottish Government Detailed demographic profiling completed due to age range of medical workforce in particular to inform recruitment plans Directorate "risk-based" workforce action plans with measurable objectives, monitored through the Staff Governance Committee. Wellbeing Controls in place - Our People Strategy, Strategic Workforce Wellbeing Plan, Wellbeing Website and Management toolkit, Culture and Compassionate Staff Programme...by at Work. Sustainable Workforce initiatives in place - suite of flexible working policies in place to ensure we can recruit and retain staff - Retire and Return e-Rostering Solution implemented to make it easier to deploy staff more effectively and efficiently. In addition, ensuring the most efficient use of staff available, ensure safe staffing levels and improving work-life balance for staff. Sustainable Workforce - Ethical International Recruitment Sustainable Workforce Initiatives in Place - Health Care Support Workers. All Band 2 nursing HCSW job descriptions have been reviewed against the newly agreed National Nursing Clinical Workers profiles. Attendance Management Action Plan - 19 actions grouped into themes - Measurement, Training, Learning from Others, Supports for Staff and Managers, Case Reviews of attendance management cases, Return to Work, Case Reviews/Audit (long term sickness) and Policy Review/Updates and ER Cases (Employee Relations)	4	5	20		Increasing employability through Anchor Invitation Work - Includes the Youth Employment Trailblazer and College Health Ambassador programmes Exploration of Regional Workforce Solutions, such as the Medical Associate Professional Roles. Action Plan which will include definitive and quantifiable actions to address identified staffing gaps, with development of key performance indicators aligned to the Five Pillars of the strategy – to be updated on a yearly basis during lifetime of the Workforce Plan. The action plan will be developed in conjunction with HSCPs and based on integrated working. Completion of the workforce actions in relation to the financial sustainability plan. Reviewing establishment and informing decisions around workforce profile which will feed into the actions to deliver our overarching organisational workforce plan.	Margaret Kerr Kevin Reith Linda Robertson Kevin Reith	31-Mar-25 31-Mar-25 31-Mar-24 31-Mar-25	31-Mar-25 31-Mar-25 31-Mar-25 31-Mar-25	45% 30% 30% 20%	2	5	10	14-Feb-25	This risk has been reviewed and there is no change to the scoring of this risk. The risk description was updated to reflect the current position.	Kevin Reith	Elaine Bell; Linda Robertson
SRR 015		Cyber Resilience	If NHS Forth Valley do not maintain the effectiveness of current cyber security controls and implement improvements to security controls where possible. There is a risk that the ability to operate as an organisation may be compromised. Resulting in a significant disruption to the services delivered by the organisation and an impact to the confidentiality, integrity, and availability of systems and data.	Service Delivery;Business Interruption	5	5	25	Cyber Resilience Framework - includes 427 controls designed to support faster recover, lower disruption and reduce data loss. Digital and eHealth Strategy - Includes cyber resilience sub-strategy aimed at lowering impact of incidents. Previously implemented NIS Audit Recommendations are specific recommendations from the auditor to help the Health Board prioritise based on risk exposure. Change Management within the organisation is supported through rigorous process and scrutiny by the Technical Steering Group and Change Advisory Board. Review of cyber roles to support recruitment and retention (a number of roles have recently been made vacant and there is potential for single points of failure) Implementation of the new NIS audit recommendations for 2024/25.	4	5	20		**IMPORTANT, PREVENTATIVE** - Cyber Security Awareness and Training - Continuous improvements and monitoring of our awareness material and training for staff. This is to ensure a high level of compliance with the mandatory return of Cyber Awareness training. **ABSOLUTELY CRITICAL, PREVENTATIVE CONTROL** - Our suppliers is better understood with a degree of assurance especially around our critical suppliers processes, polices and people. **ABSOLUTELY CRITICAL, CONTINGENCY CONTROL** - Business Continuity Plans – Embedding and testing - BCPs should be widely known, understood, and regularly tested for effectiveness. **VERY IMPORTANT, PREVENTATIVE** - Gatekeeping process for third party access Third parties (Charities, suppliers etc) have a tightest, securely managed route into our infrastructure which the Health Board controls. Review of cyber roles to support recruitment and retention (a number of roles have recently been made vacant and there is potential for single points of failure) Implementation of the new NIS audit recommendations for 2024/25.	~~Douglas Crane~~ Sarah Hughes-Jones; Scott Jaffray ~~Douglas Crane~~ Sarah Hughes-Jones; Scott Jaffray ~~Douglas Crane~~ Sarah Hughes-Jones; Scott Jaffray Scott Jaffray ~~Douglas Crane~~ Sarah Hughes-Jones; Scott Jaffray ~~Douglas Crane~~	31-Dec-21 31-Mar-25 31-Mar-24 31-Mar-24 31-Mar-24 01-Apr-25	31-Mar-25 31-Mar-25 31-Mar-24 31-Mar-25 31-Jun-25 01-Apr-25	60% 40% 75% 20% 50% 0%	4	4	16	14-Feb-25	Impact and likelihood remain the same, the Action around review of Cyber roles has not been achieved due to difficulties with the Job Evaluation process.	Andrew Murray	Sarah Hughes-Jones; Scott Jaffray
SRR 017		Environmental Sustainability & Climate Change	If NHS Forth Valley does not maximise our available resources to implement our Climate Emergency & Sustainability Strategy, there is a risk that we will be unable to comply with DL38 and not meet requirements of the Scottish Government Climate Emergency & Sustainability Strategy, resulting in an inability to operate in an environmentally sustainable manner, an inability to meet objectives, and damaging stakeholder/public confidence.	Environmental Sustainability;Climate Change	5	5	25	Climate Emergency Response and Sustainability Team This relates to the secondary roles of key members of staff within the organisation who have taken on extra responsibility to assist in the delivery of the action plan. Climate Change & Sustainability Team	4	5	20		Successful Implementation of the Environmental Management System - To reduce environmental impacts and ensure legal compliance. E.g. we are storing oil properly, maintaining boilers properly, etc, waste management, transport. Currently trying to implement. Currently live in Estates and looking to roll out further (phase 1). Communications Strategy and action plan to be developed - Both public facing and internal for staff.	Derek Jarvie Derek Jarvie	29-Mar-24 31-Mar-25	31-Mar-26 30-Jun-25	10% 60%	3	5	15	12-Feb-25	This risk has been reviewed with the Director of Facilities and the Head of Climate Change & Sustainability and the risk position remains high at this review. The funding from Scottish Government around this is still limited which in turn limits the amount of progress which can be made to comply with DL38.	Morag Farquhar	Derek Jarvie

								All Board and Committee meeting papers contain a section requiring the author to highlight any sustainability implications and to complete the sustainability declaration confirming that due regard has been given to compliance with DL38. Note: This needs to be built on as this was going to be taken forward buy previous Chief Exec.				Recruit the Waste and Compliance Support Officer role.	Derek Jarvie	31-Dec-25	31-Dec-25	0%							
								Climate Emergency & Sustainability Strategy and Action Plan, detailing the activities to be undertaken by each of the operational workstreams.				Create a process to random sample the papers presented to the Standing Assurance Committees	Derek Jarvie	31-Aug-25	31-Aug-25	0%							
								Continual review and identification of funding sources.															
SRR 020	30-Aug-24	Health Inequalities	If NHS FV does not work with partners to influence the social determinants of health and the NHS does not create a healthcare system which can be accessed by all the people of Forth Valley, there is a risk that health outcomes do not improve, and health inequalities do not reduce or may even widen. This could result in reduced healthy life expectancy for the population, or for individual population groups, and a significant financial cost through increased need and demands on services.	Health Inequalities	5	5	25	NHS Forth Valley is an Anchor Institution, working with other partner organisations in their role as Anchor Institutions, to improve the social determinants of health.	4	5	20	Development of a comprehensive healthcare inequalities delivery plan which supports investment in measures which decreases HI as mentioned at Board on	Jennifer Champion	31-May-25	31-May-25	0%	2	5	10	14-Feb-25	This risk has been reviewed by the Interim Director of Public Health and there is no change to the position of this risk at this review. Work has been progressed on the	Jennifer Champion	Andrew Murray
								Director of PH work collaboratively across the local population health system, in particular, with CPPs to embed tackling inequalities as a principal theme.				Embed mitigating Health Inequalities as a workstream within all the NHS Forth Valley programme boards.	Jennifer Champion	31-May-25	31-May-25	0%							
								NHS Forth Valley senior planners and managers contribute to multiple Community Planning Partnership theme groups to plan for improved health outcomes and reduced inequalities. Examples include Alcohol & Drug Partnerships, child poverty planning groups, children and young people's strategic service plans				Health Inequalities delivery plan should be aligned with partnership plans - Discuss at ELT and Board Seminar.	Jennifer Champion	30-Sep-25	30-Sep-25	0%							
								Anchor NHS service design planning commenced with strategic leads and service managers to improve reach and benefit of services and programmes for diverse and disadvantaged communities.				Develop staff training plan to understand responsibilities around health inequalities - this is a key enabler to embedding prevention activity.	Jennifer Champion	31-Oct-25	31-Oct-25	0%							
								Directors of Public Health are working with Heads of Population Health at the Scottish Government with a view to intelligence performance management around Health Inequalities activity, e.g. delivery plans now have commentary on Anchor work required.				Develop a systematic way to assess and monitor health inequalities, and develop performance management around outcomes on prevention and health inequalities that is embedded in Performance tables. Use of data to identify inequities, inform planning and prioritisation, and track progress DNAs (Did Not Attends to appointments) With support from PHS, standardise approach to analysing outpatients/inpatient appointments by SIMD, ethnicity, age and sex. (Example from NHS Fife identifying DNAs within planned care).Healthcare service inequalities With support from PHS, standardise approach to analysing cardiovascular disease services (including uptake of prevention e.g. type 2 diabetes) and outcomes (to be defined) by SIMD, ethnicity, age and sex. Indicators for healthcare generated health inequalities.	Jennifer Champion	31-Aug-25	31-Aug-25	0%							
								Commenced work with HR re revamped EQIA with a poverty/health inequalities focus.				Review NHS Forth Valley contribution to community planning partnerships.	Jennifer Champion	30-Sep-25	30-Sep-25	5%							
								Healthcare PH Consultant understanding health inequalities and barriers to paediatric outpatients.				Development of the Population Health & Care Strategy.	Jennifer Champion	30-Jun-25	30-Jun-25	30%							
SRR 010	22-Jan-19	Estates & Supporting Infrastructure	If a whole system, multidisciplinary approach is not applied, there is a risk that we will not make best use of available capital and revenue funding, via prioritisation and allocation, to fully proceed with existing Estates and Infrastructure plans, make new development plans, or maintain and enhance the existing estate. This will result in an inability to maintain and develop a suitable environment for modern and sustainable services.	Service Delivery/Business Interruption	5	5	25	NHS Board capital plan outlining prioritisation and funding for Infrastructure developments	4	4	16	**ABSOLUTELY CRITICAL** - Development of whole system infrastructure plan which is in effect a Programme Initial Agreement and will set out proposals on a system-wide basis for asset investment to facilitate the achievement of strategic plans (will include	Morag Farquhar	01-Jul-25	31-Jan-26	5%	2	3	6	12-Feb-25	This risk has been reviewed by the Director of Facilities and there is no change to the scoring of this risk at this review. The Business Continuity Plan was submitted to Government on the 29th of January and we are awaiting feedback from this. It is thought	Morag Farquhar	Andrew McGown
								Operational condition of estate regularly assessed and monitored through the Strategic Asset Management System.															
								Rolling estate survey programme carried out within 5 year cycle															
								Regular reviews with PPP partners for FVRH, SHCV, CCHC and planned preventative maintenance programmes in force including 'Blackstart'.															
								Prioritisation of Revenue and Capital budget planning process in place for Estates															
								Horizon scanning – keeping on top of latest developments in Estates Management, changes in guidance, awareness of national position re capital funding (through membership of national groups).															
								SCART - Statutory Compliance Audit and Risk Tool															
								Estates and Capital Planning Service Delivery															
								Facilities Management Tool.															
SRR 004	17-Aug-23	Scheduled Care	If NHS FV does not consider and plan for current and future changes to population and associated demand/case-mix, there is a risk that the model for delivery of planned care will not meet demand or prioritise effectively, resulting in poorer patient outcomes, avoidable harm and failure to meet targets.	Patient Experience	4	5	20	Scheduled Care Performance Management process in place - identification of performance issues allowing interventions	3	5	15	Implementation of a 3rd CT Scanner within acute.	Jennifer Gilchrist	31-Jan-24	28-Mar-25	90%	1	5	5	22-Jan-25	This risk has been reviewed by the Head of Scheduled Care and there is no current change to the current position of this risk.	Garry Fraser	Marie Gardiner
								All urgent and suspected cancer pathways are maintained via tracking and reporting carried out by Cancer Service Manager				Enhance the sign off of consultant job plans in Scheduled Care.	Chris Cairns; Sara Else	31-Jul-25	31-Jul-25	80%							
								Annual Delivery Plan to maximise scheduled care services.				Assessment of the effectiveness of the non-consultant model of care - outpatient area, and Advanced Practitioner clinics, surgical care practitioners delivering urology surgery.		31-Mar-24	31-Mar-25	95%							
								Approval given by NHS Board to invest NRAC monies recurrently on a sustainable solution				A 24 month plan has been developed to improve efficiency and address the impact of the NTC as far as possible with the resources available, and will require further work to change the service model to be fully effective.	Marie Gardiner	31-Mar-24	30-Apr-25	75%							
								NHS Forth Valley, in line with the rest of NHS Scotland, continues to prioritise and treat those patients - two levels - urgent and routine.				Complete the theatre efficiencies programme of work to try and increase capacity within our theatres.	Marie Gardiner	31-Mar-25	31-Mar-25	75%							
								Consultant Job Plans.				Orthopaedics recovery plan to review. Plan will be complete and submitted in January – will go to ASMG on February (7th). Planned Care Programme Board.	Marie Gardiner	31-Mar-25	31-Mar-25	75%							
								Non-medical staff delivering clinic and surgical based interventions releasing consultant time to do complex cases.															
SRR 011	21-Jan-19	Digital & eHealth - Infrastructure & Strategy	If NHS FV does not develop and effectively implement a Digital and eHealth strategy which enables transformation and improvement as well as minimising technical vulnerabilities, there is a risk that other key organisational strategies cannot fully deliver the intended benefits, or the IT infrastructure could fail, impacting on long-term sustainability and efficient and effective service delivery.	Service Delivery/Business Interruption	4	4	16	Annual Digital and eHealth delivery plan - 23/24 plan approved at March Digital and eHealth Programme Board.	3	5	15	The Director of Digital has requested full implementation of the PC/ Server & System asset management system to support the rolling infrastructure refresh. The IT team are looking at Asset Management within the new Service Now service desk tool to replace existing tools.	~~Douglas Grant;~~ Tracey Jackson ; Scott Jaffray	31-Dec-22	30-Jun-25	30%	2	3	6	17-Feb-25	This risk has been reviewed by Scott Jaffray and there is no change to the current position of this risk at this review. Work continues to be progressed to further mitigate this risk into the Boards appetite.	Scott Jaffray	Rachel Marshall
								Lifecycle System matrix reviewed annually by the Digital and eHealth Programme Board to shape future investment plans				Raise awareness and obtain clinical support throughout the organisation to understand the Delivery Plan objectives and support roll-out of the 66 projects held within.	Scott Jaffray	31-Mar-24	30-Apr-25	80%							
								Cyber security objectives and initiatives included in the annual programme of work				Increase the number of digital champions across the organisation to enhance digital/clinical partnership working.		30-Apr-25	30-Apr-25	0%							
								Windows/Office Programme team in place.				Establish a benefits realisation process to document and report on all identified benefits within digital projects and report these to the Digital & eHealth Programme Board.		30-Apr-25	30-Apr-25	0%							
								Programme of work to upgrade ICT infrastructure at FVRH as part of 20/21 delivery commenced and on track for completion this FY															
								Disaster Recovery and Business Continuity Plans are in place to improve the overall infrastructure and contingency plans. Linkages made with Business Continuity and Risk Management teams to support resilience work.															
								Digital Directorate Workforce Plan.															
								Ensure alignment of new digital & eHealth proposals are linked to current strategies of the Board and national.															
								Accredited by the Service Desk Institute Standard.															

SRR 018	03-May-24	Primary Care Sustainability	If we do not have adequate resources to support and implement a Primary Care framework, there is a risk that we don't have sufficient capacity to maintain delivery of primary care across Forth Valley, resulting in a failure to meet our statutory responsibilities.	Service Delivery / Business Interruption	4	5	20	Sustainability Improvement Isams process in place	3	4	12	Development of new/innovative portfolio roles and career pathways, and a focus on ways of supporting practice workload. This will include roles that have already proved of most value – e.g. mental health nurses, advance physiotherapists and ANP's.	~~Judith Proctor~~	31-Dec-23	30-Apr-25	64%	2	5	10	14-Feb-25	Risk is currently subject to a focused review and therefore there is no immediate progress to note on this risk.	Gail Woodcock	Scott Williams
								Primary Care Improvement Plan being delivered proactively supporting recruitment etc. (PCIP Improvement Plan iteration 3 substantively delivered in March 2022 - 160 of 200 posts).				Development of Governance routes and escalation procedures following the delegation of PC to FHSCP	~~Judith Proctor~~ Scott Williams	01-Mar-24	31-Mar-25	75%							
								Expansion of community pharmacy services. Further development of pharmacy first service.				There is a need for a wider whole system GP/PC transformation programme which would be expected to support a reduction in risk score and overall sustainability however this is a long term aspiration and work around this is not likely to commence in the medium to short term.	~~Judith Proctor~~ Scott Williams	31-Mar-23	31-Mar-25	0%							
								GP IT Programme Board established to look at wider IT issues affecting Primary Care including remote working and telephony solutions. Near Me video consultation solution - around 50 laptops were distributed.															
								Primary Care Programme Board Re-established November 2021															
								Premises improvement funding in place. Capital budget available each year. Discussions are ongoing with wider SG premises improvement grants being made available. This money would come through the FHSCP and FV Facilities will continue to monitor the position with the available capital however this is extremely limited for 2024/25.															
								Investment in quality clusters and leads to ensure GPs and multidisciplinary teams (MDT) are informed and involved in primary/community care developments, quality improvement and assurance.															
								Strong and regular engagement with SG and BMA (British Medical Association) in place regarding national MOU funding allocations / requirements															
								GP Sub-committee (GPs working collaboratively) in place. Away-day held and developed a paper outlining actions to improve recruitment and retention in FV, e.g. attracting and supporting trainee doctors. As at 06 April, currently funding GP sessions to help implement the outputs from the paper.															
								Directly appointed GPs where there are issues such as rural practices or practices under 2c contractual arrangements															
								Targeted recruitment to build GP and MDT capacity and capability – promoted NHS FV as an employer of choice for Primary Care roles – e.g. ongoing investment in investors in people, promote i-matter, work to achieve gold healthy working lives rating, support CPD.															
								Capital Investment Programme in PC premises initial agreement completion Dec-21. Initial Agreement was approved, and it a business case will be required if we commenced for significant premises replacement. As of 18 March 2024, SG asked that all Business Cases are paused and the Locality Projects will be taken forward under the Whole System Infrastructure Plan. The Initial Plan is required by the end of June 2024, and a Business Continuity option to maintain existing estate is to be submitted by Jan 2025. Capital funding is extremely limited for 2024/25 and we may have to discuss prioritisation subject to local capital constraints. The Primary Care Premises Group established deals with sustainability Isams, and the 4 business cases e.g. Falkirk Community Hospital and Primary Care Programme Board.															
								Monitoring GP sustainability and workload data to inform the development of future controls and actions															
SRR 019	05-May-22	Culture & Leadership	If NHS FV do not foster a cohesive culture with strong leadership, there is a risk that our people will not feel valued in their roles and understand how they feed into organisational success, resulting in a negative impact on staff morale, and an inability for FV to be resilient, agile and achieve long-term success.	Inspection / Audit	5	5	25	Whistleblowing procedures including 'Speak Up' service.	3	5	15	Building on staff awards, work in progressing on other staff recognition opportunities.	Kevin Reith	30-Jun-24	30-Jun-25	30%	2	5	10	14-Feb-25	This risk has been reviewed by the Director of People and there is no change to the	Kevin Reith	Margaret Kerr
								Communication - Resources supporting development of culture are available on the intranet.				Review arrangements for annual iMatter staff experience survey to ensure effective organisational engagement	Kevin Reith	31-May-22	31-May-22	50%							
								Personal Development Reviews				Implementation of the mobilisation phase one.	Kevin Reith	31-Mar-22	31-May-22	25%							
								Promotion of yearly iMatter suaveys across the organisation.				Implementation of the mobilisation phase two.	Kevin Reith	31-May-22	31-May-22	0%							
								Recognising Our People (e.g., staff															
								Culture Change and Compassionate Leadership Programme - Phase 1 (scoping) and Phase 2 Diagnostics and Discovery are complete.															
								ELT co-produced Organisational Development Programme - scoping and agreement.															
								Leadership Programme.															
								Peer Support and Wellbeing Teams in place to support staff.															
								Induction Processes.															
								Step into my Shoes initiative.															
SRR 003	22-Jan-19	Information Governance	If NHS Forth Valley fails to implement and maintain adequate Information Governance arrangements, there is a risk we would experience systemic compliance issues and inability to use our information assets effectively, resulting in reputational damage and potential legal breaches leading to financial penalties.	Inspection / Audit	5	4	20	Robust, and regularly reviewed, procedures which address information handling available to all staff involved in the activity.	3	4	12	Assess presence of Business Continuity Plans within DPA and SSA process. Include in recommendations as required.	Sarah Hughes-Jones	30-Jun-24	31-Mar-25	90%	2	4	8	17-Feb-25	Risk is being reviewed as part of the Focused Review process.	Andrew Murray	Sarah Hughes-Jones
								Adherence to IG assurance processes & documentation (Information Assets, DPIA, ISA, Contracts, Risk Assessments, Privacy notices).				Co-ordinate SLWG to review and develop mechanisms to assess information governance compliance within supplier management processes.	Sarah Hughes-Jones	31-Dec-24	30-Jun-25	50%							
								Use of approved devices, systems, and channels.				Develop a process for registering 'shadow IT' within the Information Asset Register.	Sarah Hughes-Jones	31-Dec-24	30-Apr-25	25%							
								Active supplier management (as required)				Develop arrangements to assure accuracy of joiners, movers, leavers data across the organisation.	Sarah Hughes-Jones	31-Dec-24	30-Jun-25	10%							
								Routine review and disposal processes. Ensuring regular deletion of redundant, obsolete, trivial material.				Develop mechanisms to support routine testing of back ups as part of business as usual arrangements.	Sarah Hughes-Jones	31-Dec-24	30-Apr-25	70%							
								Annual information governance training & awareness.				Introduce and embed routine assurance audit process to test compliance with DPA and SSA actions.	Sarah Hughes-Jones	31-Dec-24	30-Apr-25	90%							
								Technical & Physical Security controls to manage access & audit.				Review frequency of mandatory information governance training, and mechanisms for delivery.	Sarah Hughes-Jones	31-Dec-24	30-Jun-25	20%							
								Secure & backed up storage arrangements which avoid use of moveable media.				Roll out of DPIA process to support implementation of OneTrust - DPIA management.	Sarah Hughes-Jones	31-Mar-22	31-Mar-24	50%							
								Effective and consistent use of filing systems, structured on Business Classification Scheme.															
								Identifying records for permanent preservation.															
								Identifying critical records within local business continuity plans															
								Information Governance Security incident Management process															
								Routine processes to check & update information over time.															

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

9. Health and Care Staffing Act Annual Report
For: Approval

Executive Sponsor: Professor Frances Dodd, Executive Nurse Director
Author: Katrina Robertson, Lead Nurse for Workforce Planning

1. Executive Summary

1.1 The introduction of the Health and Care (Staffing) (Scotland) Act 2019 (HCSSA) provides the statutory basis for the provision of appropriate staffing in health and social care services, enabling safe and high quality care and improved outcomes for staff as well as service users. NHS Forth Valley has reasonable assurance that systems and processes are in place through the work of the Implementation Oversight and Operational governance structures. Updates have been given on progress quarterly during 2024/25 to the Staff Governance Committee**.** The Staff Governance Committee commended onward presentation of the Annual Report to Board at its meeting of 14 March 2025.

Recommendation

The NHS Forth Valley Board to:

- **approve** for publication the Health and Care Safe Staffing Act Annual Report 2025 as set out at appendix to this report, and
- **note** that the annual report was produced using the required national template provided by Health Improvement Scotland.

2. Purpose

2.1 This paper is presented to the Board to approve and publish the HCSSA Annual Board Report which outlines the progress being made to implement and comply with the Health and Care (Staffing) (Scotland) Act 2019.

3. Position

3.1 NHS Boards are required to demonstrate how they have met the following Duties:

- 12IA : Duty to ensure appropriate staffing
- 12IB : Duty to ensure appropriate staffing: agency workers
- 12IC : Duty to have real-time staffing assessment in place
- 12ID : Duty to have risk escalation process in place
- 12IE : Duty to have arrangements to address severe and recurrent risks
- 12IF : Duty to seek clinical advice on staffing
- 12IH : Duty to ensure adequate time given to clinical leaders
- 12II : Duty to ensure appropriate staffing: training of staff
- 12IJ : Duty to follow common staffing method
- 12IL : Training and consultation of staff (Common Staffing Method)
- 12IM : Reporting on staffing

3.2 A governance structure across Forth Valley was commenced in September 2023. This includes:-

- Oversight group chaired by the Executive Nurse Director who is executive lead for the implementation of the legislation.
- Operational working group which is chaired by the Lead Nurse for Workforce Planning where more tailored individual profession support was offered to services using a newly developed self-assessment pro-forma.

3.3 Agreement was obtained at the oversight group that the approach should facilitate whole system support and therefore membership was offered to the Chief Social Work Officers, any Health-related staff will be reported through the NHS Forth Valley arrangements and care related staff through the respective Council arrangements.

3.4 HIS also have several duties within the HCSSA to discharge. The duty 12IP relates to HIS monitoring of NHS boards compliance with specified staffing duties to provide assurance to Scottish ministers therefore they asked us to continue submitting quarterly reports. HIS also provide Boards with an opportunity to discuss compliance with legislative duties by inviting the Board representatives to attend Quarterly Board Engagement calls.

4. Main summary of the Implementation and Compliance of the Duties

4.1 A new NHS Forth Valley Workforce Plan for 2025 is being produced and will provide an overview of our population, current workforce, financial context and set out the challenges for each of the key staff groups and plans to address these challenges and described the work underway to grow the future workforce.

4.2 eRoster and Safecare systems are being rolled out across FV as part of the improvement work and align with our ability to comply with the legislative duties to have a real time staffing (RTS) assessment in place with processes to mitigate or escalate risk daily and record decisions as well as monitor over time to understand any severe or recurring risk. It is anticipated that this rollout will be completed by March 2026.

4.3 The NMAHP community have developed a five-year NMAHP Strategic Enhancement Plan, which aligns strongly with the Culture Change and Compassionate Leadership programme in relation to the work around creating an environment of psychological safety for all staff to work in and our medical community have a job planning framework. Staff wellbeing is threaded throughout the legislation implementation and staff will be given access to training regarding workforce planning. The plan calls for taking important steps to guarantee that every job family participates in meaningful workforce planning and that workforce enablers are created for each to support and underpin the plan's delivery, including patient experience, staff engagement and experience.

4.4 An operational escalation and assessment tool (OPEL) is being used within our operations room within acute services; however, this tool provides a visual overview of our whole system pressures and regularly updates to provide management information.

4.5 Clinical advice is sought through site huddles and staffing huddles using the RTS resources and other safety briefs. In addition, an escalation plan and reporting template has been developed to seek clinical advice using the common staffing method to look at gaps in the workforce. There has been strengthening of the clinical leadership structures across the majority of NMAHP services to be clear around accountability and responsibility in relation to the duties. In other services it is the most senior clinical leader on duty who provides clinical advice.

4.6 There is work ongoing on a national basis to establish a Once for Scotland approach to Protected learning Time. The Organisational Development (OD) team are leading on the work for the implementation of the Protected Learning Directive. The Leadership Development Framework will be updated as part of this work in OD and will take a regional and national approach. eJob plan will be implemented and include time to lead. eRoster will capture non-clinical time given to leaders.

5. Conclusion

5.1 The draft Annual Report ***(Appendix 1)*** is presented for approval. The report details how NHS Forth Valley has implemented the legislation across all professional groups and healthcare staff. **Please note that this report has been produced using a National Template provided to us by HIS and will be published in this format.**

5.2 NHS FV have made good progress and have engagement from all professions. Where gaps have been identified there are plans in place to resolve these. Further assessment and reporting will keep the groups on track to ensure we are working towards full compliance with the legislation (road to green).

5.3 Monitoring arrangements are in place across the operational delivery units to understand compliance with the legislation and to ensure appropriate mechanisms of accountability and responsibility are in place and functioning.

Implications

Financial Implications
There has been annual funding from Scottish Government to support implementation of the act with 2024/25 being the last year of funding for the implementation. Permanent funding will be required as we move to business-as-usual status. Currently there is permanent funding for 1WTE 8a and the SG funding has been used to employ 1 x B6 staff to assist with the legislation implementation and running of the staffing level tools.

There is also a risk emerging in relation to the outcome of the implementation of the Act regarding some of the duties resulting in additional financial pressures. This risk is being articulated by the Directors of Finance on a national basis.

Workforce Implications
The Lead Nurse for Workforce and e-rostering manager may require more personnel as further staffing groups come on board including admin support. Discussions are under way to look at the structure of the Workforce Planning team.

Infrastructure Implications including Digital
There are still some challenges in engagement with e-rostering and the rollout of Safecare due to capacity, but plans are progressing slowly. Ongoing support continues from the e-rostering manager and team.

Sustainability Implications
No sustainability implications have been identified.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process A policy for NHS Scotland on the climate emergency and sustainable development.

✓ *Yes*
□ *N/A*

Where applicable, the climate change, environmental and sustainability impacts and any mitigating measures are noted above/contained in the supporting papers.

Quality / Patient Care Implications
Healthcare staffing is aligned with the national Excellence in Care Programme and Local Care assurance processes to ensure quality of care is not compromised. This will be monitored through the NMAHP working group and the NMAHP workforce governance group. Other professions will ensure this work is an agenda item on their own reporting structures.

Information Governance Implications
No issues at the moment

Risk Assessment / Management
As part of the Oversight process, risks are being identified, mitigated and escalated as required. The Risk Register is reviewed regularly through the working group. Last updated February 2025

Relevance to Strategic Priorities

- Plan for the future
- Improve the focus on safety and quality
- Value and develop our people
- Making the best use of our resources
- Improving the health of the population

Relevance to the delivery of safe, effective, person-centred care and to provide assurance of compliance to standards and guidelines.

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that: *(please tick relevant box)*

□ Paper is not relevant to Equality and Diversity
✓ Screening completed - no discrimination noted
□ Full Equality Impact Assessment completed

Communication, involvement, engagement and consultation

To be agreed as part of the oversight and working structures

Appendices
Appendix 1 – Draft Annual Report

Health and Care (Staffing) (Scotland) Act 2019 Annual Report / Quarterly Return

This is the annual reporting template which organisations will be required to use once the Act is in force. We are testing this out for the quarterly returns submitted prior to commencement, to increase organisation's familiarity with the template and to see if any changes are required. There are differences to requirements for the quarterly returns and the annual reporting, e.g. the quarterly returns are not required to be published; where there are differences these are explained in blue text.

1 Section 12IM of the National Health Service (Scotland) Act 1978 ("the 1978 Act") as inserted by section 4 of the Health and Care (Staffing) (Scotland) Act 2019 ("the 2019 Act") requires all Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), to publish, and submit to Scottish Ministers, an annual report setting out how they have carried out their duties under sections 12IA (including how the relevant organisation has had regard to the guiding principles in section 2 of the Act), 12IC, 12D, 12E, 12F, 12IH, 12II, 12IJ and 12IL of the 1978 Act (all inserted by section 4 of the 2019 Act).

2 Section 2(1) of the 2019 Act requires Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), when carrying out the section 12IA duty to ensure appropriate staffing, to have regard to the guiding principles for health and care staffing in section 1 of the Act. Section 2(3) of the Act requires relevant organisations to provide information to the Scottish Ministers on an annual basis on the steps they have taken to comply with this and how these steps have improved outcomes for service users.

3 Section 2(2) of the 2019 Act requires Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), when planning or securing the provision of health care from a third party under the National Health Service (Scotland) Act 1978 to consider both the guiding principles for health and care staffing in section 1 of the Act and the need for the third party to have appropriate staffing arrangements in place. Section 2(3) of the Act requires relevant organisations to provide information to the Scottish Ministers on an annual basis on the steps they have taken to comply with this and how these steps have improved outcomes for service users.

4 Reporting for section 12IB (duty to ensure appropriate staffing: agency workers) is within a separate quarterly report and not included in this template.

5 Guidance on completing the template can be found below. Completed reports must be returned to {email} by 30 April 2025. If you require further assistance or have any queries, please contact {email}. Quarterly returns are to be returned as previously advised.

Report approval

6 This tab should be completed by the person signing off the report. An electronic signature is acceptable.

7 The Act requires the annual reports to be published by relevant organisations. Please enter a hyperlink to the webpage where the report can be found. This does not apply to quarterly returns.

Summary

8 This tab asks for an overall summary of how the relevant organisation has carried out all of the duties and requirements of the Act. This should include all NHS functions provided by all professional disciplines covered under the Act (see https://www.gov.scot/publications/health-and-care-staffing-scotland-act-2019-overview/pages/roles-in-scope-of-the-act/ for more details of which staff groups are covered under the Act).

9 Following receipt of the reports from relevant organisations, the Scottish Ministers must collate these and lay a combined report before Parliament, along with an accompanying statement setting out how the information will be taken into account in policies for staffing of the health service. To enable this process, the information provided by relevant organisations must be comprehensive and pertinent to the staffing of the health service. Please complete these questions in detail, setting out the key achievements, outcomes, learning and risks and how this information has been used to inform workforce planning at the local level. For the quarterly returns the information will not be collated and put before the Scottish Parliament. However please still complete this in sufficient detail .

10 The tab then asks for an overall level of assurance of the relevant organisation's compliance with the Act, using the assurance categories as detailed below.

Individual duties / requirements

11 The next tabs look at specific elements within each of the individual duties / requirements of the Act, asking relevant organisations to provide an assessment of compliance against each statement, using the RAG classification below. Again, this should include all NHS functions, provided by all professional disciplines covered under the Act, with the exception of 12IJ and 12IL which only apply to certain types of health care, in certain locations using certain employees (more information is provided in these tabs). Next to the column for the RAG status is a column entitled 'Comment'. In this column, relevant organisations should provide detail to explain the RAG status. For example, details of the organisational structures and / or processes being used, such as eRostering / SafeCare. If the RAG status is not green then explanation should be provided of the NHS functions and / or professional groups that do not have systems and processes in place or who are not using them.

12 Next, the relevant organisation is asked to provide details of areas of success, achievement and learning associated with the particular duty or requirement, along with indicating how this could be used in the future (for example, could learning in one area be applied to other areas). Again, in order to provide meaningful information that can inform health care staffing policy, relevant organisations are asked to complete this in some detail. For the quarterly returns, relevant organisations should detail areas of success, achievement or learning related to preparation for enactment in April 2024.

13 The relevant organisation is then asked to provide details of any areas of escalation where they have been unable to achieve or maintain compliance with the particular duty or requirement or where they have faced any challenges or risks in carrying out their duties or requirements. In this section, relevant organisations are also asked what actions have been or are being taken to address this. Again, in order to provide meaningful information that can inform health care staffing policy, relevant organisations are asked to complete this in some detail. For the quarterly returns, relevant organisations should detail areas of escalation / challenge / risk related to preparation for enactment in April 2024.

14 Finally, relevant organisations are asked to provide a declaration of the level of assurance they have regarding compliance with the specific section of the 1978 / 2019 Act, using the classification as below.

15 Two tabs, section 12IA and 'planning and securing services' ask additional questions. Similar to above, these should be answered in sufficient detail and more guidance is given in these two tabs.

RAG status

16 When asked to provide a RAG status, please use this key.

Green		Systems and processes are in place for, and used by, all NHS functions and all professional groups
Yellow		Systems and processes are in place for, and used by, 50% or above of NHS functions and professional groups, but not all of them
Amber		Systems and processes are in place for, and used by, under 50% of all NHS functions and professional groups
Red		No systems are in place for any NHS functions or professional groups

17 **Declaration and level of assurance**

When asked to provide declaration of the level of assurance, please use this key.

Level of assurance		System adequacy	Controls
Substantial assurance		A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable assurance		There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non- compliance.

Limited assurance		Significant gaps, weaknesses or non- compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No assurance		Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

Name of organisation:	NHS Forth Valley
Report authorised by:	*Frances Dodd* *Executive Nurse Director and Lead for Board implementation of legislation*
Location where report is published:	

Summary report

Please answer the questions below, to provide an overall assessment of how the organisation has carried out its duties under section 2 of the 2019 Act, and sections 12IA, 12IC, 12ID, 12IE, 12IF, 12IH, 12II, 12IJ and 12IL of the 1978 Act (inserted by section 4 of the 2019 Act).

1 **Please advise how the information provided in this report has been used or will be used to inform workforce plans.**

This work will inform workforce plans going forward, as well as influence the implementation of the Act. The report has enabled NHS FV to identify gaps and put plans in place to ensure actions are complete and reported into the governance structure. All information will be used to inform all decisions made about staffing levels and quality as well as identify risk or safety concerns. It will include feedback from staff and patients.

2 **Please summarise any key achievements and outcomes as a consequence of carrying out the duties and requirements in the Act.**

The current NHS Forth Valley Workforce Plan 2022-2025 is being updated this year and will be ready by June 2025 for publishing and will include an overview of our population, advise on key workforce priorities, provide financial context and will have plans to address challenges and describe the work underway to grow our future workforce, support our volunteers and recruit staff from overseas. The workforce plan will describe the work underway to grow our future workforce and support recruitment plans for the next 3 years. Our recruitment and retention programme board are looking at how service redesign can help with retention and have also implemented the 'retire and return programme'. A medical workforce group is just confirming its terms of reference and will mirror the nursing workforce governance group. Policies around supplementary staffing are being looked at and eRoster/Safecare is being rolled out across FV as part of the improvement work. The plan calls for taking important steps to guarantee that every job family participates in meaningful workforce planning and that workforce enablers are created for each to support and underpin the plan's delivery, including patient experience and staff engagement and experience. We are investing in learning and development as well as staff support and wellbeing and have a new Culture Change and Compassionate Leadership programme as well as a Workforce Wellbeing Plan. The Nursing and Midwifery community have the 'We Care Strategy ' which is now being updated and developed to include our AHP's and has become a five year NMAHP Strategy and our Medical community have a job planning framework. Our governance structures will oversee progress in implementation of these plans with professional and service leads scheduled to report during the course of the year. Staff wellbeing will be threaded throughout the legislation implementation and all staff will be given access to training regarding workforce planning.

3 **Please summarise any key learning and risks identified as a consequence of carrying out the duties and requirements in the Act.**

The main risks identified relate to the capacity of clinical teams to fully engage with the implementation of the Act, as well as fully engagement with the process of developing new systems to support the responsibilities required in the Act. All professional groups are engaged but are at different stages of implementation and compliance. The Oversight and Operational group meetings were extended until March 2025 and will move over to a business-as-usual process through each directorates governance routes in 2025/26 and assurance sought quarterly.

Real Time Staffing resources (RTS) are being widely used, and we have identified new areas of risk and been able to escalate appropriately to mitigate and we now have a better understanding of seeking clinical advice and identifying risk across the system. RTS has been beneficial, particularly to our AHPs. We will be able to adapt the Common Staffing Method (CSM) framework for wider workforce planning and will use new staffing level tools as are they are developed. The new tools will provide a structure and consistency to help support workforce planning approaches and strengthen the professional voice.

There have been delays to the implementation of eRostering and SafeCare to all professional staff in scope but NHS Forth Valley is on track and have a robust plan in place to complete this work in the next financial year.

4 **Please indicate the overall level of assurance of the organisation's compliance with the Act, reflecting the report submitted.**

Reasonable Assurance

1 Guiding principles for health and care staffing
2 Guiding principles etc. in health and care staffing and planning
12IA Duty to ensure appropriate staffing

Guidance chapter link

RAG status

Section	Item	Status	Comment
12IA(1)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary (see guidance for details of professional disciplines included within the Act) are working in such numbers as are appropriate for the health, wellbeing and safety of patients; the provision of safe and high-quality health care; and in so far as it affects either of those matters, the wellbeing of staff.	Yellow	NHS Forth Valley has good assurance that systems and processes are in place through the work of the Implementation Oversight and Operational Governance structure and all staffing groups are represented. The Implementation Oversight Group reports to the Staff Governance Committee which helps to bring together other elements relevant to the legislation. Though the implementation of eRostering we will be able to provide a consistent approach and an ability to demonstrate compliance through a range of reporting functions available within this product. Local resources have been developed including a self-assessment proforma for quarterly reporting on compliance and we have been able to highlight good practice and identify gaps. Action logs support the gaps and areas that require further work, to ensure there is oversight of risk, and a pathway to achieving compliance. The Board has a robust recruitment and retention plan for all professions and are working towards filling vacancies and ensuring steps are being taken to look after staff wellbeing to assist retention. Training, guidance and support has been offered/provided to all staff groups to ensure an understanding of the Act, and how they can support the Board to meet all legislative duties, and ensure there is appropriate staffing for the health, well-being and safety of patients, and wellbeing of staff.
12IA(2)(a)	These systems and processes include having regard to the nature of the particular kind of health care provision	Yellow	Staffing level tools will be run annually as part of the decision-making process and help to determine skill mix and numbers of staff required to provide high quality care as part of the common staffing method (CSM) triangulation process. Whilst other professions are not in scope to use the CSM, there already exists a robust process of workforce planning considering demand, capacity, activity and quality that considers the kind of healthcare provision on an ongoing basis and the professional leads, clinical teams and managers will review changes that may require adjustments to staffing requirements, skill mix, or service capacity. There is therefore systems and processes in place to support future workforce planning, as well as consider any immediate and medium terms changes that may create a risk or change, to ensure appropriate staffing provision is in place. The new eRoster and Safecare product/systems are being rolled out and the work is expected to be completed by March 2026. Safecare will be used as a Real Time Staffing (RTS) resource which provides a platform for staff on an individual shift the ability to apply professional judgement and in some areas the acuity of the patients being cared for on that day. Safecare provides information to determine whether staffing is sufficient, or to consider a change where the kind of healthcare provision may have shifted (for example, during winter pressures there may be a planned reduction in elective care to increase capacity for unscheduled care, which may require a different staffing compliment). In the Interim those areas that do not have eRoster/Safecare will use another RTS resource to improve current practice to ensure compliance with the duties. Through these processes we will be able to have regard to the nature of the particular kind of healthcare and ensure we have the right staff available. Training has been ongoing and will continue on a rolling programme to ensure all staff have access to learning. A web page has been developed to ensure staff are kept up to date with any new developments, newsletters, training date ect.
12IA(2)(b)	These systems and processes include having regard to the local context in which it is being provided	Yellow	Service planning is the responsibility of local managers, engaging with local teams and services to ensure local context is recognised, considered and had regard to when considering staffing requirements. Reporting templates have been developed for the duty to follow the common staffing method (CSM). The template brings together the results from the Staffing Level Tool runs and will incorporate local context as part of the reports and workforce plans, and will reflect dynamic service review and planning. The road to green will include all other professions looking at the common staffing method framework and utilising it along with the multidisciplinary professional judgement tool (MD PJ) to produce a consistent approach to reporting across the board. The new MD PJ tool will be tested over the next few months and then utilised by teams who currently do not have a specific staffing level tool.
12IA(2)(c)	These systems and processes include having regard to the number of patients being provided it	Yellow	All systems and processes described above will have regard to the number of patients being provided care. The development of calculators for Safecare will improve accuracy of patient dependency scores and a broader understanding of how to apply professional judgement. The common staffing method reporting will include data collected over time through RTS resources. This then forms part of any service or performance review, any risks or impact on patient quality and safety will be escalated and considered through clinical and staff governance forums as appropriate, and informs all levels of workforce planning, and establishment setting.
12IA(2)(d)	These systems and processes include having regard to the needs of patients being provided it	Yellow	All systems and processes described above will have regard to meeting the needs of patients being provided care and consider speciality specific information reflecting the specific needs of patients within individual services. The road to green will see patient acuity measured as part of the RTS processes and assists in decision making daily. The common staffing method reports will include patient feedback alongside other quality measures and feedback sources. Real-time staffing assessment will be embedded in practice and will ensure that any changes to patient needs can be assessed and any risk to providing appropriate staff to meet the needs of the real-time demands can be identified, mitigated or escalated for support.
12IA(2)(e)	These systems and processes include having regard to appropriate clinical advice	Yellow	NHS Forth Valley has developed robust escalation plans to be used in conjunction with the CSM reporting and RTSR's and both include how to seek appropriate clinical advice. Daily safety huddles and the use of a whole system escalation tool (OPEL) facilitates conversations about safety across the site and mitigation can take place early.
2(1)	These systems and processes include having regard to the guiding principles when carrying out the duty imposed by section 12IA	Yellow	The guiding principles are threaded through the systems and processes we deploy at NHS Forth Valley and ensure we have audits in place to measure care outputs to continue to improve services. We identify areas for improvement using CAIR dashboard outputs, Safeguard, CSM, feedback from staff and patients, Staffing huddles along with RTS resources, Care assurance and 'Transforming care at the bedside (TCAB)' to measure and audit care given. Our TCAB data collection dashboard gathers information about direct patient care from each of our inpatient areas and improves care through audit, review and support. Care assurance walk rounds and other measurement processes are included to ensure we take a triangulated approach; this includes all of the common staffing method elements. Through the governance structure work will continue to ensure all other professions utilise the CSM framework and develop ways to capture and measure service outputs to deliver high quality care and reduce risk to our service users. imatter and supervision will be used board wide as a measure of staff wellbeing. We have set up a dedicated web page for Staff wellbeing and support and have whistle blowing, complaints procedures, governance processes, adverse event reviews inclusive of near misses.
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Yellow	Each profession/service used a Self-Assessment Proform to update on progress being made with legislation implementation and compliance. Monitoring relies on several different processes and therefore, we have variation and a lack of consistency to provide full assurance. Each profession/service will include the legislation on the agendas of their senior leadership team meetings and will report quarterly on compliance for 2025/26. The information will be collated by the HR Workforce Lead Nurse and form the annual Scottish Government Report. This does provide a structure for receiving feedback of any risks to compliance to allow mitigation or actions to be taken to address any areas of non-compliance. Once eRostering and SafeCare is fully rolled out across the organisation the Board will have more reliable data and consistent mechanisms for monitoring compliance and addressing any areas of risk, concern or non-compliance.

Please provide information on the steps taken to comply with section 12IA.
These are steps taken to comply with 12IA in general. Examples could include information about workforce planning, national and international recruitment, retention, retire and return, service redesign, innovation, staff wellbeing, policies around supplementary staffing,

The Workforce plan is being updated this year and will be ready by June 2025 for publishing and will include an overview of our population, advise on key workforce priorities, provide financial context and set out the current challenges for each of the key staff groups. The workforce plan will describe the work underway to grow our future workforce and support recruitment plans for the next 3 years. Our recruitment and retention programme are looking at how service redesign can help with retention and have also implemented the 'retire and return programme' which is discussed with all staff considering retirement to help retain high levels of experience and expertise. The International Recruitment programme has been paused for review but will be revisited.

A new vacancy control panel had been developed to streamline recruitment processes and will ensure rigor with agreeing new posts with timeliness of progressing through recruitment to advert. We are having targeted recruitment and are planning for the new graduates in September 2025. This range of initiatives will enable effective recruitment, attract staff to the Board, to value, support and develop staff and ensure the most efficient and effective use of staff to meet the needs of patients. It will fill vacancies and relieve the burden of the lengthy process.

NHS Forth Valley collaborate with the local College to develop and deliver a related education programme. We have also worked with the College to develop a Modern Apprenticeship route for Band 3 roles to provide a structured career development framework for Health Care Support Workers. We work closely with the University of Stirling and The Open University.

NHS Forth valley has done extensive work with supplementary staffing, reducing the use of agency, and building resilience in the staff to improve quality of care, support substantive and bank staff, and to provide a high-quality service to patients. Policies around supplementary staffing will be updated and eRoster/Safecare will continue to be rolled out across FV as part of the improvement work.

The workforce plan calls for taking important steps to guarantee that every job family participates in meaningful workforce planning and that workforce enablers are created for each to support and underpin the plan's delivery, including patient experience and staff engagement and experience. We are investing in learning and development as well as staff support and wellbeing and have a new Culture Change and Compassionate Leadership programme as well as a Workforce Wellbeing Plan. Our Nursing and Midwifery community have the 'We Care Strategy' which is now being updated and developed to include our AHP's and has become a five-year NMAHP Strategy and our Medical community have a job planning framework. The Clinical Supervision programme supports Nursing and AHP's to address workforce needs and the programme will be rolled out in the future to other professions

Our governance structure will oversee progress on the implementation of plans with professional and service leads scheduled to report quarterly in line with the reporting timeline set out by Health Improvement Scotland Monitoring and Compliance Team. Staff wellbeing will be threaded throughout the legislation implementation and all staff will be given access to training regarding workforce planning.

Please provide information on how these systems and processes, and their application, have improved outcomes for service users

This should include, but not be limited to data in relation to patient safety and quality of care measures and outcomes, patient feedback and adverse event reporting.

NHS Forth Valley recognises the need for the inclusion of patient outcome data and whether staffing problems have had an impact on safety and quality of care provided. The new clinical governance structures will review all the data from our various systems and processes and use this to support improvement planning with the patient/service user at its heart. We are developing digital solutions to ensure data is easily obtained and reported on. Across all professions, the Quality Improvement and Assurance team will provide on-the-ground local and strategic support to teams to bring about tangible and sustainable improvement in experience and outcomes of care. SPSP sits within this team, and the SPSP, EiC, Practice Development and Workforce Leads work closely together to ensure alignment of work. NHS Forth Valley demonstrates an ongoing commitment to listening and learning from the experience of patients/ carers and service users and seeks feedback using a range of methods. Care Opinion is a central component in the way in which we receive feedback and continues as a key approach for receiving feedback which can then be used to influence simple changes in practice and/ or procedures.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, application of eRostering has allowed senior personnel to be able to see staffing in real-time across all areas, allowing staff to be reallocated as required to reduce level or risk.	This should describe how the success, achievement or learning could be used in the future. Continue the roll out of eRostering across the organisation, using learning from areas that have already implemented.
Web page has been developed to support all staff	To build sustainability the Board has developed a web page that provides a range of information about the Act, access to internal an external resources to support staff as a refresher, or reference for new staff / staff changing roles who will therefore have a different level of responsibility or requirements to support the Board meet the duties off the Act.	To continue to update, refine and seek feedback on the content and use of web page to ensure it is meeting the needs of staff and leaders within the organisation.
Nursing and Midwifery	Nursing and Midwifery have made good progress with regards to having Real Time Staffing in place. This will enhance the ability to record staff movement, establish real-time skill mix, mitigation and raise red flags. Staffing level tools have a schedule and escalation plan for and will use the CSM to triangulate and the results and reports will be used to review staffing levels and make decisions about staffing.	Departments who do not have a staffing level tool will still be involved the CSM training and will be encourged to use the MD Professional Judgement tool to produce an annual report and allow for a similar review as those who do have a staffing level tools to utilise.
Skilled TURAS Modules for the HCSSA 2019	Nearly 5000 Skilled level modules have been completed by NHS Forth Valley Staff covering the four domains of Health and Care Act. That figure is almost a quarter of all skilled level modules completed to date across Scotland.	Completion of the modules will continue to be encouraged during this next financial by all staff in scope.

All	NHS FV have an active role on many of the national working groups and have made significant contributions to the shaping of the national guidance documents. All teams involved in RTS are being supported by our eRoster Manager/Team, Workforce Lead and Safer Staffing team. The local team have provided support and training during each part of the implementation process.	Roll out will continue for eRoster and Safecare. A training schedule will be built into the plans for the Staffing Level Tool runs 2025/26.

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge / risk	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with recruiting a particular staff speciality or in a remote / rural location.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in recruiting in a particular speciality or remote / rural location, the relevant organisation may have investigated retire and return schemes or upskilling and career development for existing staff. It may also have looked at how the service could be redesigned.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance

12IC Duty to have real-time staffing assessment in place

Guidance chapter link

RAG status

Section	Item	Status	Comment
12IC(1)	Clearly defined systems and processes are in place, and utilised, for the real-time assessment of compliance with the duty to ensure appropriate staffing, in all NHS functions and professional groups.	Green	Safecare is being rolled out across NHS FV and will be complete by March 2026 for all areas in scope of the legislation. To date SafeCare has been rolled out to adult inpatient areas including the Acute and Community Hospitals as well as pharmacy, Maternity, Mental health and learning disabilities. This work will link in with the safety huddles and other touchpoints including the operational escalation and assessment tool (OPEL) which is being used within our operations room within acute services. This tool provides a visual overview of our whole system pressures and regularly updates to provide management information. New governance structures oversee multidisciplinary efforts to create a reliable, systematic approach that will apply to all services and offer assurance that we are compliant with this duty. While Safecare is being embedded all areas will operate a dynamic risk assessment either through use of safety huddles or in response to unplanned absence/vacancy which impact staffing levels. All Staff can voice concern regarding appropriate staffing in real time directly to their line manager, who can take action to mitigate any risk identified. An example of this would be bringing in additional resource from another areas, redeployment of available staff and/or a re-prioritising of workload for the staff in the area. All services have an agreed process in place that enable real-time staffing assessment to identify risk to patient safety, quality and outcomes. Assurance will be sought through a self-assessment return ahead of each internal quarterly report on the functioning of RTSRs or safety huddles for services that do not yet use SafeCare.
12IC(2)(a)	These systems and processes include the means for any member of staff to identify any risk caused by staffing levels to the health, well-being and safety of patients; the provision of safe and high-quality health care; or, in so far it affects either of those matters, the wellbeing of staff.	Green	Safecare is a system that all staff have access to and gives the ability for any member of staff to identify any risk. The team leader will assess the staffing available against the planned workload and use their professional judgement to determine whether there is a risk or not. Action will be taken at a local level to address or mitigate any identified risk, where appropriate. All staff have been offered training in the new system and are encouraged to report concerns through the escalation process. Safety huddles take place throughout the day to discuss risk, mitigate and escalate ongoing issues. AHP's and other Professions have developed their own system while they wait on Safecare being implemented. The Safeguard (IR1) system will be used to report any ongoing 'Red' risks and provides the ability to look at any severe and recurring risk along with reports gained using the Safecare system. All staff have access to Safeguard where a risk, issue or concern not mitigated would then be escalated.
12IC(2)(b)	These systems and processes include the means for the initial notificaiton / reporting of that risk to the relevant individual with lead professional responsibility.	Green	On a day to day basis risk is discussed and mitigated through safety huddles and using tools such as Safecare and TURAS or another locally developed resources. There is a lead professional on duty for staffing who will be available to contact at anytime out with the huddles including night duty. All other professions who do not currently have Safecare or TURAS RTS have a plan to highlight interim measures to ensure a robust process is in place within their service. Ongoing assurance will be sought through the governance process. It is linked to the roll out of eRostering and the generic RTSR. Our Safeguard (IR1) system is part of the process and will alert the relevant lead with professional responsibility for each service and will be used to record, mitigate or escalate any ongoing red risk where nessesary.
12IC(2)(c)	These systems and processes include the means for mitigation of risk, so far as possible, by the relevant individual with lead professional responsibility, and for that individual to seek, and have regard to, appropriate clinical advice as necessary.	Green	Safecare and TURAS resources do include the means for mitigation of risk, so far as possible, by the relevant individual with lead professional responsibility, and for that individual to seek, and have regard to, appropriate clinical advice as necessary. Teams have developed standard operational processes to support escalation. All other professions/services waiting on Safecare have implemented interim measures to ensure a process is in place within their service. We also have Safeguard (IR1) system for reporting red unmitigated staffing concerns which are incorporated into the escalation process so that any risk not safely mitigated is escalated to the next level.
12IC(2)(d)	These systems and processes include means for raising awareness among all staff of the methods for identifying risk, reporting to the individual with lead professional responsibility , mitigation, and seeking and having regard to clinical advice.	Yellow	The systems and processes do include means for raising awareness among all staff of the methods for identifying risk, reporting to the individual with lead professional responsibility, mitigation, and seeking and having regard to clinical advice. All staff have been trained to use Safecare as part of the implementation and are using a Standard Operational Process (SOP) to support escalation. All other professions who do not currently have Safecare or TURAS RTS access now have their own interim process/system to highlight and implement the measures to ensure a robust process is in place within their services. **Road to Green -** Assurance will be sought through the ongoing reporting to local governance and Senior Leadership Teams as well as ongoing quarterly updates for Staff Governance Commitee meetings.
12IC(2)(e)	These systems and processes include means for encouraging and enabling all staff to use the systems and processes available for identifying and notifying risk to the individual with lead professional responsibility.	Yellow	Training has taken place across NHS FV for the RTS resources to ensure all staff have access and can use the system and understand the process to identify and notify risk and who to report too. Staff are encouraged to access the available TURAS learning resources, as well as information developed locally, shared via the internal staff briefs / communications, and is available within the Boards intranet site. Standard Operational Processes (SOP) support escalation and outline roles and responsibilities. **Road to Green -** As eRoster is rolled out, all other professions will receive training and support. This training includes the process for recording staffing levels and reporting risk. All data entered on these systems are reviewed by the individuals with lead professional responsibility and are reported through the governance processes.
12IC(2)(f)	These systems and processes include the means to provide training to relevant individuals with lead professional responsibility on how to implement the arrangements in place to comply with this duty.	Yellow	Training is ongoing and individuals with lead professional responsibility have been signposted to complete the TURAS modules hosted on knowledge and skills framework. nearly 5000 modules have been understaken and completed by NHS Forth Valley Staff to date. A dedicated web page has been developed on the intranet 'Learning Zone' which will house all related learning and links to information on the legislation moving forward. An additional day has been added to the organisational development leadership course to include workforce planning and Safe Staffing legislation. To date the workforce lead has engaged with all professions through the legislation implementation operational group and supported the ongoing work in the sub groups dedicated to legislation implementation.
12IC(2)(g)	These systems and processes include means for ensuring that individuals with lead professional responsibility receive adequate time and resources to implement those systems and processes.	Yellow	Risk management and risk escalation is a well embedded informal process already both through the use of Safety Huddles and real time staffing assessment. The activity of lead professionals and senior decision makers related to management of risk escalation and management of risk is routinely incorporated into daily work activities. Time is already set aside each day to consider staffing risk and with the introduction of Safecare across all services it will be done in a more consistent and formal way. This sub-duty will be taken forward into the Protected Learning Directive SOP once we have the final version of it in Board. The Organisational Development have this as part of the agenda.
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Yellow	**Road to Green -** The monitoring of compliance will be the responsibility of each Directorate through their own governance structure using performance review. The Workforce Lead Nurse is a permanent member of the HR Resourcing team and will continue to collate information quarterly for the Staff Governance Commitee meetings and the development of the Annual Report. All reporting lines use the self-assessment proforma which will form the basis of the key performance indicators.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, areas that have implemented and are using SafeCare are finding it easy to be able to record risks that are identified and the mitigation measures implemented and clinical advice received. Reports extracted from the system are demonstrating an auditable trail of decision-making.	This should describe how the success, achievement or learning could be used in the future. This success is being used to demonstrate to other areas the benefits of using SafeCare and supporting its implementation.
Safecare within eRoster	The imlementation of Safecare across NHS FV is going well with all of our Adult Inpatient areas now on board along with the Community Hospitals, Maternity Services and Mental Health inpatients.	The plan is to have all professions in scope to be onboard and using Safecare by the end of March 2026. We continue to work with Optima and have a plan laid out.
Other RTS resources	All other professions have an interim resource in place while they wait for Safecare.	They have been sharing success and learning from each other as they have implemented the resource within their own setting
Path to Green	There has been good engagement and all professions now have a resource to use, however they are all at different stages of implementation. We will not reach green until we are assured that all professions are using Safecare proficiently and in a consistent way.	Quarterly updates will be sought from the lead professional in the operational group and through any updates provided by the eRoster team through the local workforce governace groups.

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge /	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with encouraging and enabling certain professional groups to use the systems and processes.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in engaging certain professional groups, what measures have been put in place with regard to increasing this such as using professional networks, staff representatives etc.
Acute Medical Teams and Advanced Practice	Medical and Advanced Practice have got a plan and have made some steps to implementing their resouce, however they are still at an early stage.	Ongoing support from the eRoster Manager and team as well as the Workforce Lead has been offered. The teams will remain under closer review and will report on progress.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance

12ID Duty to have risk escalation process in place

Guidance chapter link

Section	Item	Status	Comment
12ID(1)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, for the escalation of any risk identified through the real-time staffing assessment processes which has not been possible to mitigate.	Green	Safecare will be rolled out across NHS FV and the process will be complete by March 2026 for all areas in scope of the legislation. This will link in with the safety huddles and other touchpoints. New governance structures oversee multidisciplinary efforts to create a reliable, systematic approach that apply to all services and offer assurance that this duty is being complied with. Escalation and mitigation of risks identifed takes place during the safety huddles daily.An identified risk that cannot be mitigated (Red) will be escalated onto the Safecare and Safeguard (IR1)system as part of the process and informal lines such as telephone notification to a senior manager. The escalation of risk will be supported by local Standard Operating Procedure (SOP) to ensure awareness of the process, and give consistency. The SafeCare project is being driven forward to support escalation of risk through this programme.
12ID(2)(a)	These systems and processes include the means for the lead with professional responsibility to report the risk to a more senior decision-maker.	Green	Local SOP's with onward advice on reporting have been developed. Safecare and the TURAS RTS resource along with the safety huddles provide a platform to report and escalate risk to a senior decision maker. Senior decision makers are present at huddles and they have clear processes for onward escalation if no mitigation. An identified risk that cannot be mitigated would then be escalated through our safeguard system and/or through rapid escalation through informal lines such as telephone notification to the professional lead where rapid action is required, with onward escalation to an executive level decision if required.
12ID(2)(b)	These systems and processes include the means for that senior decision-maker to seek, and have regard to, appropriate clinical advice, as necessary, when reaching a decision on a risk, including on how to mitigate it.	Green	Clinical advice is sought throughout the day through our site huddles using the RTS resources and annually through using the common staffing method. As previous with the revised configuration of SafeCare and use of RTSR there will be the opportunity to review processes within these systems to strengthen existing structures and this will include how to mitigate risk. There has been strengthening of the clinical leadership structures across all services to be clear around accountability and responsibility in relation to this duty. NHS FV have Workforce Governance Groups and a Recruitment and Retention programme where Professional leads are in place for all services and provide representation and will oversee workforce monitoring and planning at operational level and corporate level within their areas of responsibility (Acute services, Public Health, Pharmacy and HSCPS ect). The areas in scope to follow the CSM are using a reporting template following the staffing level tool runs along with a robust escalation plan to look at gaps in the workforce.
12ID(2)(c)	These systems and processes include the means for the onward reporting of a risk to a more senior decision-maker in turn, and for that decision-maker to seek, and have regard to, appropriate clinical advice as necessary, when reaching a decision on a risk, including on how to mitigate it.	Green	The process described above includes the onward escalation of risk if no mitigation can be done. There is a system in place for escalation to seek bank staff and onwards to agency if all other avenues have been explored. Mitigation processes are in place and being used for all of the clinical and non-clinical teams. If an identified risk cannot be mitigated it will be escalated onto the Safecare/Safeguard system as part of the process and informal lines such as telephone notification to a senior manager. The escalation of risk will be supported by local SOPs to ensure awareness of the process, and give consistency. We have a supplementary staffing escalation SOP and pathway in place for nursing and midwifery which clearly lays out this requirement to escalate and seek clinical advice through professional lines.
12ID(2)(d)	These systems and processes include means for this onward reporting in (c) to escalate further, as necessary, in order to reach a final decision on a risk, including, as appropriate, reporting to members of the relevant organisation.	Green	Safecare will include the means for onward reporting in order to reach a final decision. As Safecare is embedded it would be our plan to review this and continue to improve escalation processes. At the moment we can report workforce risk on our Safeguard system which has the capacity for onward escalation up to executive level if required to achieve mitigation or reduction of the risk as far as possible. High level risks are automatically escalated to executive level and this will be improved through the use of the OPEL tool previously mentioned. A large majority of our services have in place Business Continuity plans, service level risk registers and escalation of risks through governance groups up to strategic risk registers as required which are reviewed by members of the relevant organisation. There are existing mechanisms in place to allow rapid escalation through the relevant professional and managerial lines, with appropriate clinical advice, to respond to any urgent concerns.
12ID(2)(e)	These systems and processes include means for notification of every decision made following the initial report, and the reasons for that decision, to anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice.	Yellow	Safecare includes means for notification of decisions made at each stage of assessing risk, recording risk, mitigation of risk and where no mitigation can be done the risk can be escalated up to executive level. The SOP strenghens the process and ensures everyone knows their role and responsibility in the process and will be reviewed and improved as we implement.
12ID(2)(f)	These systems and processes include means for anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice to record any disagreement with any decision made following the initial identification of a risk.	Yellow	Safecare captures all decisions on mitigation and can also record any disagreements as part of the ongoing narrative within the PJ section. There will be gaps here until Safecare is completely rolled out. Areas without Safecare are using other means to record decisions and any disagreements. Road to green is successful roll out and use of Safecare.
12ID(2)(g)	These systems and processes include means for anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice to request a review of the final decision made on an identified risk (except where that decision is made by members of the relevant organisation).	Yellow	Safecare is accessable to all staff to view as well as add PJ narrative and all staff are encouraged to engage in the process. All staff can raise a red flag or disagree with decisions made and can go on to use Safeguard to log a disagreement. Review and feedback will need to be built into the process as the system is used more across all services.
12ID(2)(h)	These systems and processes include means for raising awareness amongst all staff of the arrangements stated in (a) to (g) above.	Yellow	The process will become part of the education roll out and will be shared widely. We will use email, Staff Brief, Intranet and Learning Zone.
12ID(2)(i)	These systems and processes include the means to provide training to relevant individuals with lead professional responsibility and other senior decision-makers on how to implement the arrangements in place to comply with this duty.	Yellow	Training and information sessions have already taken place with Lead professionals and work will continue to increase knowledge with this duty. As the processes are completed information will be cascaded to all professional groups to be shared. The modules available on TURAS e learning are being shared and all staff at all levels are being encouraged to complete them. Our web page on the learning zone will host all legislation related links and information.
12ID(2)(j)	These systems and processes include means for ensuring that individuals with lead professional responsibility and other senior decision-makers receive adequate time and resources to implement the arrangements.	Yellow	Time is set aside each day to review staffing levels. Staffing huddles take place across the whole of FV.
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Yellow	**Road to Green -** The monitoring of compliance will be the responsibility of each Directorate through their own governance structure using performance review. The Workforce Lead Nurse is a permanent member of the HR Resourcing team and will continue to collate information quarterly for the Staff Governance Commitee meetings and the development of the Annual Report. All reporting lines use the self-assessment proforma which will form the basis of the key performance indicators.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, senior decision-makers in paediatric nursing were identified and chain of escalation communicated to all personnel. Individuals are now much better aware of who to contact during any particular shift in the event that a risk needs to be escalated.	This should describe how the success, achievement or learning could be used in the future. The procedures for identifying the chain of escalation that were used in paediatric nursing are now be trialled and rolled out across other areas.
Path to green	Ensuring that all risk escalation processes take account of each part of the duty and that the SOP's are robust and easy to follow.	Build on what has been achieved so far and continue to improve and embed the system and process across the organisation.

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge / Risk	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with ensuring relevant individuals involved in reporting, mitigating, escalating or giving clinical advice on a risk are notified of decisions made the reasons for them.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in notifying relevant individuals about decisions made and the reasons for them, what measures have been put in place to ensure this happens, such as providing training, increasing awareness and auditing to identify root causes.
All Professions	Time is always a challenge when is comes to embedding a new system and process and in the current climate. Delays have happened during the implementation period but everyone is commited to getting this right and understands the importance of the legislation.	The Directors are working with their senior leaders and operational managers to ensure this system is embedded well into our culture.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance

12IE Duty to have arrangements to address severe and recurrent risks

Guidance chapter link

Section	Item	Status	Comment
12IE(1)(a)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, for the collation of information relating to every risk escalated to such a level as the relevant organisation considers appropriate.	Yellow	Collecting data over time from the Safecare and TURAS RTS resources will enable reports to be generated and analysed. This function will allow for collation of information relating to every risk escalated to such a level as the relevant organisation considers appropriate. The Safecare system keeps data for 7 years at the moment and all risks raised on the Safeguard system are allocated a rating for impact (severity) and likelihood (anticipated likelihood of reoccurrence). All Safeguard submissions can be reviewed across our governance groups for trends and occurrences. Actions are decided at this level on mitigation requirements to prevent reoccurrence including escalation if appropriate. Each service area can pull risks specific to their area to provide localised and operational picture of risk. . Together these systems will provide robust data on severe and recurrent risks.
12IE(1)(b)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to identify and address risks that are considered severe and / or liable to materialise frequently.	Yellow	The ability to identify and address risks that are considered severe and / or liable to materialise frequently will be built into the processes within the RTS resources. RTSR and SafeCare will have more reliable information to support the identification of recurrent risk within the system. All identified severe and recurring risks are reported and reviewed through the clinical governance process. Themes coming through will be identified and discussed for each area to assess severity and/ or recurring risk within their local context, for nursing and midwifery this is also built into the common staffing method of triangulation. Each professional group/ service will determine what constitutes a severe risk to their safe service delivery within the clinical governance frameworks. Discussions are going to determine what is considered a severe risk. Through the use of Safeguard and the risk management scoring system we can look at trends and recurrence of same or similar reports.
12IE(2)(a)	These systems and processes include the means for recording risks that are considered severe and / or liable to materialise frequently.	Yellow	The ability to record risks that are considered severe and / or liable to materialise frequently built into the processes within the RTS resources. The reporting template for use when following the common staffing method has a section for recording risk and pulling together RTS data for review. All professions will eventually be using this framework for reporting giving a consistenty to the use of recorded data.
12IE(2)(b)	These systems and processes include the means for reporting of a risk considered severe and / or liable to materialise frequently, as necessary, to a more senior decision-maker, including to members of the relevant organisation as appropriate	Yellow	The ability to report risks that are considered severe and / or liable to materialise frequently built into the processes within the RTS resources. The reporting template for use when following the common staffing method has a section for recording risk and pulling together RTS data for review. All professions will be using this framework for reporting giving a consistenty to the use of reported data. The escalation plan will ensure relevant members of the organisation recieve the information in a timely way to support decision making. Governance structures already exsist with ELT, SLT, and other programme boards and clinical governce arragements in place across all professions.
12IE(2)(c)	These systems and processes include means for mitigation of any risk considered severe and / or liable to materialise frequently, so far as possible, along with a requirement to seek and have regard to appropriate clinical advice in carrying out such mitigation.	Yellow	Safeguard system allows for application of mitigating actions to be applied with involvement of clinical advisors. SafeCare and RTSR will be able to record and report on mitigations in place for risks, along with assurance that clinical advice has been sought. This will strengthen the current process described above.The means for mitigation of any risk considered severe and / or liable to materialise frequently, so far as possible, along with a requirement to seek and have regard to appropriate clinical advice in carrying out such mitigation will be built into the processes within the RTS resources. and escalated through our new clinical governance routes.
12IE(2)(d)	These systems and processes include means for identification of actions to prevent the future materialisation of such risks, so far as possible.	Yellow	Our governance processes includes robust Adverse Event Reviews relevant to the reported severity, including significant adverse event reviews (SAER) for specific severe events to mitigate the risk of reoccurrences to Executive strategic level risks. The governance processes are embedded within operational structures, and are reviewed and reported through governance structures.This endures identification of actions to prevent the future materialisation of such risks, so far as possible and will be built into the processes within the RTS resources.
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Yellow	**Road to Green -** The monitoring of compliance will be the responsibility of each Directorate through their own governance structure using performance review. The Workforce Lead Nurse is a permanent member of the HR Resourcing team and will continue to collate information quarterly for the Staff Governance Commitee meetings and the development of the Annual Report. All reporting lines use the self-assessment proforma which will form the basis of the key performance indicators.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, a recurrent risk was identified in the capacity of one laboratory, leading to a delay in testing samples and communicating sample results. Following investigation, the process for booking in samples was streamlined and an admin coordinator was appointed. This has improved performance and the lab is now meeting its targets.	This should describe how the success, achievement or learning could be used in the future. For example, the organisation is now looking at whether the changes implemented in the one lab could be applied to other labs, to improve performance across the division.
Path to Green	Safecare will be rolled out to all areas in scope by March 2026. This will give us the ability to analyse data over time and help to identify any severe and recurring risk. The reporting process will ensure escalation to the relevant clinical governance groups for action planning and mitigation.	
Workforce Visualisation	Currently working on how we can bring all the data together onto a dashboard. We currently use a system called Pentana. The dashboard will help to identify ongoing risk by showing data over time for all areas such as vacancy and sickness as well as qulaity data and workload tool resuts.	
Governance	All professions are strengthening the governance structures to include safe staffing. Agendas will include analysis of the outputs from the RTS resources and staffing level tools.	

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge /	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, collation of data in a particular NHS function has identified a risk that materialises frequently, however identification of actions to prevent future materialisation has not improved the situation.	This should describe what actions have been / are being / will be taken to address the situation. For example, if identification of actions to prevent a frequent risk has not improved the situation, measures to address could have included establishing a working group to investigate and make recommendations, observing practice in the area, interviewing staff, addressing the staff skills mix, allocating additional assistance, redesigning the service etc.
Overall implementation and Assurance	Some professions are still behind in the implementation of parts of the legislation. The oversight group will continue until at least March 2025 and support ongoing implementation. After March 2025 the monitoring of compliance will be the responsibility of each Directorate through their own governance structure using performance review.	Continue to support and seek assurance through our governance structure. Work through the gaps.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance

12IF Duty to seek clinical advice on staffing

Guidance chapter link

Section	Item	Status	Comment
12IF(1)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to seek and have regard to appropriate clinical advice in making decisions and putting in place arrangements relating to staffing under sections 12IA to 12IE and 12IH to 12IL and to record and explain decisions which conflict with that advice.	Yellow	The Board is moving towards a model of Triumvirate service management: this consists of Nursing Lead, Service Lead (inclusive of all professions and functions within the services) and Medical Lead to ensure all service decisions are jointly discussed and agreed. Clinical advice is sought throughout the day through our site huddles and staffing huddles using the RTS resources and other safety briefs. An escalation plan and reporting template has been developed to seek clinical advice annually through the use of the common staffing method to look at gaps in the workforce. NHS FV professional groups/functions have Workforce Governance arrangements in place and a Recruitment and Retention group set up and are working towards delivering the goals. There has been strengthening of the clinical leadership structures across all NMAHP services to be clear around accountability and responsibility in relation to this duty. In other services it is the most senior clinical leader on duty who provides clinical advice. The plan to move us to green is to develop workforce governance across all professional groups including HSCPs with membership from relevant professionals and clinicians. All NHS functions are represented on the Oversight group. With the ongoing implementation of eRostering and SafeCare and access to the generic RTSR when available, there will be the ability to improve recording of the advice sought and considered on a more informal basis. These resources will also enable a more consistent approach across all services.
12IF(2)(a) (i) and (ii)	These systems and processes include the means whereby if a relevant organisation makes a decision which conflicts with clinical advice received, any risks caused by that decision are identified and mitigated so far as possible.	Yellow	SafeCare supports this function, and have built a process into the SOP to look at how Safeguard (IR1s) can be incorporated to record clinical advice and clearly lay out the steps required to record any conflict with clinical advice given. It will be important that we align the use of the different systems functions available.
12IF(2)(a) (iii) and (iv)	These systems and processes include the means whereby if a relevant organisation makes a decision which conflicts with clinical advice received, any person who provided clinical advice on the matter is notified of the decision and the reasons for it and this person is able to record any disagreement with the decision made.	Yellow	Discussions are recorded within huddle notes, professional judgement notes within SafeCare, meeting minutes or other local processes, and the clinical manager is generally present and involved in that decision making process. Disagreements or concerns would be recorded within these processes to ensure this is auditable and any actions taken, feedback or further risk assessment can be captured. As above, the use of Safecare and Safeguard will incorporate recording of clinical advice. The SOP clearly lays out the steps required to record any conflict with clinical advice given will meet this requirement.
12IF(2)(b)	These systems and processes include the means for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the relevant organisation on at least a quarterly basis about the extent to which they consider the relevant organisation is complying with the duties in 12IA to 12IF and 12IH to 12IL.	Yellow	All clinical professional leads will report quarterly through established governance routes to give assurance to the board on progress. HR resourcing will oversee the workforce planning team to build capacity for business as usual working.
12IF(2)(c)	These systems and processes include the means for individuals with lead clinical professional responsibility for a particular type of health care to enable and encourage other employees to give views on the operation of section 12IF and to record those views in the reports to the members of the relevant organisation.	Yellow	There are a range of ways that we collect feedback from staff, and this will be reflected in compliance monitoring of the different duties in such a report. We have questions within the annual staff survey regarding staff opinion on how well they believe their views are listened to and acted upon. We will be using the reporting function in SafeCare to get additional views from red flags and the use of Safeguard for adverse events. Professional leads also conduct their own staff engagements exercises along professional lines and this will be captured on our dashboard (TCAB). We utilise annual imatter staff survey (with cognisance of professional specific responses) and have a new way to capture excellence reporting to ensure staff can celebrate success as well as report on things that are not going well.
12IF(2)(d)	These systems and processes include the means to raise awareness among individuals with lead clinical professional responsibility for a particular type of health care in how to implement the arrangements in this duty.	Yellow	There has been information sessions and training for individuals with lead clinical professional responsibility at an executive level but also throughout the professional structures. The HCSA implementation team have delivered internal engagement sessions with accountable managers and professional leads. The Skilled Level modules have been accessed well by staff with nearly 5000 modules completed to date.
12IF(2)(e)	These systems and processes include means for ensuring that individuals with lead clinical professional responsibility for a particular type of health care receive adequate time and resources to implement the arrangements.	Yellow	All professions have time to lead built in to their job descriptions or have job plans that can be updated to include adequate time to implement the arrangements. We have already rolled our eRoster to all acute areas and have Safecare and RTSRs highlighting clinical leaders working clinically to mitigate risk. In addition and in tandem with Duty 12IC and 12ID reviews identified risks through risk management systems and processes review the impact on patient outcomes where a risk is identified. The Protected Learning Directive will be implemented in NHS FV and work is under way to develop a plan for this by our Organisational Development Team.
12IF(3)	These systems and processes include means for the relevant organisation to have regard to the reports received.	Yellow	A reporting process is being established and will be supported by the workforce planning team.
	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Yellow	**Road to Green -** The monitoring of compliance will be the responsibility of each Directorate through their own governance structure using performance review. The Workforce Lead Nurse is a permanent member of the HR Resourcing team and will continue to collate information quarterly for the Staff Governance Commitee meetings and the development of the Annual Report. All reporting lines use the self-assessment proforma which will form the basis of the key performance indicators.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, the views of employees included in the reports prepared by individuals with lead clinical professional responsibility for a particular type of health care identified a potential improvement in working practices in one area.	This should describe how the success, achievement or learning could be used in the future. For example, the potential improvement is being trialled in the one area and if successful will be rolled out across other areas in the organisation.
Safecare	Implementation of Safecare wil support this duty and give everyone a formal process to seek clinical advice and record mitigation or escalate further.	Continue with implementation plan to get all areas in scope onboard with Safecare.

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge /	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, in compiling the reports made to the members of the Health Board, there is are good mechanisms in place for the Medical Director to enable and encourage medical employees to give their views, but the mechanisms for seeking the views of other professional groups for which they are responsible, such as pharmacy employees, are not well established. Hence, the views of these employees are not being sought or incorporated into the reports.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the views of all professional groups are not being sought, what measures have been put in place to engage these groups and proactively seek out their opinions.
Acute Medical/ANPs/ Radiology and H@H	Some services are still working through the RTS implementation and putting interim process in place until Safecare can be implemented.	Give support to teams to set up interim measures and work towards Safecare implementation.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance

12lH Duty to ensure adequate time given to clinical leaders

Guidance chapter link

Section	Item	Status	Comment
12lH	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to ensure that all individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to discharge that responsibility and their other professional duties.	Green	NHS Forth Valley provides a clear development framework and plan for both developing existing leaders and teams and nurturing potential leaders. NHS Forth Valley supports a set of competencies which outline leaders and managers roles, responsibilities, qualities and behaviours at different levels of leadership and management. These competencies require to be demonstrated at all levels in NHS Forth Valley. The competencies are designed as a guide to identify areas of future development. They are based on the six national NHS Leadership capabilities and more information can be found on TURAS learn. All Leadership and Management programmes, courses and development activities are aligned to ensure appropriate skills are attainable at each level for the range of competencies required. Each level describes a range of skills and knowledge required and also provides an explanation of the behaviours which would demonstrate these. eRoster has the ability record time given for non clinical work and TURAS will record the type of time out if specific training is being attended.
12lH	These systems and processes include time and resources for these individuals to supervise the meeting of the clinical needs of patients in their care; to manage, and support the development of, the staff for whom they are responsible; and to lead the delivery of safe, high-quality and person-centred health care.	Yellow	NHS FV will implement the 'Protected Learning Directive' and implement an SOP to ensure all parts of the legislation including the guiding principles are taken into consideration and that all clinical leads have appropriate and proportionate time to lead within the role and responsibilities. Clinical leaders will be supported to have the time and resources to undertake these roles, or seek support and highlight risks where this is not sufficient.
12lH	These systems and processes include the means to identify all roles, and therefore individuals, with lead clinical professional responsibility for a team of staff.	Yellow	Multiple systems have the means to identify all roles and individuals with lead clinical professional responsibility for a team. This includes SSTS payroll systems, eRoster and eEES (Employee Electronic Staff System). NES TURAS are all arranged through job role and titles. Staff job descriptions reflect the specific leadership responsibilities, requirements and expectations within each role and the SOP will ensure all parts of the legislation including the guiding principles are taken into consideration and that all clinical leads have appropriate and proportionate time to lead within the role and responsibilities.
12lH	These systems and processes include the means to determine what constitutes sufficient time and resources for any particular individual.	Yellow	This will be developed through the work to bring in the protected learning directive and will define what is sufficient time is and will be included in any professional judgement discussions when job planning is being done. TURAS appraisal, activity manager discussions and outcomes will form part of the process where all outcomes can be recorded. This can then be reviewed through appraisal and PDP, as well as lines of escalation in the event a risk to quality and safety is identified.
12lH	These systems and processes include the means for ensuring this duty has been reviewed and considered within the context of job descriptions, job planning and work plans, as appropriate.	Yellow	The Protected Learning Directive with the SOP will ensure all parts of this duty is encapsulated. As described above, job descriptions, job planning and work plans are all assessed at appropriate time, for example, through appraisal and PDP, job planning, service change and redesign. Workforce group when developing their workforce plans currently review staffing levels, levels of redeployment, non case holding time of clinical leaders and quality indicators when developing workforce plans.
12lH	These systems and processes include the means to consider outputs from activities carried out to meet this duty in order to inform future workforce planning and protect the leadership time required for clinical leaders.	Yellow	Outputs will be reviewed through our governance structures for all professions and will form part of the SOP being developed.
	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)		Outputs will be reviewed through our governance structures for all professions and will form part of the SOP being developed. The Organisational Development team will be driving this work forward.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, senior physiotherapists and team leaders convened a working group to determine what sufficient time and resources would look like for individuals with lead clinical professional responsibility for a team of staff. The outcome of the project was a determination of time and resources for different team leaders and feedback so far has been positive.	This should describe how the success, achievement or learning could be used in the future. This has now been extended to other AHP areas and trialled to see applicability.
All	There is a commitment from NHS FV to focus on completion of PDPs and ensuring agreed actions are completed to support ongoing learning and development of staff. Senior NMAHP leadership development is being led by the Executive Nurse Director and all staff in Senior NMAHP leadership positions are co-producing the strategic ambitions of professional leadership and sharing across the organisation, aligned to the duties within the legislation which are aligned to the principles of professional leadership responsibilities.	An ongoing action plan being developed and executed to support time being given to clinical leaders.
Protected Learning Directive	Organisational Development are going to bring the directive into the board and ensure the SOP includes the legislative needs	SOP to be developed. SLWG currently being recruited for and lead by OD .
Audit	Recording of training to be moved to TURAS or eESS/OLM as an official way to capture all training being done across the organisation.	Scoping being done through the Operational Group to see what everyone currently does to record training. We need to ensure we complying with GDPR as well.

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge /	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, the process in place to identify the roles, and therefore indivduals, with lead clinical professional responsibility for a team of staff does not consistently identify who these individulas are, and therefore sufficient time and resources for these individuals to discharge their responsibilities has not been considered.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the process in place to identify the roles, and therefore individuals, does not consistently identify who those indivduals are, what measures have been taken to address this, e.g. working with all staff groups / clinical areas / teams to identify job titles / roles, utilising HR processes and data, utilising eRostering to identify team leaders etc.
All	Early stages of scoping and getting a SLWG together	Need to fully understand the position to move forward. The OD team and WFL will work across professions to ensure all training is being captured and that the PLD is implemented across all groups. Feedback will be sought through the operational group.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance

12II Duty to ensure appropriate staffing: training of staff

Guidance chapter link

Section	Item	Status	Comment
12II	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to ensure that all employees receive such training as considered appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b) and such time and resources as considered adequate to undertake this training.	green	NHS Forth Valley have clearly defined systems and processes in place. They are utilised in all NHS functions and professional groups, to ensure that all employees receive training appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b). Resources are available and include the TURAS Learn platform and NHS FV - Learning Zone. The Learning Zone has links to various training and support as well as advice on funding and opperturnities.There is work being undertaken to implement the Protected Learning Directive to ensure adequate time is given to undertake training across all professional disciplines. Individual training needs are identified and supported during Personal Professional Development Planning (PPDP) discussions. PPDP completion is monitored through the TURAS Learn platform with reports being available on the completion of mandatory and essential training. Practice Development/Education Facilitators (Nursing, medical and AHP specific) and identified development learning facilitators in other professions will deliver outcomes of training needs assessments, development plans and meet identified new knowledge and skill requirements. All employees undergo induction and orientation. Recording of training is being streamlined to ensure it is on our two approved systems (TURAS/eESS-OLM) and will make it easier to track training and report on training outputs.
12II	These systems and processes include means to determine the level of training required, and time and resource to support this, for all relevant employees.	green	The systems and processes do include means to determine the level of training required, and time and resources to support this, for all relevant employees. Part of the training stategy for NHS FV will focus on completion of PPDPs, Job plans ect and ensuring agreed actions are completed to support ongoing learning and development of staff. Training within the organisation is clearly determined along the lines of mandatory, essential and developmental requirements for each profession and role. Different professions have different set national training curriculums. These are supported through professional lines and training needs analysis, funding and expert support e.g. practice Development Facilitators, and clinical educators.
12II	These systems and processes include the means to deliver the agreed level of training to all relevant employees.	green	In house education teams for professions monitor and provide extensive educational support through Practice Development/Education Facilitators (Nursing, medical and AHP specific) and identified development, learning facilitators in other professions to deliver outcomes of Training Needs Assessments, development plans and meet identified new knowledge and skills requirements. PPDP completion monitored through TURAS platform along with completion of mandatory and essential training at one to one meetings between managers and staff within all professions. NHS FV also have the simulation centre which will be utilised for all professions to support training of new staff and current staff. The Protected Learning Directive will strenghen the process we have and give a consistency to what we offer across the board.
12II	These systems and processes include the means to ensure all relevant employees receive both time and resources to undertake the training.	green	eRoster will help to build in time for training and keep track of time given. Leaders can monitor and report on this quarterly through the governance structure. The Protected Learning Directive will support implementation of this duty and give direction to all professions.
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)		

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, the psychology division, in conjuction with HR, has just completed a project to promote more accurate capturing of information relating to continued professional development for psychology colleagues. Feedback from employees is that they have found the new system much easier to use and are now recording relevant CPD.	This should describe how the success, achievement or learning could be used in the future. AHP colleagues have now expressed interest in the new system and are undertaking a project to see if they could implement something similar.
Protected Learning Directive	Organisation Development team are progressing the work to bring the directive into the board. A SLWG is being set up with representation across professions to ensure the new SOP covers the legislative requirements as well as everything set out in the directive. Once agreed there will be a roll out programme for the introduction of the Protected Learning Directive and it will include an SOP on how to operationalise it. This will also include how we record training being completed and reported on through our governance processes. This in turn will allow our leads to manage training better and give time equally to all staff within the services	Still in the early stages however there is a plan to achieve all outputs and update the relevant bodies on progress. This will strenghen what we already have in place.
TURAS Learn	NHS FV use TURAS Learn which is NHS Education for Scotland's (NES) single, unified platform where staff can access health and social care tools and learning resources relevant to their professional development & practice. Core applications include Turas Learn, Turas Appraisal, Professional Practice, ePortfolio to name but a few. There are various applications available on a single dashboard depending on your role, providing a single* 'go to' place. TURAS Learn gives access to all staff for mandatory and role specific training including the Health and Care (Staffing) (Scotland) Act 2019 domains/SWAY*s.	
FV- Learning Zone	The learning zone is a dedicated web page on the Intranet and is available to all employees at NHS FV. Resources include Employee Induction, Personal Development, Practice Education, Practice Development Resusitation Training and other links to systems and applications. It is easy to access and use and provides a one stop shop.	
All NHS FV Functions	There is a commitment from NHS FV to focus on completion of PDPs and ensuring agreed actions are completed to support ongoing learning and development of staff. Senior NMAHP leadership development is being led by the Executive Nurse Director and all staff in Senior NMAHP leadership positions are co-producing the strategic ambitions of professional leadership and sharing across the organisation, aligned to the duties within the legislation which are aligned to the principles of professional leadership responsibilities.	An ongoing action plan being developed and executed to support time being given to all staff.

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge /	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, clearly defined processes and procedures exist for some groups of staff, e.g. nursing and midwifery, but don't exist for other groups of staff, e.g. healthcare scientists.	This should describe what actions have been / are being / will be taken to address the situation. For example, if procedures and processes are not in place for healthcare scientists, what measures need to be put in place to ensure this, such as working with HR and healthcare scientist representatives to define an appropriate training programme, assess training needs of employees and plan for required training to be undertaken.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Substantial Assurance

12IJ Duty to follow the common staffing method
(*The relevant organisation **must only** report on the types of health care, location and employees as detailed in section 12IK)

Section	Item	Status	Comment
12IJ(1)	Clearly defined systems and processes are in place, and utilised, in all the types of health care, locations and employees listed in section 12IK, to follow the common staffing method no less often than the frequency prescribed in Regulations (see https://www.legislation.gov.uk/ssi/2024/43)	Green	NHS Forth Vally have clearly defined systems and processes in place to enable all types of health care, locations and employees listed in section 12IK, to follow the common staffing method (CSM) as prescribed in the regulations. A dedicated HR Nursing Workforce team supports all relevant clinical areas to meet this duty. An annual schedule is delivered to all Nursing and Midwifery Leads in scope and includes Medical Staff when planning the Emergency Care Provision tool run. Training is provided locally and synchronised to an areas application of the CSM and associated tool run. Staff have full access to all resources and are directed to the Healthcare Staffing Programme web site. A reporting template using the CSM framework has been developed for all staffing level tools along with an escalation plan. All other services and professions who are not currently in scope have been asked to familiarise themselves with this duty with a view to using the CSM framework to guide them in developing a reporting system in the absence of speciality specific tools. The CSM is still a useful framework to use even without the specific tool being available to them at this time and will future proof the method as more tools come online.
12IJ(2)(a)	These systems and processes include use of the relevant speciality specific staffing level tool and professional judgement tool as prescribed in Regulations (see https://www.legislation.gov.uk/ssi/2024/43), and taking into account results from those tools.	Green	The systems and processes include the use of the relevant speciality specific staffing level tool and professional judgement tool as well as the quality tool where applicable as prescribed in regulations and take into account results from those tools. The results will be reported using the reporting template and will use the CSM guidance to triangulate findings. The results will be sent through our escalation and governance process to be reviewed, approved or escalated as appropriated.
12IJ(2)(b)	These systems and processes include taking into account relevant measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H(1) of the 1978 Act by the Scottish Ministers (including any measures developed as part of a national care assurance framework).	Green	The systems and processes include taking into account relevant measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H(1) of the 1978 Act by the Scottish Ministers. They include measures developed as part of the national care assurance framework as well as clinical quality indicators, patient safety data, HEAT targets, waiting times, incidents, complaints and feedback from staff and patients. Care assurance visits take place across Nursing and Midwifery and is an embedded system/process. Plans are ongoing to upscale and spread across all services/professions and is being led by the Practice Development Unit. The information is gathered, analysed and reported with data/outputs used to inform and improve service delivery as part of a wider workforce and financial planning approach. Local governance around the quality measures and care assurance goes through the Quality Management Programme Board (QMPB) and is fed through the Workforce Governance Groups and Senior Leadership Teams (SLT) for approval and feedback.
12IJ(2)(c)(i)	These systems and processes include taking into account current staffing levels and any vacancies	Green	The systems and processes do consider current staffing levels and vacancies and are included in section one and four of the CSM reporting template. This section asks about funded establishment, in post staffing, vacancies, predicted absence allowance in comparison to actual absence. Health Roster and SSTS (Boxi) both have extensive reporting capabilities for data to be gathered to complete this section of CSM. In addition, NHS FV are working towards utilising the Pentana Risk Management system to pull together all workforce data to make it easily accessible and visible to those that require it. This will then be utilised annually as part of the triangulation process through the Staffing Level Tool runs and CSM reporting process.
12IJ(2)(c)(ii)	These systems and processes include taking into account the different skills and levels of experience of employees	Green	The different skills and levels of experience of employees are discussed as part of the review process. Section four of the CSM reporting template asks about local context and to consider skill mix, experience of employees and age profile of employees (succession planning). All the information reported is considered along with the staffing level tool results and outputs from the real time staffing resource.
12IJ(2)(c)(iii)	These systems and processes include taking into account the role and professional duties of individuals with lead clinical professional responsibility for the particular type of health care.	Green	The CSM escalation process details roles and responsibilities at each stage and who should be involved in decisions for each type of healthcare. The HR Nursing Workforce team is on hand to support and deliver training to Lead professionals with responsibility for the delivery of successful tool runs and CSM triangulation.
12IJ(2)(c)(iv)	These systems and processes include taking into account the effect that decisions about staffing and the use of resources taken for the particular type of health care may have on the provision of other types of health care (particularly those to which the common staffing method does not apply).	Green	The sevice as a whole is reviewed as part of the CSM and will include all MDT members. The reporting template has a section for local context and narrative can be added.
12IJ(2)(c)(v)	These systems and processes include taking into account the local context in which health care is provided.	Green	Local context is included in the reporting template.
12IJ(2)(c)(vi)	These systems and processes include taking into account patient needs.	Green	The Staffing level tools take into account patient care needs and allow the staff to comment on any issues using the PJ tool as well as the speciality specific tool. Patient feedback will also be included as part of the reporting process.
12IJ(2)(c)(vii)	These systems and processes include taking into account appropriate clinical advice.	Green	This is asked as part of the CSM reporting template and will be part of the bigger governance system. The escalation plan details a pathway for clinical advice. A triumvirate approach is being developed in the Acute Services directorate to ensure a model of nurse, operations manager and senior clinician exists and in other services a professional lead will be in charge of clinical advice within the organisation.
12IJ(2)(c)(viii)	These systems and processes include taking into account any assessment by HIS, and any relevant assessment by any other person, of the quality of health care provided.	Green	CSM guidance has been followed when developing the reporting template.
12IJ(2)(c)(ix)	These systems and processes include taking into account experience gained from using the real-time staffing and risk escalation arrangements under 12IC, 12ID and 12IE.	Green	It would be the intention to incorporate real-time staffing (RTS) and risk escalation arrangements into the annual reports as part of the triangiulation process. The RTS resources are a new addition to the monitoring of staffing and are curently being rolled out to all services.
12IJ(2)(c)(x)	These systems and processes include taking into account comments by patients and individuals who have a personal interest in their health care, which relate to the duty imposed by section 12IA.	Green	This is asked as part of the CSM reporting template.
12IJ(2)(c)(xi)	These systems and processes include taking into account comments by employees relating to the duty imposed by section 12IA.	Green	This is asked as part of the CSM reporting template.
12IJ(2)(d)	These systems and processes include means to identify and take all reasonable steps to mitigate any risks.	Green	The escalation process will take account of risk and has a pathway to enable mitigation up to executive level.
12IJ(2)(e)	These systems and processes include means to decide what changes (if any) are needed to the staffing establishment and the way in which health care is provided as a result of following the common staffing method.	Green	Changes will be decided though the escalation process and will go through our new workforce governance group. Workforce reviews have begun and are due to continue into 2025 and beyond.
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)		

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, application of the common staffing method in adult inpatient provision identified some areas where the staffing establishment needed to be changed and some areas with potential for service redesign. These changes are now in progression and will be trialled to monitor the outcomes.	This should describe how the success, achievement or learning could be used in the future. For example, following completion of the trials regarding changes in staffing establishment and service redesign, decisions will be taken as the changes made. These could then be used as case studies to inform training for staff about the use of the common staffing method.
Nursing Staffing Level Tools	Following the application of the common staffing method and workforce review in adult inpatient provision, NHS FV identified some areas where staffing establishments needed to be escalated in relation to our Healthcare Support Worker provision. All the Staffing Level Tools have run on a schedule throughout 2024/25 and outputs are being reviewed through the NMAHP workforce governance group.	The escalation of any requirements are being escalated and a business case is in progress for the Senior Leadership Team.
Maternity Staffing Level Tools	NHS FV took part in the national expert working groups (EWG) and observational studies for the development of the new Maternity Tool and are currently in the process of trialling the tool. The teams will also be running the current tool in Jan/Feb as mandated in the legislation.	All learning from running the new tool and comparing to the old tool in real time will be fed back to the national EWG and used to improve and finalise the new Maternity Staffing Level Tool.

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge /	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, the common staffing method was followed at the required frequency in all areas except emergency care provision with an explanation of why this was not completed, e.g. lack of knowledge / training of personnel.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the common staffing method was not followed in emergency care provison and this was due to lack of knowledge / training, what measures were put in place to address this, e.g. identifying key personnel, provision of training, assistance from experienced personnel in other areas etc.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Substantial Assurance

12IL Training and consultation of staff
(*The Health Board and Agency **must only** report on the types of healthcare, location and employees as detailed in section 12IK)

Guidance chapter link

Section	Item	Status	Comment
12IL	Clearly defined systems and processes are in place, and utilised, in all the types of health care, locations and employees listed in section 12IK, for the training and consultation of employees.	Green	In relation to the duty to follow the common staffing method all staff working in Adult Inpatient, Clinical Nurse Specialist, Community Nursing, Community Childrens Nursing, Emergency Care, Maternity, Mental Health and Learning Disability, Neonatal, Paediatric and small wards are offered training prior to running the staffing level tools. This is included in the schedule as part of the process. There is a rolling programme of training, including refresher training. This is required to keep both existing and new staff up to date. Staff access and complete the relevant level of training within the framework of the learning resource on TURAS. This supports staff to gain the knowledge and skills outlined within the Knowledge and Skills Framework with a minimum of the informed level being completed as part of their induction. Quick guides relating to the Act are also available on this platfrom.
12IL(a)	These systems and processes include means to encourage and support employees to give views on staffing arrangements for the types of health care described in section 12IK.	Green	Encouragement and support are given as part of the part of the training and uses the guiding principles for employees to give views on staffing arrangements. Professional judgement captures some of this data but main infomation comes from staff opinion questionaires which are currently being developed and tested through Clinical governace, Patient Relations Team and Practice Development.
12IL(b)	These systems and processes include means for taking into account and using views received to identify best practice and areas for improvement in relation to staffing arrangements.	Green	Staff opinion is asked for as part of the process to enable a robust structure to ensure our staff are consulted.
12IL(c)	These systems and processes include training employees (in particular those employees of a type mentioned in section 12IK) who use the common staffing method on how to use it.	Green	This training is in place and runs in line with the staffing level tool schedule. The new 2025/26 schedule of training dates are developed and forms part of the Staffing level tool run preparation.
12IL(d)	These systems and processes include ensuring that employees who use the common staffing method receive adequate time to use it.	Green	The schedule will be shared ahead of time with training dates included as well as timelines for reporting and feeedback built in. Time will be agreed locally for each tool and is planned in advance.
12IL(e)	These systems and processes include providing information to employees engaged in the types of health care mentioned in section 12IK about its use of the common staffing method, including the results from the staffing level tool and professional judgement tool; the steps taken under 12IJ(2)(b), (c) and (d) and the results of the decisions taken under 12IJ(2)(e).	Green	A robust governance structure has now been agreed for results to go through and for feedback to be given. Each service is going through a workforce review at the moment and any concerns or requirements are being escalated.
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)		

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, key personnel who were very experienced in using the common staffing method were engaged to train and mentor other personnel involved in the process.	This should describe how the success, achievement or learning could be used in the future. For example, those key personnel have now decided to meet regularly in a forum to discuss shared learning and to ensure the common staffing method is used consistently across all relevant areas in the organisation.
N&M & MHLD/Childrens Services	Staffing level tools are already being run on a schedule and training takes place 6-8 weeks before to ensure all staff taking part understand how to collect and input data as well as the process to report results using the whole triangulation process.	Evaluation of training will take place and will inform changes for the next financial year of Staffing Level Tool runs. A more consistent approach to attendance will be taken to ensure quality of data collected.

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge /	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, issues were identified with the lack of training and adequate time for personnel in emergency care provision.	This should describe what actions have been / are being / will be taken to address the situation. For example, arranging and delivering training, provision of mentoring from experienced personnel, job planning to ensure adequate time is available for designated personnel to follow the common staffing method.
Nursing Staffing Level Tool	One of the main challenges around training is ensuring all staff who need to attend do so. Following the tool run it became apparent that not all staff had attended a session who should have and this did led to some of the data being unreliable.	Training dates are sent out in advance, however next time more engagement and responsibility will be given to team leaders to ensure all staff who need training sign up for a session. Recording and monitoring of those in attendance will take place and Cloinical Nurse Managers /lead Nurses will be kept up to date on engagement numbers. Additional support will be offered throughout the tool run in the form of drop in sessions each day.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Substantial Assurance

1 Guiding principles for health and care staffing

2 Guiding principles etc. in health and care staffing and planning

Guidance chapter link

RAG status

Section	Item	Status	Comment
2(2)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups to ensure that when the Health Board is planning or securing the provision of health care from another person, it has regard to the guiding principles for health and care staffing and the need for that person from whom the provision is being secured to have appropriate staffing arrangements in place.		New GMS contractors are required as part of the commissioning process in Forth Valley to outline in their business case their intended clinical staffing to cover the contract they are applying for. Consideration is given by the deciding panel as to if this is appropriate for the size of the Practice (number of registered patients) and the access model they outline (ie. if branch surgeries may be involved etc). This would be explored further during the prospective contractor interview/presentation. PCIP allocations would be separate from this which would cover third party employed staff only. Any SLA commissioned would also include reference to safe staffing levels and a standard clause has been agreed with Primary Care leads in other Boards and Scottish Government that is suitable for that purpose.

Suggested evidence: 1
A procedure for planning or securing health care from third parties that incorporates having regard to the guiding principles of the Act and the need for that third party to have appropriate staffing arrangements in place;
2. Documentation of considerations made when planning or securing health care from third parties; and
3. Examples of contracts, agreements or arrangements.

Please provide information on the steps taken to comply with section 2(2)

These are steps taken to comply with 2(2) in general. Examples could include information about procurement and commissioning processes, how the guiding principles are taking into account and what procedures are in place for obtaining information about staffing arrangements.

New GMS contractors are required as part of the commissioning process in Forth Valley to outline in their business case their intended clinical staffing to cover the contract they are applying for. Consideration is given by the deciding panel as to if this is appropriate for the size of the Practice (number of registered patients) and the access model they outline (ie. if branch surgeries may be involved etc). This would be explored further during the prospective contractor interview/presentation. PCIP allocations would be separate from this which would cover third party employed staff only. Any SLA commissioned would also include reference to safe staffing levels and a standard clause has been agreed with Primary Care leads in other Boards and Scottish Government that is suitable for that purpose.

Please provide information on how these systems and processes, and their application, have improved outcomes for service users

This should include, but not be limited to data in relation to patient safety and quality of care measures and outcomes, patient feedback and adverse event reporting.

These systems have been part of the procurement process previously and ensured new contractors meet contractual responsibility for Partner commitment per week and have assessed clinical care to be provided under new contracting arrangements within GMS. No data is available as these principles have not been used since the Safe Staffing legislation was introduced.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
NA		

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge / Risk	Details	Action
NA		

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Substantial Assurance

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

10.1 Finance Report
For: Approval

Executive Sponsor: Ross McGuffie, Chief Executive
Authors: Mr Scott Urquhart, Director of Finance / Mrs Jillian Thomson, Deputy Director of Finance

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Executive Summary

This report presents a high-level summary of the financial results for the 11-month period ending 28 February 2025 together with an updated outturn projection for the year.

Following an in-depth review of the February financial results, together with a reassessment of savings delivery, funding allocations, and planning assumptions, the revised projected outturn for 2024/25 is a break-even position against budget.

This represents an improvement on the previously reported forecast deficit position, due to continued reduction in supplementary staffing costs which has continued to be sustained over winter, further reductions in national CNORIS costs, and confirmation of additional unplanned non-recurring funding from Scottish Government.

The forecast position remains subject to a small number of outstanding assumptions and risks including receipt of drug rebates, final written confirmation of funding allocations, and confirmation of IJB outturns and associated risk share contributions between partner organisations.

The apportionment basis of IJB risk share payments have not yet been formally agreed between partner bodies, however estimates have been factored into year-end projections in respect of 2024/25 requirements and also provide a level of cover for 2025/26.

It is important to note that whilst the in-year financial position has moved in a positive direction, the non-recurring nature of the improvements do not address the underlying recurring financial gap which will roll forward into 2025/26. The need for sustainable cost improvement and continued application of enhanced internal financial controls to support a path to recurring financial balance will therefore remain in place for 2025/26.

A draft 3-Year Financial Plan covering 2025/26 to 2027/28, underpinned by the principles of Value Based Health and Care to drive improved value and efficiency from resources, is presented as a separate agenda item.

Recommendations
The NHS Board is asked to:

- **note** that a break-even position projected for 2024/25 against both revenue and capital budgets, in line with the statutory requirement for NHS Boards.
- **note** that the projected outturn includes provision for additional payments in respect of contributions towards estimated IJB financial pressures.
- **approve** delegated authority for the Chief Executive and Director of Finance to work with partner organisations to finalise and agree the value of IJB risk share payments, to be reported back through the Strategic Planning, Performance and Resources Committee.
- **note** the significant level of ongoing service and financial pressure across the whole health and care system and the underlying recurring implications which will be carried forward into 2025/26.

Key Issues to be considered

Based on initial financial planning assumptions presented to the NHS Board in March 2024, together with the impact of recurring pressures and unachieved recurring savings carried forward from 2023/24, an opening funding gap of £58.4m (8.6% of our baseline budget) was identified for 2024/25. This gap has steadily reduced over the course of the year with changes in non-recurring funding arrangements and delivery of cost improvements - most notably across nurse agency usage and medicines spend – and the latest forecast is now at break-even.

Work will continue over the remaining month of the financial year, via the Financial Sustainability Oversight Board, to maximise further scope to accelerate recurring savings to set the conditions to ensure a positive start on delivery of 2025/26 cost improvement plans.

Implications

Financial Implications
Financial implications are considered in the main body of the report.

Workforce Implications
There are no immediate workforce implications associated with this report. However, it is recognised that Workforce accounts for a significant proportion of total operating expenditure and is therefore a key financial risk area and a key feature of our Financial Sustainability Action Plan

Infrastructure Implications including Digital
There are no immediate infrastructure or digital implications associated with this report. However, it is clear that digital opportunities are key element of the Financial Sustainability Action Plan.

Sustainability Implications
There are no direct sustainability implications arising from this report. Climate Change and Sustainability initiatives across the five priority areas for NHS Scotland (i.e. Sustainable Buildings & Land; Sustainable Travel; Sustainable Goods & Services; Sustainable Care; and Sustainable Communities) will contribute to efficiency savings, reducing waste, cost avoidance and productivity gains. A range of sustainability initiatives are already included in our Financial Sustainability Action Plan.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process A policy for NHS Scotland on the climate emergency and sustainable development*. (please tick relevant box)*

□ *Yes*
□ *N/A*

Where applicable, the climate change, environmental and sustainability impacts and any mitigating measures are noted above/contained in the supporting papers.

Quality / Patient Care Implications
It is imperative that quality of care and overall service provision is underpinned by a sustainable financial strategy. This is supported by the concept of “spending well” and making the most of our resources in terms of cost effectiveness and best value which is a key strand of our Financial Sustainability Action Plan.

Information Governance Implications
There are no direct information governance implications arising from this report.

Risk Assessment / Management
Financial sustainability continues to be reported as very high risk in the NHS Board's strategic risk register. This reflects the financial impact of ongoing operational service and capacity pressures.

Relevance to Strategic Priorities
There is a statutory requirement for NHS Boards to operate within the Revenue Resource Limit (RRL), Capital Resource Limit (CRL) and Cash Requirement set by the Scottish Government.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that: (*please tick relevant box)*

- Paper is not relevant to Equality and Diversity

Communication, involvement, engagement and consultation
This report was prepared in consultation with Senior Finance colleagues.

Additional Information
N/A

Appendices
Appendix 1 High level variance analysis & key cost trends - pay
Appendix 2 2024/25 YTD savings delivery

1.0 OVERVIEW OF MONTH 11 FINANCIAL RESULTS

1.1 Revenue year to date (YTD) results for the 11-month period ending 28 February 2025

An overspend of £2.5m is reported for the 11-month period ending 28th February as summarised in Table 1 below, with a projected balanced year end position. The YTD overspend continues to be driven by pressures in the Acute Services Directorate and Women and Children's Directorate. However unprecedented financial pressures are also being experienced in various corporate functions (particularly in relation to Externals, Digital and Facilities).

TABLE 1: NHS Forth Valley 2024/25 Financial performance	Annual Budget £m	Apr - Feb Budget £m	Apr - Feb Expenditure £m	Underspend/ (Overspend) £m	Forecast Outturn £m
Set Aside & Non-Delegated Functions*					
Acute Servies	246.251	224.210	249.290	(25.080)	(25.873)
Women & Children's	61.077	55.607	60.454	(4.847)	(4.495)
Cross Boundary Flow/External SLAs	70.049	64.102	65.474	(1.372)	(2.522)
Non-delegated Community Services	39.495	36.083	37.810	(1.727)	(1.939)
Facilities	115.268	106.150	107.435	(1.285)	(1.256)
Digital	24.673	22.532	22.997	(0.465)	(0.937)
Corporate Functions	33.302	30.505	30.482	0.023	1.293
Ringfenced and Contingency Budgets	49.047	32.500	0.000	32.500	35.702
Income	(33.969)	(30.655)	(30.398)	(0.257)	0.027
Sub total	**605.193**	**541.034**	**543.544**	**(2.510)**	**0.000**
Delegated Functions					
Operational Services	145.177	132.040	126.623	5.417	
Universal Services	182.255	170.049	178.943	(8.894)	
IJB reserves	4.229	3.477	0.000	3.477	
Sub total	**331.661**	**305.566**	**305.566**	**(0.000)**	
Reserve transfers (to)/from IJB					
Clackmannanshire & Stirling IJB					
Falkirk IJB					
Sub total	**0.000**	**0.000**	**0.000**	**0.000**	
TOTAL	**936.854**	**846.600**	**849.110**	**(2.510)**	

* Note that these budgets include specialties defined as "large hospital services" which form part of IJB Set Aside budgets. The total Set Aside budget included in the total of £605.193m above is £82.947m. An overspend of £10.405m is reported at month 11.

The year-to-date position reflects a wide range of financial pressures across the whole health and care system including:

- the ongoing use of unfunded contingency areas and Covid legacy arrangements (whilst good progress had been made to close contingency beds on a phased basis, this was not sustained due to the peak in flu and respiratory admissions over winter);
- increases in the cost of medicines and devices (particularly in relation to the uptake of new drugs and devices including hep C medication and diabetes technology such as insulin pumps and continuous glucose monitors);
- the impact of unavoidable inflationary pressures on a range of contracts, particularly relating to IT, energy and premises which has been exacerbated by the flat cash funding settlement for 24/25.
- Delays in the pace of delivering efficiency savings (including unachieved historic savings targets from prior years).

Further insight on the financial position, including high level variance analysis and trends in key costs is presented in Appendix 1, focussing on pay costs, including costs of supplementary/ temporary staff. Overall costs of supplementary/ temporary staff have reduced by £12.8m (or 28%) compared to the same period in the previous year as summarised in Table 2 below.

Table 2: Non-Core Staffing Costs	Apr 23 to Feb 24 £	Apr 24 to Feb 25 £	Better/ (Worse) £	% Change
Admin agency	56,492	46,385	10,107	17.9%
Admin bank	1,332,540	1,136,150	196,390	14.7%
Medical agency	4,385,418	4,297,939	87,479	2.0%
Medical bank	3,016,148	2,205,934	810,214	26.9%
Medical locum	3,277,861	2,065,087	1,212,774	37.0%
Nurse agency	12,959,778	2,259,389	10,700,389	82.6%
Nurse bank	17,767,893	18,010,144	(242,251)	(1.4%)
Other agency	288,852	269,822	19,030	6.6%
Other bank	1,366,641	1,221,520	145,121	10.6%
Overtime	1,394,535	1,552,633	(158,098)	(11.3%)
Total	**45,846,158**	**33,065,003**	**12,781,155**	**27.9%**

The overall reduction reported on Table 2 is largely being driven by the positive impact of actions relating to nurse agency use as per the Financial Sustainability Action Plan and this is contributing to the improving trends in nurse pay budget overspends. As expected, an element of the previous nurse agency usage has switched to nurse bank and the focus is now on reducing staff bank costs as part of efforts to return the nursing workforce back to approved budgeted establishment levels. Whilst nurse bank costs remain higher than the same period in the previous year, costs incurred in the last 3 months are lower than previous trends following specific targeted work in this area.

Whilst medical supplementary staffing costs are in total £2.1m lower than the same period last year, overall medical pay budgets are significantly overspent (and this has now overtaken nursing as the key pay pressure for the NHS Board). As previously reported, the increase in our medical agency costs in 2023/24 represented the largest relative increase in agency costs in Scotland and there has been very little change to date, with YTD medical agency costs reported at end February sitting broadly in line with the same period in the previous year. A Medical Workforce Governance Group has been established which will lead work to review medical staffing levels, together with the introduction of enhanced approvals/controls in relation to the engagement of supplementary medical staff, consideration of escalated rates and development of a longer-term medical workforce strategy.

1.2 Efficiency savings

Implementation of the Financial Sustainability Action Plan is ongoing, with excellent progress being made in relation to the nursing workforce and hospital prescribing workstreams. Overall savings of £32.2m have been achieved to date (£14.8m on a recurring basis with the balance of £17.4m being delivered on a non-recurring basis) as summarised in Table 3 overleaf.

As highlighted above, significant savings have been realised in relation to nurse agency staff, following actions to stop the use of unregistered nurse agency staff and off framework nurse agency in line with the recommendations of the national Supplementary Staffing Task and Finish Group. In addition, actions to support local enhanced governance arrangements to agree nurse staffing establishment levels have been implemented (including reintroduction of escalation/authorisation arrangements for approval of supplementary staff usage). Innovative recruitment campaigns have also been taken

forward to fill substantive vacancies to avoid the need for supplementary staffing to cover vacant posts (including a local generic recruitment programme for newly qualified nurses, participation in the international recruitment programme for nurses and a series of local recruitment fairs with accelerated pre-employment checks and onboarding arrangements).

Annual plan £m	TABLE 3: 2024/25 Finanical Sustainability Action Plan - YTD saving delivery	Apr - Feb plan £m	Apr - Feb actual £m	Variance £m
9.542	Workforce	8,816	8,605	**(212)**
0.328	Procurement	301	183	**(118)**
4.583	Prescribing (Hospital based)	4,201	4,632	**431**
1.733	Estates & infrastructure	1,589	121	**(1,468)**
0.010	Income Generation	9	0	**(9)**
0.142	Innovation, Productivity & Digital	130	0	**(130)**
5.490	Value Based Health & Care	5,033	3,221	**(1,812)**
22.013	Other (slippage, reprioritisation & other financial benefits)	20,497	15,396	**(5,102)**
43.841	**TOTAL**	**40,575**	**32,157**	**(8,418)**
21.664	Recurring	19,928	14,753	**(5,175)**
22.177	Non-recurring	20,648	17,404	**(3,243)**
43.841	**TOTAL**	**40,575**	**32,157**	**(8,418)**

With respect to hospital prescribing, a number of efficiency initiatives linked to various technical switches are complete and these are delivering more savings than originally planned (despite the fact that 2 switches have been delayed due to supply issues linked to manufacturing problems and legal disputes regarding patents/exclusivity). Good progress has also been made in relation to energy efficiency plans (reported under the estates and facilities workstream) however delays in the receipt of energy consumption data for various premises, together with the complexity of contractual arrangements for PFI sites, means it has not been possible to fully quantify savings delivery, however this will continue to be monitored as data becomes available.

Despite the positive action taken to date, savings delivery is £8.4m behind plan at this stage in the financial year as summarised in Table 3 above. This is largely due to delays in the closure of contingency areas (which impacts on savings reported under the Workforce and Value Based Health and Care workstreams) and delays in achieving savings reported under Estates and Infrastructure and the other category (specifically in relation to covid legacy costs and the decision not to apply a direct 3% cut to Directorate budgets).

2.0 SET ASIDE & NON- DELEGATED FUNCTIONS - CLINICAL DIRECTORATES

Clinical Directorates reported a combined overspend of £0.8m as at 28th February 2025 as summarised in Table 4 below.

TABLE 4: Clinical Directorates*	Annual Budget £m	Apr - Feb Budget £m	Apr - Feb Expenditure £m	Underspend/ (Overspend) £m
Acute Servies	246.251	224.210	249.290	(25.080)
Women & Children's	61.077	55.607	60.454	(4.847)
Cross Boundary Flow/External SLAs	70.049	64.102	65.474	(1.372)
Non-delegated Community Services	39.495	36.083	37.810	(1.727)
Ringfenced and Contingency Budgets	49.047	32.500	0.000	32.500
Income	(33.969)	(30.655)	(30.398)	(0.257)
Sub total	**431.950**	**381.847**	**382.630**	**(0.783)**

* Note that these budgets include specialties defined as "large hospital services" which form part of IJB Set Aside budgets. The total Set Aside budget included in the total above is £82.947m. An overspend of £10.405m is reported at month 11.

Acute services – an overspend of £25.1m is reported as at end February 2025 (an adverse movement of £1.8m compared to the position reported at end January). This reflects ongoing service pressures within A&E and various inpatient specialties due to increased demand and length of stay together with ongoing use of contingency areas and additional workforce costs to cover sickness absence. The adverse year to date position is also exacerbated by ongoing staffing challenges across other parts of the health and care system which is delaying an element of the planned discharge profile from the hospital. Ongoing work to close contingency areas must be targeted to areas with patients who do not clinically require to remain on the acute hospital site.

£17.3m of additional temporary staffing costs have been incurred to date within the Acute Services Directorate. Of this total, £9.8m (56%) relates to nurse bank and agency use – key service areas where temporary staff have been deployed include Acute Assessment, the Emergency Department, Intensive Care and wards A11, A22, B11, B21, B22 and B32. Overall Medical bank, agency and locum costs remain high, contributing to a £6.2m overspend on medical staffing budgets.

Unachieved historic recurring savings targets are also a key factor together with a number of ongoing Covid legacy costs arising from previous gold command decisions and Scottish Government directives. A range of other unfunded service areas, previously supported by non-recurring funding require urgent review. Clear exit strategies are required to reduce and stop costs being incurred going forward and this is currently being assessed by the Acute Services Management team and will also feature in the forthcoming Value Based Health and Care programme for 2025/26 onwards which aims to ensure that all services can operate within their approved budgets. Significant increases in the cost of drugs and devices are also being experienced (particularly in relation to the uptake of new drugs and devices including hep C medication and diabetes technology such as insulin pumps and continuous glucose monitors – going forward, the roll out of new drugs and devices must be planned as part of a managed introduction with clear oversight of the overall financial implications (including impacts on other service areas).

Women & Children's – an overspend of £4.8m is reported at end of February (an adverse movement of £0.6m compared to the position reported at end January). This reflects ongoing pressure in medical staffing budgets, high uptake levels of new Paediatric diabetes technologies, overspends associated with paediatric complex care packages and national funding reductions in relation to CAMHS and the immunisation team. Discussions are ongoing with colleagues to mitigate financial risk as far as possible (including follow up with Scottish Government to clarify funding allocations).

Cross boundary flow/external SLAs – an overspend of £1.4m is reported at the end of February (a favourable movement of £0.6m compared to the position reported in January). This overspend is largely due the cost of an unexpected rise in the number of Transcatheter Aortic Valve Implantations provided through NHS Lothian and high-cost complex care packages provided out with Forth Valley (these costs are not normally charged to this particular budget, however, to avoid any unnecessary delay in treatment commencing it was agreed these costs would be charged to the NHS Board initially pending further discussion and agreement with IJBs).

Non-delegated community services – an overspend of £1.7m is reported at the end of February (an increase of £0.1m compared to the previous month). This reflects ongoing financial pressures in Prison services due to additional costs associated with the new prison pharmacy contract (linked to the withdrawal of discount on generic drugs and the increase in the management fee under the new contract), and the SLA with the State Hospital for psychiatric sessions. Financial pressure is also being experienced as a direct result of decisions taken by the Scottish Prison Service (SPS) to realign the prisoner population in order to relieve accommodation pressures (resulting in an additional 260 prisoners being transferred to Polmont and 100 to Glenochil) together with changes in SPS working hours which affect NHS employed staff resulting in pay protection. Pressures are also reported in set aside mental health services due to higher-than-average staff absence levels (c11-12%), together with the requirement for special observations, necessitating the use of ongoing supplementary staff to cover, however this has reduced in the last 2 months. In addition, delays in the planned recruitment

of 7.0 WTE psychiatrists from overseas through the CESR fellowship programme has meant that medical locum usage has not reduced as anticipated (with only 3.0 WTEs appointed to date).

Ringfenced and contingency budgets – £32.5m of funding has been released in the month 11 position to reflect a proportion of the expected slippage on the Agenda for Change reform allocation and other recent unplanned funding allocations from the Scottish Government.

Income – income received as at end January was £0.3m higher than planned levels. This is largely due to additional income anticipated from inflow SLAs being rebased to reflect the most up to date 3-year average activity levels (rebasing was previously paused due to Covid) with the balance relating to income from NES in respect of Doctors in training.

3.0 SET ASIDE & NON- DELEGATED FUNCTIONS - CORPORATE DIRECTORATES

A combined overspend of £1.7m is reported for Corporate Services, Facilities and Digital as at 28th February 2025 as summarised in Table 5 below.

TABLE 5: Corporate Functions and Facilities & Infrastructure	**Annual Budget**	**Apr - Feb Budget**	**Apr - Feb Expenditure**	**Underspend/ (Overspend)**
	£m	**£m**	**£m**	**£m**
Facilities	115.268	106.150	107.435	(1.285)
Digital	24.673	22.532	22.997	(0.465)
Corporate Functions				
Director of Finance	6.938	6.334	6.273	0.061
Area Wide Services	(5.162)	(5.718)	(4.038)	(1.680)
Medical Director	12.541	11.410	10.599	0.811
Director of Public Health	3.232	2.904	2.734	0.170
Director of HR	6.825	6.267	6.502	(0.235)
Director of Nursing	4.553	4.064	3.894	0.170
Chief Executive	0.766	0.679	0.683	(0.004)
Strategic Planning & Performance	2.497	2.249	1.996	0.253
Immunisation / Other	1.112	2.316	1.839	0.477
Corporate Functions sub total	33.302	30.505	30.482	0.023
Sub total	**173.243**	**159.187**	**160.914**	**(1.727)**

Facilities – an overspend of £1.3m is reported at the end of February (an adverse movement of £0.1m compared to the position reported at end January). This is primarily due to ongoing pressures in relation to non-emergency patient transport, clinical waste, postages and energy. A number of immediate actions have been identified to strengthen financial controls around postage and early indications suggest that a significant reduction in 1st class franked mail has been achieved in the last 2 months (awaiting formal confirmation from the supplier). Work is ongoing to review hospitality ordered by staff through the FVRH PFI operator. We are also working with the PFI operator to deliver a local resolution to recent VAT charges on PFI energy costs (£1.3m impact in 24/25).

Digital - an overspend of £0.5m is reported at the end of February (a favourable movement of £0.6m compared to the position reported at end January). The overall pressure on the budget reflects unavoidable inflationary uplifts on a range of local and national IT contracts and minor equipment replacement (including the impact of withdrawal of support for certain key information systems and liquidation of suppliers). Note that the Health Records team are now operationally managed under

the Digital Directorate and the budget has now been reparented to Digital from the Acute Services Directorate.

Corporate Functions – a combined underspend of £0.02m is reported at the end of February (an adverse movement of £0.7m compared to the position reported in January). Whilst a combined underspend is reported at end February, this masks pressures in HR linked to unachieved historic savings targets and pressures within area wide controls relating to legal fees and provisions.

4.0 DELEGATED FUNCTIONS – HEALTH & SOCIAL CARE PARTNERSHIPS

Delegated health functions reported under the Health and Social Care Partnerships (HSCPs) returned a combined overspend as at 28th February 2025, however this is assumed to be partly offset by corresponding reserve movements, with an additional payment expected to be required to support the projected net 2024/25 deficit for Clackmannanshire and Stirling IJB on a risk share basis.

TABLE 6: Health & Social Care Partnerships	**Annual Budget** **£m**	**Apr - Feb Budget** **£m**	**Apr - Feb Expenditure** **£m**	**Underspend/ (Overspend)** **£m**
Clackmannanshire and Stirling HSCP				
Operational Services	65.832	59.775	57.778	1.997
Universal Services	91.511	85.153	91.918	(6.765)
Ringfenced and Contingency Budgets	2.208	4.768	0.000	4.768
Subtotal	159.551	149.696	149.696	0.000
Falkirk HSCP				
Operational Services	79.345	72.265	68.845	3.420
Universal Services	90.744	84.896	87.025	(2.129)
Ringfenced and Contingency Budgets	2.021	(1.291)	0.000	(1.291)
Subtotal	172.110	155.870	155.870	(0.000)
TOTAL	**331.661**	**305.566**	**305.566**	**(0.000)**

The HSCP budgets summarised in table 6 exclude budgets in respect of large hospital services, also referred to as set aside, which amount to £82.9m. Responsibility for the operational and financial management of Set Aside functions currently resides with NHS Forth Valley (with the exception of set aside Mental Health services which are operationally managed by Clackmannanshire and Stirling HSCP).

In terms of the year-to-date position for delegated functions, the key financial challenge experienced by both HSCPs continues to relate to primary care prescribing which is reported under universal services in table 6. Both volume growth in the number of items prescribed and the average cost per item remain higher than original planning assumptions (up 4% compared to the same period last year). This reflects ongoing demand and short supply issues. Delays in achieving prescribing efficiency savings also contribute to the adverse position reported to date. Note that the Falkirk HSCP prescribing budget has been increased by £4.4m in year (comprised of £3.5m of non-recurring reserves and £0.9m of virement from other operational budgets) as agreed under Direction from the IJB.

As reported in Table 6, the pressure on the primary care prescribing budget is partially offset by non-recurring underspends on operational services in Clackmannanshire and Stirling HSCP due to vacancies and slippage in recruitment within community District Nursing Services, Mental Health services, Health Improvement and community based AHP services.

Similarly, Falkirk HSCP are also experiencing ongoing vacancies and associated non-recurring underspends in community District Nursing, Mental Health services, community based AHP services, community Learning Disability services and Health Improvement. In addition, continued slippage in service developments, including the new slow stream rehab service which was funded by re-purposing part of the FCH closed ward budgets continues to be reported.

5.0 CAPITAL

The total annual net capital budget for 2024/25 is £12.2m as summarised in table 7 below. This reflects the core Capital Resource Limit (CRL) of £6.4m, together with £0.2m of Property Sales retained by the Board and a £5.6m of anticipated allocations and other adjustments which are expected to be applied to the CRL during the remainder of the year.

TABLE 7: 2024/25 NHS Forth Valley Capital Position	**Annual Budget £m**	**April - February Budget £m**	**April - February Expenditure £m**	**Underspend/ (Overspend) £m**
Elective Care	0.750	0.702	0.702	0.000
Information Management & Technology	3.419	2.290	2.290	0.000
Medical Equipment	6.260	5.808	5.808	0.000
Facilities & Infrastructure	2.190	1.768	1.768	0.000
NHS Board corporate projects	0.003	0.022	0.022	0.000
Right of Use Assets IFRS16	0.921	0.891	0.891	0.000
Indirect Capital Charged to Revenue	(1.343)	(0.120)	(0.120)	0.000
Total	**12.200**	**11.362**	**11.362**	**0.000**

As reported in table 7, a balanced position is reported for the 11-month period ending 28th February 2025. To date expenditure of £11.4m has been incurred leaving a balance of £0.8m to be spent over the final month of the financial year.

Key areas of expenditure are summarised below:

Elective Care – the National Treatment Centre continues to be delayed due to a number of technical issues relating to pipework and fire compliance regulations. A potential solution has been submitted to building control for review and we await feedback. Once a solution has been approved and agreed by all parties, a detailed workplan will be developed to take forward the required changes along with a timetable for the completion of this work. As such uncertainty remains over the go-live date until the technical solutions are assessed and resolved. As at year end 2023/24 the sum of £10.0m had been incurred on the project. Additional costs incurred during 2024/25 relate to ongoing advisor and professional fees.

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Information Management and Technology – a total of £2.2m has been spent on Information Management and Technology projects to date. Key projects include the GMS IT system refresh, NHS Board infrastructure refresh procurement, Inpatient Electronic Patient Record (EPR) and cyber security. The additional in year unplanned funding from the Scottish Government (£0.3m) will be used to purchase additional Desktops, including Laptops for the completion of Windows 11 rollout.

Medical Equipment – expenditure incurred on Medical Equipment items equates to £5.8m to date. The majority of the spend to date relates to the purchase of a 3rd CT scanner (as approved by the NHS board on 30 July, funded through slippage on the overall capital plan for 2024/25 and rephasing certain projects to 2025/26), replacement of the pharmacy robot, new image intensifiers and defibrillators. The additional in year unplanned funding from the Scottish Government (£2.6m) will be

used to purchase Dialysis Machines, Endoscopes, Camera Stacks and ASDU decontamination equipment and instruments.

Facilities and Infrastructure – a total of £1.8m has been spent on various facilities and infrastructure projects including salary recharges and the installation of PV panels and LED lighting at FVRH. Planned improvement works at Dunblane Health Centre are delayed due to affordability challenges following receipt of the tender prices which have come in significantly higher than the allocated budget. As previously reported, the planned project to replace the outdated heating system at Meadowbank Health Centre will also not progress due to concerns regarding value for money. An alternative proposal has now been agreed and approved and this will be complete by the end of the financial year. Plans are also being developed to respond to a recent Health and Safety Executive improvement notice in respect of anti-ligature works, early indications suggest that cost of the works required is likely to be significant, requiring this to be phased across several years. This has been built into the Business Continuity Plan submission to the Scottish Government for 2025/26 with provision for future years included as part of the new 3-year capital plan.

NHS Board and Property Sales – as at 31st January 2025, the sale of a surplus property in Barnton Street, Stirling has been concluded yielding a sales receipt of £0.1m and the sale of Carronshore Clinic for £0.1m. The purchase of Killin Medical practice was also completed in early January 2025 with a purchase price of £0.2m.

Appendix 1 – Key Cost Trends

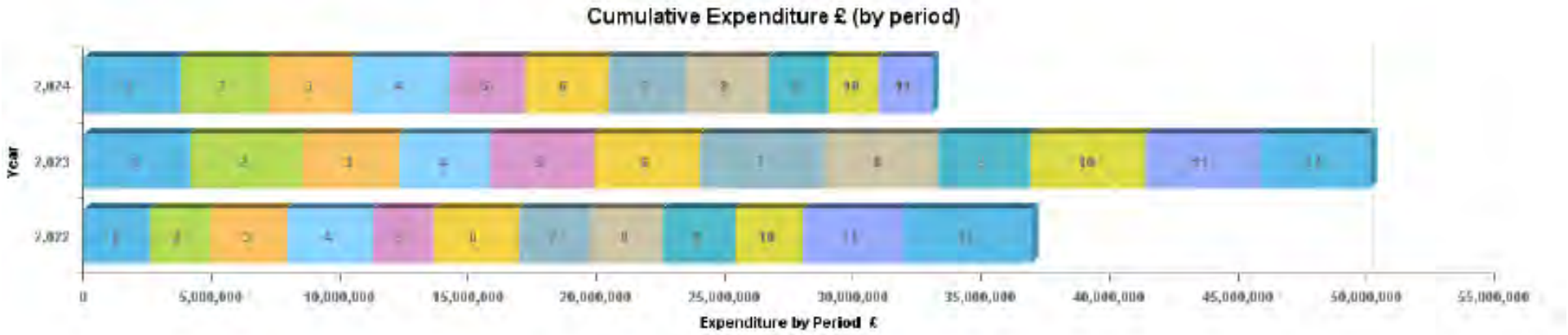
Pay costs

Total year to date pay costs amount to £333.6m at end February (up £24.4m or 8% on the previous year), this reflects agreed pay award, and additional supplementary staff costs to cover sickness absence, use of contingency areas and the impact of Agenda for Change reform (in terms of protected learning time and the reduction in the working week) as summarised in the tables below:

Pays expenditure by staff group	2024/25 Apr to Feb Actual	2023/24 Apr to Feb Actual
Nursing & Midwifery	£142,837,382	£139,415,795
Medical & Dental	£93,501,494	£81,014,131
Admin & Clerical	£41,248,429	£37,089,433
Allied Health Professionals	£19,511,800	£17,641,750
Other Therapeutic	£10,571,754	£9,198,406
Healthcare Sciences	£10,500,132	£10,040,250
Support Services	£10,199,134	£10,103,165
Medical & Dental Support	£3,198,562	£2,537,991
Senior Managers	£1,826,063	£1,857,213
Personal Social Care	£248,695	£297,310
TOTAL	**£333,643,445**	**£309,195,445**

Pay expenditure by Directorate	2024/25 Apr to Feb Actual	2023/24 Apr to Feb Actual
VACUTE: Acute Services	185,350,096	171,825,872
VWCSHS: Women + Children Directorate	54,985,615	50,094,609
VFK: Falkirk Hscp	578,842	551,885
VCS: Clacks Stirling Hscp	18,548,120	18,324,745
VOTHCM: Other Community Services	15,873,736	14,432,561
VFINF: Facilities	10,205,459	9,978,452
VDIGI: Digital	16,240,441	14,946,606
VEXT: Externals	43,039	22,408
VFIN: Director Of Finance	4,232,047	4,045,461
VMED: Medical Director	10,024,083	8,946,422
VPBH: Director Of Public Health	2,543,749	2,327,817
VHR: Director Of Human Resources	6,153,612	5,381,165
VAWC: Area Wide Controls Hb	2,041,695	2,129,113
VNUR: Nmahp Directorate	3,921,815	3,466,283
VCEX: Chief Executive	946,968	1,008,566
VPMO: Portfolio Management Office	1,954,129	1,713,479
TOTAL	**333,643,445**	**309,195,445**

Note that year to date pay costs include additional supplementary/temporary staff costs of £33.1m (this compares to £45.8m in the same period last year) as summarised in the graph below. As reported in the main body of the report, this reflects significant reductions in nurse agency usage as per the agreed actions in our Financial Sustainability Action Plan.



Appendix 2 - 2024/25 YTD savings delivery

Savings delivery - April 2024 to February 2025	Plan £000s	Actual £000s	TOTAL £000s	RAG status
Workforce - nursing				
Nursing sickness absence- acute	2,017	0	(2,017)	RED
Nursing sickness absence - WCSHS	733	0	(733)	RED
Cessation of unregistered nurse agency	833	833	0	GREEN
Cessation of all nurse agency usage	3,300	3,600	300	GREEN
Reduce requirement for enhanced observations	0	0	0	GREEN
Enhanced controls	0	2,804	2,804	GREEN
	6,883	**7,237**	**354**	
Workforce - medical				
Medical locum review of rates	0	0	0	RED
Medical sickness absence	0	0	0	RED
Reduce locum usage in unplanned care areas	0	0	0	RED
Jnr Dr rota compliance in planned care areas	0	0	0	RED
International recruitment (psychiatry)	553	330	(223)	AMBER
	553	**330**	**(223)**	
Workforce - other				
Retinue fees & charges	121	121	0	GREEN
Targeted vacancy review	917	917	0	GREEN
Sickness absence other staff groups	0	0	0	RED
Agile working	0	0	0	RED
Review of T&Cs eg pay protection	343	0	(343)	RED
Review of workforce controls	0	0	0	GREEN
	1,381	**1,038**	**(343)**	
Procurement				
Enhanced Spend Analytics Tool	0	0	0	RED
Review of Children's ordering process for supplies	0	0	0	RED
Complex Care Education Provision Review	66	0	(66)	RED
Review of Complex Care Third Party Provision	191	0	(191)	RED
Non-pay: review of non-discrectionary spend	0	183	183	GREEN
Review of ward consumables	0	0	0	RED
Procurement of cardiology devices	44	0	(44)	RED
	301	**183**	**(118)**	
Prescribing (switches)				
Lenalidomide switch - full year effect	184	184	0	GREEN
Tecfidera / Dimethyl Fumerate	669	598	(71)	GREEN
Xarelto / Rivaroxaban	57	35	(22)	GREEN
RoActemra / Tocilizumab	115	0	(115)	RED
Xolair / Omalizumab	171	0	(171)	RED
Aubagio / Teriflunomide	92	90	(2)	GREEN
Further tehcnical switches	0	393	393	GREEN
	1,288	**1,300**	**12**	

Prescribing Acute + Women & Children's				
Review of inflation for hospital Rx	2,475	2,700	**225**	GREEN
Oncology (near patient preparation)	48	0	**(48)**	RED
PAS & PCRS rebates	0	0	**0**	RED
Off patent savings	183	632	**449**	GREEN
Medicines of low clinical value	0	0	**0**	RED
Complex rebates/review of contracts	138	0	**(138)**	RED
Environmental sustainability/medical gases/green theatres	0	0	**0**	
Review of homecare arrangements	9	0	**(9)**	RED
Review of Covid antivirals	0	0	**0**	RED
Reduction in cold chain medicine waste	61	0	**(61)**	GREEN
Transition to Regional Formularies	0	0	**0**	RED
Acceleration of digital prescribing	0	0	**0**	RED
Affordability of new medicines	0	0	**0**	RED
	2,913	**3,332**	**419**	
Estates & Infrastructure				
PPP/PFI insurance	0	0	**0**	GREEN
PPP/PFI review of energy contract arrangements	1,192	0	**(1,192)**	RED
PPP/DBFM review of contractual arrangements	46	0	**(46)**	RED
PPP/PFI refinancing	0	0	**0**	RED
PFI Benchmarking	0	0	**0**	GREEN
Energy efficiency - full year effect	234	0	**(234)**	AMBER
Portering FVRH Blood products	110	110	**0**	GREEN
Asset management/review of agile working	0	0	**0**	RED
Non-Emergency Patient Transport	0	0	**0**	RED
Sale of surplus property	7	11	**4**	GREEN
	1,589	**121**	**(1,468)**	
Income Generation				
Review of FOC travel vaccines	0	0	**0**	RED
Provision of training to other bodies/agencies/3rd parties	9	0	**(9)**	RED
Introduction of charging policy for DNAs	0	0	**0**	RED
Develop a mutual aid strategy	0	0	**0**	AMBER
	9	**0**	**(9)**	
Innovation, Productivity & Digital				
Remote outpatient appointments	0	0	**0**	RED
Theatre optimisation	0	0	**0**	RED
Review of procedures of low clinical value	0	0	**0**	RED
Review of Integration Schemes	0	0	**0**	RED
Introduce Patient Level Information Costing System	0	0	**0**	RED
Voice recognition business case	0	0	**0**	RED
Electronic Patient Record	0	0	**0**	RED
Net call patient hub	130	0	**(130)**	RED
M365	0	0	**0**	RED
	130	**0**	**(130)**	

Value Based Health & Care				
Whole system hip fracture prevention	0	0	**0**	RED
Review of Flow Navigation Centre	550	0	**(550)**	RED
Hospital at Home Capacity and closure of contingency beds	4,483	3,221	**(1,262)**	AMBER
Develop Target Operating Model for the front door	0	0	**0**	RED
Discharge Without Delay	0	0	**0**	RED
Whole systems working to reduce Length of Stay	0	0	**0**	RED
National Value Based Health & Care Action Plan	0	0	**0**	RED
	5,033	**3,221**	**(1,812)**	
Other				
Review of Covid legacy costs	2,177	0	**(2,177)**	RED
Annual leave carry forward	642	0	**(642)**	AMBER
Anticipated slippage on investment	458	0	**(458)**	GREEN
Unplanned financial benefits	3,323	8,205	**4,882**	GREEN
Technical accounting opportunities	500	2,242	**1,742**	GREEN
Review & re-prioritisation of local service developments	4,767	3,596	**(1,171)**	AMBER
3% recurring budget deduction	8,630	0	**(8,630)**	RED
	20,497	**15,396**	**(5,102)**	
Total	**40,575**	**32,157**	**(8,418)**	

2024/25: progress against 3% recurring target	Plan £m	Actual £m	Balance £m
Set Aside & non-delegated services			
Workforce	1.339	7.688	-6.349
Procurement	0.328	0.183	0.145
Prescribing (Hospital based)	4.497	4.632	-0.135
Estates & infrastructure	1.733	0.121	1.612
Income Generation	0.010	0.000	0.010
Innovation, Productivity & Digital	0.142	0.000	0.142
Value Based Health & Care	0.600	0.000	0.600
Other (slippage, reprioritisation & other financial benefits)	13.015	2.129	10.886
Total Set Aside & non-delegated services	**21.664**	**14.753**	**6.911**
Delegated services (HSCPs)			
Clacks/Stirling HSCP			
Primary Care Prescribing	1.709		1.709
Community Healthcare Services	0.508		0.508
	2.217	0.000	2.217
Falkirk HSCP			
Primary Care Prescribing	1.664		1.664
Community Healthcare Services	0.191		0.191
	1.855	0.000	1.855
Total Delegated services (HSCPs)	**4.072**	**0.000**	**4.072**
Grand Total	**25.736**	**14.753**	**10.983**
Scottish Government 3% total recurring target	20.148		

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

10.2 Draft Financial Plan
For: Approval

Executive Sponsor: Professor Ross McGuffie, Chief Executive
Authors: Mr Scott Urquhart, Director of Finance / Mrs Jillian Thomson, Deputy Director of Finance / Mrs Alison Mackintosh, Senior Financial Planning Manager

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Executive Summary

This paper presents the 3 year financial plan covering the period from 2025/26 to 2027/28.

Recommendations

The Forth Valley NHS Board is asked to:

- **note** the 3-year financial plan, including the key financial planning assumptions and estimates applied.
- **note** the significant level of financial challenge identified and the associated risk to delivery of financial balance during the 3-year period.
- **approve** the proposed payments to IJBs for financial year 2025/26 which reflect the agreed uplift as advised by the Scottish Government, and which were considered by the Strategic Planning, Performance and Resources Committee in February.

Key Issues to be considered

The plan sets out an ambitious 3-year strategy to restore recurring financial balance through whole system reform and innovation, guided by the principles of Value Based Health and Care. A summary of the 3-year revenue projection is presented in the table below (further detail is provided in appendix 1):

NHS Forth Valley	2025-26			2026-27			2027-28		
	Rec £m	Non-Rec £m	Total £m	Rec £m	Non-Rec £m	Total £m	Rec £m	Non-Rec £m	Total £m
Financial gap before savings	(49.155)	11.120	**(38.035)**	(47.423)	(1.746)	**(49.169)**	(36.395)	(0.605)	**(37.000)**
Savings plans/ targets	19.000	19.035	**38.035**	30.000	12.000	**42.000**	36.000	1.000	**37.000**
Residual deficit	**(30.155)**	**30.155**	**0.000**	**(17.423)**	**10.254**	**(7.169)**	**(0.395)**	**0.395**	**0.000**

The plan reflects feedback from the Scottish Government on the earlier draft submitted in February together with a number of changes in funding assumptions and costs which have been confirmed in the last month. The plan also reflects the refreshed 15 box grid and associated actions issued by the Scottish Government on 13 March 2025 – see appendix 2.

Implications

Financial Implications

Financial implications are considered in the main body of the report.

Workforce Implications

Workforce accounts for around half of our total operating expenditure and is therefore a key financial risk area. As such, workforce optimisation continues to be a key feature of our savings plan.

Infrastructure Implications including Digital
There are no immediate infrastructure or digital implications associated with this report. However, it is recognised that digital innovation is a key enabler of transformation and reform of service delivery in terms of enhanced patient experience and improved efficiency and productivity.

Sustainability Implications
There are no direct sustainability implications arising from this report. Climate Change and Sustainability initiatives across the five priority areas for NHS Scotland (i.e. Sustainable Buildings & Land; Sustainable Travel; Sustainable Goods & Services; Sustainable Care; and Sustainable Communities) will continue to contribute to efficiency savings, reduction of waste, cost avoidance and productivity gains.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process A policy for NHS Scotland on the climate emergency and sustainable development*. (please tick relevant box)*
□ *Yes*
√ *N/A*

Where applicable, the climate change, environmental and sustainability impacts and any mitigating measures are noted above/contained in the supporting papers.

Quality / Patient Care Implications
It is imperative that quality of care and overall service provision is underpinned by a sustainable medium term financial strategy that reflects the principles of Value Based Health and Care and the concept of "spending well" (ensuring we make the most of the limited resources we have available).

Information Governance Implications
There are no direct information governance implications arising from this report.

Risk Assessment / Management
Financial sustainability continues to be reported as very high risk in the NHS Board's strategic risk register, this is unlikely to change during the 3-year timeframe of the medium term financial strategy.

Relevance to Strategic Priorities
The medium-term financial strategy outlines the total resources available to meet the NHS Board's strategic priorities over the next 3 years. It is essential that strategic priorities are delivered on a sustainable financial basis.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that: (*please tick relevant box)*
- Paper is not relevant to Equality and Diversity

Communication, involvement, engagement and consultation
This report was prepared in consultation with Senior Finance colleagues.

Additional Information
N/A

Appendices
Appendix 1: 3-year Financial Plan 2025/26 to 2027/28
Appendix 2: Refreshed 15 box grid

DRAFT 3 YEAR FINANCIAL PLAN

2025/26 to 2027/28

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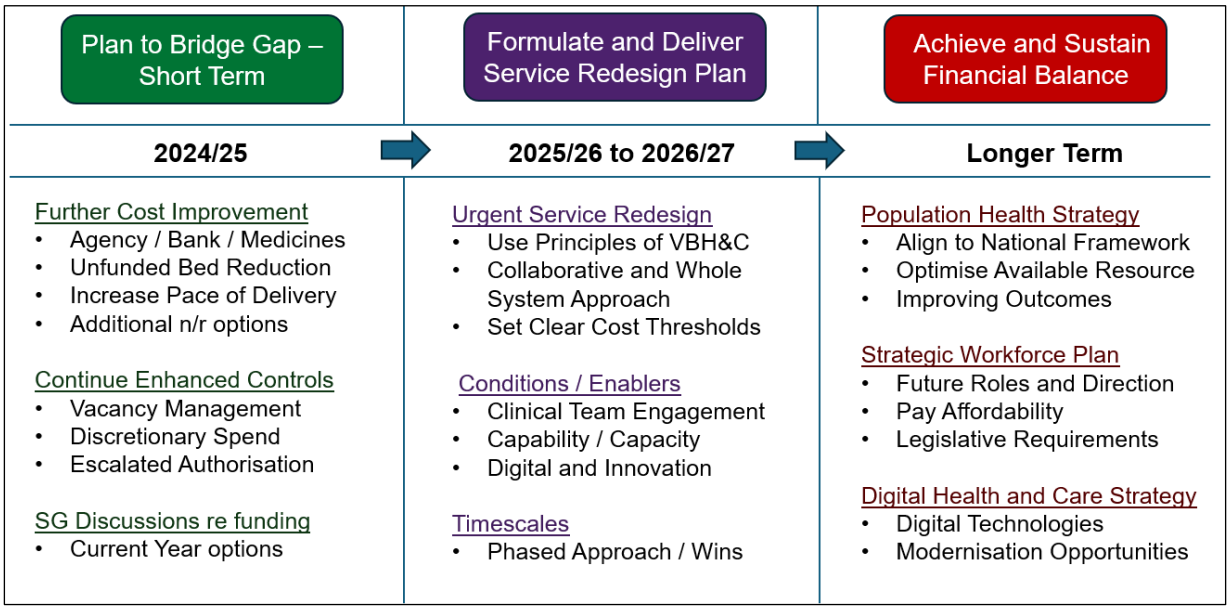
1. Executive Summary

This document outlines the NHS Board's 3-year financial plan covering the period from 2025/26 to 2027/28.

The plan confirms the total resources available to meet the NHS Board's strategic priorities over the next 3 years and has been informed by input and engagement from the Senior Leadership Team, staff side and clinical representatives. The plan is a live document which will be subject to continuous review and updated to reflect the impact of our forthcoming local Population Health and Care Strategy, new national policy developments and changes in financial planning assumptions over time.

The plan sets out an ambitious 3-year strategy to restore recurring financial balance through whole system reform and innovation, guided by the principles of Value Based Health and Care as summarised below:



This builds on the Financial Sustainability Action Plan developed during the 2024/25 financial year and will be supported through the implementation of a new Value Based Health and Care programme designed to optimise population health from our available resources.

The Value Based Health and Care programme will drive forward the required redesign and reform of our services and facilitate a shift in resources towards prevention and early intervention during 2025/26 and beyond. It is recognised that the programme must be delivered at pace and will require challenging decisions to be taken on priorities and disinvestment to deliver cost savings, improve value for money and maximise outcomes for patients and service users.

2. National financial context

The financial position of NHS Scotland remains extremely challenging as we enter the next three-year planning cycle which requires all NHS Boards to ensure that all expenditure incurred delivers the best possible value for money within available resources and maximises outcomes by providing high quality care for the local population. Embedding a culture of stewardship, where everyone feels responsible for the effective use of resources, is essential to ensure the longer-term sustainability and resilience of the NHS.

The draft Scottish Government budget settlement letter for 2025/26, issued on 4th December 2024, highlights the need for NHS Scotland to work collaboratively across organisational boundaries and to demonstrate more joined up, whole system collaborative working across health and social care. The letter sets out an expectation of a stepped change in service redesign to improve financial and service sustainability, alongside continued delivery of the '15 box grid' cost improvement priorities, a renewed focus on productivity to meet growing demand, and the adoption of a Value Based Health and Care approach. The letter also confirms an end to brokerage arrangements from 2025/26, with any future overspends leading to a potential qualification of accounts, combined with a formal report to the Scottish Parliament by the Auditor General for Scotland under Section 22 of The Public Finance and Accountability (Scotland) Act 2000.

A revised national Medium Term Financial Framework is expected to be published by Scottish Government during 2025/26, developing a vision and programme of reform based on prevention and early intervention using digital technology and innovation to drive improvements. A Population Health Framework is also planned for publication, setting out a coherent long-term approach to whole system, primary preventative actions.

Audit Scotland, in their recently published report titled NHS in Scotland 2024: Finance and performance, highlighted the scale of the current financial pressures, and recommend that NHS Boards and Scottish government consider fundamental changes in how services are provided and the range of services offered to improve efficiency and reduce waste.

3. Local financial context

Financial sustainability remains one of the highest strategic risks for NHS Forth Valley and mitigation actions continue to be prioritised and delivered through the Financial Sustainability Oversight Board.

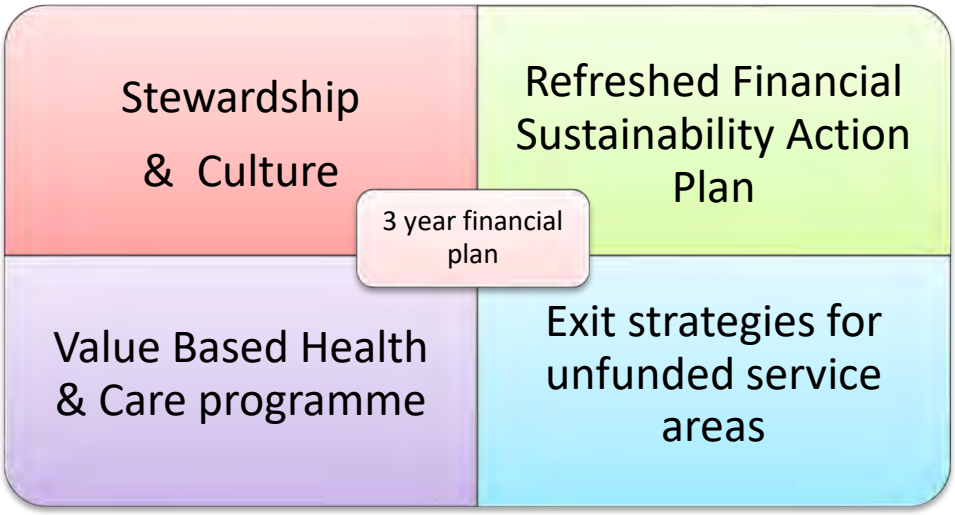
NHS Forth Valley faced an unprecedented level of financial challenge during 2024/25 with significant cost pressures across workforce, medicines, supplies and contract spend areas. Despite improvements on the in-year financial position there remains a significant underlying recurring financial gap to be addressed over the next three-year period.

During 2024/25 the Director of Finance led a two-stage financial self-assessment process encompassing financial management, systems of internal control and governance arrangements as well as consideration of the in-year financial position and forecast outturn. The self-assessment was reviewed by Scottish Government who confirmed that

NHS Forth Valley remain on Level One, the lowest level of the NHS Scotland Support and Intervention Framework for finance, based the strength of financial leadership management and controls in place. We aim to maintain this Level One position during the 3-year timeframe of the plan.

4. Financial priorities

There are 4 key priorities which underpin our 3-year financial plan, aligned with our emerging Population Health and Care Strategy as summarised below:



4.1. Stewardship and culture

Successful delivery of the plan will require an effective culture of stewardship with clear lines of financial accountability. Creating this culture requires cost transparency, improved financial literacy across the organisation and engagement with clinical teams. The finance team are developing a schedule of work to support this, including redesign of budget statements and provision of tailored financial analysis, alongside new training materials for non-finance managers to improve understanding of financial governance and financial management. In addition, a Finance and Value Based Health and Care Toolkit is being developed by NHS National Education Scotland (NES) which we will implement locally once it is available.

4.2. Refreshed Financial Sustainability Action Plan

The Financial Sustainability Action Plan developed during 2024/25 has been updated to include a range of savings schemes and efficiency initiatives aligned to the new refreshed version of the “15-box grid”. The 15-box grid has been updated by the Scottish Government for 2025/26 to direct NHS Boards to the areas that are considered to offer the greatest opportunities in terms of cash releasing savings, productivity gains and efficiency improvements.

This includes the further roll out of savings schemes relating to Innovation and Value-Based Healthcare, workforce optimisation and service optimisation as illustrated in the new 15-box grid overleaf.

15 Box Grid refreshed for 2025/26		
Innovation & Value-Based Healthcare	**Workforce Optimisation**	**Service Optimisation**
1. Medicines of Low Clinical Value	6. Agency Reduction	11. Theatres Optimisation
2. Clinical Variation Review	7. Sustainable Staff Bank Usage	12. Remote Outpatient Appointments
3. Digital Savings	8. Sickness Absence Reduction	13. PLICS Roll Out
4. Energy Efficiency Schemes	9. Non-Compliant Rotas Review	14. Length of Stay Reductions
5. Prescribing Savings	10. Central Functions Job Family Review	15. Non-pay Spend Review

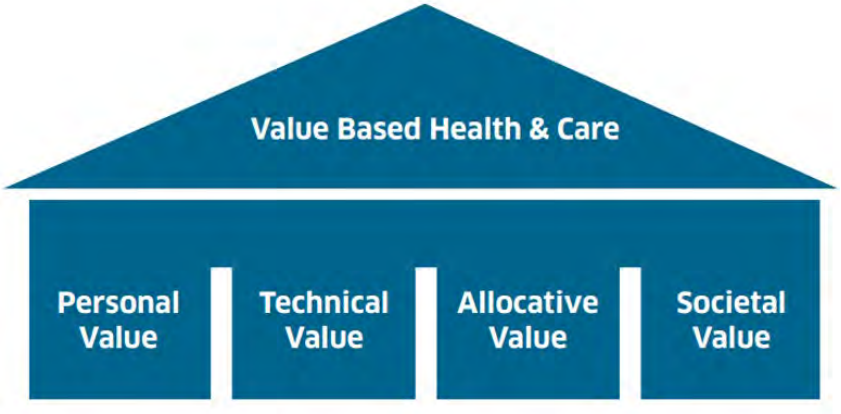
4.3. Value Based Health and Care programme

A programme of service redesign and reform based on the principles of Value Based Health and Care (VBHC) and Realistic Medicine will be taken forward during 2025/26. The VBHC programme aims to support all services to operate within their available budget, whilst maximising value to the local population, by the end of the 3-year term of the financial plan.

As part of the VBHC programme, every service area will be required to formally evaluate their service against a range of factors which are aimed at reducing/removing waste and unwarranted variation from our pathways and processes, investing in preventative interventions where appropriate and disinvesting in areas that do not represent best value.

A series of engagement and education events are currently underway and the programme will commence in April. £0.4m of non-recurring funding has been secured from the Scottish Government to ensure sufficient leadership and operational capacity is available to drive the programme forward. In addition, colleagues from NES and NHS Healthcare Improvement Scotland (HIS) will also support the programme.

The concept of **value** is key element of the overall VBHC programme. Value in a Health and Care context does not solely refer to finance – it relates to everyone's responsibility to act as a steward of the finite resources we have available and to ensure that these resources are directed to areas that improve and maximise patient outcomes and experience. The VBHC programme and the 3-year financial plan are therefore framed around the 4 pillars of value as summarised below:



4.3.1. Personal Value

The concept of **Personal Value** is concerned with our ability to provide health and care outcomes that meet the personal goals and "what matters most" to our patients and service users. This requires patients, service users and their families to be involved in decisions relating to their care in collaboration with Clinicians and Healthcare Professionals who understand and respect what is important to them. This is delivered through Shared Decision Making which enables individuals to make an informed choice about the care and treatment options which best meet their personal goals.

The 3-year financial plan aims to improve Personal Value through the following actions:

- Ensuring Personal Value is one of the specific factors/considerations included in our service redesign process through the VBHC programme.
- Ongoing promotion of local Public and Patient Involvement activities.
- Clear communication and public messaging relating to our financial position and the measures being taken to restore financial balance.

4.3.2. Technical Value

Technical Value is concerned with ensuring our resources are invested in the most effective treatments at the lowest cost. Ineffective and/or overuse of treatments do not generate technical value as they provide no/little clinical benefit to patients or service users (and in some cases patients and service users may be exposed to unnecessary harm as a result). Similarly underuse, where clinically beneficial and effective treatments and services are not utilised, is of equal concern.

The 3-year financial plan includes a number of actions to improve overall Technical Value as summarised below:

- Expanding the roll out of "blueprints" and enhanced governance arrangements to specialist nursing areas as part of efforts to return the overall nurse staffing profile back to approved budgeted establishment levels, with further reductions in nurse bank costs targeted for 2025/26. This builds on the successful reduction in nurse agency costs in 2024/25.
- Introducing the "blueprint" approach to the medical workforce to agree optimum staffing levels and reduce medical bank, locum and agency costs.
- Ongoing implementation of a range of medicine switches to ensure only the most cost-effective drugs are prescribed.
- Progressing actions arising from the refreshed 15-box grid, including clinical variation reviews and benchmarking to identify and reduce unwarranted variation in clinical practice and associated costs.
- Installing a Patient Level Information and Cost System (PLICS) to facilitate a better understanding of how resources are used at patient-level, together with analysis of outcomes relative to cost.

4.3.3. Allocative Value

Allocative value is concerned with ensuring that resources are distributed across our local population in a transparent and equitable manner based on need. The distribution of resources should reflect the entire end to end pathway of care, including prevention and early intervention. The VBHC programme is expected to produce a significant improvement in Allocative Value and it is acknowledged that this will require challenging decisions to be taken on priorities and disinvestment going forward.

The 3-year financial plan is expected to contribute to improved Allocative Value through the following actions:

- Implementation of major reform and service redesign through the VBHC programme and application of zero-based budgeting principles to ensure all services can operate within their approved budget on a sustainable basis by 31 March 2028.
- Review of budgets and costs to identify the total resources available to support primary, secondary and tertiary prevention initiatives.
- Establishment of whole system pilot in falls prevention following initial scoping by Public Health colleagues.
- Agreement that the first call on any additional funding allocated by the Scottish Government is ring fenced locally for prevention and early intervention initiatives.

4.3.4. Societal Value

Societal Value refers to the wider impact that the provision of health and care services has on society. This includes benefits such as the creation of local employment opportunities and social cohesion. However, it also includes adverse impacts linked to environmental concerns and climate change though our greenhouse gas emissions.

The 3-year financial plan improves Societal Value through the following measures:

- Our commitment, as an Anchor Institution, to fostering community wealth by actively supporting local people into stable employment and prioritising the procurement of goods and services locally whenever possible.
- Ongoing implementation of a range of energy efficiency and conservation projects designed to reduce energy consumption (including LED lighting, new roof and cavity insulation and installation of solar panels across the estate). In addition, a range of other measures have been implemented to reduce our carbon footprint, including the introduction of digital patient letters etc through the new netcall hub and the phasing out of paper pay slips.
- Delivery of key climate related targets.

4.4. Exit strategies for unfunded service areas

Clear exit strategies will be brought forward in relation to ongoing unfunded service areas (including Covid legacy arrangements) and historic unfunded posts based on a risk

assessment of options and continued vacancy controls to ensure that all posts recruited to have sufficient funding in place to meet recurring costs.

5. Financial planning assumptions

The 3-year financial plan is predicated on a number of financial planning assumptions and estimates. All assumptions have been benchmarked nationally through the Peer Review sub-group of the Corporate Finance Network and amended to reflect local circumstances and risk where appropriate.

5.1. Funding

The plan incorporates the indicative one-year funding settlement advised by the Scottish Government on 4 December 2024 for 2025/26. This confirmed a 3% baseline budget uplift with additional sums relating to NRAC parity and other recurring adjustments taking our initial Revenue Resource Limit (RRL) to £770.1m as summarised in exhibit 1 below.

Exhibit 1: NHS Board Initial Revenue Allocation 2025/26

	£ million
Baseline budget: 2024/25 Revenue Allocation	**658.877**
24-25 Recurring Allocations	**65.910**
Opening baseline	**724.787**
3.0% Core uplift	**21.744**
NRAC Funding	**5.216**
Total per Dec 24 Budget Letter	**751.746**
25-26 Opening Adjustments (further 24-25 recurring adj)	**18.332**
Total Initial Budget 2025/26	**770.078**

In line with previous years, a range of further separate allocations are expected to be added to the 2025/26 RRL during the course of the year relating to a number of specific policy areas including Family Health Services, Mental Health, Elective and Unscheduled Care, the New Medicines Fund and the National Treatment Centre. Note that the Scottish Government intends to reduce and provide earlier notice of the number and value of separate in year allocations with a commitment to issue 80% of these allocations in the first quarter of the financial year. This is a welcome development which will support more effective workforce and service planning.

In addition, the Scottish Government has recently confirmed that a £320m national sustainability fund has been created for 2025/26 (comprised of £70m of recuring funding and £250m non-recurring) with the strict condition that this is to be used to reduce

projected deficits/in year pressures in 2025-26 and must not be used for any additional investment. Our NRAC share of this fund has been included in the projections.

When all separate anticipated allocations are added to the £770.1m baseline budget, our total overall Revenue Resource Limit is expected to equal £977.5m for 2025/26. In terms of future years, a 3% uplift to the baseline RRL is assumed in 2026/27 and 2027/28 for planning purposes.

5.2. Inflation estimates

The 3-year plan is based on a number of cost inflation assumptions as summarised in exhibit 2 below. For context, and as part of scenario planning, exhibit 2 also illustrates the financial impact of a 1% change in inflationary assumptions (for example every 1% change in overall total pay cost assumptions equates to £3.2m).

Exhibit 2: Cost inflation estimates 2025/26	**Baseline Budget £m**	**Funding uplift/ Inflation Projections %**	**Funding uplift/ Inflation Projections £**	**£m impact per 1% variance**
NHS Forth Valley baseline funding				
NHS Core & Set Aside baseline funding	534.090	2.90%	15.473	5.341
HSCP Operational baseline funding	142.282	3.00%	4.268	1.423
HSCP Universal baseline funding	66.746	3.00%	2.002	0.667
2025/26 baseline budget*	**743.119**	**2.93%**	**21.744**	**7.431**
Analysis of NHS Core & Set Aside Inflation				
Pays - Agenda for Change	228.742	3.07%	7.026	2.287
Pays - Medical	88.250	3.02%	2.668	0.883
Pays - Senior Managers	2.013	3.02%	0.061	0.020
Pays - Other	6.803	3.02%	0.206	0.068
External CBF Outflow	62.764	3.00%	1.883	0.628
Unitary Charge Inflation	53.820	3.20%	1.722	0.538
Hospital Drugs	37.305	10.00%	3.731	0.373
Capital Charges	19.370	0.00%	0.000	0.194
Energy	12.027	-19.00%	(2.285)	0.120
Rates	7.442	5.00%	0.372	0.074
Voluntary Bodies / other providers	0.507	3.00%	0.015	0.005
Other Supplies	45.986	2.20%	1.012	0.460
Other	5.020	3.00%	0.151	0.050
External CBF Inflow	(15.493)	3.00%	(0.465)	(0.155)
Income	(20.467)	0.00%	0.000	(0.205)
Total for NHS Core & Set Aside	**534.090**	**3.01%**	**16.097**	**5.341**

**opening baseline £724.787m + opening adjustments £18.332m*

The 2025/26 pay award is currently under negotiation and the Scottish Government have advised that Boards should continue to assume that funding will be allocated to meet the cost of this in full. Similarly, our current working assumption is that the cost impact associated with the ongoing reform of Agenda for Change (AfC) terms and conditions (i.e. the further 1-hour reduction in the working week and band 5 to 6 nursing reviews) will also be fully funded. Approximately 60% of the increase in employer National

Insurance Contributions is expected to be funded, with the balance to be managed locally.

Inflationary pressures on a range of contracts which are linked to RPI (most notably our 3 PFI/PPP contracts) are included in the plan. Our current estimate of the likely RPI is 3.2% which equates to a £1.7m increase in unitary charge payments during 2025/26.

For other premises costs, a 19% reduction is assumed in relation to energy costs for 2025/26, offset by a 5% increase in water charges. A overall 10% increase in energy costs is provided for in later years of the strategy. Non-domestic rates are expected to increase by 5% in each of the next 3 years.

Increases in the cost of hospital prescribed drugs is currently estimated at 10% in each of the next 3 years. Further horizon scanning work is underway to refine this estimate. Note that no provision in included in relation to the introduction of GLP1/GIP medicines for the treatment of obesity. This is a significant risk area and at present we do not have a local pathway for the prescribing or monitoring of these drugs. Assuming these drugs are implemented locally in line with the recommendations of the national Short Life Working Group, the cost is expected to be in the region of £10.0m to £12.0m pa (excluding service-related costs for monitoring etc). It is envisaged that the majority of this cost would fall under the Health and Social Care Partnership budgets. A local position statement is being drafted however a national consensus is required in relation to the managed introduction and affordability of these medicines.

Note that an estimate to reflect potential demand linked to ongoing demographic change is included in 2026/27 and 2027/28. This is broadly in line with the planning assumptions outlined in the Scottish Government's original medium term financial framework for Health and Care published in October 2018. This will be revisited when the new updated medium term financial framework is published during 2025/26.

5.3. Proposed IJB payments

The Scottish Government has advised that payments to Integration Joint Boards (IJBs) in respect of delegated health functions during 2025/25 must deliver an uplift of 3% over 2024-25 recurring budgets. Exhibit 3 overleaf sets out the proposed initial payment to both IJBs in respect of the 3% uplift. Note that further payments are expected to be made to the IJBs during 2025/26 once funding is confirmed for various delegated Health and Social Care policy developments and other relevant ring-fenced areas which are not part of the baseline RRL. Many of these allocations remain subject to national negotiation and/or Scottish Government approval (for example agreed uplifts for Family Health Service contractors and pay awards).

In line with previous years, further funding will also be transferred from the health portfolio to Local Government to support integration, specifically in relation to the recurring pay commitments associated with the real living wage (£125.0m), increases to free personal nursing care rates (£10.0m) and to provide additional voluntary sector short breaks funding for unpaid carers (£5.0m). The Scottish Government has advised that this funding should be additional and not substitutional to each Council's 2024-25 recurring budgets for delegated adult social care services. This means that, when taken together, Local Authority adult social care budgets for allocation to Integration Authorities must be £140m million greater than 2024-25.

The funding position presented in exhibit 3 is consistent with the funding assumptions applied by the IJBs as part of their financial planning processes. Note that both IJBs have identified significant financial gaps for 2025/26 and beyond.

Exhibit 3: IJB Initial Payments

Category	Falkirk £ million	Clacks/ Stirling £ million
Baseline budget: 2024/25 Revenue Allocation		
Set Aside	44.263	35.275
Operational budgets	63.789	52.072
Universal budgets (Prescribing / Family Health Services)	32.333	34.413
Integration Funding (Pass Through)	12.863	9.304
Transformation Funding	0.850	3.405
	154.098	134.469
3% Core Uplift	4.623	4.034
Universal Funding outwith recurrent baseline	49.296	52.406
Total Initial Budget 2025/26	**208.017**	**190.909**

The draft business case considered by Clackmannanshire and Stirling IJB identifies a significant funding shortfall of £21.2m against the integrated budget for 2025/26. Similarly, Falkirk IJB's draft business case for identifies a £13.9m against the integrated budget for 2025/26. A summary of the 3-year projected IJB deficit position is presented in table 1 below:

Table 1: IJB 3-year projected deficit (before savings)	2025/25 £m	2026/27 £m	2027/28 £m
Clacks/Striling IJB	21.248	28.437	35.625
Falkirk IJB	13.907	17.392	21.165
TOTAL	**35.155**	**45.829**	**56.790**

Both IJBs and the HSCPs are developing savings plans to reduce the projected budget deficits as far as possible and recognise that whole system reform and transformation is required to deliver financial balance on a sustainable footing. Both IJBs have indicated that the lead in time required to deliver the transformation programme is likely to extend beyond 2025/26 and this may require potential risk sharing arrangements to be enacted

during that year. This is currently being considered by the NHS Board and Local Authority partners.

5.4. Savings plans

In line with previous years, the Scottish Government has set a 3% recurring savings target on baseline budgets (including those budgets delegated to IJBs) which equates to £22.6m in 2025/26. Approximately £8.8m of the 3% recurring savings target relates directly to IJBs.

A refreshed Financial Sustainability Action Plan has been developed which outlines the programme of work and supporting actions to deliver a total of £38.0m of savings in respect of Set Aside and non-delegated functions during 2025/26. The Financial Sustainability Oversight Group will continue to oversee delivery of the action plan.

Of the £38.0m total targeted savings, £19.0m (50%) is expected to be delivered on a recurring basis (£3.7m short of the 3% Scottish Government target, assuming the entire £22.6m targets applies to the NHS Board), with the other half relating to various non-recurring measures and one-off funding sources (see exhibit 4 below).

Note that a c£4.0m of savings have still to be fully identified and risk assessed at this stage, this will be closely monitored as the plan is implemented.

Exhibit 4: 2025/26 Financial Sustainability Action Plan - saving targets	**Rec £m**	**Non-Rec £m**	**TOTAL £m**
Workforce	5.409	1.080	**6.489**
Procurement	0.220	0.001	**0.221**
Prescribing (Hospital based)	2.608	0.100	**2.708**
Estates & infrastructure	3.497	0.950	**4.447**
Service redesign & reform	4.816	6.588	**11.404**
Non-pay & other measures	1.450	7.281	**8.731**
Savings under development	1.000	3.035	**4.035**
TOTAL	**19.000**	**19.035**	**38.035**

A high-level summary of each workstream is provided below (see further detail in appendix A):

- Workforce (£6.5m saving identified to date) – savings reported under this workstream are linked to ongoing targeted actions to reduce nurse bank and medical locum, bank and agency staff as part of the phased closure of contingency areas, enhanced sickness absence monitoring to support staff to return to work and ongoing implementation of escalation/authorisation controls in line with the recommendations of the national Supplementary Staffing Task & Finish Groups.

- Procurement (£0.2m saving identified to date) – a range of cost reduction and cost avoidance proposals are included under this workstream linked to various commercial improvements for certain goods and services purchased through national contracts as advised by National Procurement.

- Prescribing (£2.7m identified to date) – various efficiencies relating to hospital prescribing are reported under this workstream, mainly relating to ongoing technical switches, off-patent benefits and a review of medicines of low clinical value (eg Lidocaine patches). New stock management arrangements (in terms of taking advantage of prompt payment discounts and reducing off contact spend) alongside a review of the technical accounting treatment of price changes are also included for 2025/26.

- Estates & Infrastructure (£4.4m identified to date) – a range of savings schemes are reported under this workstream, mainly carried forward from 2024/25 relating to energy efficiency, PFI contractual arrangements, non-emergency patient transport and postage.

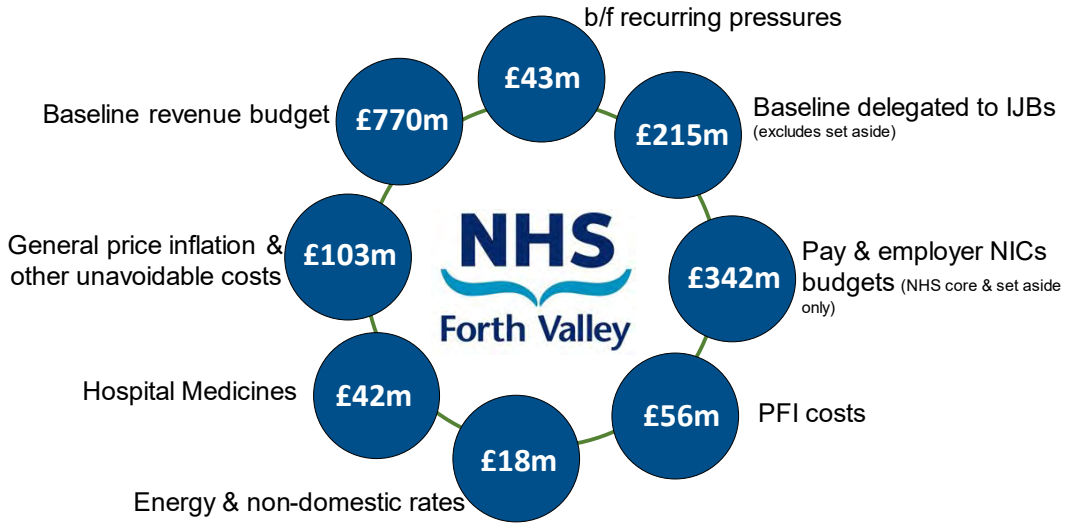
- Service redesign & reform (£11.4m targeted to date) – a range of savings plans linked to the 15 box grid are reported here, including service optimisation initiatives related to theatre efficiency, improving remote outpatient appointment uptake and digital innovation opportunities. However, the most significant element of the savings targeted under this workstream are expected to be delivered through service redesign as part of the roll out of the wider VBHC programme.

- Non-pay & other measures (£8.7m identified to date) – this workstream is comprised of a number of largely non-recurring measures and estimates arising from potential fortuitous changes in financial planning assumptions and slippage on investment and service developments.

- Savings under development (£4.0m to be confirmed) – these savings have still to be fully identified.

6. Three-year revenue projection

Based on the financial planning assumptions set out in this document, the total revenue baseline budget available to the NHS Board in 2025/26 equates to £770m. A summary of the key metrics relating to this budget is illustrated below:



When assessing the available budget, together with the impact of recurring pressures and unachieved recurring savings carried forward from prior years, an underlying recurring deficit of £49.2m has been identified for 2025/26 (6.4% of our baseline RRL), reducing to £47.4m in 2026/27 and £36.4m in 2027/27 as summarised in table 2 below (see further details in appendix B):

Table 2: 3 year revenue projection	2025-26			2026-27			2027-28		
	Rec £m	Non-Rec £m	Total £m	Rec £m	Non-Rec £m	Total £m	Rec £m	Non-Rec £m	Total £m
Financial gap before savings	(49.155)	11.120	**(38.035)**	(47.423)	(1.746)	**(49.169)**	(36.395)	(0.605)	**(37.000)**
Savings plans/ targets	19.000	19.035	**38.035**	30.000	12.000	**42.000**	36.000	1.000	**37.000**
Residual deficit	**(30.155)**	**30.155**	**0.000**	**(17.423)**	**10.254**	**(7.169)**	**(0.395)**	**0.395**	**0.000**

The scale of the financial pressure we are facing over the next 3 years is unprecedented and given the nature of the current financial environment and operating context, it is recognised that it will be extremely challenging to deliver recurring financial balance by the end of the 3-year term without fundamental service redesign and reform. The VBHC programme will inform this essential redesign work.

The scale and recurring nature of the overall savings requirement over the 3-year term of the plan means that the VBHC programme must be delivered at pace, with appropriate leadership and operational capacity to drive forward progress. As highlighted in section 4.3, funding has been secured from the Scottish Government to support this, together with external support from NES and HIS.

7. Three-year capital projection

The core Capital formula allocation is assumed at £6.7m pa for the for the duration of the 3-year plan and is expected to be supplemented by additional anticipated allocations relating to property sales and the return of banked monies linked to slippage on various projects from prior years (eg delays in implementing the national Laboratory Information Management System). Note that no additional funding is assumed from the National Infrastructure Board at this stage.

Key investments been prioritised in the following areas:

- Information Management and Technology to support software replacement and upgrades, introduction/replacement of new national and local systems and various digital innovation developments (including netcall and electronic patient records).
- Medical Equipment: on new and replacement key medical equipment items as advised by the Medical Devices Group and prioritised in line with the agreed rolling replacement programme.
- Facilities and Infrastructure: to support a range of projects aimed at statutory compliance (an estimate for the required anti ligature works across the estate as per the recent Health and Safety Executive improvement notice has been included in 2026/27 and 2027/28), backlog maintenance, energy efficiency and a limited range of premises improvements.

- Board wide/corporate projects: a contingency balance is being held for 2025/26 pending confirmation of the outcome of the Business Continuity Plan submission and associated funding request.

A summary of the 3-year projection is outlined in table 3 below (see further detail in appendix C):

Table 3: NHS Forth Valley 3-year capital projection	**2025/25 £m**	**2026/27 £m**	**2027/28 £m**
Capital Resource Limit (CRL)	6.701	6.701	6.701
Anticipated CRL allocations	0.855	0.260	
Sale of property proceeds	1.500		0.500
Total estimated Capital funding	**9.056**	**6.961**	**7.201**
Planned expenditure			
IM&T	3.945	2.497	2.277
Medical Devices	1.379	2.230	3.285
Estates & Facilities	2.110	2.234	1.639
Board/Corporate projects & contingency	1.622		
Total estimated capital expenditure	**9.056**	**6.961**	**7.201**
Projected surplus/(deficit)	**0.000**	**0.000**	**0.000**

In addition to the above, a separate Business Continuity Plan (BCP) has been submitted to the Scottish Government in line with the new NHS Scotland strategic infrastructure planning and investment process seeking capital funding of £10.4m over the next 3 years.

The BCP submission is primarily a maintenance-only plan based on a risk-based assessment of the Board's existing infrastructure and covers 24 key projects (including the technical accounting treatment relating to right of use assets and an estimate in 25/26 for immediate anti-ligature works). A high-level summary is provided in table 4 below. The Scottish Government have not confirmed whether the funding is likely to be available and we await formal feedback on our submission.

Table 4: NHS Forth Valley BCP submission	**2025/25 £m**	**2026/27 £m**	**2027/28 £m**
Funding requested:			
Information Management & Technology	1.210		
Medical Equipment	0.500		
Facilities & Infrastructure	5.200	1.500	0.400
Board wide /corporate	0.100	0.688	0.811
Total as per BCP submission	**7.010**	**2.188**	**1.211**

8. Key risks

In light of the scale of the financial challenge described in this document, together with ongoing uncertainty linked to the current economic climate, financial sustainability continues to be reported as very high risk in our strategic risk register.

Specific risks associated with the 3-year financial plan include:

- Our ability to fully identify and deliver the level of recurring savings required in 2025/26 and beyond to address the underlying deficit and return to recurring financial balance by the end of 2027/28.

- Potential delays in delivering efficiency savings due to the lead in time necessary to develop and implement the associated project plans, coupled with the limited availability of key staff to drive progress if they continue to be required to focus on immediate front-line service and capacity pressures.

- Workforce pressures, including the uncertainly regarding the financial impact of safe staffing legislation, ongoing AfC reform, the increase in employers National Insurance Contributions (including the knock on impact to independent contractors and providers) and pay awards. Recruitment and retention challenges may also impact on our ability to successfully implement our workforce plan and service delivery plan, resulting in continued use of temporary bank and agency staffing solutions.

- Ongoing delays in implementing exit strategies in respect of unfunded service areas (including Covid legacy costs, historic unfunded posts alongside the cumulative burden of a number of unfunded national policy commitments).

- Ongoing whole-system capacity and workforce pressures across the entire health and social care sector is likely to continue which will impact on our ability to close contingency beds.

- Ongoing uncertainty regarding price inflation which will have a direct impact on the cost of goods and services (particularly in relation to contracts which are linked to the Retail Price Index). A number of national contracts in respect of IT and other managed service contracts are also expected to incur significant cost increases.

- Affordability challenges regarding the introduction of new drugs and therapies leading to increased treatment costs and demand over and above initial planning assumptions (particularly in relation to GLP1/GIP medicines for the treatment of obesity and ongoing uptake of diabetes technologies).

- Financial pressures associated with the disproportionately high prison population in Forth Valley and the impact of decisions taken out with our control by the

Scottish Prison Service (eg SPS have recently increased the number of prisoners in HMYOI Polmont and HMP Glenochil as part of measures to alleviate overcrowding across other parts of the Scottish prison estate – we are not staffed or funded to accommodate this change).

- IJB risk sharing arrangements in terms of overall affordability to the NHS Board and Local Authority partners of any potential additional non-recurring payments to IJBs in 2025/26 and beyond.

- Lack of funding to progress major capital investment priorities including the redevelopment and modernisation of our Primary Care estate and Falkirk Community Hospital, combined with uncertainty regarding approval of funding requested through the BCP process.

9. Appendix A: 2025/26 Financial Sustainability Action Plan

Financial Sustainability Action Plan (Set Aside & NHS Core only)	Rec £000s	Non-Rec £000s	Total £000s	RAG Status	Comments/Status
15 Box Grid: Innovation & Value-Based Healthcare					
1. Medicines of Low Clinical Value	0	0	**0**		Majority of the spend on this item falls under the HSCPs however there is a small element in Acute that is currently being reviewed in respect of Lidocaine (£100k). Saving TBC following feed back from Clinicians.
2. Clinical Variation Review	0	0	**0**		
3. Digital savings	142	250	**392**	GREEN	Includes savings from implementation of netcall patient hub expected to go live at end March, plus voice recognition business case.
4. Energy Efficiency Schemes	665	0	**665**	GREEN	Reflects a number of planned savings from energy efficiency initiatives eg installation of LED lighting, insulation, PV panels etc across the estate.
5. Prescribing savings	2,608	100	**2,708**	AMBER	Includes a range of routine technical switches & off patent benefits in hospital prescribing. Amber status reflects potential delays with certain switches where the generic is not available due to manufacturing issues/short supply or ongoing legal challenges re patent exclusivity.
Sub total	3,415	350	**3,765**		
15 Box Grid: Workforce Optimisation					
6. Agency Reduction	540		**540**	RED	Potential invest to save is under development in relation to Acute Medical & Ageing & Health receiving front door rotas & the associated medical cover required in relevant downstream wards. Further work required to fully quantify savings & SPRIG approval. Red status reflects the fact that this is not approved as yet.
7. Sustainable staff bank usage	4,869	80	**4,949**	GREEN	Saving reflects the agreed nurse bank target reduction of 50% by 31 March is delivered (saving assumes reduced bank rates at Dec 24 hold for 25/26).
8. Sickness absence reduction	0	0	**0**		TBC - note that there will be an element of double count with scheme 8 above.
9. Non-compliant rotas review	0	0	**0**		TBC - current financial pressure estimated at £1.044m (based on 6 non-compliant rotas in 24/25)
10. Central functions job family review	0	0	**0**		TBC - HR are leading work to assess Corporate Support Functions with a view to identifying actions to ensure we are utilising our workforce resources in the most effective way. Recommendations from this work will inform further actions.
Sub total	5,409	80	**5,489**		
15 Box Grid: Service Optimisation					
11. Theatres optimisation	500	0	**500**	AMBER	Project underway, digital theatre scheduling tool already in place for 3 specialties & review of processes to reduce downtime & improve efficiency in colorectal and orthopaedic procedures. Saving reflects Scottish Government figures - amber status reflects the fact that this may not be cash releasing - still to be fully quantified.
12. Remote outpatient appointments	1,909	0	**1,909**	RED	Saving based on Scottish Government figures linked to increased uptake of remote outpatient appointments & considering opportunities where this could improve efficiency, reduce travel costs, reduce DNA rates & reduce emissions through less travel. Red status reflects the risk that may not be cash releasing - still to be fully quantified.
13. PLICS roll out	0	0	**0**	GREEN	No immediate cash releasing savings. Implementation plan is underway.
14. Length of stay reductions	0	0	**0**		Weekly length of stay meetings are being facilitated for all services / wards with MDT attendance. Hospital Flow Service Manager is working whole system to identify & manage opportunities to support reduction in length of stay and reduce delayed discharges. Saving TBC.
15. Non-pay spend review	220	1	**221**	AMBER	Includes a range of CITF buyers guides in respect of national contracts for wound care products, advertising, stationery & general & clinical waste bags . Amber status reflects potential risk re capacity & lead in time to implement.
Sub total	2,629	1	**2,630**		
Total 15 Box Grid	**11,453**	**431**	**11,884**		
Other local savings plans					
Workforce		1,000	1,000	GREEN	Saving reflects routine slippage on recruitment
Estates & Infrastructure	2,832	950	3,782	AMBER	Includes PFI insurance rebates, review of PFI energy contract process & review of PFI contract specifications. Amber status reflects the requirement for contract negotiations & associated approvals.
Service redesign & reform	2,265	6,338	8,603	RED	Reflects exit strategies in relation to unfunded service areas eg linked to Covid legacy service models & costs & service redesign through the VBHC programme. Red status reflects the fact the VBHC programme hasn't started as yet.
Non-pay & other measures	1,450	7,281	8,731	AMBER	Includes anticipated slippged on planned investment, technical accounting opportunities & changes in/ongoing review of financial planning assumptions (eg CNORIS contributions). Amber status relicts uncertainty at this early stage in the financial year.
Savings under development	1,000	3,035	4,035	RED	Savings still to be identified in order to deliver a break-even position.
Total other local savings plans	**7,547**	**18,604**	**26,151**		
GRAND TOTAL	**19,000**	**19,035**	**38,035**		

10. Appendix B: 3-year revenue projection

3 year revenue projection	Year 1 (2025/26)		Year 2 (2026/27)		Year 3 (2027/28)	
	%	Total £m	%	Total £m	%	Total £m
Funding						
Base Uplift	3.00%	21.744	3.00%	22.840	3.00%	23.525
NRAC	0.72%	5.216	0.00%	0.000	0.00%	0.000
Employers National Insurance		5.744		0.000		0.000
Sustainability Payment recurring		3.829		0.000		0.000
Sustainability Payment non-recurring		13.675		0.000		0.000
Elective Capacity Development SEU-FV		9.549		9.740		9.740
New Medicines Fund (NRAC share of £250m)		13.675		13.675		13.675
Total Resource Increase		**73.430**		**46.255**		**46.940**
Costs						
Brought forward pressures		42.821		30.166		17.434
Pay & Prices Inflation						
Pay Inflation - Agenda for Change	3.07%	5.345	3.10%	5.554	3.09%	5.720
Pay Inflation - Medical	3.02%	2.163	3.05%	2.248	3.05%	2.315
Pay Inflation - Senior Managers	3.02%	0.061	3.05%	0.063	3.05%	0.065
Pay Inflation - Other	3.02%	0.210	3.05%	0.218	3.05%	0.225
General Price Inflation	2.28%	1.002	3.00%	1.350	3.00%	1.390
General Income Inflation	0.00%	0.000	0.00%	0.000	0.00%	0.000
Unitary Charge Inflation	3.20%	1.778	4.00%	2.283	4.00%	2.373
Energy	-19.00%	(2.285)	10.00%	0.974	10.00%	1.072
Rates	5.00%	0.372	5.00%	0.391	5.00%	0.410
Resource Transfer	3.00%	0.000	3.00%	0.000	3.00%	0.000
Voluntary Bodies / other providers	3.00%	0.015	3.00%	0.016	3.00%	0.016
External CBF Outflow	3.00%	2.643	3.00%	2.762	3.00%	2.887
External CBF Inflow	3.00%	(0.465)	3.00%	(0.479)	3.00%	(0.493)
Hospital Drugs	10.00%	3.430	10.00%	3.773	10.00%	4.150
HSCP Set Aside Inflation	3.00%	2.393	3.00%	2.465	3.00%	2.539
Clacks/Stirling HSCP baseline inflation - Operational & Universal	3.00%	2.790	3.00%	2.874	3.00%	2.960
Falkirk HSCP baseline Inflation - Operational & Universal	3.00%	3.115	3.00%	3.208	3.00%	3.305
HSCP baseline funding still to be allocated	3.00%	0.368	3.00%	0.380	3.00%	0.391
Other Inflation		1.534		1.647		1.719
Other Pay & Prices		12.124		0.958		0.984
Agenda for Change Pay Reform		0.000		0.000		0.000
Drugs and Medicines		13.839		15.059		15.197
eHealth		1.788		0.190		0.045
Property		0.522		0.000		0.000
Capacity & Flow (SEU-FV)		9.549		9.740		9.740
Regional Issues		3.132		0.243		0.098
National Strategy / Policy Impact		0.835		0.456		0.463
Demographic Change		0.000		4.500		5.000
Non Demographic Growth		0.000		3.250		3.750
Local Developments/ Investments/ Initiatives		1.641		1.145		0.249
New & Emerging Pressures		0.743		(0.008)		(0.065)
Partnership Risk Share		0.000		0.000		0.000
Total cost increase		**111.465**		**95.424**		**83.939**
Net Savings Requirement		(38.035)		(49.169)		(37.000)
Estimated Savings Delivery		38.035		42.000		37.000
Net Gap		0.000		(7.169)		0.000

11. Appendix C: 3-year capital projection

	2025/26	2026/27	2027/28
SOURCES OF GENERAL FUNDING	**£'m**	**£'m**	**£'m**
Scottish Government General Allocation	6.708	6.708	6.708
SGHD - Improving Access to Elective Care			
SGHD - LIMS Implementation	0.056	0.260	
SGHD - Projects C/Fwd From 2024/25	0.799		
SGHD - Capital Grants - Revenue to Capital			
SGHD - Indirect Capital Exp. Charged to Revenue	-0.900	-0.600	-0.600
SGHD - Asset Sales Retained	1.500	0.000	0.500
Total Net Core Capital Resource Limit	**8.163**	**6.368**	**6.608**
PLANNED CAPITAL EXPENDITURE	**£'m**	**£'m**	**£'m**
Elective Care			
Information Management & Technology	3.945	2.691	2.355
Medical Equipment	1.379	2.230	3.285
Facilities & Infrastructure	2.110	2.234	1.639
Capital Grants & Capital to Revenue	-0.900	-0.600	-0.600
Board wide/corporate & contingency	1.629	-0.186	-0.071
Total Capital Expenditure	**8.163**	**6.368**	**6.608**
Balance Available / (Required)	**0.000**	**0.000**	**0.000**
Memorandum - Forecast Property Sales	**2025/26**	**2026/27**	**2027/28**
Bellsdyke Land			0.500
Surplus Stirling Royal Infirmary Site Land	1.500		
Total Forecast property Sales	**1.500**	**0.000**	**0.500**

Annex – 15 Box Grid requirements in 2025-26

Innovation and value-based healthcare			
Area		**Action required**	**More information**
1	Sustainable Prescribing	1. Implement pathway development to increase and mainstream polypharmacy reviews in line with findings from iSIMPATHY and polypharmacy guidance. 2. Optimisation preventative therapy for asthma care, reducing overuse of short-acting beta agonist inhalers. 3. Enhance Planned Preventative Maintenance on all piped medical gases to mitigate system loss and improve medical gas management. 4. Minimise patient stockpiling using patient advice and education.	Benchmarking will be available in the 15 Box Grid benchmarking pack. Polypharmacy reviews must be consistently coded in line with guidance. Refreshed guidance will be published shortly. New guidance on medical gas management to be released summer 2025. Boards should review NHS Dorset model to minimise patient stockpiling and monitor impact.
2	Clinical Variation Review	1. Once available, implement the refreshed guidance to ensure appropriate access to Procedures of Limited Clinical Value ('PLCV'). 2. Engage with Centre for Sustainable Delivery on Patient Initiated Review (PIR) and Active Clinical Referral Triage (ACRT) and Opt-in pathways. 3. Develop and implement a local Realistic Medicine action plan for 2025-26. 4. Review available resources to identify and reduce unwarranted variation.	Refreshed Exceptional Referral Protocol guidance for PLCV to be published in Spring 2025. Quarterly information will be collected from Centre for Sustainable Delivery in relation to number of appointments released through ACRT & PIR. Realistic Medicine Action Plans should be delivered in accordance with NHS Scotland's Chief Medical Officer's Annual Report. Resources include Public Health Scotland Atlas of Variation Reports, Discovery dashboards, and Chief Medical Officer's Annual Report (linked above).
3	Digitally Enabled Savings	1. Review options to continue to reduce printing and posting costs through, for example, increasing take up of e-payslips, sending letters digitally and using automation to reduce manual time.	Benchmarking will be available in the 15 Box Grid benchmarking pack.

		2. Conduct a review to identify digital savings opportunities and share nationally, leaning on the national eHealth Leads Finance Group. 3. Remain aware of development in the national Operational Delivery Group for M365, developing local plans for implementation and benefits realisation.	
4	Energy Efficiency Schemes	1. Implement best practice across estates, including switching off lights, Anaesthetic Gas Scavenging Systems (AGSS), and Heating, Ventilation and Air Conditioning (HVAC) outside working hours. 2. Set multi-year targets and progress work to deliver a 30% reduction in the total weight of clinical waste (yellow and orange). NHS Boards should be actively reviewing waste data for opportunities. 3. Urgently embed waste segregation across all theatres.	Boards should consult the MRI Energy Portal (more information on the portal can be provided by the FDU). Boards should use the invoice data from clinical waste supplier invoices.
5	Prescribing Savings	1. Ensure medicine switches are implemented as soon as possible once the originator medicine has lost exclusivity and a generic/biosimilar alternative is clinically appropriate and provides more value for money. 2. Boards should implement Medicines of Low and Limited Clinical Value guidance, including: • appropriate IV to oral switches • appropriate liquid to tablet/capsule switches • optimise course length of prescribed medicine (i.e. 5 day antibiotic prescribing for lower respiratory tract infections)	Available switches are outlined in the quarterly NSS Medicines Procurement Newsletter. Biosimilar uptake is shared within 15 Box Grid benchmarking packs. National uptake of medicines switches are monitored by National Procurement. Spend on Medicines of Low and Limited Clinical Value will be tracked on a quarterly basis.
Workforce optimisation			
Area		**Action required**	**More information**

6	Agency Reduction	1. Boards should continue to review staffing establishments to plan for current and future workforce needs. 2. Ensure ongoing compliance with agency controls and best practice as identified by the Supplementary Staffing Task & Finish Group and the Medical Locum Engagement Task and Finish Group. 3. Where possible, Boards should implement additional recruitment and capacity building measures (e.g.) international medical recruitment. 4. Adopt direct engagement for, at least, medical locums and Allied Health Professions ('AHPs'). Where possible this should be extended further to other staffing areas.	Bank and agency usage will be regularly monitored and will form part of quarterly finance reviews. Direct engagement uptake will be monitored through Financial Performance Returns.
7	Sustainable Staff Bank Usage	1. Ensure best practice checklists are used for staff bank recruitment. 2. Use national staff bank marketing materials. 3. Develop bank facilities for the AHPs and medical workforce where this does not currently exist.	Staff bank practice checklists can be shared by the FDU. Staff Bank National Marketing Materials are available on TURAS.
8	Sickness Absence Reduction	1. Implement the Once for Scotland (OfS) absence management policies by employers. Boards must ensure adherence to policies and compliance with the Staff Governance Standard. 2. Ensure regular reporting on areas of concern on sickness absence are discussed at Board meetings with improvement plans agreed and set into action.	An Absence Analysis Report will shortly be available on TURAS. Colleagues from the FDU will share as soon as possible.
9	Non-Compliant Junior Doctor Rotas Review	1. Reduce number of non-compliant Junior Doctor rotas in 2025-26 vs. 2024-25.	The FDU will gather quarterly spend data which will be shared within 15 Box Grid benchmarking packs.

		2. Establish drivers of non-compliant rotas at local level and ensure non-compliant rotas are challenged where appropriate. 3. Create an action plan to reduce non-compliant rotas within existing frameworks and T&Cs, including robust job planning processes.	
10	Central Functions Job Family Review	1. Implement a plan to rationalise WTE in central functions job families. The plan must work within NHS Scotland's employment terms and conditions and consider: • Effective vacancy panels. • Skills mix and grade profile. • Opportunity to automate roles • Shared services between Boards	Central functions should align with the definition found on TURAS. The FDU will provide frequent updates through the 15 Box Grid benchmarking pack.
Service optimisation			
Area		**Action required**	**More information**
11	Theatres Optimisation	1. Review specialties with highest inefficiency at appropriate local meetings and set an action plan to improve. 2. Complete implementation of digital theatre scheduling tool before the end of December 2025. Roll out to two specialities and develop a local plan for rollout to all surgical specialities.	More information can be found on Discovery and will be shared via 15 Box Grid benchmarking packs.
12	Remote Outpatient Appointments	1. Continue adopting digital first options to deliver care, with an emphasis on enhancing productivity and reducing costs. E.g. utilisation of national services such as Near Me and Connect Me.	More information can be found on Discovery and will be shared via 15 Box Grid benchmarking packs.
13	PLICS Roll Out	1. Adhere with national timelines set by the FDU.	Guidance and information on timelines can be provided by the FDU.
14	Length of Stay Reductions	1. Review specialties with the highest lengths of stay and understand from service managers what	More information can be found on Discovery and will be shared via 15 Box Grid benchmarking packs.

		corrective action can be taken. E.g. integrated planned date of discharge process and practice, compliance with discharge before noon rates, and planned discharge dates.	
15	Non-pay Spend Review	1. Ensure Buyers' Guides issued by NSS National Procurement are fully considered and implemented. 2. Review non-pay spend to identify and remove any unwarranted variation to be shared across NHS Scotland.	Buyers Guide implementation will be discussed at quarterly finance meetings.

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

11. Draft NHS Forth Valley Corporate Objectives
For: Approval

Executive Sponsor: Professor Ross McGuffie, Chief Executive
Author: Mr Kevin Reith, Director of People

Executive Summary
The NHS Forth Valley Corporate Objectives reaffirm our ambition and purpose as an organisation, setting out the response to key priorities for NHS Forth Valley in 2025/2026. They are aligned with our first 3-year Delivery Plan which delivers against Planning Priorities detailed in Scottish Government Guidance and provides the link between national and local context. The Corporate Plan also refers to our corporate objectives and how they support the wider NHS Forth Valley vision and aim, aligning with NHS Scotland Values.

Recommendation
The Forth Valley NHS Board is asked to:

- **approve** the Corporate Plan which also set out the Health Board's vision and corporate objectives for 2025/26.

Key Issues to be Considered
The Health Board annually revisits its corporate objectives (in line with national policy) to provide direction for staff whilst promoting action towards goal-related activities and behaviours that align with our values. Staff will be supported when developing and agreeing their objectives and personal development plans to which they will be held to account for.

Taking cognisance of the Corporate Objectives, the SLT in setting team and personal objectives is asked to consider SMART objectives (Specific, Measurable, Achievable, Relevant, and Time-Bound) supporting the creation and delivery of goals in line with NHS Forth Valley's priorities.

Implications

Financial Implications
There are no direct financial implications associated with this paper.

Workforce Implications
The paper supports the outcome of championing a culture where staff feel valued, safe and have a voice, which sits under the 'Collaborative' corporate objective – 'Work collaboratively across our Whole System to improve population health.'

Infrastructure Implications including Digital
No infrastructure implications identified**.**

Sustainability Implications
Our commitment to Climate Change and Sustainable is incorporated within our priorities with particular emphasis under the Transformation and Stewardship themes.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process A policy for NHS Scotland on the climate emergency and sustainable development.
☒ Yes
☐ N/A

Quality / Patient Care Implications
This paper supports the outcome of ensuring safe, high quality and sustainable patient care, which sits under the 'Transformation' corporate objective – 'Redesign health and care to create a future-ready system that supports evolving or changing ways of working.'

Information Governance Implications
No Information Governance implications identified.

Risk Assessment / Management
Objective setting contributes to improved alignment of Board strategic direction and staff engagement in supporting overall improved performance - helps minimise risks at operational and strategic levels.

Relevance to Strategic Priorities
This paper refers to both the strategic priorities of the Board and proposes the corporate objectives for the year ahead.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process. Through delivery of our corporate objectives we aim to ensure that equality & inclusion is incorporated within the strategic objectives and is seen as everyone's responsibility throughout the organisation.

Further to an evaluation it is noted that:

- Screening completed - no discrimination noted. Assessment of equality impact will be a continued feature of the delivery of our Corporate Objectives.

Communication, involvement, engagement, and consultation
Corporate objectives and the need to present these annually to the Board for approval has been discussed at the SLT and presented to the Strategic Planning, Performance and Resources Committee for comment and endorsement prior to approval by the NHS Forth Valley Board. A commitment has been made to support the roll out of the objectives notably to support Team and individual objective setting and will be a key feature in SLT priorities for the year ahead.

Additional Information
N/A

Appendices

- Appendix 1 - NHS Forth Valley Corporate Objectives 2025/2026

Appendix 1: NHS Forth Valley Corporate Plan 2025-26

1. Introduction

This Corporate Plan sets out the response to key priorities for NHS Forth Valley in 2025/2026. It is aligned with our Delivery Plan 2025/26 which sets out our planning priorities as detailed in Scottish Government Guidance and provides the link between the national priorities of the Scottish Government and NHS Scotland as a whole and NHS Forth Valley's strategic context and priorities.

The Delivery Plan includes key deliverables linked to patient facing core services and corporate business functions.

- Core Services
- Planned Care
- Urgent and Unscheduled care
- Cancer care
- Mental Health
- Primary and Community Care
- Women and Children's Health
- Population Health and Reducing Health Inequalities

Corporate Business Functions

- Finance, Infrastructure and Value Based Health and Care
- Workforce
- Digital and Innovation
- Climate

2. Our Purpose and Priorities

Effective NHS Boards articulate an ambition for their organisation whilst managing the risk contained within that ambition and demonstrating leadership by undertaking 3 key roles:

- Formulating strategy for the organisation, including the development of a Delivery Plan that also focuses on the long term.
- Ensuring commitment and accountability by holding the organisation (all staff) to account for performance and the delivery of both improvement in population health, individual experience of care whilst operating with a context of affordability and sustainability.
- Shaping a positive and compassionate culture (open, just, and fair) for the Board and organisation.

In Forth Valley, we embrace the roles outlined above whilst at the same time being informed by -

- the external context within which we operate.
- the intelligence which provides trend and comparative information on how our Board is performing.
- dialogue and engagement with our patients, staff, partners, and the people of Forth Valley, using a whole-system approach.

Our Vision is 'To improve the health and wellbeing of everyone living in Forth Valley by preventing people from becoming unwell, reducing inequalities and making the best use of the resources available to achieve better outcomes.' As a Population Health and Care organisation, we want to improve the health and wellbeing of everyone living in Forth Valley by focusing not just on care and treatment, but on how we can help prevent people from becoming ill in the first place. We aim to achieve this by taking a Value Based Health and Care approach to the design and delivery of local health services to ensure that we focus our resources on the areas that will achieve the greatest impact and outcomes within the funding available.

This approach, which builds on the principles of Realistic Medicine, will help manage demand and help us achieve greater financial sustainability in the longer term. This requires health and social care staff, primary care colleagues and partners to work together to achieve joint health priorities and outcomes rather than working in individual organisational or service silos, recognising the many wider social and lifestyle factors which have an impact on an individual's health and wellbeing.

Our Population Health and Care Strategy will set out our plans and priorities for the next decade to achieve a healthier population, take account of an ageing population, a growing gap in life expectancy between the poorest and the wealthiest, and that people are spending more of their life in ill health. With these growing challenges, innovation and different approaches to how we deliver health and care services will be essential and understood by all, with a key focus on increasing and embedding prevention activities which are proven to be effective across the health and care The ongoing cost of living crisis and the focus on climate change has informed the Board's continued commitment to sustainability and to reforming the services we provide, to improve the health and wellbeing of the people who live and work in Forth Valley.

The two local Integration Joint Boards will continue to play a key role in commissioning services in ways that support people to stay and keep well in their own homes and/or communities and we remain committed working with a range of partners to deliver improved outcomes for the people of Forth Valley.

3. Our Corporate Objectives

Every year, the Board review and approve its corporate objectives. These objectives are intended to inform team and individual objectives for the year ahead. Table 1 below sets out our corporate objectives for 2025/2026 and illustrates how they support the overall NHS Forth Valley vision and aim, aligned with NHS Scotland values.

Table 1. Corporate Objectives 2025/2026

Vision	**Life Changing Transformation for Better Health, Care and Wellbeing.**			
NHS Scotland Values	Care and compassion; dignity and respect; openness, honesty and responsibility; quality and teamwork.			
NHS Forth Valley	To improve the health and wellbeing of everyone living in Forth Valley by preventing people from becoming unwell, reducing inequalities and making the best use of the resources available to achieve better outcomes			
Corporate Objectives	**Collaboration** We will work collaboratively with staff, primary care colleagues' partners and our communities to improve the health and wellbeing of local people. .	**Transformation** We will reform and redesign the way we deliver health and care services to meet current and future challenges.	**Stewardship** We will take collective responsibility for ensuring that we stay within our budget and that the resources available are used effectively to deliver long-term financial sustainability	**Outcomes** Focus our services, funding and efforts on the areas which will achieve the greatest impact, benefits and outcomes to improve the health and wellbeing of our whole population
Deliverables	Greater collaboration with partners and communities across Forth Valley. Integrated and aligned goals and governance arrangements	Reduced reliance on hospital-based care, through greater investment in preventative and proactive community care services I supported by a skilled workforce Ongoing investment in digital technology and innovation to support improvements across our health and care system.	Greater financial sustainability and reduced waste through programmes to increase efficiency and innovation Improved health outcomes and patient experience through the best use of our available resources	Reduce health inequalities reflecting the diversity of our communities. Improve health and wellbeing outcomes to ensure the best start for children and young people.

	More integrated services locally and regionally. Staff feel more valued and involved and are empowered and given more opportunities to contribute Create an environment where diversity is valued, and people are treated with respect. Improved health and wellbeing of staff, patients and the wider community.	Increased focus on the delivery of safe, high quality and sustainable patient care through the outcomes of the Patient Safety Collaborative. Reduce the levels of disease and premature death through targeted action and investment to address health inequalities, increase prevention programmes, and improve uptake across local communities. Develop a wider understanding of the health needs of our population and communities. Demonstrate behaviours that nurture and support transformational change across our health and care system. Improved staff recruitment and retention through staff feeling valued, involved and empowered to make positive change	Shared decision making to inform plans and priorities. Improved health and wellbeing of the whole population. Reduce variation in prescribing and medical treatment with fewer procedures and medications of lower clinical value in line with national guidance and best practice.	Improve mental health and wellbeing in all ages. Improve patient safety outcomes with reduced rates of infection and adverse events. Improved access to services by considering the needs of our communities. Ongoing progress against the targets in our Climate Emergency & Sustainability Action Plan

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

12(a) Update on Communication Priorities – April 2025 – March 2026
For: Assurance

Executive Sponsor: Kevin Reith, Director of People
Author: Elsbeth Campbell, Head of Communications

Executive Summary
This paper provides an update on the key communication plans and priorities over the next year.

Recommendation
The Forth Valley NHS Board is asked to:
- **approve** the key plans and priorities outlined in this update

Key Issues to be considered
A number of specific communications plans are being taken forward over the next year to support wider organisational plans and priorities.

These include plans to support:-

NHS Reform
The First Minister announced on 27 January 2025 plans to protect, strengthen and renew services across NHS Scotland. These include specific plans in the following four key areas - improving access to treatment, shifting the balance of care, increasing the use of digital and technological innovations and preventing ill health. A summary of the key plans and priorities are outlined in appendix one.

These plans set out a number of priorities which all NHS Boards are required to deliver over the next year as well as a several specific priorities for NHS Forth Valley. These include:-

- **Providing additional planned activity** – NHS Forth Valley will be required to deliver a share of the additional 150,000 extra appointments and procedures in 2025/26, supported by increased National Treatment Centre activity.

- Ensuring 95% of **radiology referrals** are seen within six weeks by March 2026

- Introducing a new **Rapid Cancer Diagnostic service** in Forth Valley for patients with non-specific symptoms of cancer (the six service of its kind in Scotland)

- Providing access to a **Frailty team** in our Emergency Department by summer 2025.

Work to support the NHS Scotland reform agenda and highlight progress in delivering these national these key priorities locally in NHS Forth Valley will be a key communication priority over the next 12 months.

Population Heath and Care Strategy – work will be undertaken to support the development and publication of NHS Forth Valley's new healthcare strategy which will set out our plans and priorities to prevent ill health and improve care and treatment over the next 10 years. This will include work to raise awareness of and capture additional feedback on the draft strategy from

a wide range of stakeholders to inform the development of the final strategy which will be submitted to the Board for approval in Summer 2025.

Culture Change and Compassionate Leadership Programme (CCCL) – work continues to promote, encourage participation and highlight progress in the development and delivery of the CCCL programme. The focus for 2025/26 will be the implementation phase which includes the development and delivery of 8 key projects which reflect the key themes and priorities identified from the extensive feedback provided by staff, students and partners over the last 18 months. This will include regular updates on the changes and improvements being taken forward through the 8 new projects, along with details of the benefits and impact that the programme is making across the organisation.

Value Based Health & Care – work is underway to implement a Value Based Health and Care approach across all services over the next three years, in partnership with Health Improvement Scotland. This approach, which will underpin the delivery of the goals set out in our new Population Health and Care Strategy, aims to ensure we make the best use of the resources we have available to improve the health of all local people, achieve better outcomes for patients and deliver sustainable health services. An outline communication plan has been developed to support the rollout of the programme over the next 12 months.

Climate Change and Sustainability – work continues to reduce energy use, harmful emissions and waste across the organisation as part of wider efforts across NHS Scotland to respond to climate change. Good progress has been made in many areas and further action will be taken in the next three years as part of NHS Forth Valley Climate Emergency & Sustainability Strategy and Action Plan. This includes the transition to a fully electric vehicle fleet, adaptions to create more energy efficient healthcare buildings and work to highlight the difference individuals can make by taking simple steps at work and home to reduce our impact on the environment.

Equality and Inclusion – a new Equality and Inclusion Strategy is being produced which will set out the equality outcomes we aim to achieve over the next four years (2025 – 2029) to meet the needs of the diverse communities we serve. This will include details of initial equality objectives, developed in response to feedback from service users, local communities and staff. Initial priorities include work to develop an anti-racism plan to help tackle the impact on racism on staff, service users and health outcomes as well as work to reduce inequalities and improve the experience of people with diabetes, cardiovascular disease, mental illness and pregnant women. Service plans will be informed by Equality Impact Assessments (EQIAs), ongoing engagement and service user feedback to ensure local services continue to meet the needs of local patients and communities. The Communications Department will continue to work with NHS Forth Valley's Equality, Inclusion and Wellbeing Service to support the development of a number of staff networks and initiatives including the Ethnic Diversity Network. This will include raising awareness of a range of events and share staff stories to support greater awareness and understanding of the diverse range of cultures and religions across the organisation.

National Treatment Centre – Forth Valley – work continues with Forth Health, the contractor and NHS Scotland Assure to address the remaining outstanding technical issues relating to the pipework and fire compliance regulations for the new NTC inpatient ward. A potential solution to address these issues has been submitted to Falkirk Council's Building Standards and is currently under review. In the meantime, an interim NTC service is in place to support the delivery of additional orthopaedic operations for patients from other NHS Boards until the new NTC inpatient ward is operational. Once a solution has been approved and agreed by all parties, a detailed workplan will to be developed to take forward the required changes along with a timetable for the completion of this work. This will include a communication plan to

support the completion, commissioning and opening of the new national facility supported by a new NTC website.

Patient Hub – work is underway to roll out a new online system aims to provide a range of benefits to local patients by enabling them to manage appointments, keep in touch and complete any questionnaires or forms online, prior to attending their appointments. The Communications Department will continue to support the implementation of the new Patient Hub during 2025/26. This includes providing expert advice and guidance on the content and format of patient communications as well raise awareness of the new system as it is rolled out over the coming months. Work will also be undertaken to explore how these developments will tie in with and support national plans to introduce a new Health and Social Care app across NHS Scotland which will enable people to manage hospital appointments online, receive communications, find local services and access and update their personal information.

Prison Healthcare – work will be undertaken to highlight progress in ongoing work to further develop and improve healthcare in all three national prisons in the Forth Valley area. This will include work to respond to any recommendations from the prison inspections carried out by HM Inspectorate of Prisons for Scotland (including the report from the inspection of HMP Glenochil on 25 February 2025) and respond to the healthcare related recommendations from the recent FAI report on the deaths of Katie Allan and William Brown at HMP/YOI Polmont in 2018. A number of filming projects, which feature healthcare staff at HMP Stirling and HMP Glenochil, are also due to be broadcast during 2025/26.

Non-Executive recruitment – communication plans were developed and implemented over the last three months to support the recruitment of new Non-Executive Board members. The selection process is currently underway, and it is hoped that the new Board members will take up their roles in April 2025. Work will then commence on the recruitment process to appoint a permanent Chair and communication plans will be developed to support this, building on the work undertaken to recruit the recent Non-Executive Board members.

Patient and Staff Stories – plans have been developed to create a suite of patient and staff stories, linked to key plans and priorities as well as showcasing local service developments, innovations and improvements. These will be show at Board meetings during 2025/26 and also shared on the NHS Forth Valley website and YouTube channel.

Digital developments –digital versions of some of the most commonly used forms in the organisation, including those for payroll, HR and finance, have been created to help make it easier and quicker for staff to complete and submit information required. A number of digital forms have already been introduced, including ones which combine information from several separate forms to cut down on workload and duplication. Work will be undertaken with eHealth, HR and ICT colleagues during 2025/26 to explore opportunities to further streamline recruitment and HR processes. Efforts continue to develop and improve the range of content on the NHS Forth Valley web and intranet sites. This includes a new automated process to ensure services review and maintain content on a regular basis, the creation of additional information and resources to support people with dementia and their families and work to extend the content in the Learning Zone to support staff education and training. The Communications Department is also exploring how AI can support work in a number of areas include web and digital developments.

Social media – efforts to maintain and build our social media presence on existing social media channels as well as develop a presence on a number of new platforms, including Bluesky and Threads over the next 12 months.

Implications

Financial Implications
There are no specific financial implications in respect of this paper.

Workforce Implications
There are no specific workforce implications in respect of this paper.

Infrastructure Implications including Digital
The new Patient Hub will enable patients to manage their appointments, keep in touch and complete any questionnaires or forms online in advance. New digital forms will make it quicker and easier for staff to provide the information required by HR, finance and payroll by avoiding the need for these to be printed off, completed and scanned or posted to return.

Sustainability Implications
There are no specific sustainability implications in respect of this paper.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process A policy for NHS Scotland on the climate emergency and sustainable development. *(please tick relevant box)*

□ *Yes*
✓ *N/A*

Where applicable, the climate change, environmental and sustainability impacts and any mitigating measures are noted above/contained in the supporting papers.

Quality / Patient Care Implications
There are no specific quality or patient care implications in respect of this paper.

Information Governance Implications
There are no specific information governance implications in respect of this paper.

Risk Assessment / Management
There are no specific risks in regard to this report however it is recognised that effective communications play a vital role in educating, informing and reassuring local patients and members of the public who use our services. Honest, open and timely communications are also important to ensure staff are kept informed on any changes or issues which affect them, and that media receive the information they require to help achieve accurate, fair and balanced coverage. If NHS Forth Valley's communication plans and priorities are not aligned to strategic plans and priorities and do not respond to the changing needs of our staff, patients and the public then there is a risk to the organisation's reputation and credibility. This could result in a loss of trust and confidence in local services, reduce uptake and engagement with local services and impact on the wellbeing of local patients and staff.

Relevance to Strategic Priorities
Communication plans and priorities reflect the wider strategic and operational priorities of the organisation and the national priorities for NHS Scotland set out by the Scottish Government.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity

Communication, involvement, engagement and consultation
Where required, the action owners have reviewed and provided a progress update against the actions assigned to them. This update has been shared with Internal Audit colleagues.

Appendix 1

Improving Access to treatment

Operations and outpatient appointments deliver over 150,000 extra appointments and procedures in 2025/26 supported by a network of National Treatment Centres across Scotland

Radiology 95% of referrals to be seen within six weeks by March 2026, through seven day services, recruitment and use of mobile scanning units.

Cancer care - expanding Rapid Cancer Diagnostic services with the sixth service in Forth Valley opens in the Spring 2025 for those patients with non-specific symptoms of cancer.

Hospital capacity & flow - free up capacity and reduce occupancy levels to get our acute hospitals working towards an optimal level for quality and patient flow of 85%. This will include reducing delayed discharges, increasing the number of short stays and reducing people staying in hospital over 14 days.

Child and Adolescent Mental Health Services – meet the 18-week target nationally by December 2025 through a substantial increase in capacity, with 150,000 additional appointments per year.

Shift the balance of care

Hospital at home: we will expand the combined number of Hospital at Home and virtual beds to at least 2,000 by December 2026 or sooner if possible.

Frailty: direct access to specialist Frailty teams in every Emergency Department by summer 2025. This will enable people who experience frailty to be referred directly by GPs and the Scottish Ambulance Service to specialist frailty services as an alternative to admission or attending A&E

Primary Care increase the capacity in general practice to make it easier for people to get an appointment and develop a new quality framework in 2025 to make GP services more consistent across Scotland,

Eyecare deliver a new acute anterior eye condition service during 2025, which, together with the impact of the Community Glaucoma Service, when fully rolled out will free up a combined 40,000 hospital appointments per year.

Pharmacy: expand the NHS Scotland Pharmacy First Service so that community pharmacies can treat a greater number of clinical conditions, such as sinusitis and sore throats, and prevent the need for a GP visit.

Dentistry: targeted investment in the workforce to improve capacity and patient access in the short to medium-term, including a 7% increase in student numbers from September 2025 nad a review of existing incentives for rural practices

Digital and technological innovations

Dermatology – roll out a new Digital Dermatology Pathway in all GP practices across Scotland by Spring 2025.

Health and Social Care app - roll-out of a new Scottish health and social care app – a 'Digital Front Door from December 2025, starting in NHS Lanarkshire, so people can securely access and manage their hospital appointments online, receive communications, find local services and access and update their personal information.

Theatre capacity roll out a theatre scheduling tool that has been shown to increase productivity in operating theatres by 20% by June 2025.

Genetic testing – before the end of 2025-26 genetic testing will be used to deliver improved clinical outcomes and target medications, for recent stroke patients and newborn babies with bacterial infections.

Diabetes - support 3,000 people newly diagnosed with type 2 diabetes over the next three years with a new national digital intensive weight management programme to put their type 2 diabetes into remission.

Preventing ill health

Population Health - a new 10-year Population Health Framework will be published by Spring 2025

Health and social care reform plans – publish a medium term approach to health and social care reform before summer 2025 Parliament recess: This will set out how services will be planned for the whole population over the period 2025-2030.

Proactive prevention - invest in general practice and community-based teams to enable more proactive outreach in areas of greatest need and work with people who have a high risk of Cardio Vascular Disease (CVD) or frailty, to reduce their risk. Alongside this enhanced service commencing in April 2025, the wider CVD Risk Factors programme will support people to reduce key risk factors including high cholesterol, high blood sugar, obesity and smoking.

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

12(b) Participation and Engagement Strategic Framework - 2025 – 2028
For: Assurance

Executive Sponsor: Kevin Reith, Director of People
Author: Elsbeth Campbell, Head of Communications

Executive Summary

This Strategic Framework outlines NHS Forth Valley's commitment to working collaboratively with staff, patients, service users, partner organisations, local communities and other key stakeholders to plan, develop and improve local health services.

It provides examples of engagement underway across the organisation as well as outlining key plans and priorities for the next three years.

In addition, it highlights national standards and legislative requirements to help ensure best practice and increase the quality and range of engagement work undertaken across the organisation. These standards also aim to ensure a more inclusive approach to community engagement which takes account of the needs and preferences of stakeholders as well as the additional support which may be required to overcome any barriers to participation. An EQIA has been carried on the Framework and is attached for reference.

In addition, a more detailed version of this Framework has also produced for local staff which provides practical advice on planning effective engagement activities as well as details of key contacts across NHS Forth Valley, local Health and Social Care Partnerships and councils who can provide additional advice and support. This will help ensure a more joined up and coordinated approach to engagement, avoid duplication and make best use of the existing resources.

Recommendation
The Forth Valley NHS Board is asked to:

- **approve** the Participation and Engagement Framework (staff and public versions) and note the key plans and priorities highlighted.

Key Issues to be considered
Effective participation and engagement can result in significant benefits for the Health Board, local patients, staff and communities by: -

- Informing key plans and priorities
- Identifying individual and community healthcare needs, preferences and issues.
- Highlighting potential barriers and solutions
- Strengthening and influencing decision making

NHS Forth Valley engages with patients, partners and local communities through a range of forums, partnerships and engagement activities. Feedback is also captured and responded to directly in a range of ways including through patient surveys, events, inspections, Care Opinion, formal complaints and social media.

Implications

Financial Implications
There are no specific financial implications in respect of this paper however it is important to recognise that participation and engagement can lead to the delivery of more effective services and solutions which better meet the needs of local people. This in turn can help reduce costs and potential waste.

Workforce Implications
Staff and primary care colleagues have a role to play in ensuring patients are involved in decisions about their own care and treatment and have the opportunity to contribute to the design and delivery of local services.

Infrastructure Implications including Digital
A number of new digital developments will support participation and engagement activities including the development of a new Patient Hub within NHS Forth Valley and plans to roll out a new national Digital Front Door app which will enable people to access to access, self-manage, and contribute to their own health and care information online.

Sustainability Implications
There are no specific sustainability implications in respect of this paper although it is recognised that working collaboratively with partners on joint engagement events can help avoid duplication, save costs and avoid the need for people to attend multiple events.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process A policy for NHS Scotland on the climate emergency and sustainable development. *(please tick relevant box)*

□ *Yes*
✓ *N/A*

Where applicable, the climate change, environmental and sustainability impacts and any mitigating measures are noted above/contained in the supporting papers.

Quality / Patient Care Implications
Participation and engagement are key to the delivery of effective, person centred, high quality patient care.

Information Governance Implications
There are no specific information governance implications in respect of this paper.

Risk Assessment / Management
There are no specific risks in regard to this report however it is recognised that effective participation and engagement plays an important role in building trust with patients and local communities. If our patients are not involved in decisions which affect them there is a risk to the organisation's reputation and credibility. This could also result in a loss of trust and confidence in local services and impact on the wellbeing of local patients and staff.

Relevance to Strategic Priorities
Participation and engagement plans and priorities reflect the wider strategic and operational priorities of the organisation and the national community engagement and participation standards and guidance for health and social services.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:

- An EQIA has been carried on the Framework and is attached for reference - no negative or adverse impacts were identified and the Framework is expected to make a positive difference by helping to ensure that engagement activities carried out across the organisation meet the needs of patients, services users, community organisations and easy to miss groups.

- National Standards and guidance referenced in the Framework take account of relevant legislation, including those outlined in the Equality Act (2010); Public Services Reform (Scotland) Act 2010 and Patient Rights (Scotland) Act 2011.

Communication, involvement, engagement and consultation
The Framework has been informed by plans developed by other NHS Boards, HSCPs and councils as well as feedback from a wide range of departments and services across NHS Forth Valley including Public Health, Planning and Patient Relations.

Appendices
Appendix 1 – NHS Forth Valley Participation and Engagement Strategic Framework (Public)
Appendix 2 – NHS Forth Valley Participation and Engagement Strategic Framework (Staff)
Appendix 3 – Participation & Engagement Framework EQIA

Appendix 1

NHS Forth Valley

PARTICIPATION AND ENGAGEMENT FRAMEWORK

2025 - 2028

Introduction

NHS Forth Valley is committed to listening to and working with staff, primary care colleagues, patients, partner organisations and local communities to improve the way local health services are designed and delivered.

Effective engagement and participation are important to help identify potential issues and areas for improvement. We also know that by working together we can address some of the challenges we face, achieve better outcomes and improve the experience of people who use our services.

This Strategic Framework outlines our approach to engagement based on national standards for community engagement as well relevant legislative requirements to help ensure best practice.

A more detailed version of this Framework has also produced for local staff which provides practical advice and details of key contacts across NHS Forth Valley, local Health and Social Care Partnerships and councils to help ensure a joined up and coordinated approach to engagement.

The national Planning with People guidance also sets out how NHS Boards, Integration Joint Boards and local councils should involve people and communities throughout the development, planning and decision-making process for service change. This is particularly important when a proposed service change will have a major impact and there is a specific requirement for NHS Boards to formally consult on issues which are considered to be major service change. A full public consultation process is required and NHS boards' final recommendations for major changes are subject to Ministerial approval.

Benefits of Engagement

Effective engagement has several benefits including: -

- Strengthening and improving decision making
- Informing the development of key plans and priorities
- Identifying the needs of the local communities we serve
- Identifying potential issues and how these can best be addressed

Our Approach

When planning and carrying out engagement we aim to follow the National Standards for Community Engagement. These 7 good-practice principles are designed to help improve how we plan, implement and evaluate engagement activities to achieve the best outcomes.

Planning

Effective planning is vital to ensure any engagement undertaken has a clear purpose and aims and there is a shared understanding of what is being asked, why we are asking and how we will measure success

Inclusion

We are committed to providing opportunities for people to get involved with issues that affect or are important to them as we recognise this is vital to help people be more active in their care and treatment and to live healthier, happier and more fulfilling lives. We will achieve this by being as inclusive as possible and ensuring that individuals, groups and communities that may have an interest or be affected any proposed service developments or changes have an opportunity to contribute and share their views.

Support

We recognise that some patients and service users may require additional support or alternative ways to get involved or share their feedback. We will therefore seek to:-

- Understand and address any barriers which may prevent you from getting involved
- Connect with diverse and under-represented groups
- Use a range of methods and approaches to support greater participation.
- Support our staff to have meaningful conversations to help identify what matters most to you

Working Together

We will work closely with local partner organisations and communities across the Forth Valley area to achieve a more joined-up and coordinated approach to engagement. This will

help avoid duplication and make it easier for you to share feedback on a range of issues at a single event rather than having to attend several separate meetings or events.

Methods

We will use the most appropriate ways to engage with you and, wherever possible, offer a range of options and opportunities to participate and share feedback. We will also consider the format, timing and length of any planned activities to make it as easy and accessible as possible for people to attend.

Communication

Clear and timely communication is important to ensure local people, organisations and communities affected by any potential developments or changes are kept updated and have the opportunity to share their views. We will therefore aim to explain:-

- **What** we are proposing
- **Why** we are doing it
- **Who** is involved
- **When** it is happening
- **Where** you find out more information
- **How** we plan to keep you updated

Impact

We will monitor and evaluate the impact of local engagement activities to identify whether it achieved the original objectives, what went well and what we could do differently or better in future. This will increase learning and inform how we plan future community engagement activities.

Local Participation and Engagement

A wide range of participation and engagement activities take place across Forth Valley to engage with local partners, community organisations and other stakeholders.

Partner Organisations

Community Planning Partnerships (CPPs) – bring a wide range of public services, community and voluntary organisations together to work with each other and local communities to plan and deliver better public services in their local areas. NHS Forth Valley is a member of all three CPPs in the Forth Valley area and further information can be found on the individual websites Stirling Community Planning Partnership; Falkirk Community Planning Partnership and Clackmannanshire Community Planning Partnership

Local Councils – NHS Forth Valley works closely with all three local councils in the Forth Valley area to discuss how we can work together to take forward key local plans and priorities. Council representatives from all three local councils are members of the NHS Forth Valley Board and the two local Health and Social Care Partnerships (Clackmannanshire and Stirling HSCP and Falkirk HSCP) also have representatives from local councils and the Health Board to support joint planning.

Carers – NHS Forth Valley works closely with local carers centres in the Forth Valley area to provide updates on local service developments, health information and advice as well as responding to any questions, concerns or issues raised by carers. Carer representatives are also members of the Integration Joint Boards for both local Health and Social Care Partnerships (HSCPs) to help ensure the voices of carers are represented when planning or commissioning local health and care services.

Community and Voluntary organisations – NHS Forth Valley works closely with all three local voluntary services organisations which provide a wide range of support and services for charitable organisations, community and voluntary action groups, volunteering and social enterprises across their local areas (CTSI – Clackmannanshire Third Sector Interface), Stirling (Stirlingshire Voluntary Enterprise) and CVS Falkirk.

As an Anchor Institution, NHS Forth Valley also works closely with other large organisations in the Forth Valley area to support local communities through creating employment and training opportunities, buying goods and services locally, whenever possible, and enabling local organisations to make use of the local buildings and other facilities we own. Community representatives are also represented on the Integration Joint Boards and Strategic Planning Groups for Clackmannanshire and Stirling HSCP and Falkirk HSCP.

Education partners – The Forth Valley University College NHS Partnership brings together NHS Forth Valley, the University of Stirling and Forth Valley College and builds on the long-standing relationship between the three organisations. It is focussing on four key priority areas: (learning, careers, research and innovation) and aims to deliver new learning opportunities, drive forward world-class research and innovation and improve patient care and treatment across the region.

Local businesses – as part of our Healthy Working Lives programme our Health Improvement team work with local employers across Forth Valley to help develop a safer and healthier work environment. This includes providing free training, support and resources to support employee health and wellbeing, organising a range of workplace-based health initiatives, training and campaigns, including running sessions to help employees quit smoking.

Patients and Service Users - Patients are involved in a wide range of services, committees and forums across NHS Forth Valley to help inform the development and delivery of local services, plans and priorities.

We also encourage you to be involved in decisions about your care and treatment by asking four key questions at local appointments and consultations. In addition, we want you to share your experiences of local health services to help identify local issues and improvements required. You can do this via Care Opinion; online feedback forms on the NHS Forth Valley website and by completing patient experience surveys.

Local patients and service users have the opportunity to participate in a wide range of **research and clinical trials** led by our Research and Development Team. These include a number of international, national and local research to improve care and treatment across a wide range of service areas. SHARE is a national initiative which has been created to establish a register of people, aged 11 years and over, interested in participating in health research. More information about clinical research and trials underway in NHS Forth Valley can be found on Research section on the NHS Forth Valley website.

Volunteers NHS Forth Valley has developed a new Volunteering Framework which sets out how we aim to attract, engage and support a wide range of volunteers across local health services, over the next three years. Further information on volunteering opportunities and other ways of getting involved can be found on the Get

Involved section of the NHS Forth Valley website. A new **Public Involvement Network** is also being developed which will build on and extend the work of the previous Patient Public Panel to support wider engagement with a larger and more diverse range of people and service users.

Key Plans and Priorities

A wide range of engagement activities will be taken forward over the next three years to support the delivery of a number of key organisational plans and priorities. These include:-

Value Based Health & Care – an approach to help ensure we make the best use of the resources available to improve the health of all local people, achieve better outcomes for patients and deliver sustainable health services.

Equality and Inclusion – a new Equality and Inclusion Strategy is being produced which will set out the equality outcomes we aim to achieve over the next four years (2025 – 2029) to meet the needs of the diverse communities we serve. This will include the development of an Anti-Racism plan to reduce inequalities, particularly in relation to diabetes, cardiovascular disease, mental illness and pregnancy.

Engaging with Children and Young People – work is being taken forward to support greater engagement with children and young people on a wide range of issues and services. This will be based on a Hearing, Engaging, Acting, Responding Together (HEART) approach to capture the views of children and young people and ensure they are involved in developing local services.

Treatment Planning – this includes work to roll out Treatment Escalation Planning (TEP) to record the personal goals of treatment, values and preferences that are important to you if your condition should change or deteriorate.

Service Developments – there are plans to carry out engagement activities to support and inform the planning, development and delivery of a range of services including palliative care, orthopaedic services and breast clinic services.

Improvements and Innovation our Forth Valley Quality Strategy and Innovation Plan aims to involve patients, service users, partners and local communities in local quality improvement and innovation plans. These include initiatives to help diagnose skin cancers (AI Skin Cancer Consortium) and work to improve access to specialist ophthalmology services from local opticians and community clinics.

Alternative Formats or Languages

To request this document in another language please call 01324 590886. To request this document in another format call 01324 590886, text 07990 690605 or email fv.interpretation@nhs.scot

NHS Forth Valley

PARTICIPATION AND ENGAGEMENT FRAMEWORK

2025 - 2028

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Introduction

NHS Forth Valley is committed to listening to and working with staff, primary care colleagues, patients, partner organisations and local communities to improve the way local health services are designed and delivered.

Effective engagement and participation can help identify barriers and areas for improvement to help achieve better outcomes. It can also help identify sustainable, innovative and practical solutions to address some of the challenges faced by our workforce and local communities.

This document provides a strategic framework to help ensure a consistent and coordinated approach to participation and engagement across NHS Forth Valley. It outlines the purpose and principles which underpin effective engagement as well as providing practical advice and guidance for local services to support local engagement activities.

Purpose of this Framework

This Framework highlights the importance of participation and engagement in designing and delivering health services which meet the needs of local people.

It provides practical guidance as well as highlighting relevant legislative requirements and standards to help ensure best practice.

In addition, it provides examples of the participation and engagement activities underway across the organisation and details of how to get involved and key contacts for advice and support.

Collectively, it aims to increase the quality and range of work undertaken and support a more coordinated approach to engagement, working closely with Health and Social Care Partnerships and council colleagues, wherever possible, to avoid duplication and make best use of existing resources.

Benefits of Engagement

Effective participation and engagement can result in significant benefits for the Health Board, local patients, staff and communities. It can: -

- Strengthen decision making - people and communities challenge, strengthen and broaden the decision-making process
- Inform and influence key plans and priorities - services and plans that have been designed from a service user perspective often achieve better outcomes
- Help us to identify and respond to individual and community needs, preferences and issues.
- Identify potential barriers and solutions including ways we can support and encourage behaviour change

National Standards

The National Standards for Community Engagement are good-practice principles designed to improve and guide the process of community engagement.

Each of the seven standards (Planning; Inclusion; Support; Working Together; Methods; Communication and Impact) provide information and advice which can be used to achieve high quality results and the greatest impact. They show what good engagement looks like, and how to do it.

We are committed to following these national standards and using them to inform how we carry out engagement activities locally across Forth Valley. Further information, including a Participation Toolkit is available on the Healthcare Improvement Scotland and a checklist is provided at Appendix 1. This summarises some of the key questions and actions for each of the national standards and provides a useful guide for local staff and services.

The national Planning with People guidance also sets out how NHS Boards, Integration Joint Boards and local councils should involve people and communities throughout the development, planning and decision-making process for service change. This is particularly important when a proposed service change will have a major impact and there is a specific requirement for NHS Boards to formally consult on issues which are considered to be major service change. A full public consultation process is required and NHS boards' final recommendations for major changes are subject to Ministerial approval.

Planning

Planning for engagement and participation is vital as it:-

- Helps ensure there is a clear purpose and aims
- Engagement and participation activities are planned the right way, as opposed to the quick way
- There is a shared understanding of what is being asked, why we are asking and how we will measure success

Inclusion

Providing opportunities for people to get involved with issues that affect or are important to them is vital to help people be more active in their care and treatment and live healthier, happier and more fulfilling lives. To support this, we aim to be as inclusive as possible by ensuring that individuals, groups and communities that may have an interest or be affected any proposed service developments or changes have an opportunity to contribute and share their views.

Support

Everyone has a right to share their opinions and experiences to help shape health and care services. However, we recognise that some patients and service users may require additional support or alternative ways to get involved or share their feedback. We will therefore seek to: -

- Understand and address any barriers which may prevent people from getting involved
- Reach out and connect with diverse and underrepresented groups
- Use a range of methods and approaches to support greater participation.
- Support our staff to have meaningful conversations to help identify what matters most to you.

We will also carry out Equality Impact Assessments to inform the development of local plans and strategies.

Working Together

We will work closely with local staff, primary care colleagues, partner organisations and local communities to achieve a more joined-up and coordinated approach to engagement based on openness, honesty, trust and respect.

NHS Forth Valley's Volunteering Framework also provides information and advice to help set out what volunteers can expect when working with us.

Methods

It is important to use the most appropriate methods of engagement to meet the purpose, scope and timescale of any planned engagement activities. This will vary depending on whether the aim is to inform, involve or formally consult.

Wherever possible, we will include people and groups in discussions about how they would like to be engaged and offer a range of options and opportunities (for example, opportunities for people to participate and share feedback who may be unable to attend local events or meetings). These may include:-

- Focus Groups
- Meetings (in-person and online)
- Engagement Events (including Citizens Panels which can be set up to gather feedback on specific issues or service areas)
- Surveys to capture feedback and suggestions
- Discussions at clinics or appointments

We will also consider the format, timing and duration of any planned engagement activities to make it as easy and accessible as possible for people to attend.

In addition, we will work closely with local partner and community organisations to identify any opportunities for joint engagement activities to help avoid duplication and make it easier for people to participate rather than having to attend separate meetings or events. Details of key partner and community organisations at the end of this Framework.

Communication

We will aim to communicate clearly and regularly with the people, organisations and communities affected by any planned service developments or changes. We will aim to explain:-

- **What** (is proposed)
- **Why** (why we are doing it)
- **Who** (what is involved)
- **When** (it is happening)
- **Where** (people can find out more / get involved etc)
- **How** (we plan to communicate).

Impact

It is important to monitor and evaluate the impact of any planned engagement activity to determine whether it meets its purpose and has achieved the agreed outcomes. Agreeing key clear performance criteria, goals and desired outcomes also helps inform future learning and the way we involve people in the future.

We will therefore seek to review and assess:-

- Were the objectives met?
- What worked well and not so well?

- What could be improved?
- Did it achieve intended outcomes?
- What was the impact?

Local Participation and Engagement

A wide range of participation and engagement activities take place across Forth Valley to engage with local partners, community organisations and other stakeholders. A number of these are outlined below along with contacts for key leads who can provide further information and advice.

Staff

The national NHS Scotland Staff Governance Standards aim to ensure that staff are: well informed and involved in decisions which affect them. In NHS Forth Valley, staff are involved in service planning and any proposed service changes through a number of staff advisory groups and forums. These include the Area Partnership Forum and Area Clinical Forum along with other professional advisory groups. Staff representatives also attend all of the Board's governance committees, including the Staff Governance, Clinical Governance and Strategic Planning, Policy and Resources Committees. Staff are also encouraged to share their views and feedback in a range of ways through staff surveys, workshops, Q&A sessions, service visits and inspections as well as raising any issues or concern through initiatives such as Speak Up and Whistleblowing. Further information on internal communications can also be found in the Board's Communications Framework (2023 – 2028)

Partner Organisations

Community Planning Partnerships (CPPs) – bring a wide range of public services, community and voluntary organisations together to work with each other and local communities to plan and deliver better public services in their local areas. NHS Forth Valley is a member of all three CPPs in the Forth Valley area and further information, including details of the membership, can be found below

Stirling Community Planning Partnership

Falkirk Community Planning Partnership

Clackmannanshire Community Planning Partnership

Local Councils – NHS Forth Valley's Chair meets with local council leaders to discuss key local issues and NHS Forth Valley's Chief Executives also meet regularly with the Chief Executives of Falkirk, Stirling and Clackmannanshire Councils to discuss how we can work together to take forward key local plans and priorities. Council representatives from all three local councils are members of the NHS Forth Valley Board and local councils and NHS Forth Valley also have representatives on both local Health and Social Care Partnerships to support joint planning.

Carers – NHS Forth Valley works closely with local carers centres in the Forth Valley area and attends their meetings to provide updates on local service developments, health information and advice as well as responding to any questions, concerns or issues raised by

local staff and carers. Carer representatives are also members of the Integration Joint Boards for both local Health and Social Care Partnerships (HSCPs).

Community and Voluntary organisations – NHS Forth Valley works closely with all three voluntary services organisations which provide a single point of access point for a wide range of support and services for charitable organisations, community and voluntary action groups, volunteering and social enterprises across their local areas **(**CTSI – Clackmannanshire Third Sector Interface), Stirling (Stirlingshire Voluntary Enterprise) and Falkirk (CVS Falkirk). These organisations provide a valuable way to engage with local community and voluntary organisations on a wide range of issues as well as helping to coordinate the distribution of health information and advice. As an Anchor Institution, NHS Forth Valley also works closely with other large organisations in the Forth Valley area to support local communities through employment opportunities, prioritising the procurement of goods and services locally whenever possible and ensuring local buildings and other resources benefit the local communities we serve. Representatives from the third and independent sectors are also represented on the Integration Joint Boards and Strategic Planning Groups for Clackmannanshire and Stirling HSCP and Falkirk HSCP

NHS Forth Valley also produces an Equality and Inclusion Strategy every four years with details of equality outcomes which aim to ensure we are meeting the needs of local communities across Forth Valley

Education partners – The Forth Valley University College NHS Partnership brings together NHS Forth Valley, the University of Stirling and Forth Valley College and is the first formal regional partnership between a Health Board, university and college in Scotland. The Partnership builds on a long-standing relationship between the three organisations and works across four priority areas: learning, careers, research and innovation. It aims to deliver new learning and development opportunities for students and staff, drive forward world-class research and innovation and improve patient care and treatment across the region.

Forth Valley University College NHS Partnership

Local businesses – as part of our Healthy Working Lives programme our Health Improvement team work with local employers across Forth Valley to help develop a safer and healthier work environment. This includes providing free training, support and resources to support employee health and wellbeing, organising a range of workplace-based health initiatives, training and campaigns, including running sessions to help employees quit smoking.

Healthy Working Lives

National prisons – work is being carried out with staff and prisoners at HMP Glenochil and HMP/YOI Polmont to capture feedback on health services provided in each establishment. This includes opportunities to attend on-site engagement sessions meetings within each hall and buildings used to accommodate different categories of offenders. Prisons are also supported to complete compliment and concern, self-referral and dental treatment request

forms, if appropriate, which are shared with health centre staff. This has helped identify service users who have required additional support with literacy, physical and mental health issues which have been addressed by members of the healthcare and spiritual care teams. It has also identified helped identify changes and improvements which have been followed up by SPS and healthcare teams and helped to reduce the number of complaints and missed appointments.

MSP/MP meetings - NHS Forth Valley's Chief Executive, Chair, along with other senior service and clinical leads, regularly meet with local MSPs and MPs from across the Forth Valley, Central Scotland and Mid Scotland and Fife regions. These meetings provide an opportunity to provide an update on local health developments as well as respond to any local issues or concerns.

Patients and Service Users

Are involved in a wide range of services, committees and forums across NHS Forth Valley to help inform the development and deliver of local services, plans and priorities. This includes:

- Service user groups to support participation and engagement in a range of services including Maternity and the Child and Adolescent Mental Health Services (CAMHS).

- Use of the HEART (Hearing, Engaging, Acting, Responding Together) approach to engaging with young people, particularly in relation to Getting it Right for Every Child (GIRFEC) and work to recognise, support and promote children's rights across the organisation.

- Patients/Service User representatives are members of the **Integration Joint Boards** and **Strategic Planning Groups** of both local Health and Social Care Partnerships (Clackmannanshire and Stirling HSCP and Falkirk HSCP).

- Clacks and Stirling HSCP have three **locality planning forums** (covering Clackmannanshire, Stirling Central and Stirling Rural) which hold regular meetings and engagement events that are open to all members of the public. The bi-monthly meetings are held in different areas of each locality to make it easier for people to attend.

- Falkirk HSCP is also developing **locality groups** for three areas (East, West and Central Falkirk) to support greater engagement with members of the public and local service users across the Falkirk Council area.

- NHS Forth Valley's Public Involvement Coordinator works closely with the **Community Engagement** and **Community Learning and Development Teams and Older People's Forums** in all three local council areas to share health and advice and capture feedback on a range of services, including those for older people. In addition, they also work with People First and the Clackmannanshire Access Panel to support local people with learning and physical disabilities and help them access local services.

Local patients and service users have the opportunity to participate in a wide range of **research and clinical trials** led by our Research and Development Team. These include a number of international, national and local research to improve care and treatment across a wide range of service areas. SHARE is a national initiative which has been created to establish a register of people, aged 11 years and over, interested in participating in health research. More information about clinical research and trials underway in NHS Forth Valley can be found on Research section on the NHS Forth Valley website.

- Local patients and service users are encouraged to be involved in decisions about their care and treatment by asking four key questions as part of wider work to deliver Realistic Medicine.

- Service users and their families are encouraged to share their experiences of local health services in a number of ways to help identify local issues and take forward any changes or improvements required. These include Care Opinion and online feedback forms on the NHS Forth Valley website, patient experience surveys and a range of activities to support What Matter's to You day.

Public and Volunteers

- A new **Public Involvement Network** is being developed which will build on and extend the work of the previous Patient Public Panel to support wider engagement with a larger and more diverse range of people and service users This will be supported by the use of **Citizen Panels** to support engagement on specific services or issues to increase opportunities to engage online and in person.

- NHS Forth Valley has developed a new Volunteering Framework which sets out how we aim to attract, interact with, engage and support a wide range of volunteers across local health services, committees and forums over the next three years. Further information on volunteering opportunities and other ways of getting involved can be found on the Get Involved section of the NHS Forth Valley website.

- Members of the public can share feedback in a number of ways including via the Care Opinion website and online feedback forms on the NHS Forth Valley website. They can also keep updated on the latest service developments and receive invites to local events by signing up to receive a monthly e-bulletin and following our social media channels for the latest news and health advice.

Key Plans and Priorities

A wide range of engagement activities will be taken forward over the next three years to support the delivery of a number of key organisational plans and priorities. A number of key projects and workstreams are below:-

Value Based Health & Care – is an approach to help ensure we make the best use of the resources available to improve the health of all local people, achieve better outcomes for patients and deliver sustainable health services. It builds on the principles of Realistic Medicine and there are plans to roll it out across all local health services over the next three years to help ensure that services are designed and delivered in ways that achieve the biggest impact, reduce health inequalities, prevent ill health and reduce waste. This system-wide approach will underpin the delivery of NHS Forth Valley's new 10 year Population Healthcare Strategy and be supported by ongoing engagement with staff and service users, including more vulnerable groups, to inform future plans and priorities.

Culture Change and Compassionate Leadership Programme – Widespread engagement has been carried out with staff, students, primary care colleagues and partner organisations to inform the development of a Culture Change and Compassionate Leadership Programme. The next phase will focus on eight key priorities which reflect the key themes highlighted in the extensive feedback gathered over the last two years. The Programme will be supported by the ongoing participation and engagement of a wide range of staff, staff-side representatives and HSCP colleagues across all eight priority workstream areas.

Volunteering – NHS Forth Valley's new Volunteering Framework sets out four key goals for the next two years. This work will be supported by a new Volunteering Stakeholder Group and a number of sub-groups to take forward key actions outlined in the Framework.

- Develop volunteering roles that are meaningful and innovative that supports our Person-Centred values.
- Develop and embed a robust infrastructure to promote safe and good practice of volunteering.
- Embed our volunteering programme as a visible and valued part of NHS Forth Valley
- Celebrate volunteering by recognising and promoting the impact of volunteering
- Design roles that add value to the lives of volunteers, patients and local communities.

Equality and Inclusion - a new NHS Forth Valley Equality and Inclusion Strategy is being produced to help ensure we meet our legislative requirements under the Public Sector Equality Duty. Our Strategy will set out the Equality Outcomes we aim to achieve over the next four years (2025 – 2029) to meet the needs of the diverse communities we serve. This will include details of initial equality outcomes, developed in response to feedback from

service users, local communities and staff. One initial priority includes work to develop an Anti-Racism Plan to help tackle the impact of racism on staff, service users and health outcomes. The development of this Plan will work to reduce racial inequalities, in particular improving the experience of people with diabetes, cardiovascular disease, mental illness and pregnant women. Service plans will be informed by Equality Impact Assessments (EQIAs), ongoing engagement and feedback to ensure local services continue to meet the needs of local service users and communities. We will work towards achieving our equality outcomes over this four-year period through a series of initiatives and targeted activities and will produce annual updates to highlight progress.

Engaging with Children and Young People – work is being taken forward to support a Hearing, Engaging, Acting, Responding Together (HEART) approach to engaging with children and young people. This will include the development of a toolkit to support a range of engagement activities and plans to explore the development of Children's Panels to engage on specific services and issues. In addition, there are plans to develop a children's EQIA / statement of understanding and insight which can be used by groups across the organisation involved in making any decisions or changes which may impact on children.

Anchor plans and priorities - Anchor institutions, so called, as they are fixed in one location and have a stake in the local area, are large organisations that have a strong community presence and influence in their local area as major employers, buyers of goods and serivces and owners of land and buildings.

NHS Forth Valley's role as an Anchor Institution is central to achieveing our goals of improving the health and wellbeing of local people and tackling poverty and inequalities across local communities.

There are five ways in which NHS organisations act as anchor institutions:

- Workforce – we can employ more local people and provide fair stable work
- Spend – we can buy more goods and services locally and develop the local supply chains to contribute to local economic growth
- Land and assets – we can use our land and buildings for community benefit
- Environmental sustainability – minimise our impact on the environment
- Partnerships – we can work with partners to develop good practice and anchors approaches

NHS Forth Valley will continue to work closely with other Anchor institutions across the Forth Valley area to take forward work in all five areas, informed by ongoing engagement with partner organisations and local communities. This will include work deliver a wide range of employment and work experience projects in partnership with local community planning partners. Specific employment projects will target young

people with learning disabilities and parents as well as initiatives to help local women gain additional skills and build their confidence. Work will also continue with local schools across the local area to promote NHS Forth Valley as an employer or choice and increase awareness of the wide range of career opportunities across health and social care services. This includes work to highlight alternative routes into employment out-with the traditional university pathways. The Academy training programme for Healthcare Support Workers will continue to develop along with work to create new apprenticeship opportunities for adults as well as younger people.

Clackmannanshire Alliance Anchor Partnership is undertaking a review of the current Clackmannanshire Council Anchor plan to identify agree future priorities. Falkirk Community Planning Partnership (CPP) Community Wealth & Health Building Partnership is focussing on employment and procurement and will develop action plans to deliver progress in both of these initial priority areas.

A new Shadow Regional Anchor Partnership Board is also being developed which will bring together a wide range of partners across the Forth Valley area and beyond.

Treatment Planning - a number of engagement events have been held with staff and patient representatives to support the introduction of Treatment Escalation Planning (TEP) – a tool which records and communicates the personalised goals of treatment, values and preferences that are important to the person receiving care if their condition should deteriorate. There are plans to run further engagement events in a number of ward areas with simulated patient scenarios to support and inform the wider roll-out across the organisation.

Service Developments – there are plans to carry out engagement activities to support and inform the planning, development and delivery of a range of services including palliative care, orthopaedic services and breast clinic services.

Quality Improvement and Innovation

The Forth Valley Quality Strategy and Innovation Plan aims to involve patients, service users, partners and local communities in local quality improvement and innovation plans and provide them with the tools and knowledge to enable them to contribute to this important work. Key priorities include work to respond to NHS Health Improvement Scotland safe delivery of care inspection reports, identify funding opportunities and take forward new service developments and improvements. The include initiatives to help diagnose skin cancers (AI Skin Cancer Consortium) and work to improve access to specialist ophthalmology services from local opticians and community clinics.

Key Contacts

Everyone has a part to play in supporting effective participation and engagement in the design and delivery of local healthcare services. For more information, advice and support on engagement and participation please contact:

NHS Forth Valley

Patient Centred Care Team fv.patientexperience@nhs.scot

Communications Team fv.comms@nhs.scot

Equality, Inclusion and Wellbeing Service fv.equality@nhs.scot

Information Governance fv.informationgovernance@nhs.scot

Research and Development Team fv.randd@nhs.scot

Quality Improvement Team fv.fvquality@nhs.scot

Innovation Team fv.innovation@nhs.scot

Falkirk Council

Brian Pirie – Democratic Services (community councils, community engagement and policy development) - brian.pirie@falkirk.gov.uk

Falkirk Health and Social Care Partnership

Community engagement and participation and citizens panel citizenspanel@falkirk.gov.uk

Lesley McArthur - Planning and Performance Team Manager - lesley.macarthur@falkirk.gov.uk

Stirling Council

Community Engagement and Development communitydevelopment@stirling.gov.uk

Stephen Bly – Policy Officer (community councils and citizens panel) blys@stirling.gov.uk

Clackmannanshire Council

Lesley Baillie - Strategy and Performance Manager (community councils and citizens panel) - lbaillie@clacks.gov.uk
Citizens Panel - customerservice@clacks.gov.uk.

Clackmannanshire and Stirling Health and Social Care Partnership

fv.clackmannanshirestirling.hscp@nhs.scot

Health Improvement Scotland – Service Change Team his.engageservicechange@nhs.scot

Additional Information and Resources

- Planning with People - community engagement and participation guidance for NHS boards, Health and Social Care Partnerships and Local Authorities (Updated May 2024)

- National Standards for Community Engagement - 7 good-practice principles designed to improve and guide the process of community engagement.

- Quality Framework for Community Engagement and Participation (HIS) - supports NHS boards, local authorities and Integration Joint Boards to carry out effective community engagement and demonstrate how they are meeting their statutory duties for public involvement.

- Service change resources (HIS) a range of resources to help NHS boards, integration authorities and local councils effectively engage with patients, carers and the public on service changes, including Guidance on identifying major health service changes and involving people in temporary changes.

- Communication and engagement plans (HIS) guidance and templates to support the development of effective communication and engagement plans

- The Health and Social Care Standards - set out what people should expect when using health, social care or social work services in Scotland. They seek to provide better outcomes for everyone; to ensure that everyone is treated with respect and dignity, and that the basic human rights we are all entitled to be upheld.

- Community Empowerment (Scotland) Act 2015 - aims to empower community bodies through the ownership or control of land and buildings, and by strengthening their voices in decisions about public services.

- Human Rights Act 1998 aims to create an inclusive Scotland that protects, respects and fulfils internationally recognised human rights.

- Equality and diversity (HIS) Engage – provides advice and guidance on encouraging people from all sections of society to get involved as active partners in their own care or through engagement in wider discussions about health and care services.

- The Fairer Scotland Duty - aims to reduce inequalities and requires public bodies to evidence how they actively consider the reduction in inequalities in any major strategic decisions.

- Equality Act 2010 - legally protects people from discrimination in the workplace and in wider society.

- Engaging children and young people (RCPCH) provides guidance and best practice examples to help healthcare staff collaborate with children, young people and their

families.

- Meaningful Participation and Engagement of Children and Young People Children in Scotland's Principles and Guidelines (Children in Scotland) – provides guidance on how to engage children and young people in meaningful, ongoing dialogue and enable them to have effective and fulfilling participation.

- Falkirk Council Local Outcome Improvement Plan (2021 -2030)

- Stirling Council Local Outcome Improvement Plan – (2021 - 2027)

- Clackmannanshire Council Local Outcomes Improvement Plan – (2024 - 2034)

Appendix 1

Participation and Engagement Checklist (National Standards for Community Engagement)

Planning	Why are you engaging with people? (purpose) What do you need to know? (scope) Who should be involved? (primary and secondary stakeholders who are likely to be most affective or indirectly affected) When is the best time to engage? (timescale) What do you want to achieve? (benefits and outcomes) Are there any costs you need to consider (e.g. venue costs, volunteer expenses etc) Are there any potential risks associated with the planned engagement activities? How will you measure the success and impact of your engagement? (see impact for more info)
Inclusion	Have you included all the individuals, groups and communities that may have an interest or be affected by the focus of your engagement activity? Your list could include: • patients and people who may be directly affected by change, including family members and carers • groups or organisations who support people who may be affected • health and social care staff who deliver services being considered for change • managers of services being considered for change • members of the local community who may not be affected directly but have an interest in potential changes • public representatives including elected members and government officials. Undertaking an Equality Impact Assessment (EQIA) can help to identify potential disadvantages and offer an opportunity to take appropriate actions to remove or minimise any adverse impact. NHS Forth Valley's Equality, Inclusion and Wellbeing Service Equality can provide support on carrying out an EQIA fv.equality@nhs.scot as well as providing advice on engaging with wider, more diverse and easy-to-miss communities. You can view a helpful video (2 mins) about barriers to participation here.

Support	Have you considered the different support and access needs patients or service users may need to get involved?
Working Together	Are there any other local partner and community organisations you could carry out engagement with to help avoid duplication and make it easier for people to participate? (see key contacts on P15 for more information).
Methods	What methods of engagement do you plan to use?
Communication	**What** (you are doing) **Why** (you are doing it) **Who** (is involved) **When** (it is happening) **Where** (people find out more / get involved etc) **How** (the methods of communication you will use and the frequency of those communications).
Impact and evaluation	Were the objectives met? What worked well and not so well? Were the methods and techniques appropriate? What could be improved? Did it achieve intended outcomes? Guidance on evaluating participation can be found on the NHS Health Improvement Scotland website

NHS Forth Valley Equality Impact Assessment Document (EQIA)
Please complete electronically and answer all questions unless instructed otherwise. Once finished please email to FV.EQIA@nhs.scot and someone will be in touch shortly.

Section A

Q1: Name of EQIA being completed i.e. name of policy, function etc.

Participation and Engagement Framework

Q1 a; Function ☐ **Guidance** ☒ **Policy** ☐ **Project** ☐ **Protocol** ☐ **Service** ☐ **Other, please detail** ☐

Q2: What is the scope of this SIA

NHSFV wide ☒ Service Specific ☐ Discipline Specific ☐ Other (Please Detail) ☐

Q3: Is this a new development? (see Q1)

Yes ☒ No ☐

Q4: If no to Q3 what is it replacing?

Q5: Team responsible for carrying out the Standard Impact Assessment? (please list)

Communications Team

Q6: Main person completing EQIA's contact details

Name:	Elsbeth Campbell	Telephone Number:	01786 457264
Department:	Communications Department	Email:	elsbeth.campbell@nhs.scot

Q7: Describe the main aims, objective and intended outcomes

This Strategic Framework outlines our approach to engagement based on national standards for community engagement as well relevant legislative requirements to help ensure best practice. It highlights the importance of participation and engagement in designing and delivering health services which meet the needs of local people. Collectively, it aims to increase the quality and range of work undertaken and support a more coordinated approach to engagement, working closely with Health and Social Care

Partnerships and council colleagues, wherever possible, to avoid duplication and make best use of existing resources.

A more detailed version of this Framework has also produced for local staff which provides practical advice and details of key contacts across NHS Forth Valley, local Health and Social Care Partnerships and councils to help ensure a joined up and coordinated approach to engagement.

Q8:

(i) Who is intended to benefit from the function/service development/other (Q1) – is it staff, service users or both?

Staff ☒ Service Users ☒ ☒Other Please identify: Bank Staff, Students, locums – community groups, voluntary organisations, partner organisations

(ii) Have they been involved in the development of the function/service development/other?

Yes ☒ No ☐

(iii) If yes, who was involved and how were they involved? If no, is there a reason for this action?

A number of services and individuals have been involved in developing the Participation and Engagement Framework including Patient Relations, Public Health, Quality Improvement and Innovation, Equality and Diversity leads, Planning and Community Engagement colleagues. It also reflects feedback from local patients and service users who want to have the opportunity to engage and contribute in different ways and participate in more joint events with other partner organisations to help avoid duplication or the need to attend multiple meetings.

(iv) Please include any evidence or relevant information that has influenced the decisions contained in this piece of work; (this could include demographic profiles; audits; research; published evidence; health needs assessment; work based on national guidance or legislative requirements etc)

It is based on and reflects the national Planning with People community engagement guidance for NHS Boards, Integration Joint Boards and Local Authorities which was reviewed and updated in 2024 to make sure it continues to meet the needs of patients, service users and local communities. It also reflects feedback from public and service user consultations, the wider Scottish public, individuals, organisations representing the equality sector and health and social care engagement professionals.

Q9: When looking at the impact on the equality groups, you must consider the following points in accordance with the General Duty of the Equality Act 2010 see below:

In summary, those subject to the Equality Duty must have due regard to the need to:

- **Eliminate unlawful discrimination, harassment and victimisation;**
- **Advance equality of opportunity between different groups; and**
- **Foster good relations between different groups**

Has your assessment been able to demonstrate the following:

Positive Impact ☒ Negative / Adverse Impact ☐ Neutral Impact ☐

Comment:

What impact has your review had on the following 'protected characteristics':	Positive	Adverse/ Negative	Neutral	Comments Provide any evidence that supports your conclusion/ answer for evaluating the impact as being positive, negative or neutral (do not leave this area blank)
Age	✓			The Planning with People guidance which the Framework is based on applies to all health and care services for children, young people and adults. The Framework will provide opportunities to explore the different needs of different age groups and enable us to tailor our approach to suit. We know from evidence that younger people are less likely to participate in engagement activity with their local healthboard (Goodyear et al, 2018) and are therefore underrepresented. This Framework will enable us to adopt person-centred approaches that take this into account and try more creative and digital-based engagement approaches to target this group. Conversely, we know that people over the age of 65 are less likely to use the internet and more likely to experience digital exclusion. The Framework will equally enable us to consider in-person engagement methods alongside other non-digital methods to encourage update from this group.

Disability (incl. physical/ sensory problems, learning difficulties, communication needs; cognitive impairment)	✓			The national standards for community engagement outline in the Framework recognise that some patients and service users may require additional support or alternative ways to get involved or share their feedback. The Framework will provide an opportunity to ensure engagement approaches are tailored to the individual to suit their needs and preferences, including consideration of barriers to engagement that may be faced by disabled individuals such as extensive travel time, digital exclusion or cognitive impairments that require alternative formats or support, including BSL Interpretation.
Gender Reassignment			✓	There are no known impacts relating to gender reassignment, however the Framework highlights the need to understand and address any barriers which may prevent people from getting involved as well as the need to connect with diverse and under-represented groups.
Marriage and Civil partnership			✓	There are no known impacts relating to marriage and civil partnership.
Pregnancy and Maternity	✓			The Framework takes into account the additional challenges and barriers pregnancy and maternity may bring and therefore will encourage engagement at a time most suited to individuals, being mindful and supportive of people with young children and families. People would be able to access information in a range of ways and choose a method of engagement that bests suits their personal circumstances and needs.

				Furthermore, the Framework will be utilised to support the development of our new Anti-Racism plan which aims to reduce racial inequalities. A key focus area involves addressing the racialised inequalities experienced by women during pregnancy.
Race/Ethnicity	✓			The Framework aims to support engagement with the needs of the diverse communities we serve. This will be supported by the development of an Equality and Inclusion Strategy and Anti-Racism plan to reduce health inequalities associated with race. It will also encourage the use of Interpretation and Translation services where required to support engagement for those where English is not their first language.
Religion/Faith	✓			The Framework promotes greater inclusion to meet the needs of the diverse communities we serve, including people from different faith groups, religions and backgrounds.
Sex/Gender (male/female)			✓	There are no known impacts relating to gender, however the Framework promotes greater inclusion to meet the needs of people of all genders and takes into account the different engagement methods that may be required to ensure equal opportunity of contribution.
Sexual orientation			✓	There are no known impacts relating to sexual orientation, however the Framework highlights the importance of being as inclusive as possible and ensuring that individuals, groups and communities that may have an interest or be affected any proposed service

				developments or changes have an opportunity to contribute and share their views in a way that feels safe to them.
Staff (This could include details of staff training completed or required in relation to service delivery)	✓			The Framework provides practice advice, guidance and details of support to help staff carry out effective engagement.
People who are Carers or Care Experienced	✓			The Framework highlights the need to understand and address any barriers which may prevent people from getting involved as well as the need to connect with diverse and under-represented groups. We know from evidence that Carers are less likely to engage if the method is onerous or would impact upon their care-giving responsibilities. The framework will encourage creative, flexible approaches that take this into account and are person-centred. Furthermore, we know that care experienced individuals can require additional accommodations to support engagement such as a trauma-informed approach and consideration of follow-up support if information is likely to be sensitive or triggering (LGA, 2024)
People who are socio-economically disadvantaged	✓			The Framework highlights the need to understand and address any barriers which may prevent people from getting involved which can include financial barriers. The framework encourages considerations around engagement methods that do not place any financial burden or disadvantage on an individual and also to be mindful of the need for flexible

				approach. Digital exclusion may also come into play and would be mitigated against.
People living in poverty	✓			The Framework appreciates the use of language and the importance of being mindful of how an individual chooses to identify. It's uncommon for people to identify as 'living in poverty', especially due to stigma and misconceptions. The Framework encourages meaningful methods of engagement that build relationships and tackle barriers such as mistrust and financial constraints. As with above, the framework encourages considerations around engagement methods that do not place any financial burden or disadvantage on an individual and also to be mindful of the need for flexible approach.
People Serving a Prison Sentence/Involved in Community Justice Programme	✓			Within NHS Forth Valley we have three Prisons in our remit and will work closely with our partners to ensure engagement methods and targeted outreach for this community that is often forgotten or excluded due to a lack of opportunity.
People experiencing homelessness	✓			The Framework highlights the need to understand and address any barriers which may prevent people from getting involved as well as the need to connect with diverse and under-represented groups. We know from evidence that individuals experiencing homelessness can require additional accommodations to support engagement such as a trauma-informed approach. The Framework also encourages partnership working to help build relationships. A lack of a

				permanent address can also be a misinformed barrier to engagement so awareness and education around this will be pivotal.

Q10: If actions are required to address changes, please attach your action plan to this document. Action plan attached?

Yes ☐ No ☒

Q11: Is a more detailed, fuller EQIA required?

Yes ☐ No ☒

Please state your reason for choices made in Question 11. The Framework is based on national guidance, standards and best practice which take account of and reflect the need to tailor engagement activities to meet the needs of patients, services users, community organisations and easy to miss groups. It is designed to complement and strengthen existing activities and encourage closer working between bodies to minimise duplication and share learning.
N.B. If the screening process has shown potential for a high negative impact you will be required to complete a detailed impact assessment.

Date EQIA Completed	5 March 2025		
Date of next EQIA Review	5 March 2028		
Signature	Elsbeth Campbell	Print Name	Elsbeth Campbell
Department or Service	Communications Department		

Please keep a completed copy of this template for your own records and attach to any appropriate tools as a record of EQIA completed. Please remember to send a copy to FV.EQIA@nhs.scot

Equality, Inclusion and Wellbeing Service Response and Next Steps:
COMMENT: EQIA received, information sufficient and adequate considerations in place to support policy. No negative or adverse impacts identified therefore more detailed EQIA not required. Review date in place.
ACTION: Filed and returned to Author.
EQIA Number: FVEQIA-25/003

B: **Standard/Detailed Impact Assessment Action Plan *(N/A)***

Name of document being EQIA'd:

Date	Issue	Action Required	Lead (Name, title, and contact details)	Timescale	Resource Implications	Comments
DD / MM / YYYY						
DD / MM / YYYY						
DD / MM / YYYY						
DD / MM / YYYY						
DD / MM / YYYY						
DD / MM / YYYY						

Further Notes:

Signed: Date:

C: Quality Assurance – Policies and Guidance only

QA Section

Lead authors details?

Name:	Elsbeth Campbell	Telephone Number:	01786 457264/07500108847
Department:	Communications	Email:	elsbeth.campbell@nhs.scot

Does your policy / guideline / protocol / procedure / ICP have the following on the front cover?

Version Status	☐	Review Date	✓	Lead Author	☐
Approval Group	☐	Type of Document (e.g. policy, protocol, guidance etc)			✓

Does your policy / guideline / protocol / procedure / ICP have the following in the document?

Contributory Authors	☐	Distribution Process	☐	Implementation Plan	☐
Consultation Process	☐				

Is your policy / guideline / protocol / procedure / ICP in the following format?

✓	Arial Font	✓	Font Size 12	✓	Alt. Text Descriptions

Signature:

Lead Author:	Elsbeth Campbell	Date:	5 March 2025

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

13. Board Assurance Framework
For: Approval

Executive Sponsor: Ms Kerry Mackenzie, Acting Director of Strategic Planning and Performance
Author: Ms Kerry Mackenzie, Acting Director of Strategic Planning and Performance

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1. Executive Summary

1.1 To support the delivery of good governance, this paper serves as a point of reference to the NHS Forth Valley Board Assurance Framework, bringing together the organisation's strategic planning, risk management and assurance information systems.

2. Recommendation

2.1 The Forth Valley NHS Board is asked to:

- **consider** the draft Board Assurance Framework in line with the Blueprint for Good Governance and NHS Forth Valley Board functions and responsibilities.
- **note** the work underway aligned to the Board Assurance Framework that supports governance improvements.
- **note** the Board Assurance Framework is an iterative document.
- **agree** the next steps detailed within the paper.
- **approve** the Board Assurance Framework.

3. Key Issues to be Considered

3.1 Following escalation to Stage 4 of the NHS Scotland Performance Escalation Framework (now Support and Intervention Framework) for concerns relating to Governance, Leadership and Culture a Corporate Governance Review was commissioned. This was to assist NHS Forth Valley in identifying any improvements to the approach taken to corporate governance that would be required to address the range of performance-related issues included in the NHS Forth Valley Escalation Improvement Plan.

3.2 A number of recommendations were published in the review, including:

- The NHS Forth Valley Boards should commission work to establish or confirm the connections, alignment and dependencies between the component parts that make up an assurance framework. The output from this initiative should be a comprehensive assurance framework that supports the NHS Forth Valley and Standing Committees in delivering good governance at all levels of the governance system.

- The NHS Forth Valley Board Chair should also consider inviting NHS Education for Scotland to repeat the workshop on Active Governance with particular emphasis on the importance of developing an assurance information system that meets the needs of the Board Members and supports them in delivering active governance.

3.3 A Board Development Session was held on 3 December 2024 around Active Governance and was supported by colleagues from NHS Education for Scotland. The aims of the session were to:

- better understand active governance and application of the Board Assurance Framework.
- discuss how risk can be used effectively in active governance.
- learn from others – how they have implemented Board Assurance and Risk.
- strengthen our approach to assurance.

3.4 The outputs from the session in terms of potential actions, detailed in Appendix 1, have been considered in the development of the draft Board Assurance Framework. This sets out the key controls in place to support delivery of NHS Forth Valley priorities and to mitigate risk. The framework supports the Board and its committees to discharge their overall governance responsibilities.

3.5 Assurance is evidence-based confidence that internal controls are in place, that they are operating effectively and that objectives are achieved. The Board Assurance Framework is designed to ensure that there are clear links between the governance responsibilities of the Board, the lines of accountability across the Executive Directors and the assurance activities of the Board's Governance Committees.

3.6 A number of other actions are underway that align to the Board Assurance Framework and support governance improvements, namely:

- Review and update of the Board and Governance Committee paper template. This will be undertaken in two stages. The March Board will see the removal of the levels of Assurance section of the paper with a revised format in place for the May Board, as discussed at the Active Governance Board session, along with the strengthening of the Risk section of Board papers.
- Review and update of Governance Committee Terms of Reference with agreed format/template to ensure consistent information is provided.
- Review and update of the Code of Corporate Governance and the Scheme of Delegation taking account of benchmarking from other NHS Board areas.
- Governance Committee annual planners drafted to ensure read across to NHS Board and to ensure Assurance and Improvement Plan thematic actions are captured.
- Review of the Board workplan in line with priorities and ensuring alignment with Governance Committee workplans.
- Review of Endowment Trust meetings to ensure appropriate governance is in place.
- Review of minutes to ensure consistency of approach across Board and Governance Committees.
- Review of the induction programme for Non-Executive Directors.

3.7 The Board Assurance Framework should be seen as an iterative and evolving document that will be reviewed on an ongoing basis and updated in line with structural and organisational changes.

4. Next Steps

4.1 The Board Assurance Framework will continue to change and develop as governance improvements become embedded and key activities and documents that support our ongoing assurance are reviewed and updated.

4.2 The Risk Management Strategy will be revised over the summer period along with our risk appetite and tolerance statements. A short life working group will be convened to support this work with presentation and discussion scheduled for the Board Seminar on 12 August 2025 ahead of approval by the Forth Valley NHS Board.

4.3 The Performance Framework will be reviewed in line with the focussed approach being taken to ensure and support Directorate, including Partnership, Reviews with onward reporting to the Board. The Performance Framework will be updated for consideration at the Strategic Planning, Performance & Resources Committee on 26 August 2025.

4.4 Work will continue to progress to ensure that corporate objectives, audit follow up actions and performance themes are aligned to the relevant committee for scrutiny and monitoring with this reflected through the Board Assurance Framework.

4.5 A formal annual review and update of the Board Assurance Framework will be undertaken to ensure it remains current and continues to align with NHS Forth Valley priorities, Corporate Objectives, Risk management Strategy / Framework and Performance Framework.

Implications

5. Financial Implications

5.1 Financial implications and sustainability are being considered on an ongoing basis working closely with Scottish Government colleagues and Health & Social Care Partnership Chief Finance Officers. Financial Breakeven is detailed on the Strategic Risk Register as a Very High risk for NHS Forth Valley. As such it is reviewed and managed as a risk assigned to the Strategic Planning, Performance & Resources Committee.

5.2 The Board Assurance Framework supports oversight and management of the Financial Breakeven Strategic Risk.

6. Workforce Implications

6.1 Workforce Implications are considered on an ongoing basis through the oversight and management of the Workforce Strategic Risk supported by the Board Assurance Framework structures.

7. Infrastructure Implications including Digital

7.1 There are no specific infrastructure implications in respect of this paper.

8. Sustainability Implications

8.1 There are no specific sustainability implications in respect of this paper.

8.2 ***Sustainability Declaration***

Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process A policy for NHS Scotland on the climate emergency and sustainable development*. (please tick relevant box)*

□ *Yes*
✓ *N/A*

Where applicable, the climate change, environmental and sustainability impacts, and any mitigating measures are noted above/contained in the supporting papers.

9. Quality / Patient Care Implications

9.1 There are no specific quality or patient care implications in respect of this paper although the Board Assurance Framework references oversight of Quality and Patient Care through the Clinical Governance Committee.

10. Information Governance Implications

10.1 Information Governance Implications are considered on an ongoing basis through the oversight and management of the Information Governance Strategic Risk supported by the Board Assurance Framework structures.

11. Risk Assessment / Management

11.1 Adequate monitoring, scrutiny and management of performance supports the organisation to manage its risk with performance reporting linked to Strategic Risks. The Board Assurance Framework supports oversight and management of Risk through the Risk Management Strategy and regular reporting to the NHS Forth Valley Board.

12. Relevance to Strategic Priorities

12.1 The NHS Board is responsible for:

- Setting the direction, including clarifying priorities and defining change and transformational expectations.
- Holding the Executive Leadership Team to account by seeking assurance that the organisation is being effectively managed, and change is being successfully delivered.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with key stakeholders, as and when appropriate.
- Influencing the Board's and the wider organisational culture.

13. Equality Declaration

13.1 The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity

14. Communication, involvement, engagement and consultation

14.1 Cognisance has been taken of feedback and comments from Non-Executive and Executive Director colleagues at and following the Board Development Session on 3 December 2024 and consideration at the Strategic Planning, Performance and Resources Committee on 25 February 2025.

15. Appendices:

Appendix 1 – Board Development Session Outputs
Appendix 2 – NHS Forth Valley Board Assurance Framework

Appendix 1

Potential Actions

Development of the Board Assurance Framework	Clarify vision and direction: Ensure the Board sets a clear organisational vision and aligns accountability. Ensure there is clarity on the roles and responsibilities of the Board/NXDs. Embed ToRs in supporting documents.
	Assurance is also needed around co-production and engagement: Articulate triangulation evidence such as engagement with staff and patients, patient stories, safety visits, and complaint themes in addition to performance indicators.
	Strategic alignment: Create a clear line of sight and flow of information from corporate objectives and delivery plans to assurance, including mapping of links such as hosted services, local and national policies, CPPs so that assurance is whole system and measures are more than just the Annual Delivery Plan.
	We should consider a further session on presentation of and handling of data to support assurance and performance monitoring.
	Need to ensure value/quality are also considered and that there is a cultural change in focusing on what matters and that the Board is agile enough to consider emerging issues
	Committee oversight: Ensure risks align with the appropriate committees and reflect integrated systems. Be clear where areas sit in each committee and create a clear route to the Board. Ensure the right people with the right skillsets are on the right committee.
Better Use of Internal Audit	Enhance alignment and links to risks and priorities: Connect internal audit plans with risk management and delivery priorities.
	Strengthen purpose: Use audits to actively address gaps in assurance and governance processes. Use internal audit actively and strategically to address emerging issues.
	Commission effectively: Clearly define what is needed from internal audits to add value to decision making.
Assurance Levels and Strengthening Risk	Reassess whether assurance levels are helpful: Transition to a robust, consistent methodology aligning with strategic risks. Are you assured, not how assured are we as there is variation in how this is being interpreted and used – often a judgement.
	Improve linkages: Tie assurance to recommendations and risk management explicitly. Embed risk escalation processes: Ensure clarity and effectiveness in how risks move through committees to the board
	Address confusion: Clarify the purpose of assurance, ensuring it is actionable and consistent. Be clear on next steps and where to report if Board members are not assured or require more information to support assurance.

Difference Between Risk and Assurance	Binary assurance: Adopt a straightforward approach and remove levels of assurance from Board papers e.g. discussion should focus on, assured or not assured and whether risks are mitigated or what further actions are required.
	Emphasise decision making: Highlight risks clearly and link them to decision points in Board papers .
	Clarity on purpose: Define how risk and assurance integrate into governance and performance. Link assurance and risk better. Revisit risk register, strategic handling of risk, risk tolerance and appetite.
Review of Board Papers and Template	Simplify content: Shorten papers, with details in appendices, focusing on key decisions and risks. Undertake benchmarking with other Board's papers.
	Align to strategy: Ensure Board papers link directly to strategic objectives and operational risks.
	Improve structure: Make recommendations and associated risks clearer. Emphasise risk in papers. And link to operational update.
	Highlight context and impacts: Ensure board papers address what is and isn't working, including knock-on effects and benchmarking information with other boards.
	Align to value-based healthcare (VBH&C): Include sections demonstrating value and linking recommendations to corporate objectives.

NHS Forth Valley
Board Assurance Framework

Version number	Author	Date Issued	Date of Board Approval
Version 1.1	Acting Director of Strategic Planning & Performance	18/03/2025	25/03/2025

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1. Introduction

1.1. This document describes the Assurance Framework which is the high-level system of assurance that operates within NHS Forth Valley. This framework aligns to the NHS Scotland Blueprint for Good Governance which describes the Assurance Framework as promoting and delivering good governance by bringing together the organisation's purpose, aims, values, corporate objectives and risks with the strategic plans, change projects and operating plans to deliver the desired outcomes.

1.2. Assurance is evidence-based confidence that internal controls are in place, that they operate effectively and that objectives are achieved. The Board Assurance Framework is designed to ensure that there are clear links between the governance responsibilities of the Board, the lines of accountability across the Executive Directors and the assurance activities of the Board's Governance Committees. The framework enables the Board and its committees to discharge their overall governance responsibilities and to gain assurance on delivery of objectives.

1.3. The framework is also used to:

- identify and resolve any gaps in control and assurance.
- identify any areas where assurance is not present, insufficient or disproportionate in relation to the delivery of NHS Forth Valley corporate objectives or operational priorities.
- provide evidence to support the Governance Statement published within the Annual Report and Accounts.

2. The Assurance Framework within NHS Forth Valley

2.1. The Assurance Framework provides a clear picture of the links between the outcomes expected by the Board and the strategic plans, transformational change projects and operational plans developed by the Executive Leadership Team and Senior Leadership Team to deliver those outcomes. Within NHS Forth Valley, it is comprised of the elements described in Appendix 1. These function in alignment to support integrated governance, as detailed in the Blueprint for Good Governance. The construction of the Assurance Framework also ensures the systems for strategic planning and commissioning, implementing change, managing risk and providing assurance information are all aligned and focused on the corporate objectives and operational priorities.

2.2. The Assurance Framework supports NHS Forth Valley to deliver its duty of Best Value, namely:

- to make arrangements to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost; and, in making those arrangements and securing that balance.

- to have regard to economy, efficiency, effectiveness, the equal opportunities requirements and to contribute to the achievement of sustainable development.

2.3. NHS Forth Valley operates on a model of three lines of defence. Each line of defence has a purpose and can provide robust assurance. There is no one line which provides better quality assurance than any of the others however the third line is independent and therefore provides a more objective and higher level of assurance. A range of assurance activities from across all lines of defence provides a rich and value-add assurance picture.

2.4. **First Line of Assurance** - This sits at an Executive, operational and management level, using business as usual activities such as, good policy and performance data, risk registers, reports on routine system controls and other management information. This level ensures that operational units, departments and teams have ownership, responsibility and accountability for controlling and mitigating risks through their processes and day to day activities.

2.5. **Second Line of Assurance** - This is an oversight function and sits at governance Committee and Board level. It is distinct from executive management and from those who are responsible for delivery. This level of defence seeks assurance that objectives, laws, regulations, directions and requirements for public accountability are met. The second line of defence takes its assurance from the first line of defence as it oversees, monitors and scrutinises implementation of activity and delivery of services.

2.6. **Third Line of Assurance** - This represents objective and independent assurance; internal audit forms the organisation's third line of defence. Our independent internal audit function, through a risk-based approach, provides assurance to the Board, Executives and stakeholders. This assurance will cover how effectively NHS Forth Valley assesses and manages its risks and includes support and assurance on the effectiveness of the first and second lines of defence.

2.7. External independent bodies such as external auditors, Audit Scotland, Scottish Government and regulatory bodies can be included as a third line of assurance or can be described as a fourth line of assurance.

3. Key Controls

3.1. The Assurance Framework sets out the key controls which are in place to support delivery of priorities and to mitigate risk. Where gaps in controls or assurance are identified, action plans are put in place, which are designed to either provide additional assurance or reduce the likelihood or consequence of the control weakness or risk identified towards the target. Strategic risks are identified by the Senior Leadership Team and the Corporate Risk Register is actively used by the Board to oversee, scrutinise and as appropriate agree further mitigating controls.

3.2. Responsibilities

- The Chief Executive has overall responsibility for the system of internal control.
- All Executive Directors, Corporate Directors e.g., Director of People, and Chief Officers are responsible for the related management assurances and internal controls in relation to those strategic objectives delegated to them by the Chief Executive.

- All Unit or Divisional Directors and Clinical Directors are responsible for the management of risks and internal controls, and assurance within their divisional area.

- All Managers are responsible for the management of risks and internal controls within their area.

- All members of staff are responsible for adhering to internal controls in the undertaking of their work.

- The Board is responsible for clarifying expectations around the scope and depth of Board assurance requirements.

- The Audit and Risk Committee supports the Board by critically reviewing the governance, risk and assurance processes on which the Board places reliance.

4. Accountability for Risk and Performance

4.1. Risk management is a key component of corporate governance. The role of the Board and its committees with respect to risk management differs from that of managers.

4.2. Effective risk management is the systemic application of principles and processes to identify, assess, evaluate and control risks to NHS Forth Valley objectives and to core service delivery and performance. Effective risk management throughout the organisation will assist NHS Forth Valley to achieve corporate and operational objectives, improve performance and service delivery whilst increasing efficiency and supporting informed decision making to provide a safe, person-centred organisation.

4.3. Managers are responsible for managing risk and developing and implementing the detailed systems of internal controls in their areas of responsibility. This effort should be aimed at delivering the Board's Corporate objectives and improvement. Consequently, management need to assure themselves that those systems of internal control and risk management are operating as intended. By implementing the Risk Management Strategy, managers should be able to provide assurance to the Board and its committees as and when required. The Risk Management Strategy, including appetite and tolerance, is approved by the NHS Board.

4.4. The Board and its committees are not involved in operational management and delivery but exercise oversight of the management of the organisation. The Board and its committees require assurance from management (and other sources) in order to carry out their role in corporate governance.

4.5. Performance management is an integral part of corporate governance and the role of the Board and committees with respect to performance management contrasts from that of managers.

4.6. NHS Forth Valley's Board agrees the organisational aims and objectives and along with the committees will require assurance that the organisations performance is in line with the Board's expectations. Where performance is not progressing as expected, committees can commission further information to be provided to seek assurance that

the drivers of such performance levels are understood and that a remedial action plan is comprehensive and deliverable within an appropriate timescale.

5. System Wide Assurance

5.1. In terms of independent source of assurance, the Board's Audit and Risk Committee has responsibility to ensure that an effective system of internal control is maintained and that a strong corporate governance culture is in operation. The committee is charged with approving and monitoring the delivery of internal and external audit plans to evaluate the effectiveness of the systems, processes and procedures implemented system wide.

6. Governance Committee Assurance

6.1. Within the Board structure the Standing Governance Committees are responsible for ensuring that management implement appropriate arrangements to manage key risks in relation to finance, performance, workforce, clinical activities, patient safety, remuneration and appraisal arrangements, and public and patient involvement. The Standing Governance Committees are, Audit and Risk; Clinical Governance; Staff Governance; Remuneration Committee (as a sub-Committee of the Staff Governance Committee); Strategic Planning, Performance and Resources. These committees are responsible for regularly reviewing and updating relevant policies in each of their areas of responsibilities on behalf of the Board.

6.2. Each committee:

- Is chaired by a Non-Executive Director and is supported by an Executive Lead and Governance Officer.
- Sets and agrees an annual work plan for each Committee.
- Has terms of reference which are reviewed annually, and this is submitted to the Board for approval.
- The agenda for each meeting is set by the Committee Chair in discussion with the Executive Lead, supported by the Governance Officer.
- Agendas and approved minutes from each meeting are submitted to the Board as part of the Committee Chairs update to each Board meeting.
- Undertakes an annual self-assessment.
- Produces an annual report which is submitted to the Board for assurance that the Committee is meeting its terms of reference.

6.3. **Standing Governance Committees**

Committee	Principal Function
Audit and Risk	Ensures that NHS Board activities are within the law and regulations governing the NHS, and that an effective system of internal control is maintained to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided, and reliable financial information produced and that value for money is continuously sought.
Clinical Governance	Ensures effective Clinical Governance is in place and effective throughout the local NHS system and services and is effective in services that are commissioned from independent providers and other partner agencies. Ensures that the principles and standards of clinical governance are applied to the health improvement, health protection and healthcare public health activities of the NHS Board. Receives assurance that an appropriate approach is in place to deal with clinical risk management across the system, working within the NHS Forth Valley Risk Management Strategy
Staff Governance	Holds the organisation to account in terms of meeting the requirements of the NHS Scotland Staff Governance Standard. Specifically, supports and maintains a culture where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon partnership and collaboration. Ensures that robust arrangements to implement the Standard are in place and monitored, and that any associated risks assigned to the Committee are managed. The Remuneration Committee also has a direct reporting link to the Board performing a specific assurance role that appropriate arrangements are in place to meet the statutory requirements laid out in the Staff Governance Standards in respect of the application and implementation of fair and equitable pay and performance management systems for Executive Directors and Senior Managers on Executive pay grades.
Strategic Planning, Performance & Resources	Influences, scrutinises and oversees the early development of the strategic direction of the NHS Board, including: the setting of the Board's vision and corporate objectives; planning and development of corporate policies and strategies for onward referral to the NHS Board for decision; planning and performance of areas related to Integration arrangements; the implementation of service redesign and transformation change programmes taking a Values Based Health and Care approach. It also acts as the Performance Management Committee of the NHS Board with specific scrutiny of Financial and Operational performance.

6.4. Ongoing assurance is provided through a regular cycle of reports to the NHS Forth Valley Board. Assurance reporting addresses the effectiveness of the internal arrangements implemented to support delivery of our strategic plans and manage the

key risks facing NHS Forth Valley. In addition, Governance Committees submit annual reports to the Board, through the Audit and Risk Committee, providing a formal statement of assurance on their effectiveness.

7. Monitoring of the Board Assurance Framework

7.1. It is the duty of Board members to appropriately monitor the NHS Board's significant risks and associated controls and assurances. This includes focusing on the progress of action plans to address gaps in control and assurance.

7.2. An Annual Reports & Assurance Statements paper is brought to the Audit & Risk Committee each year to provide assurance on the key issues and risks identified from the Standing Committee annual reports, and to confirm consistency with Directors' annual assurances and the Governance Statement. Assurances are received from Directors that adequate and effective internal controls and risk management have been in place across their areas of responsibility.

8. Board Assurance Framework Tools

8.1. It is proposed that the effectiveness of the Assurance Framework is assessed through two lenses: the effectiveness of the system and, the culture and leadership driving the adoption of the system. A suite of tools is therefore required to measure the different components. These tools will be embedded into Forth Valley's teams and used on an ongoing basis to measure progress.

8.2. **Code of Corporate Governance** - describes the governance framework within NHS Forth Valley and sets out the standing orders for the Board, the terms of reference for its Governance Committees including the remits delegated to them by the Board and the Standing Financial Instructions. The Code of Corporate Governance requires that all Governance Committees provide an annual report to the Board setting out what areas of assurance they have considered during the year and confirming that they have delivered their remit.

8.3. **Strategic and Operational Planning** – the Corporate Objectives set out the organisation's purpose, vision, values and contribution, and is approved by the NHS Forth Valley Board. Operational plans are created each year in line with Scottish Government guidelines and statutory requirements. These include the Annual Delivery Plan, the Financial Plan and the Workforce Plan. Each plan is considered by the relevant Governance Committee and approved by the Board. Performance reporting against these plans is described below.

8.4. **Corporate Objectives** - Every year the Board review and approve its corporate objectives. These objectives are intended to inform team and individual objectives for the year ahead. The Corporate Plan sets out our corporate objectives and illustrates how they connect to the wider corporate governance arrangements.

8.5. **Assurance Information System** – a Performance Management Framework is in operation within NHS Forth Valley that sets out the governance infrastructure in place to ensure that processes are in place and responsibilities are defined that enable the NHS Board and other key personnel to understand and monitor the Board's achievement

against financial, quality and operational performance, enabling appropriate action to be taken when performance against set targets deteriorates. The framework explains the operating environment to support effective performance management rather than the specific measures to be monitored and provides a framework for leadership from 'Floor to Board' to support effective decision making and ensure that performance management is integral to organisational planning and service delivery. The implementation of an effective system involves Board Members and all employees and affects all stakeholders and service users. It is applied to organisational, financial and commissioning systems and processes. The Performance Framework is detailed in Appendix 2.

8.6. Assurance is provided to the Board through standard reporting formats which align to the NHS Scotland model meeting paper template detailed in DL (2021) 31 Model Meeting Paper Template and Guidance DL(2021)31 - Model Meeting Paper Template and Guidance.

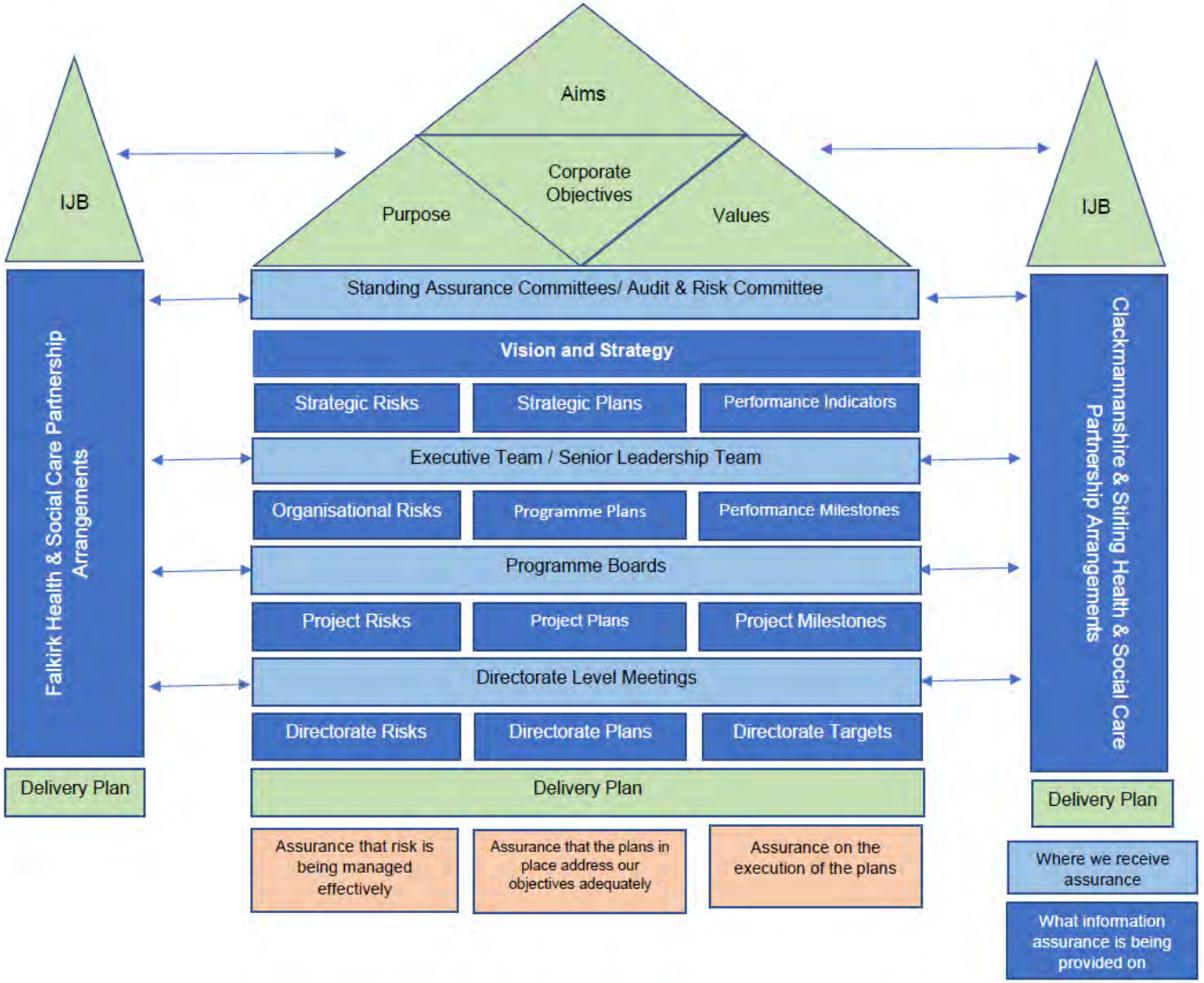
8.7. The Blueprint for Good Governance describes the use of active governance which enables members to focus on the right things, consider the right evidence and respond in the right way. This is supported in NHS Forth Valley by the governance committee structure and conjunction with the processes described for reporting on performance and risk.

8.8. **Risk Management** – a Risk Management Strategy is in place in NHS Forth Valley. This ensures that strategic, operational plan and project risks are recorded, mitigated and reported upon. It also sets out roles and responsibilities in relation to risk management. The approach includes the use of risk appetite which enables the identification of risks which are out with appetite and therefore require focused attention. The Board, Audit and Risk Committee and the Executive Team consider the full strategic risk register at their meetings while other Governance Committees consider the risks aligned to them.

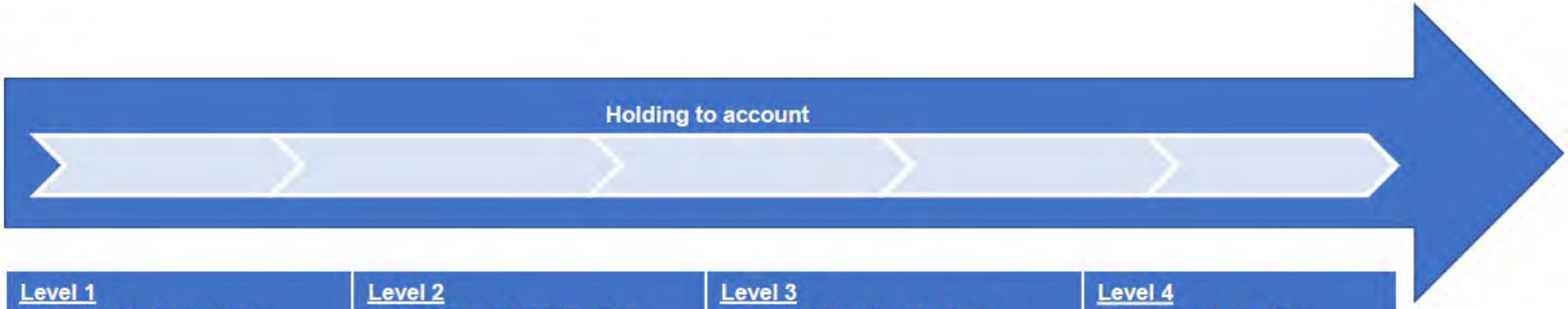
8.9. **Internal Audit** – the Internal Auditors report directly to the Audit and Risk Committee and provide an independent, objective assurance and advisory service designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management, and control processes. Internal Audit provide an annual work plan based on the key risks facing the organisation which also tests the main internal controls. This plan is approved by the Audit and Risk Committee, and they receive progress reports throughout the year. The Committee receive all internal audit reports and updates on progress with recommendations arising from those reports. Internal audit reports are shared with other Governance Committees where the topic falls within or links to their remit for oversight and scrutiny of actions.

8.10. **External Audit** – provide an objective assessment of the financial statements and related processes. An opinion is provided by an independent third party, appointed by the Auditor General for Scotland. The Audit and Risk Committee receive from External Audit the annual audit plan, the independent auditors report and other information in the Annual Report and Accounts.

Board Assurance Framework



Performance Framework



Level 1 Board Risk Assurance		Level 2 Corporate / Operational / Programme Risk Registers	Level 3 Project / Directorate Risk Registers		Level 4 Area / Service Risk Registers
NHS Board	**Board Committees**	**Senior Leadership Team**	**Directorates & HSCPs**	**Service**	**Frontline**
Performance Reports	Performance Reports Delivery Plan Updates Thematic Reports	Regular monthly reporting Exceptions monthly Directorate/ Partnership Performance Reviews	Dashboard reviewed monthly – service specific and core metrics	Key metrics and actions reviewed monthly/ weekly as appropriate	Individual/ team performance reviewed daily/weekly/ monthly as appropriate months
Assurance on Performance, Improvement and Monitoring of Risks	Detailed scrutiny and Monitoring of Performance	Scrutiny on Performance and Improvement	Scrutiny & Support on Performance and Improvement	Scrutiny & Support on Performance and Improvement	Scrutiny & Support on Performance and Improvement

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

14. Code of Corporate Governance – Annual Review
For: Approval

Executive Sponsor: Ms Kerry Mackenzie, Acting Director of Strategic Planning and Performance
Author: Jack Frawley, Board Secretary

Executive Summary
This report provides, as an appendix, the revised Code of Corporate Governance for approval. A table of changes is provided at appendix 1 for information.

Recommendation
The Forth Valley NHS Board is asked to:

- **approve** the Code of Corporate Governance.

Key Issues to be considered
The revised Code of Corporate Governance has been updated to align more closely with the model Code and pulls in best practice from other areas. The Terms of Reference of Committees contained within have been approved by the respective Committees and are more consistent having been developed on the corporate template.

The review of the Scheme of Delegation was led by the Deputy Director of Finance and was supported by working group of other senior officers. The Scheme is now included in full, in line with standard practice nationally. The Standing Financial Instructions have also been reviewed by the Deputy Director of Finance and are presented for approval as part of the Code.

The Risk Management section of the Code will be subject to further review work, led by the Corporate Risk Manager, in the coming months. An updated Risk Management section will be presented to Board for approval later in the year and incorporated into the Code.

A significant change proposed in the Standing Orders is the introduction of a deputation procedure, with the text drawn from one of the optional annexes to the Model Code. This section is proposed for inclusion following consultation with the Board Chair.

The revised Code was subject of consultation with Audit & Risk Committee Members. Additionally, the Code was provided to Board Members and SLT for comment prior to submission to this meeting.

If approved, the appended Code of Corporate Governance will be uploaded to the Board's website.

Implications

Financial Implications
There are no direct financial implications in respect of this paper.

Workforce Implications
There are no direct workforce implications in respect of this paper.

Infrastructure Implications including Digital
There are no direct infrastructure implications in respect of this paper.

Sustainability Implications
There are no direct Sustainability Implications in respect of this paper.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process. (A policy for NHS Scotland on the climate emergency and sustainable development)

☒ Yes
☐ *N/A*

Where applicable, the climate change, environmental and sustainability impacts and any mitigating measures are noted above/contained in the supporting papers.

Quality / Patient Care Implications
None.

Information Governance Implications
There are no direct information governance implications in respect of this paper.

Risk Assessment / Management
There are no direct risk management implications in respect of this paper.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:
- Paper is not relevant to Equality and Diversity

Communication, involvement, engagement and consultation
Engagement has been undertaken with the Board/Senior Leadership team members to get their input and feedback.

Appendices
- Appendix 1: Table of Changes
- Appendix 2: Code of Corporate Governance

NHS Forth Valley – Code of Corporate Governance
Table of Changes

- Text changed throughout document to replace he/she with they.

Section	Change	Rationale
Index	Replace P&R Committee with SPPR Committee	Reflect current Committee Structure
Introduction		
1. Code of Corporate Governance (Section E)	Replaces Annexes with full Scheme of Delegation Document as new Section E.	The full details of delegation should be included in the Code to align with national practice.
2. Xenotransplantation	Duplicate text removed.	Typographical
4. Function of the Board	Reposition of text from later in section.	Improved comprehension of section.
5. Composition of the Board	Replace Directors with Members.	Standard wording.
5. Composition of the Board	Increase to 8 Non-Executive Lay Members	Reflect actual size of Non-Executive cohort.
5. Composition of the Board	Delete 'Lay'	Standard wording is 'Non-Executive Members'
14. Definitions	'Regulations 2011' corrected to 'Regulations 2001'.	Typographical
14. Definitions	Add 'Board Secretary'	Defined as standard nationally.
14. Definitions	Add 'Director of Finance'	Defined as standard nationally.
14. Definitions	Add 'Member'	Defined as standard nationally.
14. Definitions	Add 'Officer'	Defined as standard nationally.
14. Definitions	Delete 'Lay Member'	Not used in document.
14. Definitions	Vich Chair – corrected to reflect appointment by Cabinet Secretary	Reflect appointment procedure.
Section A: Standing Orders		
1.1 General	Amend to 'Holding the ***Executive Leadership Team*** to account'	Reflects wording of the Blueprint and model SOs.
1.5 General	Paragraph reference updated for accuracy.	Typographical
1.6 Ethical Conduct	Corrected title 'Commissioner for Ethical Standards'.	Typographical

1.8 Ethical Conduct	References updated for accuracy.	Typographical
4.8 Calling and Notice of Board Meetings	Addition of 'Advisory' to distinguish from Assurance Committees.	Typographical
4.9 Calling and Notice of Board Meetings	Addition of Deputation provision adopted from Annex of Optional Provisions in the Model Code.	Set out a framework for how deputations and petitions will be handled.
5.8 Quorum	Reference updated for accuracy.	Typographical
5.14 The Agenda	Reference updated for accuracy.	Typographical
5.25 Minutes	Replace Corporate Business Manager with Board Secretary.	Updated to reflect practice.
6.2(a) Reservations	Wording expanded to incorporate Code of Corporate Governance rather than just Standing Orders.	Reflect practice.
6.2(i) Reservations	Delete SFIs and Scheme of Delegation.	Now incorporated in 6.2(a)
6.2(k) Matters Reserved to the Board	Add link to the Scottish Capital Investment Manual	Link added.
7.3 Delegation of Authority by the Board	Add link to the NHS Scotland Property Transactions Handbook	Link added.
9.5 Committees	Replace 'Person Presiding' with 'Chair of the Committee'	Updated to standard wording.
Annex B – Assurance Committee ToRs	Delete 'Clinical Governance Ethical Issues Sub-Committee'	Stood down by decision of Board in November 2024.
Terms of Reference of Committees	All updated to revised versions approved by Committees in their annual review.	
Section D: The Fraud Standards & Policy		Reviewed by Internal Audit & DoF
Throughout	Addition of 'embezzlement and bribery'	
1.2	Updated explanation of PA.	
2.3	Embezzlement defined.	

3.1	Public Service Values explanation updated.	
4.4	Whistleblowing added.	
5.1	Accountable Officer added.	
5.3	Updated to add all staff duty.	
5.4	Updated to add CFC role.	
5.9	Updated to add NFI role.	
7.2	Controlled Drugs wording updated.	
8.7	Section repositioned.	
9.3	Additional provision.	
10.5	Additional provision.	
11.3	Additional provision.	
Section E: Scheme of Delegation		
Full review conducted and revised document now included in Code.		
Section F: Standing Financial Instructions		
1.3.2	Cash Requirement Limit	Typographical
1.3.4	ELT replaced with SLT	Typographical
5.6.2	Updated wording	Accuracy - DDoF
5.6.3	Emergency and unscheduled care	Typographical
Section 6	Cash and Banking	Update - DDoF
6.2 & 6.3	Cash Handling and Security sections added.	Update – DdoF
6.4	Bank Accounts revised	Update – DdoF
6.5	Banking Procedures revised	Update – DdoF
Investments	Removed	Update - DDoF
7.2	Updated to ‘Privately Financed Infrastructure Investment’	DDoF
8.2.12(d)	Addition on software procurement.	DDoF
Section 9	Updated to remove Security of Cash and other Negotiable Instruments	Covered in earlier revisions.
9.2.2	Addition of UNPACS information.	DDoF
Section 11	Updated to ‘Accounts Payable’	DDoF
11.2.1(b)	List updated.	Update - DDoF

12.3.7	New provision on legal claims.	DDoF
12.4.1	Confirmation of write-off procedure.	
16.1.3 & 16.1.4	New provisions on Annual Report & Accounts procedure.	

Code of Corporate Governance

Version	Purpose/Change	Author	Date
1.0	Annual Review of Code of Corporate Governance.	Cathie Cowan, Chief Executive Kerry Mackenzie, Head of Policy & Performance Jackie McEwan, Corporate Business Manager Sinead Hamill, Board Secretary	September 2021
2.0	Addition of amendments following review by NHS Board in September.	Cathie Cowan, Chief Executive Kerry Mackenzie, Head of Policy & Performance	November 2021
3.0	Annual Review. Review of Assurance Committee Terms of Reference. Update to Fraud Policy.	Kerry Mackenzie, Head of Policy & Performance	March 2022
3.1	Update to Terms of Reference, Corporate Objectives, Code of Conduct, Risk Management Strategy.	Kerry Mackenzie, Head of Policy & Performance	September 2022
4.0	Update to Terms of Reference, Standards of Business Conduct, Fraud Standards and Policy, Standing Financial Instructions, Risk Management Strategy.	Kerry Mackenzie, Head of Policy & Performance Jillian Thomson, Deputy Director of Finance Shona Slayford, Principal Auditor & NHS Forth Valley Fraud Liaison Officer	March 2024
5.0	Annual Review of Code of Corporate Governance.	Kerry Mackenzie, Acting Director of Strategic Planning & Performance; Jillian Thomson, Deputy Director of Finance; Jack Frawley, Board Secretary	March 2025

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Introduction

1. Code of Corporate Governance

The Code of Corporate Governance includes the following sections:

Section A - How business is organised.
Section B - Members Code of Conduct.
Section C - Standards of Business Conduct for NHS Staff.
Section D - The Fraud Standards.
Section E - Scheme of Delegation
Section F - Standing Financial Instructions.
Section G - Risk Management.

The Board keeps the Code of Corporate Governance under review and will undertake a comprehensive review annually.

2. The NHS in Scotland

The National Health Service (NHS) was established in Britain in 1948. Despite a growth in private health provision and insurance, the NHS provides the vast majority of Healthcare in Scotland.

The purpose of the NHS is to secure through the resources available the greatest possible improvement in the physical and mental health of the Nation by: promoting health; preventing ill health; diagnosing and treating injury and disease, and caring for those with long term illness and disability who require the services of the NHS' (Department of Health 1996).

Health Policy was, in the main, devolved to the Scottish Parliament under the Terms of the Scotland Act 1998 (the '1998 Act'). However, there are some areas of Health Policy which remain reserved. These are:

- Abortion
- Xenotransplantation (the use of non-human organs for transplantation)
- Embryology, Surrogacy and Genetics
- Licensing of Medicines, Medicines Supplies and Poisons (although decisions on whether the NHS should fund licensed medicines are devolved)
- Welfare foods
- The Regulation of Health Professions (although Regulation of professions not regulated prior to the 1998 Act is devolved)
- Health and Safety

The NHS in Scotland carries on the principle of collective responsibility by the State for the provision of comprehensive Health Services free at the point of use for all. Services are funded from central taxation and access should be based on need.

3. NHS Boards

The National Health Service (Scotland) Act 1972 allows for the establishment of area Health Boards to assess health needs and administer the provision of relevant healthcare. There are 14 territorial NHS Boards in Scotland, one of which is Forth Valley NHS Board.

The main legislation providing the legal framework for the NHS in Scotland is the National Health Service (Scotland) Act 1978.

The Functions of Health Boards (Scotland) Order 1991 sets out the requirements of Scottish Ministers in terms of the functions that Health Boards have to provide for healthcare to their local population. This Order details the high-level functions which the Health Board is directed by the

Minister to provide. The Board is a Board of Governance, not a representative body, nor a management body.

4. Role of the Forth Valley NHS Board

Forth Valley NHS Board (the Board) is a strategic body, accountable to the Scottish Government Health and Social Care Directorate and to Scottish Ministers for the functions and performance of NHS Forth Valley. The Board consists of the Chair, Non-Executive and Executive Members, who are appointed by the Scottish Ministers.

The Board will not concern itself with day-to-day operational matters, except where they have an impact on the overall performance of the system.

The Overall Purpose of the Forth Valley NHS Board

Effective NHS Boards articulate an ambition for their organisation whilst managing the risk contained within that ambition and demonstrating leadership by undertaking 3 key roles:

- Formulating strategy for the organisation, including the development annually of a Delivery Plan.
- Ensuring commitment and accountability by holding the organisation (all staff) to account for performance and the delivery of both improvement in population health, individual experience of care whilst operating with a context of affordability and sustainability.
- Shaping a positive culture (open, just, and fair) for the Board and organisation.

In summary our purpose is:

- as a Board we aim to optimise health, optimise care and optimise value.

The Function of the Board

- Setting the direction, including clarifying priorities and defining change and transformational expectations.
- Holding the Executive Leadership Team to account by seeking assurance that the organisation is being effectively managed and change is being successfully delivered.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with key stakeholders, as and when appropriate.
- Influencing the Board's and the wider organisational culture.
- Strategy Development - to develop a Delivery Plan which addresses the health priorities and health care needs of the resident population.
- Monitoring the effective performance of the Board's activities and ensuring achievement of its aims.
- Ensuring that resources (staff, finance and premises) are used effectively and responsibly to support local priorities and strategic objectives.
- Ensuring that Governance arrangements are robust, rigorous and effective.
- Ensuring probity and propriety in the workings of the organisation.

Responsibilities of Members of Forth Valley NHS Board

- Shared responsibility for the discharge of the functions of the Board.
- Exercise independent, impartial judgement on issues of strategy, resource allocation, performance management, key appointments and accountability to Scottish Ministers and to the local community.
- Responsibility for the overall performance of NHS Forth Valley, using information on the performance of the organisation to assess and challenge the quality of services.

Board Members support the Chair and work with other Members to discharge the functions of the Board.

5. Composition of the Board

The Board consists of the following Members appointed by the Minister:

Non-Executive Members	Executive Members
• Chair • 8 Non-Executive Members (one is Whistleblowing Champion) • Chair - Area Clinical Forum • Employee Director • 3 Local Authority Elected Members - 1 each from Local Authority notably: Clackmannanshire, Falkirk, and Stirling.	• Chief Executive • Director of Finance • Director of Public Health and Strategic Planning • Medical Director • Nurse Director

6. Individuals Roles, Responsibilities and Accountabilities[1]

	Chair	**Chief executive**	**Non-executive director**	**Executive director**
Formulate Strategy	Ensures board develops vision, strategies, and clear objectives to deliver organisational purpose.	Leads strategy development process.	Brings independence, external skills, and perspectives, and challenge to strategy development.	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant).
Ensure Accountability	Holds CE to account for delivery of strategy. Ensures board committees that support accountability are properly constituted.	Leads the organisation in the delivery of strategy. Establishes effective performance management arrangements and controls. Acts as Accountable Officer.	Holds the executive to account for the delivery of strategy. Offers purposeful, constructive scrutiny and challenge. Chairs or participates as member of key committees that support accountability.	Leads implementation of strategy within functional areas.
Shape Culture	Provides visible leadership in developing a positive culture for the organisation and ensures that this is reflected and modelled	Provides visible leadership in developing a positive culture for the organisation and ensures that this is reflected in their own	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour. Provides a safe point	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour.

[1] NHSLeadership-TheHealthyNHSBoard.pdf (leadershipacademy.nhs.uk)

	in their own and in the board's behaviour and decision making. Board culture: Leads and supports a constructive dynamic within the board, enabling contributions from all directors.	and the executive's behaviour and decision making.	of access to the board for whistle-blowers.	
Context	Ensures all board members are well briefed on external context.	Ensures all board members are well briefed on external context.		
Intelligence	Ensures requirements for accurate, timely & clear information to board/ directors (and governors for FTs) are clear to executive.	Ensures provision of accurate, timely & clear information to board/ directors (and governors for FTs).	Satisfies themselves of the integrity of financial and quality intelligence.	Takes principal responsibility for providing accurate, timely and clear information to the board.
Engagement	Plays key role as an ambassador, and in building strong partnerships with: • Patients and public • Member and governors (FT) • Clinicians and Staff • Key institutional • Stakeholders • Regulators	Plays key leadership role in effective communication and building strong partnerships with: • Patients and public • Member and governors (FT) • Clinicians and Staff • Key institutional • stakeholders • Regulators	Ensures board acts in best interests of the public. Senior independent director is available to members and governors if there are unresolved concerns (FTs).	Leads on engagement with specific internal or external stakeholder groups.

7. Values

The Purpose, Role, Functions and Responsibilities of Forth Valley NHS Board and Board Members, will be delivered in a way which upholds the organisational values. NHS Forth Valley's values represent the care our patients can expect, and how this care should be delivered by our staff.

Our local values in NHS Forth Valley are:

- Be person centred
- Be respectful
- Have integrity
- Be ambitious
- Be supportive
- Be a committed team member

Our Values should be visible in everything we do and drive the improvement of our services.

NHS Forth Valley's values are closely aligned to the NHS Scotland's values, which are shared by all staff throughout Scotland:

- Care and Compassion
- Dignity and Respect
- Openness, Honesty and Responsibility
- Quality and Teamwork

Both sets of values underpin and support NHS Scotland's national quality ambitions:

- Person-centred
- Safe
- Effective

8. Conduct, Accountability, and Openness

Members of Forth Valley NHS Board (Executive and Non-Executive) are required to comply with the Members' Code of Conduct and the Standards of Business Conduct for NHS Staff.

Board Members and staff are expected to promote and support the principles in the Members' Code of Conduct and to promote by their personal conduct the values of:

- Public Service
- Leadership
- Selflessness
- Integrity
- Objectivity
- Openness
- Accountability and stewardship
- Honest
- Respect

9. Understanding our responsibilities arising from the Code of Corporate Governance

It is the duty of the Chair and the Chief Executive to ensure that Board Members and staff understand their responsibilities. Managers are responsible for ensuring their staff understand their own responsibilities. The Code of Corporate Governance will be published on the Board's website.

10. Endowment Funds

The principles of this code of Corporate Governance apply equally to Member of Forth Valley NHS Board who have distinct legal responsibilities as Trustees of the Endowment Funds.

11. Advisory and Other Committees

The principles of this Code of Corporate Governance apply equally to all NHS Forth Valley Advisory Committees and all committees and groups which report directly to a Forth Valley Board Committee.

12. Review

The Board will review the Code of Corporate Governance on an annual basis and will revise the Code to reflect any National or Local Changes which impact on the Board and its functions. The Board may, on its own or if directed by the Scottish Ministers, vary and revoke Standing Orders for the regulations of the procedures of business of the Board and of any Committee.

13. Feedback

NHS Forth Valley aims to continuously improve the services we deliver, and it is important that this Code remains relevant, we would therefore be happy to hear from you regarding new operational statements or any other matter connected with the Code.

Comments and suggestions for improvement are most welcome and should be sent to:

Corporate Business Manager
NHS Forth Valley
Carseview House
Castle Business Park
Stirling
FK9 4SW

14. Definitions

Any expressions to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts Shall have the same meaning in the interpretation and in addition:

Definition	Meaning
The Accountable Officer	Is the Chief Executive of NHS Forth Valley, who is responsible to the Scottish Parliament for the economical, efficient, and effective use of resources. The Chief Executive of NHS Forth Valley is also accountable to the Board for clinical, staff and financial governance, including controls assurance and risk management, and for delivery of other statutory requirements. This is a legal appointment made by the Principal Accountable Officer of the Scottish Government. (Public Finance and Accountability (Scotland) Act 2000 Memorandum to Accountable Officers for other Public Bodies).
The Act	The National Health Service (Scotland) Act 1978 as amended.
The 2001 Regulations	The Health Board's (Membership and Procedure) (Scotland) Regulations 2001.
The 1960 Act	The Public Bodies (Admission to Meetings) Act 1960 as amended.
Board Member	A person appointed as a Member of the Board by Scottish Ministers and who is not disqualified from membership.
Board Secretary	Responsible for ensuring that the Board complies with relevant legislation and governance guidance. The Board Secretary will ensure that meetings of the Board and its Committees run efficiently and effectively, and that they are properly recorded.
Budget	Money proposed by the Board for the purpose of carrying out, for a specific period, any, or all of the functions of the Board.

Chair	The person appointed by the Scottish Ministers to lead the Board and to ensure that it successfully discharges its responsibility as a whole. The Chair of a Committee is responsible for fulfilling the duties of a Chair in relation to that Committee only.
Chief Executive	The Accountable Officer of NHS Forth Valley.
Committee	A Committee established by the Board and includes "Sub-Committee".
Committee Members	People formally appointed by the Board to sit on or to Chair specific committees.
Contract	Any arrangements including an NHS Contract.
Co-opted Member	An individual, not being a Member of the Board, who is appointed to serve on a Committee of the Board.
Community Planning Partners	Statutory Service providers, third and independent sector organisations with a stake in providing services and support to people in Forth Valley.
Director of Finance	The Chief Finance Officer of the Board.
Integration Joint Board	The constitutional arrangements for the establishment of Integration Joint Boards are set out within Scottish Statutory Instrument 2014 No. 285 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.
Meeting	A meeting of the Board or any Committee.
Member	A person appointed as a Member of the Board by Scottish Ministers, and who is not disqualified from membership. This definition includes the Chair, Executive and Non-Executive Members.
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within the Code of Corporate Governance.
Officer	An employee of NHS Forth Valley.
Department of Health and Social Care	The Scottish Government and is its legal name.
SFIs	Standing Financial Instructions.
Vice Chair	The Non-Executive Member appointed by the Cabinet Secretary Health & Social Care to take on the Chair's duties if the Chair is absent for any reason.

SECTION A

How Business is Organised - Standing Orders

Standing Orders for the Proceedings and Business of Forth Valley NHS Board

1. General

1.1. These Standing Orders for regulation of the conduct and proceedings of Forth Valley NHS Board, the common name for Forth Valley Health Board, [the Board] and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3)[2].

The Blueprint for Good Governance in NHS Scotland Second Edition[3] has informed these Standing Orders. The Blueprint describes the functions of the Board as:

- Setting the direction.
- Holding the Executive Leadership Team to account.
- Managing risk.
- Engaging stakeholders.
- Influencing culture.

Further information on the role of the Board, Board members, the Chair, Vice-Chair, and the Chief Executive is available on the NHS Scotland Board Development website (https://learn.nes.nhs.scot/17367/board-development).

1.2. The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension, and disqualification of members in line with the above regulations. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

1.3. Any statutory provision, regulation, or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.4. Any one or more of these Standing Orders may be varied or revoked at a meeting of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition, or amendment. The Board will annually review its Standing Orders.

1.5. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a member from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

[2] http://www.legislation.gov.uk/ssi/2001/302/pdfs/ssi_20010302_en.pdf

[3] The Blueprint for Good Governance in NHS Scotland - Second Edition (www.gov.scot)

Board Members – Ethical Conduct

1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of the Forth Valley NHS Board. The Commissioner for Ethical Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Board will have appointed a Standards Officer. This individual is responsible for carrying out the duties of that role, however they may delegate the carrying out of associated tasks to other members of staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend their entry in the Register, they must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.

1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.

1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations or cross-refer to where the information is published.

1.11 The Board's Corporate Business Manager shall provide a copy of these Standing Orders to all members of the Board on appointment. A copy shall also be held on the Board's website.

2. Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board.

3. Vice Chair

3.1 The Chair shall nominate a candidate or candidates for Vice Chair to the Cabinet Secretary. The candidate(s) must be a non-executive member of the Board. A member who is an employee of a Board is disqualified from being Vice Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position. Following the decision, the Board shall appoint the member as Vice Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice Chair is the process described at paragraph 3.1.

3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform their duties due to illness, absence from Scotland or for any other reason, then the Board Secretary should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair. Where the Chair is absent for a short period due to leave (for whatever reason) the Vice Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the

duties, be taken to include references to either the interim chair or the Vice Chair. If the Vice Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

4 Calling and Notice of Board Meetings

4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least 6 times in the year and will annually approve a forward schedule of meeting dates.

4.2 The Chair will determine the final agenda for all Board meetings. The agenda may include an item for any other business; however, this can only be for business which the Board is being informed of for awareness, rather than being asked to decide. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member at which meeting the item will be discussed. If any member has a specific legal duty or responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.

4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.

4.5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

4.6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least seven (7) days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point**.**

4.7 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.8 Board meetings shall be held in public. A public notice of the time and place of the meeting shall be provided at least seven (7) days before the meeting is held and shall be placed on the Board's website. The meeting papers shall be placed on the Board's website the morning of the meeting. The meeting papers will include the minutes of Board Committee and Advisory Committee meetings. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. The Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available. For items of business which the Board will consider in private session (see paragraph 5.22), only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them.

4.9 Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken.

Any member may put any relevant question to the deputation, but will not express any opinion on the subject matter until the deputation has withdrawn. If the subject matter relates to an item of business on the agenda, no debate or discussion will take place until the item is considered in the order of business.

Any individual or group or organisation which wishes to submit a petition to the Board will deliver the petition to the Chair's Office at least 21 working days before the meeting at which the subject matter may be considered. The Chair will decide whether or not the petition will be discussed at the meeting.

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

5.1 The Chair shall preside at every meeting of the Board. The Vice Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of a Board to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video conferencing, teleconferencing. For the avoidance of doubt, those members using such facilities will be regarded as present at the meeting.

5.4 In the event that any member who disregards the authority of the person presiding, obstructs the meeting, or conducts themselves inappropriately the person presiding may suspend the member for the remainder of the meeting. If a person so suspended refuses to leave when required by the person presiding to do so, the person presiding will adjourn the meeting in line with paragraph 5.12. For paragraphs 5.5 to 5.20, reference to 'Chair' means the person who is presiding the meeting, as determined by paragraph 5.1.

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for committees will be set out in their terms of reference, however it can never be less than two Board members.

5.6 In determining whether or not a quorum is present the Chair must consider the effect of any declared interests.

5.7 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under

consideration and should not be counted as participating in that meeting for quorum or voting purposes.

5.8 Paragraph 5.7 will not apply where a member, or an associate of theirs, interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of any question with respect to that contract or matter. In March 2015, the Standards Commission granted a dispensation to NHS Board members who are also voting members of Integration Joint Boards. The effect is that those members do not need to declare as an interest that they are a member of an Integration Joint Board when taking part in discussions of general health & social care issues. However, members still have to declare other interests as required by Section 5 of the Board Members' Code of Conduct.

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.10 Paragraphs 5.6-5.9 shall equally apply to members of any Board committee, whether or not they are also members of the Board, e.g, stakeholder representative.

5.11 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close.

Adjournment

5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to another day, time, and place. A meeting of the Board, or of a committee of the Board, may be adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

The Agenda

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, they must make a request to the Chair ideally in advance of the day of the meeting and certainly before the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting.

5.14 The Chair may change the running order of items for discussion on the agenda at the meeting. Please also refer to paragraph 4.2.

Decision-Making

5.15 The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. Members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.

5.16 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.

5.17 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.

5.18 The Board may reach consensus on an item of business without taking a formal vote, and this will normally be what happens where consensus has been reached.

5.19 Where the Chair concludes that there is not a consensus on the Board's position on the item and/ or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

5.20 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines.

5.21 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting.

Board Meeting in Private Session

5.22 The Board may agree to meet in private in order to consider certain items of business. Items will be detailed on the Board meeting agenda noting the grounds for consideration in closed session. The Board may decide to meet in private on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters and needs time for private deliberation.
- The business relates to the commercial interests of any person and confidentiality is required, e.g., when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

5.23 The minutes of the meeting will reflect when the Board has resolved to meet in private.

Minutes

5.24 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded in the minute of the meeting. The names of other persons in attendance shall also be recorded.

5.25 The Board Secretary (or their authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft minutes at the following meeting. The person presiding at that meeting shall sign the approved minute.

6 Matters Reserved to the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at an NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board and should be read in conjunction with Section 3 of the Scheme of Delegation:

a) Approval of the Code of Corporate Governance, which encompasses: Standing Orders, Committee arrangements and Terms of Reference, Scheme of Delegation, Fraud Standards and Policy, and Standing Financial Instructions.
b) The establishment and terms of reference of all its committees, and appointment of committee members.
c) Organisational Values.
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Delivery Plan for submission to the Scottish Government for its approval.
(Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Delivery Plan, the Board should receive it at a public Board meeting).
f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Annual accounts and report.
(Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts, or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly, the Board cannot publish the report of the external auditors of their annual accounts in this period).
j) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
k) The Board shall approve the content, format, and frequency of performance reporting to the Board.
l) The appointment of the Board's chief internal auditor.
(Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment).

6.3 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g, the integration schemes for a local authority area.

6.4 The Board itself may resolve that other items of business are deemed to be reserved for the Board.

7 Delegation of Authority by the Board

7.1 Except for the Matters Reserved for the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions and the Scheme of Delegation available on the NHS Board website.

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any decision for itself. The Board may withdraw any previous act of delegation to allow this.

8 Execution of Documents

8.1 Where a document requires to be authenticated under legislation or rule of law relating to the authentication of documents under the Law of Scotland, or where a document is otherwise required to be authenticated on behalf of the Board, it shall be signed by an executive member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the Requirements of Writing (Scotland) Act 1995. Before authenticating any document, the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

8.2 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management, and disposal of land.

8.3 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

9 Committees

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board Development website will identify the committees which the Board must establish.
https://learn.nes.nhs.scot/17367/boarddevelopment)

9.2 The Board shall appoint the chairs of all committees. The Board shall approve the terms of reference and membership of the committees. The Board shall review these as and when required and shall review the terms within 2 years of their approval if there has not been a review.

9.3 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed.

9.4 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a committee member who is also a non-executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members include some of the Board's members, the committee's meetings shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise. Generally, Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However, if the committee elects

to consider certain items as restricted business, then the meeting papers for those items will normally only be provided to members of that committee. The chair of the committee meeting may agree to share the meeting papers for restricted business papers with others.

9.6 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time and shall call a meeting when requested to do so by the Board.

9.7 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills, and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of Forth Valley NHS Board and is not to be counted when determining the committee's quorum.

ANNEX A: SUSPENSION AND DISQUALIFICATION

(1) Subject to paragraphs (2) and (3), a person shall be disqualified from being a Member, if:

(a) they have, within the period of five years immediately preceding the proposed date of appointment, been convicted in the United Kingdom, the Channel Islands, the Isle of Man, or the Irish Republic of any offence in respect of which they have received a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

(b) their estate has been sequestrated in Scotland or they have otherwise been adjudged bankrupt elsewhere, they have granted a trust deed for the benefit of their creditors or entered into any arrangement with their creditors, or a curator bonis or judicial factor has been appointed over their affairs.

(c) they have resigned or been removed or been dismissed, otherwise than by reason of redundancy, from any paid employment or office with a health service body.

(d) they are a person whose appointment as the chairperson, member or director of a health service body has been terminated other than by the expiration of their term of office.

(e) they are a chairperson, member, director, or employee of a health service body outwits the Forth Valley NHS Board area.

(f) they have had their name removed, by a direction under section 29 of the Act, from any list prepared under Part II of the Act and have not subsequently had their name included in such a list.

(g) they are a person whose name has been included in any list prepared under Part II of the Act, and whose name has been withdrawn from the list on their own application.

(h) they have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of the 1977 Act and have not subsequently had their name included in such a list.

(i) they are a person whose name has been included in any list prepared under Part II of the 1977 Act, and whose name has been withdrawn from the list on their own application.

(j) they are a person who is subject to a disqualification order under the Company Directors Disqualification Act 1986; or

(k) they are a person who has been removed from the position of trustee of a charity, whether by the court or by the Charity Commissioner.

(2) For the purpose of paragraph (1):

(a) the disqualification attaching to a person whose estate has been sequestrated shall cease if and when -

(i) the sequestration of their estate is recalled or reduced; or
(ii) the sequestration is discharged.

(b) the disqualification attaching to a person by reason of their having been adjudged bankrupt shall cease if and when -

(i) the bankruptcy is annulled; or
(ii) they are discharged.

(c) the disqualification attaching to a person in relation to whose estate a judicial factor has been appointed shall cease if and when -

(i) that appointment is recalled; or
(ii) the judicial factor is discharged.

(d) the disqualification attaching to a person who has granted a trust deed or entered into an arrangement with their creditors shall cease if and when that person pays their creditors in full or on the expiry of five years from the date of their granting the deed or entering into the arrangement.

(3) The Scottish Ministers may direct that in relation to any individual person or Board any disqualification so directed shall not apply in relation thereto.

(4) For the purposes of paragraph (1)(a) the date of conviction shall be deemed to be the date on which the days of appeal expire without any appeal having been lodged, or if an appeal has been made, the date on which the appeal is finally disposed of or treated as having been abandoned.

ANNEX B: ASSURANCE COMMITTEE TERMS OF REFERENCE

- Audit and Risk Committee
- Clinical Governance Committee
- Pharmacy Practices Committee
- Remuneration Committee
- Staff Governance Committee
- Strategic Planning, Performance and Resources Committee

AUDIT AND RISK COMMITTEE - TERMS OF REFERENCE

1. Purpose

1.1 The purpose of the Audit and Risk Committee is to ensure that NHS Board activities including Patients Private Funds are:

- within the law and regulations governing the NHS.
- that an effective system of internal control is maintained to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided, and reliable financial information produced and that value for money is continuously sought.

2. Duties & Responsibilities

2.1 Objectives

The main objectives of the Audit and Risk Committee are to ensure that NHS Forth Valley acts within the law, regulations, and code of conduct applicable to it and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee are in accordance with the Public Sector Internal Audit Standards and the Scottish Government Audit Committee Handbook. The Audit and Risk Committee will also periodically review its own effectiveness and report the results of that review to the Board and Accountable Officer.

2.2 Internal Control and Corporate Governance

The Committee will, in respect of the framework of internal control and corporate governance:

- evaluate the Control environment.
- evaluate the adequacy of the organisation's risk management arrangements, systems, and processes.
- approve the annual risk management reports on effectiveness, adequacy, and robustness of the risk management system.
- evaluate the adequacy of the Decision-making processes.
- evaluate Information and communication.
- be responsible for Monitoring and corrective action.
- review the effectiveness of the Anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.
- review the system of internal finance control, including:
  - (i) the safeguarding of assets against unauthorised use and disposition.
  - (ii) maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication.
- ensure the NHS Board's activities are within the law and regulations governing the NHS.
- Review, and thereafter, recommend approval to the NHS Board of the Risk Management Strategy.
- present an annual assurance statement on the above to the NHS Board to support the Governance Statement.
- take account of the implications of publications detailing best audit practice.
- take account of recommendations contained in the relevant reports of the Auditor General and the Scottish Parliament.
- provide an Annual Report of the Committee's activities to the Forth Valley NHS Board, to inform the preparation and review of the Board's Governance Statement.
- scrutinise the Strategic Risks aligned to the Committee.

2.3 Internal Audit

The Committee will:

- influence, review and approve the Internal Audit Strategic and Annual Plan.
- monitor audit progress and review audit reports.
- monitor the management action taken in response to audit recommendations.
- consider the Chief Internal Auditor's annual report and assurance statement.
- review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency, and performance measures.
- maintain direct contact with Internal Audit and provide the opportunity for discussions with the Chief Internal Auditor as required without the presence of the Executive Directors.
- review the terms of reference and appointment of the Internal Auditors.

2.4 External Audit

The Committee will:

- review the Audit Strategy and Plan, including the Performance Audit Programme.
- consider all statutory audit material, in particular:
  (i) Audit Reports (including Performance Audit Studies)
  (ii) Annual Reports
  (iii) Management Letters relating to the certification of the NHS Board.

- monitor management action taken in response to all External Audit recommendations including Performance Audit Studies following consideration by the relevant Governance Committee.
- hold meetings with the External Auditors at least once per year without the presence of the Executive Directors.
- review the extent of co-operation between External and Internal Audit.
- Annually appraise the performance of the External Auditors.
- note the appointment and remuneration of External Auditors and to examine any reason for the resignation or dismissal of the Auditors.

2.5 Standing Orders and Standing Financial Instructions

The Committee will:

- conduct an annual review of the Code of Corporate Governance and recommend approval to the Forth Valley NHS Board.
- examine the circumstances associated with each occasion when Standing Orders are waived or suspended.

2.6 Annual Accounts

The Committee will:

- review, and approve, annually any changes in accounting policy.
- review a schedule of losses and compensation payments.
- review and recommend approval to the NHS Board of the Annual Accounts.
- report in the Directors Report on the roles and responsibilities of the Audit Committee and actions taken to discharge those.
- review and recommend approval to the NHS Board of the Patients Funds Annual Accounts.
- receive reports from the FHS (Family Health Service) Performance Review /

Reference Group which is responsible for dealing with Primary Care contractor issues and alleged breaches of terms of reference.

3. Composition

3.1 Membership of the Audit & Risk Committee shall comprise:

- five Non-Executive Members of the Forth Valley NHS Board.

3.2 The Chair of Forth Valley NHS Board and Executive Forth Valley NHS Board Members are not eligible for Membership but may attend meetings of the Committee.

3.3 The Committee Chair shall be appointed at a meeting of Forth Valley NHS Board in accordance with the Standing Orders. The Chair shall preside at every meeting of the Committee. In the event that the Chair of the Committee is unable to attend, another Non-Executive Member will be designated as Chair for the meeting.

3.4 The Director of Finance shall serve as the Lead Executive Officer to the Committee.

The Executive Lead will oversee the development of an annual workplan for the Committee which reflects its remit and the need to provide appropriate assurance at the year-end for both the Committee and the Forth Valley NHS Board.

4. Quorum

4.1 No business shall be transacted unless a minimum of three Non-Executive Board Members are present.

5. Attendees

5.1 The Chief Executive, Director of Finance, the Chief Internal Auditor and the Statutory External Auditor shall normally attend meetings. The Committee can request the attendance of any officer of NHS Forth Valley at its meetings.

5.2 All NHS Board Members shall have the right of attendance and have access to papers, except where the Committee resolves otherwise.

6. Frequency

6.1 To fulfil its remit the Audit & Risk Committee will meet no fewer than four times in a year but may elect to have additional meetings, at the discretion of the Chair. The Committee will conduct its meetings in accordance with the Standing Orders.

6.2 If necessary, meetings of the Committee shall be convened and attended exclusively by Members of the Committee and/or the External Auditor or Internal Auditor.

7. Agenda & Papers

7.1 The agenda and supporting papers will normally be sent out at least five working days in advance of the meetings.

7.2 All papers will be completed on the approved NHS Forth Valley template and clearly state the agenda reference, the author and the purpose of the paper together with the action the Committee are asked to consider.

8. Minutes

8.1 Formal Minutes will be kept of the proceedings. Draft minutes shall be distributed for consideration and review to the Chair of the Committee within 2 weeks of the meeting, except in exceptional circumstances.

8.2 The draft minutes will be circulated electronically to Committee Members for approval following sign off by the Committee Chair. These minutes will then be presented to the next meeting of the Committee for ratification.

8.3 Minutes will be included for noting in subsequent Board Meeting papers following ratification by Committee.

9. Authority

9.1 The Committee is authorised to:

- ensure compliance with due process relating to any investigation of activities which are within the terms of its responsibility and duties. In doing so the Committee is authorised to seek information it requires from any Board member or employee, paying due regard to professional responsibilities and personal data rights. All members and employees are expected to co-operate with reasonable requests made by the Committee.
- approve matters as described within its responsibility and duties.

9.2 The Committee may establish sub-committees or sub-groups to support its functions.

10. Reporting Arrangements

10.1 The Committee will report to the Board through submission of its approved minutes.

10.2 The Chair of the Committee has a standing invitation to report verbally on key issues which the committee considered should be brought to the Board's attention.

10.3 The Committee will provide an Annual Report on the Committee's activities to the Forth Valley NHS Board, to inform the preparation and review of the Board's Governance Statement. The report shall include: attendees; frequency and dates of meetings; Committee activities, including confirmation of delivery of the Annual Workplan and review of the Committee Terms of Reference; improvements overseen; matters of concern and emerging issues.

11. Review of Terms of Reference

11.1 The Terms of Reference will be reviewed annually by the Committee and recommended to the Board for approval.

12. Conduct of Business

12.1 Business will be conducted in accordance with the Board's Standing Orders.

CLINICAL GOVERNANCE COMMITTEE - TERMS OF REFERENCE

1. Purpose

1.1 The purpose of the Clinical Governance Committee is to provide the NHS Board with:

- Systems Assurance – to ensure effective Clinical Governance is in place and effective throughout the local NHS system and services and is effective in services that are commissioned from independent providers and other partner agencies.
- Public Health Governance – to ensure that the principles and standards of clinical governance are applied to the health improvement, health protection and healthcare public health activities of the NHS Board.
- Clinical Risk Management – assurance that an appropriate approach is in place to deal with clinical risk management across the system, working within the NHS Forth Valley Risk Management Strategy.

2. Duties & Responsibilities

2.1 **Objectives**

The main objectives of the Clinical Governance Committee are to provide:

- Systems Assurance
- Public Health Governance
- Clinical Risk Management.

2.2 **Responsibilities**

The Committee will: -

- ensure that all elements of the Clinical Governance Framework, including learning, within the Quality Strategy are implemented effectively and efficiently across the system.
- ensure that appropriate standards of clinical governance are being applied to the health improvement, health protection, healthcare public health and screening programme activities of the Board.
- ensure that appropriate delivery of NHS Forth Valleys Clinical Governance Strategic Implementation Plan (CGSIP) is reported upon.
- ensure that follow-up action is taken in relation to external reviews to provide assurance that the quality of services is being improved.
- promote positive complaints handling, advocacy and feedback including learning from adverse events, near misses and whistleblowing cases.
- ensure review of clinical governance objectives bi-annually to gain assurance across the whole NHS system with appropriate monitoring and action planning.
- ensure systems dealing with revalidation/fitness to practice are in place.
- review performance in management of clinical and population-based risk and delivery of services, including emergency planning and service continuity planning.
- receive regular reports that allow the Committee to assure the Board on key clinical priorities within a clear forward plan.
- oversee medical education governance through receiving an annual report from the Director of Medical Education.
- receive reports from the, NHS Forth Valley Area Prevention & Control of Infection Committee, and Child Protection Action Group Quarterly Report.
- receive minutes of the Clinical Governance Working Group. Recognising the issues of relative timing and scheduling of meetings, minutes of the Clinical

Governance Working Group may be presented in draft form to the next meeting of the Clinical Governance Committee.

- receive minutes of the Organ Donation Sub-Committee.
- provide an Annual Report on the Committee's activities to the Forth Valley NHS Board, to inform the preparation and review of the Board's Governance Statement.

3. Composition

3.1 The Membership of the Committee shall comprise:

- Five Non-Executive Members of the NHS Board, including
- Chair of Area Clinical Forum
- Chair of the Board, ex-officio

3.2 The Chairperson of the Committee shall be appointed at a meeting of Forth Valley NHS Board in accordance with Standing Orders. The Committee Chair shall preside at every meeting of the Committee. In the event that the Chair of the Committee is unable to attend, another Non-Executive Member will be designated as Chair for the meeting.

3.3 The Medical Director and Executive Nurse Director shall jointly serve as the Lead Executives of the Committee.

The Executive Leads will oversee the development of an annual workplan for the Committee which reflects its remit and the need to provide appropriate assurance at the year-end for both the Committee and the Forth Valley NHS Board.

4. Quorum

4.1 No business shall be transacted unless a minimum of three Non-Executive Board Members are present.

5. Attendees

5.1 The Chief Executive, Director of Public Health, Director of Pharmacy, Head of Clinical Governance and the Infection Control Manager shall normally attend. The Committee can request the attendance of any officer or family practitioner of NHS Forth Valley at its meetings.

5.2 All NHS Board Members shall have the right of attendance and have access to papers except where the Committee resolves otherwise.

6. Frequency

6.1 To fulfil its remit the Clinical Governance Committee will meet no fewer than six times in a year but may elect to have additional meetings, at the discretion of the Chair. The Committee will conduct its meetings in accordance with the Standing Orders.

7. Agenda & Papers

7.1 The agenda and supporting papers will normally be sent out at least five working days in advance of the meetings.

7.2 All papers will be completed on the approved NHS Forth Valley template and clearly

state the agenda reference, the author and the purpose of the paper together with the action the Committee are asked to consider.

8. Minutes

8.1 Formal Minutes will be kept of the proceedings. Draft minutes shall be distributed for consideration and review to the Chair of the Committee within 2 weeks of the meeting, except in exceptional circumstances.

8.2 The draft minutes will be circulated electronically to Committee Members for approval following sign off by the Committee Chair. These minutes will then be presented to the next meeting of the Committee for ratification.

8.3 Minutes will be included for noting in subsequent Board Meeting papers following ratification by Committee.

9. Authority

9.1 The Committee is authorised to:

- ensure compliance with due process relating to any investigation of activities which are within the terms of its responsibility and duties. In doing so the Committee is authorised to seek information it requires from any Board member or employee, paying due regard to professional responsibilities and personal data rights. All members and employees are expected to co-operate with reasonable requests made by the Committee.
- obtain professional advice it considers necessary.
- approve matters as described within its responsibility and duties.

9.2 The Committee may establish sub-committees or sub-groups to support its functions, which shall include the Organ Donation Sub-Committee.

10. Reporting Arrangements

10.1 The Committee will report to the Board through submission of its approved minutes.

10.2 The Chair of the Committee has a standing invitation to report verbally on key issues which the committee considered should be brought to the Board's attention.

10.3 The Committee will provide an Annual Report on the Committee's activities to the Forth Valley NHS Board, to inform the preparation and review of the Board's Governance Statement. The report shall include: attendees; frequency and dates of meetings; Committee activities, including confirmation of delivery of the Annual Workplan and review of the Committee Terms of Reference; improvements overseen; matters of concern and emerging issues.

11. Review of Terms of Reference

11.1 The Terms of Reference will be reviewed annually by the Committee and recommended to the Board for approval.

12. Conduct of Business

12.1 Business will be conducted in accordance with the Board's Standing Orders.

PHARMACY PRACTICES COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

1.1 The Committee shall be known as the Pharmacy Practices Committee and shall consider, determine and approve/reject applications for inclusion in the Pharmaceutical List in accordance with the NHS (Pharmaceutical Services) (Scotland)Regulations 2009 and the NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 (SSI 2011 No. 32) and 2014 (SSI 2014 No. 148).

1.2 The Committee shall, within 10 working days of taking its decision, give written notification of it to the Board with reasons for that decision.

2. COMPOSITION

2.1 **Membership**

The Pharmacy Practices Committee is appointed by the Board and shall consist of seven (unless the Application is for premises in a neighbourhood or an adjacent neighbourhood to a controlled locality, in which case an additional member will be appointed by the Board from persons nominated by the Area Medical Committees).

Members of whom:

2.1.1 One (Chair) shall be a Non-Executive Member of the Board appointed as Chair of the Pharmacy Practices Committee and shall not be nor have previously been, a Doctor, Dentist, Ophthalmic Optician or Pharmacist or an employee of a Doctor, Dentist, Ophthalmic Optician or Pharmacist.

2.1.2 Three shall be Pharmacists of whom:

2.1.2.1 One shall be a Pharmacist whose name is not included in a Pharmaceutical List and who is not an employee of a person whose name is so listed and who shall be appointed from a list of persons nominated by the Area Pharmaceutical Committee.

2.1.2.2 Two shall be Pharmacists whose names are either included on a Pharmaceutical List or are employees of a person whose name is on such a list and shall be appointed from a list of persons nominated by the Area Pharmaceutical Committee.

2.1.3 Three shall be Lay Persons appointed by NHS Forth Valley, other than from members of the Board, and shall not be nor have previously been a Doctor, Dentist, Ophthalmic Optician or Pharmacist or an employee of person who is a Doctor, Dentist, Ophthalmic Optician or Pharmacist.

2.1.4 In circumstances where the premises that are the subject of the Application are located in the same neighbourhood as a controlled locality the Pharmacy Practices Committee shall have an additional member appointed by the Board from persons nominated by the Area Medical Committee.

2.2 **Appointment of Deputies**

The Board shall also appoint deputies including, as the case may be for 2.1.4 for each Committee Member using the same criteria as set out in 2.1.

2.3 **Eligibility**

The Board shall ensure in appointing Members and Deputies to the Pharmacy Practices Committee that the eligibility criterion set out in the National Health Service (General Pharmaceutical Services)

(Scotland) Regulations 2009 the NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and in accordance with the provision of The Health Act 1999 are met.

If nominations are not made available before such a date as the Board may determine, the Board may appoint as a member a person who satisfies the appropriate criteria specified in 2.1 to 2.1.4.

2.4 **Review**
Membership shall be reviewed annually.

2.5 **Attendance**
The Board may appoint an independent legal assessor to attend to provide legal and technical advice during the hearing.

A person shall attend for the purpose of taking an accurate note of the Pharmacy Practices Committee meeting.

3. MEETINGS

3.1 The Pharmacy Practices Committee shall meet as necessary to fulfil its remit.

3.2 The agenda and supporting papers will be sent at least five days before the date of the meeting. In any case where oral representations are being heard, at least 7 days' notice of the date fixed for the meeting shall be given to all parties.

3.3 **Quorum**
No business will be conducted at the meeting of the Pharmacy Practices Committee unless five Members or deputies are present of whom:

3.3.1 one shall be the Chair of the Committee or deputy Chair.

3.3.2 one shall be a non-contractor Pharmacist in accordance with 2.1.2.1 or deputy.

3.3.3 one shall be a contractor Pharmacist in accordance with 2.1.2.1 or deputy.

3.3.4 two shall be Lay Persons in accordance with 2.1.3 or deputy.

3.3.5 In circumstances where the premises that are the subject of the Application are in the same neighbourhood as a controlled locality the Pharmacy Practices Committee shall have an additional member appointed by the Board from persons nominated by the Area Medical Committee.

3.4 Formal minutes will be kept of the proceedings of the Committee and approved by Members or deputies in accordance with 3.3, with the decision and the reasons for that decision reported to the Board. A copy of the Minutes of the NHS Forth Valley Pharmacy Practices Committee will be submitted to the NHS Board for noting.

3.5 Each application submitted to the Pharmacy Practices Committee under Regulation 5 (10) shall be discussed by all Members present at the meeting but shall be determined by the following Members (or their deputies) after the Non-Contractor and Contractor Pharmacists appointed by the Pharmacy Practices Committee and, if present, the member nominated by the Area Medical Committee, have withdrawn.

3.5.1 Lay Persons in accordance with 2.1.3.

3.6 The Chair or deputy Chair shall not be entitled to vote in respect of a determination of an application submitted under Regulation 5 (10) but in the case of an equality of votes under 3.5 shall have a casting vote.

3.7 In the case of all other matters considered under Regulation 5(10) except in respect of an application submitted under Regulation 5(10) all Members of the Committee present shall determine the matter.

3.8 In the case of urgent matters the Chair, or in their absence, the deputy Chair shall be empowered by the Committee to determine matters within the remit of the Committee with the exception of applications submitted under Regulation 5(10) in circumstances where it is necessary that, as a matter of urgency, a decision should be reached between scheduled meetings of the Committee.

3.9 Any decision taken under 3.8 shall be reported to the next meeting of the Committee for endorsement.

4. REMIT

4.1 The Committee shall determine and approve/reject applications for inclusion in the Pharmaceutical List as defined in terms of Regulation 5(10) and paragraph 3 of schedule 3 of the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 2009, the National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and in accordance with The Health Act 1999.

4.2 The Committee shall also be empowered to exercise other functions as are delegated to it by Forth Valley NHS Board under the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 2009, the National Health Service (Pharmaceutical Services) (Scotland)Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and in accordance with The Health Act 1999 to the extent that those functions are not delegated to an Officer under the Scheme of Delegation.

4.3 Any Officer with delegated authority in respect of the provisions of the General Pharmaceutical Services under Part II of the National Health Service (Scotland) Act 1978, may refer to the Committee for determination of any matter within the Officer's delegated authority either as a matter of policy or in respect of a specific issue and the Committee shall be authorised to determine such matters.

4.4 In exercising and considering all applications submitted to it, the Committee shall have regard to the provisions of the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 2009, the National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and The Health Act 1999 with particular reference to:

4.4.1 consultation with interested parties, appropriate members of the public; and

4.4.2 criterion for the granting of new pharmaceutical contracts.

5. AUTHORITY

5.1 The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

5.2 The Committee has a duty to review its own performance, effectiveness including running costs and terms of reference on an annual basis.

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. Purpose

1.1 The Remuneration Committee is a sub-committee of the Staff Governance Committee. It provides assurance to the NHS Forth Valley Board that appropriate arrangements are in place to meet the statutory requirements as laid out in the Staff Governance Standard, in respect of the application and implementation of fair and equitable pay and performance management systems as determined by Ministers and Scottish Government.

2. Duties & Responsibilities

2.1 In relation to Executive Directors and Senior Managers on Executive pay grades, to:

2.1.1 review and approve the place on the grade scale for new post holders.

2.1.2 seek assurance that remuneration, benefits and employment related terms and conditions are in line with and fair, (whether on an individual or collective basis), in relation to the national system and the arrangements for determining those matters and to seek redress if this is determined to not be the case.

2.1.3 seek assurance that individual annual SMART performance objectives in place are aligned to the organisation's corporate vision, goals, purpose and values

2.1.4 review and approve individual annual SMART performance objectives, including overseeing the review of performance against these objectives at the mid-year point and agreeing any revisions to the objectives during the course of the year.

2.1.5 consider and approve proposals on the assessment of performance at the year-end (taking into account any factors which the Committee consider to be relevant and which may not have been known by the relevant parties at the time when objectives, including their weighting were agreed or at the mid-year point) and any changes to the remuneration or the Terms and Conditions of Employment arising from this assessment of performance during the review period. The Remuneration Committee will sign off the final versions, following discussion, which will then be sent to the National Performance Management Committee (NPMC). Following the initial assessment by the NPMC, the Remuneration Committee will sign off any documents which have been returned for amendment.

2.2 Review and approve annually the points awarded by the Discretionary Management Group on Consultants' Discretionary Points and provide confirmation of the process followed in the allocation of points.

2.2.1 The Remuneration Committee must be satisfied that there is equity and transparency in the process which approves performance related increases in salaries for Consultants.

2.2.2 The outcomes of the Panel convened to consider discretionary points should be in the form of a paper brought to a Remuneration Committee meeting for assurance and final approval. The purpose of this is for assurance that the Panel has reached a fair and equitable decision, and to enable final approval to be given for the remuneration award. The Remuneration Committee should also consider equality monitoring of the awarding of discretionary points to ensure equity.

2.3 In general, to:

2.3.1 Comply with any Scottish Government Health Directorates directions and take into consideration any relevant guidance on remuneration, benefits or terms and conditions of employment, including the guidance contained in the Remuneration Committee Self-Assessment Pack published by the Scottish Government and Audit Scotland in 2007.

2.3.2 Provide assurance to the Board, through the Staff Governance Committee, that systems and procedures are in place to manage the issues set out in Scottish Government guidance so that overarching staff governance responsibilities can be discharged. The Staff Governance Committee will not be given the detail of confidential employment issues that are considered by the Remuneration Committee.

2.3.3 Review and approve submissions from the Chief Executive for the terms of any Settlement Agreement, including early retiral, where there are additional costs to be borne by the Board. Such agreements may also require the approval of the Scottish Government, in accordance with procedures applicable across the public sector.

2.3.4 Seek assurance on succession planning arrangements for Executives and Senior Managers, with consideration to the skills and expertise required to meet the needs of the organisation.

2.3.5 Agree processes for Executive Level Director recruitment, including representation on recruitment panels for Chief Executive and other Executive Director appointments.

3. Composition

3.1 The membership of the Committee shall comprise of five Non-Executive Directors of the Forth Valley NHS Board, including:

- the Employee Director
- the NHS Board Chair

3.2 The Chair of the Committee will be nominated at the discretion of the Board Chair. The Chair of the Staff Governance Committee and the NHS Forth Valley Board Chair should be precluded from being appointed as the Chair of the Committee to avoid any potential conflicts of interest as the Remuneration Committee reports to the Staff Governance Committee and the Board Chair has a role in the appraisal of the Chief Executive and is the grandparent reviewer for other Executive Directors.

3.3 The Membership of the Committee will be approved by Staff Governance Committee, taking into account the views of the Board Chair and the respective portfolio assignments of Non-Executive Members.

3.4 The Director of People shall serve as the Lead Executive Officer to the Committee.

3.5 The Executive Lead will oversee the development of an annual workplan for the Committee which reflects its remit and the need to provide appropriate assurance at the year-end for both the Committee and the Forth Valley NHS Board.

4. Quorum

4.1 No business shall be transacted unless a minimum of three Non-Executive Board Members are present.

5. Attendees

5.1 The Chief Executive and Director of People will be in attendance throughout to provide support and advice (apart from during their own reviews). A senior member of HR will deputise for the Director of People in their absence as appropriate, to ensure specialist HR advice is always available to the Committee.

5.2 The Chief Executive and Director of People will leave the meeting when their own remuneration and terms and conditions are to be discussed and at other times, at the discretion of the Chair.

6. Frequency

6.1 The Committee will be scheduled to meet as a minimum four times per annum, and at the Chair's discretion, conduct business by correspondence on occasions where this provides a more timely or effective mechanism.

6.2 Remuneration issues may arise between meetings and will be brought to the attention of the Committee Chair by the Chief Executive or the Director of People. The Chair may call a special meeting of the Remuneration Committee to address the issue.

7 Agenda & Papers

7.1 Due to the confidential nature of the Remuneration Committee business, and the identifiable confidential personal data included in Committee papers, in line with General Data Protection Regulations and the Data Protection Act 2018, meeting papers will only be accessible to Committee members and the agreed regular attendees.

7.2 The agenda and supporting papers will be sent out at least five working days in advance of the meetings.

7.3 All papers will clearly state the agenda reference, the author, the purpose of the paper and the key issues that the Committee is asked to consider using the agreed Board paper template.

8 Minutes

8.1 Formal Minutes will be kept of the proceedings. Draft minutes shall be distributed for consideration and review to the Chair of the Committee within 2 weeks of the meeting, except in exceptional circumstances. The minutes should be marked confidential.

8.2 The draft minutes will be circulated electronically to Committee Members for approval following sign off by the Committee Chair. These minutes will then be presented to the next meeting of the Committee for ratification.

9 Authority

9.1 The Committee is authorised to:

- Ensure compliance with due process relating to any investigation of activities which are within the terms of its responsibility and duties. In doing so, is authorised to seek information it requires from any Board member or employee, paying due regard to professional responsibilities and personal data rights. All members and employees are expected to co-operate with reasonable requests made by the Committee;
- Approve matters as described within its responsibility and duties;
- obtain whatever professional advice it requires and invite external experts to meetings.
- Request the attendance of any employee, contractor of the Board (as/if agreed on their engagement), or seek professional advice as may be required.

9.2 No Director or senior manager shall be involved in any decisions as to their own remuneration outcome.

10 Reporting Arrangements

10.1 A summary of the key items of business considered by the Committee will be presented to the Staff Governance Committee.

10.2 The Staff Governance Committee will not be given the detail of confidential employment issues considered by the Remuneration Committee.

10.3 The Remuneration Committee will submit their annual report through the Staff Governance Committee for review and the Staff Governance Committee will recommend approval to the Board. This will give relevant assurance to the Board and Accountable Officer relating to the Governance Statement.

10.4 The Committee will undertake ongoing assessment of its performance, highlighting any steps for further improvement to the way it conducts business.

10.5 The Audit Scotland Remuneration Committee Self-Assessment Framework will be used as the basis on which the business of the committee is reviewed.

11 Review of Terms of Reference

11.1 The Committee will review its Terms of Reference annually and submit them to the Staff Governance Committee for review and recommended approval to the Board.

12 Conduct of Business

12.1 Business will be conducted in accordance with the Board's Standing Orders.

12.2 All business of the Committee will be conducted in strict confidence.

STAFF GOVERNANCE COMMITTEE - TERMS OF REFERENCE

1. Purpose

1.1 The purpose of the Staff Governance Committee is to provide the NHS Board with the assurance that:

- There is a culture within NHS Forth Valley where the highest possible standard of staff management is understood to be the responsibility of everyone working in Forth Valley and is built upon partnership and collaboration.

- Staff governance mechanisms are in place and effective throughout the local NHS system.

- Performance is reviewed against the Staff Governance standard.

2. Duties & Responsibilities

2.1 The main duties of the Staff Governance Committee are to ensure that staff governance mechanisms are in place and effective throughout the local NHS System and that performance is reviewed against relevant Staff Governance standards. The Committee shall support the creation of a culture within the health system where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the system and is built upon partnership and collaboration.

2.2 Systems Assurance and Staff Governance

The Committee will:

- receive summary reports from the Area Partnership Forum in relation to Human Resource and Organisational Development Strategy and Policies. Policy development and approval is delegated to the Area Partnership Forum.
- monitor implementation plans to deliver the aims of the Health and Social Care: National Workforce Strategy.
- commission the introduction of structures and processes which ensure that delivery against the Staff Governance Standards, including the aligned Whistleblowing Standards, is being achieved.
- ensure consistency of policy and equity of treatment of employees.
- ensure that a consistent approach to the job evaluation is in place.
- monitor Workforce Plan development and its associated action plan.
- ensure that an appropriate approach is in place to deal with staff risk management (including staff and patient safety) across the system working within NHS Forth Valley Risk Management Strategy.
- ensure that systems and procedures are in place to monitor, manage and improve performance across the whole system.
- scutinise the Strategic Risks aligned to the Committee.
- provide staff governance information for the statement of internal control.
- receive a summary of the key items of business considered by the Remuneration Committee.

2.3 Internal Review

The Committee will:

- monitor and evaluate strategies and implementation plans relating to people management.
- review staff survey results and to monitor implementation of agreed action plans.
- monitor performance in NHS Forth Valley in:
  (i) staff communications
  (ii) learning and development
  (iii) partnership working (through links with Area Partnership Forum)
  (iv) safe and healthy working environment
  (v) Human Resource Policies and Procedures

- propose and support any policy amendment, funding, or resource submission to achieve the Staff Governance Standard recognising that such proposals will require to be assessed as part of the over-arching local prioritisation process.
- receive minutes from the Health and Safety Committee and monitor governance arrangements as they relate to staff.

2.4 External Review

The Committee will:

- take responsibility for the timely submission of all staff governance information required for national monitoring arrangements and ensure follow-up action is taken in respect of relevant external reviews such as Audit Reports.
- oversee the implementation of Everyone Matters, the national workforce vision and related workforce strategies.
  (i) Partnership Information Network Guidelines
  (ii) Fair for All

- review all appropriate Performance elements routinely.
- recognise the implementation of the 'Once for Scotland' Workforce Policies.

3. Composition

3.1 The membership of the Committee shall comprise:

- Four Non-Executive NHS Board Members
- Chair of the NHS Board, ex-officio
- Employee Director, ex-officio
- Four Lay members (from Trade Union and Professional Organisations)

3.2 The Committee Chair shall be appointed at a meeting of Forth Valley NHS Board in accordance with the Standing Orders. The Chair shall preside at every meeting of the Committee. In the event that the Chair of the Committee is unable to attend, another Non-Executive Member will be designated as Chair for the meeting.

3.3 The Director of People shall serve as the Lead Executive Officer to the Committee.

The Executive Lead will oversee the development of an annual workplan for the Committee which reflects its remit and the need to provide appropriate assurance at the year-end for both the Committee and the Forth Valley NHS Board.

4. Quorum

4.1 No business shall be transacted unless a minimum of three Non-Executive Board Members are present.

5. Attendees

5.1 The Chief Executive, Director of Nursing, Director of People and Chief Officers of the Falkirk and Clackmannanshire & Stirling IJBs (or a representative) shall normally attend meetings. The Committee can request the attendance of any officer of NHS Forth Valley at its meetings.

5.2 All NHS Board Members shall have the right of attendance and have access to papers except where the Committee resolves otherwise.

6. Frequency

6.1 To fulfil its remit the Staff Governance Committee will meet no fewer than six times in a year but may elect to have additional meetings, at the discretion of the Chair. The Committee will conduct its meetings in accordance with the Standing Orders.

7. Agenda & Papers

7.1 The agenda and supporting papers will normally be sent out at least five clear days in advance of the meetings.

7.2 All papers will be completed on the approved NHS Forth Valley template and clearly state the agenda reference, the author and the purpose of the paper together with the action the Committee are asked to consider.

8. Minutes

8.1 Formal Minutes will be kept of the proceedings. Draft minutes shall be distributed for consideration and review to the Chair of the Committee within 2 weeks of the meeting, except in exceptional circumstances.

8.2 The draft minutes will be circulated electronically to Committee Members for approval following sign off by the Committee Chair. These minutes will then be presented to the next meeting of the Committee for ratification.

8.3 Minutes will be included for noting in subsequent Board Meeting papers following ratification by Committee.

9. Authority

9.1 The Committee is authorised to:

- ensure compliance with due process relating to any investigation of activities which are within the terms of its responsibility and duties. In doing so the Committee is authorised to seek information it requires from any Board member or employee, paying due regard to professional responsibilities and personal data rights. All members and employees are expected to co-operate with reasonable requests made by the Committee.
- approve matters as described within its responsibility and duties.

9.2 The Committee may establish sub-committees or sub-groups to support its functions and will as a minimum establish a Remuneration Committee.

10. Reporting Arrangements

10.1 The Committee will report to the Board through submission of its approved minutes.

10.2 The Committee will provide an Annual Report on the Committee's activities to the Forth Valley NHS Board, to inform the preparation and review of the Board's Governance Statement.

11. Review of Terms of Reference

11.1 The Terms of Reference will be reviewed annually by the Committee and recommended to the Board for approval.

12. Conduct of Business

12.1 Business will be conducted in accordance with the Board's Standing Orders.

STRATEGIC PLANNING, PERFORMANCE AND RESOURCES COMMITTEE

TERMS OF REFERENCE

1. Purpose of the Committee

1.1 The Strategic Planning, Performance and Resources Committee will:

- influence, scrutinise and oversee the development of the strategic direction of the NHS Board, including the setting of the Board's vision and corporate objectives.
- scrutinise and oversee the planning and development of corporate policies and strategies for onward referral to the NHS Board for decision.
- oversee the planning and performance of areas related to Integration arrangements.
- scrutinise and oversee the implementation of service redesign and transformation change programmes taking a Values Based Health and Care approach.
- act as the oversight Committee for the development of NHS Forth Valley as a Population Health Organisation.
- act as the Performance Management Committee of the NHS Board with specific scrutiny of Financial and Operational performance.

2. Duties and Responsibilities

2.1 The Committee will provide assurance to the NHS Board on the areas below and as appropriate refer them to the Board for decision. It will operate within the principles of The Blueprint for Good Governance – Second Edition, **to ensure effective management, improved performance and ultimately good outcomes for all stakeholders**:

2.2 The Committee's remit will include:

- Finance and Efficiency: Financial and capital plans, allocation of resources, financial performance including the setting and delivery of savings plans and efficiencies, review of Initial Agreements and Business Cases, oversight of the delivery of the Digital and eHealth Plan.
- Whole system delivery of performance against targets and key priorities, except areas that are specifically in the remit of other Board committees such as detailed workforce and patient safety metrics.
- Strategy development, endorsing and referring them to the NHS Board for approval.
- Population Health: supporting NHS Forth Valley to embed a value-based health and care approach to delivery; oversight and performance monitoring of progress and outcomes against key social determinants of health; prioritisation of prevention; early

intervention; reducing inequalities; development, implementation and monitoring of Population Health & Care Strategy; support partnership working arrangements between NHS Forth Valley and the Community Planning Partnerships and other stakeholders.

- Climate Emergency and Sustainability and the delivery of key objectives in line with the agreed strategy.

- Infrastructure, Property and Asset Management and the progression of the Whole System Infrastructure Planning approach in line with Scottish Government Guidance.

- Information Governance and the delivery of NHS Forth Valley's statutory obligation to comply with information governance, Network Information Systems Regulations (including Cyber Security) and General Data Protection Regulation (GDPR).

- Risks aligned to the remit of this Committee providing scrutiny of Risk Assurance and Mitigation Plans for those risks escalated to the Strategic Risk Register.

- Horizon scanning to detect early signs of potentially important developments e.g., the impact of technology, demographic changes and climate change.

3. Composition of the Committee

3.1 Membership of the Strategic Planning, Performance and Resources Committee, will include all Non-Executive Directors.

3.2 In the event that the Chair of the Committee is unable to attend, another non-executive director will be designated as Chair for the meeting. Normally the Chair of the Committee would arrange this in advance.

3.3 Attendees will be invited at the discretion of the Committee Chair.

3.4 The Committee may co-opt additional members for a period not exceeding a year to provide specialist skills, knowledge and experience.

4. Quorum

4.1 No business shall be transacted unless a minimum of one third of the Committee members are present.

5. Attendees

5.1 All Executive Directors and Senior Leadership Team members shall normally attend meetings.

5.2 The Committee can request the attendance of any officer of NHS Forth Valley at its meetings and shall have the right to invite, as required, external experts to attend meetings.

5.3 The Director of Strategic Planning and Performance shall serve as the Lead Executive Officer to the Committee.

5.4 The Executive Lead will oversee the development of an annual workplan for the Committee which reflects its remit and the need to provide appropriate assurance at the year end for both the Committee and the NHS Board.

6. Frequency

6.1 To fulfil its remit the Strategic Planning, Performance and Resource Committee will normally meet no less than six times in a year but may elect to have additional meetings, at the discretion of the Chair. The Committee will conduct its meetings in line with the Standing Orders of the Board.

7. Agenda and Papers

7.1 The Executive Lead will set the agenda in conjunction with the Chair and Board Secretary.

7.2 The agenda and supporting papers will normally be sent out at least five working days in advance of the meetings.

7.3 All papers require to be completed on the approved covering paper template, clearly state the agenda reference, the author, the purpose of the paper and the action the Committee is asked to consider.

8. Minutes

8.1 Formal minutes shall be taken of the proceedings of the Committee. Draft Minutes shall be distributed for consideration and review to the Chair of the meeting within 2 weeks of the meeting except in exceptional circumstances.

8.2 The draft minutes will be circulated electronically to Committee Members for review and approval within the following 10 working days.

8.3 Minutes will be included for noting in subsequent Board Meeting papers following approval by the Committee.

9. Authority

9.1 The Committee is authorised to:

- ensure compliance with due process relating to any investigation of activities which are within the terms of its responsibility and duties. In doing so the Committee is authorised to seek information it requires from any Board member or employee, paying due regard to professional responsibilities and personal data rights. All members and employees are expected to co-operate with reasonable requests made by the Committee.

- approve matters as described within its duties and responsibilities.

9.2 The Committee may establish sub-committees or sub-groups to support its functions.

10. Reporting Arrangements

10.1 The Committee will report to the Board and commend decisions to the Board, by submitting its approved minutes to the Board.

10.2 The Committee Chair will provide an annual report on the Committee's activities to the NHS Board, to inform the preparation and review of the Board's Governance Statement.

10.3 The Committee will regularly review the annual workplan including identifying any slippage of timescales or tasks including agreeing any mitigation actions (if required) to ensure the full delivery of the Committee's remit.

10.4 The Committee will scrutinise the Strategic Risks aligned to the Committee on a bi-monthly basis.

11. Review of Terms of Reference

11.1 The Terms of Reference will be reviewed annually by the Committee for submission to the Board for the Board's consideration and approval.

12. Conduct of Business

12.1 Business will be conducted in accordance with the Board's Standing Orders.

ANNEX C: SCHEME OF DECISIONS RETAINED BY FORTH VALLEY NHS BOARD

The Code of Accountability requires the NHS Board to adopt a Schedule of Decisions that are reserved for the NHS Board.

The following decisions are for determination by the NHS Board:

1. Values and aims of Forth Valley NHS Board.

2. Forth Valley Corporate Plan including the Local Delivery Plan and Regional Planning issues.

3. Strategic Health Service Plans, all Business Cases where Capital Investment exceeds £1m.

4. Five Year Financial Plan and Annual Financial Plan.

5. Five Year Capital Plan and Annual Capital Plan.

6. Endorsement of jointly published plans with public sector partners.

7. Standing Orders including Decisions retained by the Board and the Scheme of Delegation.

8. Standing Financial Instructions.

9. Establishment, terms of reference, reporting arrangements and membership of all Committees acting on behalf of the NHS Board.

10. NHS Board Members' Register of Interests.

11. Approval of NHS Board Annual Report and Annual Accounts.

12. Financial and Performance Management Reporting Arrangements.

13. Arrangements for approval of policies required as a result of national guidelines with the exception of Human Resource policies (see Staff Governance Committee remit).

14. Recommendations to the Scottish Government relating to the closure or change of use of hospitals.

15. Acquisition and disposal of any land and property above £250,000.

16. Appointment of Executive Directors of Forth Valley NHS Board.

17. Appointment of Management Consultants/Advisors where contract value exceeds £100,000.

18. Approval of delegation of any function to an agency out with the National Health Service.

The Chief Executive is authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chairperson and the Vice Chairperson of the Board and the relevant Standing Committee Chairperson. Where such powers are invoked, these shall be formally reported to the next relevant Standing Committee or NHS Board Meeting as appropriate.

ANNEX D: SCHEME OF DELEGATION

A clear set of rules for delegation, inclusive of financial limits is essential to ensure that effective management control of resources is exercised.

Decisions retained by the NHS Board are identified in Annex C.

All powers not retained by the NHS Board or delegated to a Committee or Sub-Committee shall be exercised on behalf of the NHS Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally, and which functions have been delegated to other Officers.

The Chief Executive as Accountable Officer (Revised Memorandum to National Health Service Accountable Officers: May 2002) is also accountable to the Principal Accounting Officer of the NHS in Scotland and the Scottish Parliament. The role of the Director of Finance in devising, implementing, monitoring and supervising systems of financial control is exercised on behalf of the Chief Executive and the NHS Board.

The Scheme of Delegation and the Standing Financial Instructions form a major part of the system of control. These should be used in conjunction with the system of budgetary control and other established procedures.

SECTION B

Code of Conduct

SECTION 1: Introduction to the Code of Conduct

1.1 This Code has been issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the Ethical Standards in Public Life etc. (Scotland) Act 2000 (the "Act").

1.2 The purpose of the Code is to set out the conduct expected of those who serve on the boards of public bodies in Scotland.

1.3 The Code has been developed in line with the nine key principles of public life in Scotland. The principles are listed in Section 2 and set out how the provisions of the Code should be interpreted and applied in practice.

My Responsibilities

1.4 I understand that the public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. I will always seek to meet those expectations by ensuring that I conduct myself in accordance with the Code.

1.5 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all situations and at all times where I am acting as a board member of my public body, have referred to myself as a board member or could objectively be considered to be acting as a board member.

1.6 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all my dealings with the public, employees and fellow board members, whether formal or informal.

1.7 I understand that it is my personal responsibility to be familiar with the provisions of this Code and that I must also comply with the law and my public body's rules, standing orders and regulations. I will also ensure that I am familiar with any guidance or advice notes issued by the Standards Commission for Scotland ("Standards Commission") and my public body, and endeavour to take part in any training offered on the Code.

1.8 I will not, at any time, advocate or encourage any action contrary to this Code.

1.9 I understand that no written information, whether in the Code itself or the associated Guidance or Advice Notes issued by the Standards Commission, can provide for all circumstances. If I am uncertain about how the Code applies, I will seek advice from the Standards Officer of my public body, failing whom the Chair or Chief Executive of my public body. I note that I may also choose to seek external legal advice on how to interpret the provisions of the Code.

Enforcement

1.10 Part 2 of the Act sets out the provisions for dealing with alleged breaches of the Code, including the sanctions that can be applied if the Standards Commission finds that there has been a breach of the Code. More information on how complaints are dealt with and the sanctions available can be found at Annex A.

SECTION 2: Key Principles of the Code of Conduct

2.1 The Code has been based on the following key principles of public life. I will behave in accordance with these principles and understand that they should be used for guidance and interpreting the provisions in the Code.

2.2 I note that a breach of one or more of the key principles does not in itself amount to a breach of the Code. I note that, for a breach of the Code to be found, there must also be a contravention of one or more of the provisions in sections 3 to 6 inclusive of the Code.

The key principles are:

Duty
I have a duty to uphold the law and act in accordance with the law and the public trust placed in me. I have a duty to act in the interests of the public body of which I am a member and in accordance with the core functions and duties of that body.

Selflessness
I have a duty to take decisions solely in terms of public interest. I must not act in order to gain financial or other material benefit for myself, family or friends.

Integrity
I must not place myself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence me in the performance of my duties.

Objectivity
I must make decisions solely on merit and in a way that is consistent with the functions of my public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship
I am accountable to the public for my decisions and actions. I have a duty to consider issues on their merits, taking account of the views of others and I must ensure that my public body uses its resources prudently and in accordance with the law.

Openness
I have a duty to be as open as possible about my decisions and actions, giving reasons for my decisions and restricting information only when the wider public interest clearly demands.

Honesty
I have a duty to act honestly. I must declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
I have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of my public body and its members in conducting public business.

Respect
I must respect all other board members and all employees of my public body and the role they play, treating them with courtesy at all times. Similarly, I must respect members of the public when performing my duties as a board member.

SECTION 3: General Conduct

Respect and Courtesy

3.1 I will treat everyone with courtesy and respect. This includes in person, in writing, at meetings, when I am online and when I am using social media.

3.2 I will not discriminate unlawfully on the basis of race, age, sex, sexual orientation, gender reassignment, disability, religion or belief, marital status or pregnancy/maternity; I will advance equality of opportunity and seek to foster good relations between different people.

3.3 I will not engage in any conduct that could amount to bullying or harassment (which includes sexual harassment). I accept that such conduct is completely unacceptable and will be considered to be a breach of this Code.

3.4 I accept that disrespect, bullying and harassment can be:

a) a one-off incident,
b) part of a cumulative course of conduct; or
c) a pattern of behaviour.

3.5 I understand that how, and in what context, I exhibit certain behaviours can be as important as what I communicate, given that disrespect, bullying and harassment can be physical, verbal and non-verbal conduct.

3.6 I accept that it is my responsibility to understand what constitutes bullying and harassment and I will utilise resources, including the Standards Commission's guidance and advice notes, my public body's policies and training material (where appropriate) to ensure that my knowledge and understanding is up to date.

3.7 Except where it is written into my role as Board member, and / or at the invitation of the Chief Executive, I will not become involved in operational management of my public body. I acknowledge and understand that operational management is the responsibility of the Chief Executive and Executive Team.

3.8 I will not undermine any individual employee or group of employees, or raise concerns about their performance, conduct or capability in public. I will raise any concerns I have on such matters in private with senior management as appropriate.

3.9 I will not take, or seek to take, unfair advantage of my position in my dealings with employees of my public body or bring any undue influence to bear on employees to take a certain action. I will not ask or direct employees to do something which I know, or should reasonably know, could compromise them or prevent them from undertaking their duties properly and appropriately.

3.10 I will respect and comply with rulings from the Chair during meetings of:

a) my public body, its committees; and
b) any outside organisations that I have been appointed or nominated to by my public body or on which I represent my public body.

3.11 I will respect the principle of collective decision-making and corporate responsibility. This means that once the Board has made a decision, I will support that decision, even if I did not agree with it or vote for it.

Remuneration, Allowances and Expenses

3.12 I will comply with the rules, and the policies of my public body, on the payment of remuneration, allowances and expenses.

Gifts and Hospitality

3.13 I understand that I may be offered gifts (including money raised via crowdfunding or sponsorship), hospitality, material benefits or services ("gift or hospitality") that may be reasonably regarded by a member of the public with knowledge of the relevant facts as placing me under an improper obligation or being capable of influencing my judgement.

3.14 I will never **ask for** or **seek** any gift or hospitality.

3.15 I will refuse any gift or hospitality, unless it is:

a) a minor item or token of modest intrinsic value offered on an infrequent basis;
b) a gift being offered to my public body;
c) hospitality which would reasonably be associated with my duties as a board member; or
d) hospitality which has been approved in advance by my public body.

3.16 I will consider whether there could be a reasonable perception that any gift or hospitality received by a person or body connected to me could or would influence my judgement.

3.17 I will not allow the promise of money or other financial advantage to induce me to act improperly in my role as a board member. I accept that the money or advantage (including any gift or hospitality) does not have to be given to me directly. The offer of monies or advantages to others, including community groups, may amount to bribery, if the intention is to induce me to improperly perform a function.

3.18 I will never accept any gift or hospitality from any individual or applicant who is awaiting a decision from, or seeking to do business with, my public body.

3.19 If I consider that declining an offer of a gift would cause offence, I will accept it and hand it over to my public body at the earliest possible opportunity and ask for it to be registered.

3.20 I will promptly advise my public body's Standards Officer if I am offered (but refuse) any gift or hospitality of any significant value and / or if I am offered any gift or hospitality from the same source on a repeated basis, so that my public body can monitor this.

3.21 I will familiarise myself with the terms of the Bribery Act 2010, which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality

3.22 I will not disclose confidential information or information which should reasonably be regarded as being of a confidential or private nature, without the express consent of a person or body authorised to give such consent, or unless required to do so by law. I note that if I cannot obtain such express consent, I should assume it is not given.

3.23 I accept that confidential information can include discussions, documents, and information which is not yet public or never intended to be public, and information deemed confidential by statute.

3.24 I will only use confidential information to undertake my duties as a board member. I will not use it in any way for personal advantage or to discredit my public body (even if my personal view is that the information should be publicly available).

3.25 I note that these confidentiality requirements do not apply to protected whistleblowing disclosures made to the prescribed persons and bodies as identified in statute.

Use of Public Body Resources

3.26 I will only use my public body's resources, including employee assistance, facilities, stationery and IT equipment, for carrying out duties on behalf of the public body, in accordance with its relevant policies.

3.27 I will not use, or in any way enable others to use, my public body's resources:

a) imprudently (without thinking about the implications or consequences);
b) unlawfully;
c) for any political activities or matters relating to these; or
d) improperly.

Dealing with my Public Body and Preferential Treatment

3.28 I will not use, or attempt to use, my position or influence as a board member to:

a) improperly confer on or secure for myself, or others, an advantage;
b) avoid a disadvantage for myself, or create a disadvantage for others or
c) improperly seek preferential treatment or access for myself or others.

3.29 I will avoid any action which could lead members of the public to believe that preferential treatment or access is being sought.

3.30 I will advise employees of any connection, as defined at Section 5, I may have to a matter, when seeking information or advice or responding to a request for information or advice from them.

Appointments to Outside Organisations

3.31 If I am appointed, or nominated by my public body, as a member of another body or organisation, I will abide by the rules of conduct and will act in the best interests of that body or organisation while acting as a member of it. I will also continue to observe the rules of this Code when carrying out the duties of that body or organisation.

3.32 I accept that if I am a director or trustee (or equivalent) of a company or a charity, I will be responsible for identifying, and taking advice on, any conflicts of interest that may arise between the company or charity and my public body.

SECTION 4: Registration of Interests

4.1 The following paragraphs set out what I have to register when I am appointed and whenever my circumstances change. The register covers my current term of appointment.

4.2 I understand that regulations made by the Scottish Ministers describe the detail and timescale for registering interests; including a requirement that a board member must register their registrable interests within one month of becoming a board member, and register any changes to those interests within one month of those changes having occurred.

4.3 The interests which I am required to register are those set out in the following paragraphs. Other than as required by paragraph 4.23, I understand it is not necessary to register the interests of my spouse or cohabitee.

Category One: Remuneration

4.4 I will register any work for which I receive, or expect to receive, payment. I have a registrable interest where I receive remuneration by virtue of being:

a) employed;
b) self-employed;
c) the holder of an office;
d) a director of an undertaking;
e) a partner in a firm;
f) appointed or nominated by my public body to another body; or
g) engaged in a trade, profession or vocation or any other work.

4.5 I understand that in relation to 4.4 above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of this specific public body does not have to be registered.

4.6 I understand that if a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under Category Two, “Other Roles”.

4.7 I must register any allowances I receive in relation to membership of any organisation under Category One.

4.8 When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

4.9 When registering remuneration from the categories listed in paragraph 4.4 (b) to (g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of my public body in terms of paragraph 6.8 of this Code.

4.10 Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

4.11 When registering a directorship, it is necessary to provide the registered name and registered number of the undertaking in which the directorship is held and provide information about the nature of its business.

4.12 I understand that registration of a pension is not required as this falls outside the scope of the category.

Category Two: Other Roles

4.13 I will register any unremunerated directorships where the body in question is a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

4.14 I will register the registered name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which I am a director and from which I receive remuneration.

Category Three: Contracts

4.15 I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in paragraph 4.20 below) have made a contract with my public body:

a) under which goods or services are to be provided, or works are to be executed; and
b) which has not been fully discharged.

4.16 I will register a description of the contract, including its duration, but excluding the value.

Category Four: Election Expenses

4.17 If I have been elected to my public body, then I will register a description of, and statement of, any assistance towards election expenses relating to election to my public body.

Category Five: Houses, Land and Buildings

4.18 I have a registrable interest where I own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of my public body.

4.19 I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to my public body and to the public, or could influence my actions, speeches or decision-making.

Category Six: Interest in Shares and Securities

4.20 I have a registerable interest where:

a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an interest in is greater than £25,000.

Category Seven: Gifts and Hospitality

4.21 I understand the requirements of paragraphs 3.13 to 3.21 regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

Category Eight: Non–Financial Interests

4.22 I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by my public body).

Category Nine: Close Family Members

4.23 I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

SECTION 5: Declaration of Interests

Stage 1: Connection

5.1 For each particular matter I am involved in as a board member, I will first consider whether I have a connection to that matter.

5.2 I understand that a connection is any link between the matter being considered and me, or a person or body I am associated with. This could be a family relationship or a social or professional contact.

5.3 A connection includes anything that I have registered as an interest.

5.4 A connection does not include being a member of a body to which I have been appointed or nominated by my public body as a representative of my public body or of which I am a member by reason of, or in implementation of, a statutory provision, unless:

a) The matter being considered by my public body is quasi-judicial or regulatory; or
b) I have a personal conflict by reason of my actions, my connections or my legal obligations.

Stage 2: Interest

5.5 I understand my connection is an interest that requires to be declared where the objective test is met – that is where a member of the public with knowledge of the relevant facts would reasonably regard my connection to a particular matter as being so significant that it would be considered as being likely to influence the discussion or decision-making.

Stage 3: Participation

5.6 I will declare my interest as early as possible in meetings. I will not remain in the meeting nor participate in any way in those parts of meetings where I have declared an interest.

5.7 I will consider whether it is appropriate for transparency reasons to state publicly where I have a connection, which I do not consider amounts to an interest.

5.8 I note that I can apply to the Standards Commission and ask it to grant a dispensation to allow me to take part in the discussion and decision-making on a matter where I would otherwise have to declare an interest and withdraw (as a result of having a connection to the matter that would fall within the objective test). I note that such an application must be made in advance of any meetings where the dispensation is sought and that I cannot take part in any discussion or decision-making on the matter in question unless, and until, the application is granted.

5.9 I note that public confidence in a public body is damaged by the perception that decisions taken by that body are substantially influenced by factors other than the public interest. I will not accept a role or appointment if doing so means I will have to declare interests frequently at meetings in respect of my role as a board member. Similarly, if any appointment or nomination to another body would give rise to objective concern because of my existing personal involvement or affiliations, I will not accept the appointment or nomination.

SECTION 6: Lobbying and Access

6.1 I understand that a wide range of people will seek access to me as a board member and will try to lobby me, including individuals, organisations and companies. I must distinguish between:

a) any role I have in dealing with enquiries from the public;
b) any community engagement where I am working with individuals and organisations to encourage their participation and involvement, and;
c) lobbying, which is where I am approached by any individual or organisation who is seeking to influence me for financial gain or advantage, particularly those who are seeking to do business with my public body (for example contracts/procurement).

6.2 In deciding whether, and if so how, to respond to such lobbying, I will always have regard to the objective test, which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard my conduct as being likely to influence my, or my public body's, decision-making role.

6.3 I will not, in relation to contact with any person or organisation that lobbies, do anything which contravenes this Code or any other relevant rule of my public body or any statutory provision.

6.4 I will not, in relation to contact with any person or organisation that lobbies, act in any way which could bring discredit upon my public body.

6.5 If I have concerns about the approach or methods used by any person or organisation in their contacts with me, I will seek the guidance of the Chair, Chief Executive or Standards Officer of my public body.

6.6 The public must be assured that no person or organisation will gain better access to, or treatment by, me as a result of employing a company or individual to lobby on a fee basis on their behalf. I will not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which I accord any other person or organisation who lobbies or approaches me. I will ensure that those lobbying on a fee basis on behalf of clients are not given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming.

6.7 Before taking any action as a result of being lobbied, I will seek to satisfy myself about the identity of the person or organisation that is lobbying and the motive for lobbying. I understand I may choose to

act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that I understand the basis on which I am being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code and the Lobbying (Scotland) Act 2016.

6.8 I will not accept any paid work:

a) which would involve me lobbying on behalf of any person or organisation or any clients of a person or organisation.

b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence my public body and its members. This does not prohibit me from being remunerated for activity which may arise because of, or relate to, membership of my public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

ANNEX A: BREACHES OF THE CODE

Introduction

1. The Ethical Standards in Public Life etc. (Scotland) Act 2000 ("the Act") provided for a framework to encourage and, where necessary, enforce high ethical standards in public life.

2. The Act provided for the introduction of new codes of conduct for local authority councillors and members of relevant public bodies, imposing on councils and relevant public bodies a duty to help their members comply with the relevant code.

3. The Act and the subsequent Scottish Parliamentary Commissions and Commissioners etc. Act 2010 established the Standards Commission for Scotland ("Standards Commission") and the post of Commissioner for Ethical Standards in Public Life in Scotland ("ESC").

4. The Standards Commission and ESC are separate and independent, each with distinct functions. Complaints of breaches of a public body's Code of Conduct are investigated by the ESC and adjudicated upon by the Standards Commission.

5. The first Model Code of Conduct came into force in 2002. The Code has since been reviewed and re-issued in 2014. The 2021 Code has been issued by the Scottish Ministers following consultation, and with the approval of the Scottish Parliament, as required by the Act.

Investigation of Complaints

6. The ESC is responsible for investigating complaints about members of devolved public bodies. It is not, however, mandatory to report a complaint about a potential breach of the Code to the ESC. It may be more appropriate in some circumstances for attempts to be made to resolve the matter informally at a local level.

7. On conclusion of the investigation, the ESC will send a report to the Standards Commission.

Hearings

8. On receipt of a report from the ESC, the Standards Commission can choose to:

- Do nothing;
- Direct the ESC to carry out further investigations; or
- Hold a Hearing.

9. Hearings are held (usually in public) to determine whether the member concerned has breached their public body's Code of Conduct. The Hearing Panel comprises of three members of the Standards Commission. The ESC will present evidence and/or make submissions at the Hearing about the investigation and any conclusions as to whether the member has contravened the Code. The member is entitled to attend or be represented at the Hearing and can also present evidence and make submissions. Both parties can call witnesses. Once it has heard all the evidence and submissions, the Hearing Panel will make a determination about whether or not it is satisfied, on the balance of probabilities, that there has been a contravention of the Code by the member. If the Hearing Panel decides that a member has breached their public body's Code, it is obliged to impose a sanction.

Sanctions

10. The sanctions that can be imposed following a finding of a breach of the Code are as follows:

- **Censure**: A censure is a formal record of the Standards Commission's severe and public disapproval of the member concerned.

- **Suspension**: This can be a full or partial suspension (for up to one year). A full suspension means that the member is suspended from attending all meetings of the public body. Partial suspension means that the member is suspended from attending some of the meetings of the public body. The Commission can direct that any remuneration or allowance the member receives as a result of their membership of the public body be reduced or not paid during a period of suspension.

- **Disqualification**: Disqualification means that the member is removed from membership of the body and disqualified (for a period not exceeding five years), from membership of the body. Where a member is also a member of another devolved public body (as defined in the Act), the Commission may also remove or disqualify that person in respect of that membership. Full details of the sanctions are set out in section 19 of the Act.

Interim Suspensions

11. Section 21 of the Act provides the Standards Commission with the power to impose an interim suspension on a member on receipt of an interim report from the ESC about an ongoing investigation. In making a decision about whether or not to impose an interim suspension, a Panel comprising of three Members of the Standards Commission will review the interim report and any representations received from the member and will consider whether it is satisfied:

- That the further conduct of the ESC's investigation is likely to be prejudiced if such an action is not taken (for example if there are concerns that the member may try to interfere with evidence or witnesses); or
- That it is otherwise in the public interest to take such a measure. A policy outlining how the Standards Commission makes any decision under Section 21 and the procedures it will follow in doing so, should any such a report be received from the ESC can be found here.

12. The decision to impose an interim suspension is not, and should not be seen as, a finding on the merits of any complaint or the validity of any allegations against a member of a devolved public body, nor should it be viewed as a disciplinary measure.

ANNEX B: DEFINITIONS

“Bullying” is inappropriate and unwelcome behaviour which is offensive and intimidating, and which makes an individual or group feel undermined, humiliated or insulted.

"Chair" includes Board Convener or any other individual discharging a similar function to that of a Chair or Convener under alternative decision-making structures.

“Code” is the code of conduct for members of your devolved public body, which is based on the Model Code of Conduct for members of devolved public bodies in Scotland.

"Cohabitee" includes any person who is living with you in a relationship similar to that of a partner, civil partner, or spouse.

“Confidential Information” includes:

- any information passed on to the public body by a Government department (even if it is not clearly marked as confidential) which does not allow the disclosure of that information to the public;
- information of which the law prohibits disclosure (under statute or by the order of a Court);
- any legal advice provided to the public body; or any other information which would reasonably be considered a breach of confidence should it be made public.

"Election expenses" means expenses incurred, whether before, during or after the election, on account of, or in respect of, the conduct or management of the election.

“Employee” includes individuals employed:

- directly by the public body;
- as contractors by the public body, or
- by a contractor to work on the public body’s premises.

“Gifts” a gift can include any item or service received free of charge, or which may be offered or promised at a discounted rate or on terms not available to the general public. Gifts include benefits such as relief from indebtedness, loan concessions, or provision of property, services or facilities at a cost below that generally charged to members of the public. It can also include gifts received directly or gifts received by any company in which the recipient holds a controlling interest in, or by a partnership of which the recipient is a partner.

“Harassment” is any unwelcome behaviour or conduct which makes someone feel offended, humiliated, intimidated, frightened and / or uncomfortable. Harassment can be experienced directly or indirectly and can occur as an isolated incident or as a course of persistent behaviour.

“Hospitality” includes the offer or promise of food, drink, accommodation, entertainment or the opportunity to attend any cultural or sporting event on terms not available to the general public.

“Relevant Date” Where a board member had an interest in shares at the date on which the member was appointed as a member, the relevant date is – (a) that date;

and (b) the 5 April immediately following that date and in each succeeding year, where the interest is retained on that 5th April.

“Public body” means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

“Remuneration" includes any salary, wage, share of profits, fee, other monetary benefit or benefit in kind.

“Securities” a security is a certificate or other financial instrument that has monetary value and can be traded. Securities includes equity and debt securities, such as stocks bonds and debentures.

“Undertaking” means:

a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

SECTION C

Standards of Business Conduct for NHS Staff

SECTION 1: INTRODUCTION

It is important that NHS Forth Valley and its employees maintain strict ethical standards in the conduct of NHS business and are protected from allegations of conflict of interest, acting improperly or breach of impartiality.

This Business Conduct standard reflects the three public service values which are:

Accountability
All work undertaken by NHS Forth Valley staff must be able to stand the test of scrutiny, public judgements on propriety and professional codes of conduct.

Probity
There should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff, and suppliers and in the use of information acquired in the course of NHS duties.

Openness
There should be sufficient transparency about NHS activities to promote confidence between NHS Forth Valley, its staff, and the public.

SECTION 2: AIM, PURPOSE, AND OUTCOMES

The purpose of this Business Conduct standard is to provide guidance to managers and employees of NHS Forth Valley regarding the acceptance of gifts and hospitality and on other matters relevant to standards of business conduct. This Code, and the related NHS Forth Valley Corporate Governance policies are based on legislation and NHS Circulars and Guidance documents:

- **The Legislative Framework** is contained in the Prevention of Corruption Acts 1906 and 1916 and the Ethical Standards in Public Life (Scotland) Act 2000.
- **NHS Circulars**
  - **MEL (1994) 80** entitled Corporate Governance in the NHS
  - **MEL (2000) 13,** entitled Fundraising, Income Generation and Sponsorship within the NHSiS**.**
- **Guidance** contained in the **Code of Accountability for Boards 1994** and **A Common Understanding; Guidance on Joint working between NHS Scotland and the Pharmaceutical Industry 2003**
- **The Bribery Act 2010**

A range of policy documents have been developed in NHS Forth Valley to address the requirements related to business conduct, as follows:
- The Code of Conduct for Board members
- The Standing Financial Instructions
- Theft, Fraud and Other Financial Irregularities
- Procurement Strategy
- The Whistleblowing Policy

SECTION 3: SCOPE

This Business Conduct standard will affect all employees of NHS Forth Valley

SECTION 4: PRINCIPAL CONTENT

4.1 Declaration of Interests

a) Staff are required to declare all cases where they or a close relative or associate of theirs has a controlling and/or significant financial interest in a private company, public organisation, other NHS employer or voluntary organisation which might leave the employee or NHS Forth Valley vulnerable.

b) NHS Forth Valley holds a Register of Interests and staff should declare any interests as defined above to the appropriate General Manager, using Appendix 1 (Register of Employee's Private Interests – Declaration Form).

c) Board members should declare any interests using Appendix 2 and this should be retained by the Board Secretary.

4.2 Acceptance of Gifts

Staff must never canvass or seek gifts or hospitality. Under no circumstances can staff accept personal gifts of cash. All donations of cash must be processed through the Board's Endowment arrangements.

It is acceptable for staff to receive small tokens of gratitude from a relative or carer in appreciation of care and treatment received. These are typically cards, chocolates, or biscuits. Where staff are offered gifts of greater value these must be politely refused. If this is difficult, they must refer the matter to their line manager.

It is acceptable for staff to receive small promotional items, e.g. post-its, pens, calendars, diaries. However,

- staff must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision NHS Forth Valley may be involved in determining, or who is seeking to do business with NHS Forth Valley.

- staff must not accept any offer, by way of gift or hospitality, which could give rise to a reasonable suspicion of influence on their part to show favour, or disadvantage, to any individual, organisation or company.

- staff should consider whether there may be a reasonable perception that any gift received by their spouse or partner or by any company in which they have an interest, or by a partnership of which they are a partner, can or would influence their judgement.

  Note - the term 'gift' includes benefits such as relief from indebtedness, loan concessions, or provision of services at a cost below that charged to members of the public.

4.3 Hospitality

Modest hospitality may be acceptable provided it is normal and reasonable in the circumstances e.g. lunches in the course of a working visit. Any hospitality accepted should be similar in scale to that which the NHS as an employer would be likely to offer. **All other offers of hospitality should be declined.**

Staff should register with their line manager all such modest hospitality which they wish to accept, using the hospitality register declaration form (Appendix 3). In cases of doubt, staff should seek advice from their line manager.

It may not always be clear whether an individual is being invited to an event involving the provision of hospitality (e.g. formal dinner) in a personal/private capacity or as a consequence of the position which they hold with NHS Forth Valley.

(a) If the invitation is the result of the individual's position within NHS Forth Valley, only hospitality which is modest and normal and reasonable in the circumstances should be accepted. If the nature of the event dictates a level of hospitality which exceeds this, then the individual should ensure that their line manager is fully aware of the circumstances and approves their attendance. An example of such an event might be an awards ceremony involving a formal dinner. If the line manager grants approval to attend, the individual should declare their attendance in the register of hospitality held by their line manager. The approving manager must ensure that this will not result in any future conflict of interest.

(b) If the individual is invited to an event in a private capacity (e.g. as result of their qualification or membership of a professional body), they are at liberty to accept or decline the invitation without referring to their line manager. The following matters should however be considered before an invitation to an individual acting in a private capacity is accepted.

(c) The individual should not do or say anything at the event that could be construed as representing the views and/or policies of NHS Forth Valley.

(d) If the body issuing the invitation has (or is likely to have or is seeking to have) commercial or other financial dealings with NHS Forth Valley, then it could be difficult for an individual to demonstrate that their attendance was in a private and not an official capacity. Attendance could create a perception that the individual's independence had been compromised, especially where the scale of hospitality is lavish. Individuals should therefore exercise caution before accepting invitations from such bodies and must inform their line manager.

(e) Where suppliers of clinical products provide hospitality, it should only be accepted in association with scientific meetings, clinical educational meetings or equivalent, which must be modest, normal, and reasonable in the circumstances and in line with what the NHS would normally provide. Any such hospitality should be held in appropriate venues conducive to the main purpose of the event, e.g. the sponsorship is clearly disclosed in any papers relating to the meeting; products discussed should be described in relation to the Scottish Medicines Consortium, Formulary or equivalent clinical product catalogue and the active promotion of clinical products is restricted to those in the Board's Formulary and equivalent clinical product catalogues. Any educational meetings hosted by suppliers must be approved by the line manager.

(f) Before accepting an offer of hospitality, the individual concerned should fill in a Registering Hospitality Declaration Form (attached as appendix 3) and have it approved by their line manager. A copy of the request form will be held as part of a Hospitality Register which will be available for scrutiny by the NHS Board, Corporate Management Team, members of the public or press should they request such information. The arrangements for the administration of the process will be set out locally.

NHS Forth Valley as a public body must be able to demonstrate good value when incurring expenditure. Consideration must be given to the use of NHS Forth Valley venues for hospitality and entertainment including hospitality at conferences and other external events.

All NHS Forth Valley staff who participate in or authorise the provision of hospitality involving external organisations must be able to ensure that their conduct is capable of justification in the light of the public service values outlined.

4.4 Bribery Act 2010

NHS Forth Valley will uphold all laws relevant to countering bribery and corruption, including the Bribery Act 2010 (the Act). This commitment applies to every aspect of NHS Forth Valley's activity, including dealings with public and private sector organisations and the delivery of care to patients.

The Act recognises a number of offences including the following:

- The offering, promising, or giving of a bribe (active bribery).

- The requesting, agreeing to receive or accepting of a bribe (passive bribery).

Any employee who commits active or passive bribery will be subject to disciplinary action. In addition, the matter will be referred to relevant authorities for criminal investigation.

The Act also recognises a further offence of corporate liability for failing to prevent bribery on behalf of a commercial organisation. (For the purposes of the Act, NHS Boards are considered commercial organisations.) NHS Forth Valley has put in place a range of measures intended to prevent bribery and these are subject to formal and regular review to ensure they remain fit for purpose.

4.5 Assessment and training visits for new equipment

It is not acceptable for individuals within NHS Forth Valley to accept offers of travel or overnight accommodation except where such visits do not relate to the purchase of equipment but are to do with training or familiarisation of equipment which it has already been determined will be purchased. In these circumstances it is acceptable for the cost to be met by the manufacturer or supplier.

Whilst it will be necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country or exceptionally overseas, acceptance of an offer by the manufacturer to meet the costs of such visits may cast doubts on the integrity of subsequent purchasing decisions. NHS Forth Valley will

therefore meet the costs of any visits which are considered necessary. Any such visits will require to be authorised by the appropriate line manager.

4.6 Commercial Contracts

All staff who are in contact with suppliers and contractors - including external consultants - and particularly those who are authorised to sign purchase orders or place contracts for goods, materials or services are expected to adhere to professional standards as set out in the Ethical Code of the Institute of Purchasing and Supply.

4.7 Secondary Employment

Staff should seek permission from their line manager if they are planning to undertake paid work outwith their employment with NHS Forth Valley to ensure there is no conflict of interest with their post in NHS Forth Valley.

SECTION 5: ROLES AND RESPONSIBILITIES

5.1 All staff

(a) It is a basic principle in all parts of the public service that public servants must be scrupulously impartial and honest, that they must be seen to be so and that they must be beyond suspicion in all aspects of business conduct.

(b) This primary responsibility applies to **all NHS staff** - those who commit NHS resources directly e.g. by the ordering of goods, those who do so indirectly e.g. by the prescribing of medicines or those who advise on the commitment of resources. Therefore, all staff must comply with the following responsibilities:

- To ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.
- To ensure that the interests of patients remain paramount at all times.
- To be impartial and honest in the conduct of their official business.
- To use public funds entrusted to them to the best advantage of the service, always ensuring value for money.
- Not to abuse their official position for personal gain or to benefit their family or friends.
- Not to seek to advantage or further their private business or other interests in the course of their official duties.
- Not to accept gifts or bequests which will directly or indirectly benefit them, or put pressure on patients, or others to make donations to other people or organisations.

- Not to accept gifts or hospitality liable to raise any questions regarding their judgement or impartiality. Staff should decline all offers of gifts, hospitality, or entertainment except as defined in paragraph 4.2 above.

5.2 Line Managers

Line managers are required:

- To maintain the hospitality register for their area of responsibility.
- To maintain a register of employee's private interests.
- To advise the Corporate Business Manager of the above to ensure the central organisational register is update to date.

Appendix 1

Register of Employee's Private Interests

Declaration Form

I hereby declare the following private interests, which may be material and relevant to NHS business. This declaration is made in accordance with the terms of NHS Forth Valley's Code of Conduct.

Registerable Interest	Description of Interest
Remuneration	
Related undertaking	
Contracts	
Houses, land, and buildings	
Shares and securities	
Non-financial interests	

I understand these interests will be entered into a register held by the department manager or equivalent and which is available to the public. Any material changes to my circumstances will be notified to the department manager of equivalent, so that the information can be updated.

Signed: _____ Date: _____

Name (please print) _____ **Appendix 2**

Register of Interest in respect of:

Registered Interest	**Description of Interest**
Remuneration	
Other Roles	
Contracts	
Election Expenses	
Houses, Land and Buildings	
Shares and Securities	
Gifts and Hospitality	

Non-Financial Interests	
Close Family Members	

Register of Interests – Guidance Notes

Remuneration

(i) I will register any work for which I receive, or expect to receive, payment. I have a registrable interest where I receive remuneration by virtue of being:

a) employed;
b) self-employed;
c) the holder of an office;
d) a director of an undertaking;
e) a partner in a firm;
f) appointed or nominated by my public body to another body; or
g) engaged in a trade, profession or vocation or any other work.

(ii) I understand that in relation to (i) above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of this specific public body does not have to be registered.

(iii) I understand that if a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under Category Two,
'Other Roles'.

(iv) I must register any allowances I receive in relation to membership of any organisation under Category One.

(v) When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

(vi) When registering remuneration from the categories listed in paragraph (i) (b) to (g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of my public body in terms of paragraph 6.7 of the Code.

(vii) Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

(viii) When registering a directorship, it is necessary to provide the registered name and registered number of the undertaking in which the directorship is held and provide information about the nature of its business.

(ix) I understand that registration of a pension is not required as this falls outside the scope of the category.

Other Roles

(i) I will register any unremunerated directorships where the body in question is a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

(ii) I will register the registered name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which I am a director and from which I receive remuneration.

Contracts

(i) I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in **Shares and Securities** below) have made a contract with my public body:

a) under which goods or services are to be provided, or works are to be executed; and
b) b) which has not been fully discharged.

(ii) I will register a description of the contract, including its duration, but excluding the value.

Election Expenses

(i) If I have been elected to my public body, then I will register a description of, and statement of, any assistance towards election expenses relating to election to my public body.

Houses, Land and Buildings

(i) I have a registrable interest where I own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of my public body.

(ii) I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to my public body and to the public, or could influence my actions, speeches or decision-making.

Shares and Securities

(i) I have a registerable interest where:

a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an interest in is greater than £25,000.

Gifts and Hospitality

(i) I understand the requirements of paragraphs 3.13 to 3.21 of the Code regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

Non-Financial Interests

(i) I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are

those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by my public body).

Close Family Members

(i) I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

Appendix 3

Registering of Hospitality

Declaration Form

Hospitality offered to: (Name, title, department)	
Person of Organisation offering or providing the Hospitality and date	
Nature of Hospitality	
Estimated or actual value of Hospitality	
Any reasons for accepting, returning or refusing the Hospitality	
Authorised by: (Please print name and title)	

Please complete this form for any hospitality received and return to your line manager.

SECTION D

The Fraud Standards and Policy

The Fraud Standards

Fraud Policy

1 Introduction

2 Purpose of the Fraud Standards

3 Public service values

4 NHS Forth Valley Policy, Public Interest Disclosure Act 1998, the Bribery Act 2010 and the Whistleblowing arrangements

5 Roles and responsibilities

Response Plan

6 Introduction

7 Reporting theft, fraud, embezzlement, bribery and corruption

8 Managing the investigation

9 Disciplinary/dismissal procedures

10 Gathering evidence

11 Disclosure of loss from fraud

12 Police involvement

13 Press release

14 Resourcing the investigation

15 The law and its remedies

Key Contacts

Annex 1

FRAUD POLICY

1. Introduction

1.1 One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk and the means of enforcing the rules against fraud, theft and other illegal acts involving embezzlement, bribery, corruption, dishonesty, or damage to property. This policy and response plan forms part of the Partnership Agreement between NHS Scotland Counter Fraud Services (CFS) and Health Boards and Appendix II of the Partnership Agreement (PA), Fraud, Bribery & Corruption Protocol (model policy and response plan) provides further detailed direction and help to staff dealing with circumstances suspected to be fraud.

1.2 NHS Forth Valley (the Board) has procedures in place that reduce the likelihood of fraud occurring. These include Standing Orders (SOs), Standing Financial Instructions (SFIs), operational procedures, a system of internal control and risk assessment. NHS Forth Valley engages CFS to promote a fraud awareness culture through a range of products and services. The PA outlines what must happen in the event of a fraud or other irregularity being discovered and includes reference to the Board and CFS proactively detecting and investigating fraud and assessing the risk of fraud and forms a key element of the Scottish Government's determination to counter fraud against NHS Scotland. This guidance is in line with the PA between NHS Forth Valley and the NHS Scotland Counter Fraud Services.
(See: Partnership Agreement (scot.nhs.uk)) In addition NHS Forth Valley also participates in the National Fraud Initiative (NFI) data matching exercise coordinated by Audit Scotland.

2. Purpose of the Fraud Standards

2.1 The purpose of this document is to provide guidance to employees on the action, which should be taken when fraud, theft, embezzlement, bribery or corruption is suspected. Such occurrences may involve employees of NHS Forth Valley, Suppliers/Contractors or any third party. This document sets out the Board's policy and response plan for detected or suspected fraud. It is not the purpose of this document to provide direction on the prevention of fraud. NHS Scotland's policy on countering fraud is detailed in the Health Board Partnership Agreement 2022-25. The PA forms a key element of the Scottish Government's determination to counter fraud against NHS Scotland.

2.2 The Partnership Agreement is referenced in the Fraud section of the Scottish Public Finance Manual. This can be found at:
https://www.gov.scot/publications/scottish-public-finance-manual/fraud-and-gifts/fraud/

2.3 Whilst the exact definition of theft, fraud or corruption is a statutory matter, the following working definitions are given for guidance:

- Theft is taking/removing property belonging to NHS Forth Valley, its staff or patients with the intention of permanently depriving the owner of its use, without their consent.
- Fraud or corruption broadly covers deliberate material misstatement, falsifying records, making or accepting improper payments or acting in a manner not in the best interest of the Board for the purposes of personal gain.

- Embezzlement is the felonious appropriation of property (i.e a thing or things belonging to someone) that has been entrusted to the accused with certain powers of management or control.

For simplicity this document will refer to all such offences as "*fraud*", except where the context indicates otherwise.

2.4 NHS Forth Valley already has procedures in place, which reduce the likelihood of fraud/theft occurring. These are included within the Standing Orders, Standing Financial Instructions and accounting procedures, a system of internal control and a system of risk assessment. The Board also engages in the post payment verification programme in relation to the validity and accuracy of payments made to Family Health Service contractors for Primary Care Services.

2.5 It is the responsibility of NHS Forth Valley and its management to maintain adequate and effective internal controls, which deter and facilitate detection of any fraud. The role of Internal Audit is to evaluate these systems of control. It is not the responsibility of Internal Audit to detect fraud, but rather to identify weaknesses in systems that could potentially give rise to error or fraud.

3. Public service values

3.1 High standards of corporate and personal conduct based on the recognition that patients come first, have been a requirement throughout the NHS since its inception. The Code of Conduct published by the Scottish Government Health Department (SGHSCD) in April 1994 (revised 2004) set out the following public service values:

Accountability: Everything done by those who work in the organisation must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity: Absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers and customers.

Openness: The organisation's activities should be sufficiently public and transparent to promote confidence between the organisation and its patients, staff and the public.

3.2 All those who work in the organisation should be aware of, and act in accordance with, the above values. In addition, NHS Forth Valley will expect and encourage a culture of openness between NHS bodies and the sharing of information in relation to any fraud.

4. NHS Forth Valley Policy, Public Interest Disclosure Act 1998 and Bribery Act 2010

4.1 NHS Forth Valley is committed to the NHS Scotland Counter Fraud Strategy and to the public service values outlined above. NHS Forth Valley is dedicated to maintaining an honest, open and well-intentioned atmosphere within the service and to the deterrence, detection and investigation of any fraud within the organisation.

4.2 NHS Forth Valley encourages anyone having reasonable suspicion of fraud, theft, embezzlement, bribery or corruption to report the incident. It is NHS Forth Valley policy that no staff member will suffer in any way as a result of reporting any reasonably held

suspicions. For these purposes "*reasonably held suspicions*" shall mean any suspicions other than those which are groundless and/or rose maliciously.

4.3 In addition, the Public Interest Disclosure Act 1998 protects whistleblowers from negative treatment or unfair dismissal. The disclosure must be made in good faith and workers must have reasonable grounds to believe that criminal offences such as fraud or theft have occurred or are likely to occur. The disclosure must not be made for personal gain.

4.4 NHS Forth Valley Whistleblowing Arrangements Policy aims to ensure that staff can safely raise concerns where they are witness to risk, malpractice or wrongdoing that affects others. Employees can be assured that concerns raised in good faith will be protected under current legislation. NHS Forth Valley staff can continue to raise any concerns with their line manager in the first instance and they can also seek support and advice from Human Resources (HR), staff-side representatives and occupational health in line with existing policies and procedures. Staff wishing to raise a concern under the Whistleblowing Policy should discuss this with one of the Confidential Contacts, whose details are given on the Intranet and available via e-mail. Details of the support available to staff and copies of current national and local policies (including the Bullying and Harassment Policy and Grievance Policy) can be found in the HR Connect section of the NHS Forth Valley staff intranet. Confidential Contacts are available via email on fv.confidentialcontact@nhs.scot or by telephone **01324 566415.**

4.5 Whistleblowing standards have been introduced from 1 April 2021 across NHS Scotland. The standards include the role of an Independent National Whistleblowing Officer which forms part of the Scottish Public Services Ombudsman. The phone line, 0800 008 6112 is open to anyone who wishes to raise concerns about practices in NHS Scotland. The focus of the new National Whistleblowing Policy in NHS Scotland is to:

- help staff raise concerns as early as possible, and,
- support and provide protection for staff when they raise concerns.

The Whistleblowing standards aim to support an open fair and just culture, where concerns can be raised early and dealt with promptly and professionally. The process set out by the National Whistleblowing Standards is a formal process.

4.6 Whilst we would encourage staff to raise any concerns or complaints through existing Board procedures, the National Confidential Alert Line for NHS Scotland employees has been established to provide an additional level of support for NHS employees who may wish to raise a concern about practices in NHS Scotland. This service is run by Protect on https://protect-advice.org.uk/, an independent whistleblowing charity. The Alert Line offers independent, confidential advice from legally trained expert staff on whether and how to raise a concern and can be contacted on 020 3117 2520. Further choices available to staff, patients and members of the public for reporting suspicions of fraud (either anonymously or as a named individual) are:

- the CFS Fraud Hotline, which is now powered by Crimestoppers, on 08000 15 16 28; or
- directly through the CFS Website on www.cfs.scot.nhs.uk.

4.7 The NHS Forth Valley Policy on Standards of Personal Business Conduct describes the minimum Standards of Business Conduct expected from all NHS staff. It is the responsibility of staff to ensure that they do not place themselves in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

Under the Bribery Act 2010:

- It is a criminal offence to give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad.
- The maximum penalty for bribery was increased from seven to 10 years imprisonment with an unlimited fine.
- It is a corporate offence of failure to prevent bribery by persons working on behalf of a business, which means that NHS Forth Valley can be exposed to criminal liability, punishable by an unlimited fee if it fails to prevent bribery by not having adequate procedures in place that are robust, up to date and effective. The corporate offence is not a standalone offence and will follow from a bribery / corruption offence committed by an individual associated with NHS Forth Valley, in the course of their work. NHS Forth Valley therefore takes its legal responsibilities very seriously.

4.8 If a bribery offence is proved to have been committed by an outside body corporate with the consent or connivance of a director or senior officer of NHS Forth Valley, under the Act, the director or senior officer would be guilty of an offence (section 14 offence) as well as the body corporate which paid the bribe.

4.9 Staff must be aware that a breach of the provisions of this Act renders them liable to prosecution and may also lead to potential disciplinary action and the loss of their employment and superannuation rights within the NHS.

4.10 NHS Forth Valley does not tolerate any form of bribery, whether direct or indirect by its staff, agents or external consultants or any persons or entities acting for it or on its behalf.

4.11 The success of NHS Forth Valley anti-bribery measures depend on all employees, and those acting for NHS Forth Valley playing their part in helping to detect and eradicate bribery. Therefore, all employees and others acting for or on behalf of NHS Forth Valley are encouraged to report any suspected bribery (see sections 4.4 & 4.6 on ways of reporting).

5. Roles & responsibilities

5.1 As the Accountable Officer, the Chief Executive has the responsibility for countering fraud in its broadest terms. Accountable Officers are required to have adequate arrangements in place for the deterrence, prevention and detection of fraud. Responsibility for receiving information relating to suspected frauds has been delegated to the Fraud Liaison Officer (FLO). This individual is responsible for informing third parties such as CFS, Internal Audit and External Audit or the Police (where appropriate) when suspicions of potential fraud are brought to their attention, either directly or indirectly. The Scheme of Delegation included as Annex D within the Standing Orders of the Board state that the Authorised Deputy FLO is the Director of Finance.

5.2 The FLO shall inform and consult the Chief Executive and/or Director of Finance in cases where the loss may be above the delegated limit or where the incident may lead to adverse publicity. The FLO will advise the Director of Finance on any potential referral to CFS. The roles and responsibilities of NHS Fraud Liaison Officers are set

out within Annex B of CEL 11 (2013) Strategy to Combat Financial Crime in NHS Scotland' https://www.sehd.scot.nhs.uk/mels/CEL2013_11.pdf

5.3 Where a fraud is suspected within the service including Primary Care Services such as independent contractors providing Medical, Dental, Ophthalmic or Pharmaceutical Services, the FLO will make an initial assessment and, where appropriate, advise CFS. All staff have a duty to protect the assets of the Board, which include: information, physical property and cash. The Board will maintain an honest and open culture and wishes to encourage anyone having suspicions of fraud, embezzlement, bribery, corruption or systematic theft to report them without delay.

5.4 The roles and responsibilities of the Board's nominated Counter Fraud Champion are set out within https://www.sehd.scot.nhs.uk/mels/CEL2013_11.pdf
The contact details of the Counter Fraud Champion (CFC) are included in the Key Contacts listed in Annex 1 below. The CFC role is to help with the process of promoting a counter fraud message within the organisation and is vital in representing counter fraud issues at Board level and communicating to staff to promote an anti-fraud culture.

5.5 The Director of People, or nominated deputy, shall advise those involved in the investigation on matters of employment law and other procedural matters, such as disciplinary and complaints procedures.

5.6 Where the incident is thought to be subject to either local or national controversy and publicity then the Board and the Scottish Government Health and Social Care Directorates should be notified before the information is subjected to publicity. It should be added that under no circumstances should a member of staff speak or write to representatives of the press, TV, radio, other third parties or publicise details about a suspected fraud/theft on Social Network Sites, blogs or Twitter. Employees must ensure that no action take, could give rise to an action for slander or libel.

5.7 It is necessary to categorise the irregularity prior to determining the appropriate course of action. Two main categories exist:

- Theft, burglary and isolated opportunist offences; and
- Fraud, corruption and other financial irregularities.

5.8 The former will be dealt with directly by the Police whilst the latter may require disclosure under the SGHD NHS Circular No. HDL (2002) 23 – Financial Control: Procedure where Criminal Offences are suspected.

5.9 The National Fraud Initiative (NFI) in Scotland is a counter-fraud exercise led by Audit Scotland, assisted by the Cabinet Office. Data analytics compare information about individuals held by different public bodies, on different financial systems and databases to identify circumstances (matches) that might suggest the existence of fraud or error. The NFI allows public bodies to investigate these matches and, if fraud or error has taken place, to stop payments and attempt to recover the amounts involved auditors to assess the arrangements that the bodies have put in place to prevent and detect fraud. This Board participates in this exercise which is carried out every two years.

RESPONSE PLAN

6. Introduction

6.1 The following sections describe NHS Forth Valley's intended response to a reported suspicion of theft, fraud, embezzlement, bribery or corruption. It is intended to provide procedures, which allow for gathering and collating evidence in a manner that will facilitate an informed initial decision, while ensuring that evidence gathered will be admissible in any future criminal or civil action.
Each situation is different; therefore the guidance will need to be considered carefully in relation to the actual circumstances of each case before action is taken.

7. Reporting theft, fraud and corruption

7.1 Where an NHS colleague is suspected of theft, fraud, embezzlement, bribery or corruption then it is imperative that advice is sought from HR at the earliest opportunity. However, in the first instance any suspicion of fraud, theft, embezzlement, bribery or corruption should be reported to the relevant Head of Department. If the suspected theft, fraud, embezzlement, bribery or corruption involves the Head of Department then any suspicion should be reported in writing to a more senior officer or directly to the Fraud Liaison Officer (FLO). The contact details for the FLO are shown in the Key Contacts listed in Annex 1 below.

7.2 Once a suspicion regarding an NHS colleague has been reported then it is essential that contact should be made with HR before proceeding with any internal investigation. This will allow senior HR officers and line managers to make any decision on potential suspension or Police involvement. It will also allow discussion and agreement between the Head of Department/senior officer and HR regarding formal referral of the suspicion to the FLO. Once an agreement is reached, the suspicion and the grounds for that suspicion should be submitted to the FLO. If a suspicion relates to desirable medication or Controlled Drug (schedules 2, 3, 4 & 5) under the Misuse of Drugs Act 1971, the Controlled Drugs Accountable Officer* (who is also the Director of Pharmacy) should be contacted to enable a risk assessment to be undertaken.

* The roles and responsibilities of CDAOs are governed by the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

7.3 Where the suspicion relates to potential or actual fraud or corruption, information provided will be utilised by the FLO to populate a CFS1 form for formal referral of the matter to CFS who will consider the referral and take a view on whether a criminal investigation is justified.

7.4 For incidents involving Executive Directors of the Board, the FLO should contact the Chair of the Board or the Chair of the Audit and Risk Committee. It is important to act quickly when a suspicion is reported in order to minimise further losses to the Board. This also allows action to be taken to secure evidence required for any future proceedings; criminal or disciplinary.

7.5 Where the subject of the suspected theft, fraud, embezzlement, bribery or corruption is not an NHS colleague then the suspicion should be reported in writing to the Head of Department. It is important to capture as much information as is readily available regarding the person (or persons) suspected of fraud, theft or corruption for reporting to the FLO. The Head of Department and the FLO will then discuss and agree the most appropriate way forward, which may or may not include reporting the matter to Police Scotland and/or CFS.

7.6 For all instances where fraud or corruption is suspected a "nominated officer" will be appointed as the main point of contact for all stakeholders. For NHS Forth Valley, this officer is the FLO (see paragraph 5.1 above). In the absence of the FLO, the Deputy FLO will deal with the issue. For incidents involving any Executive Directors of the Board, the FLO will liaise with the nominated officer, who will be the Board Chairperson. It is important to act quickly when a suspicion is reported in order to minimise further losses to the Board and to allow action to be taken to secure any evidence that may be required for any future disciplinary or criminal proceedings.

7.7 CEL 44 (2008) updated the required reporting standards in a revised SFR 18 (Scottish Financial Return). The SFR 18 forms part of the Board's annual accounts and the change was to improve reporting of all relevant items. The purpose of enhanced recording and reporting is to enable the Scottish Government and NHS bodies to better understand the scale and types of identified NHS frauds, the categories within which these fall, the amounts involved, where applicable (since not all frauds/attempted frauds reported will have an attributable cost), and recoveries made.

7.8 The FLO will maintain a log of any reported suspicions of fraud, theft or corruption. The log will document, with reasons, the decision to take further action or to take no further action. The log will also record any actions taken and conclusions reached. This log will be utilised to help populate the Boards SFR 18.2 form which forms part of the Board's annual accounts.

7.9 The nominated officer (i.e the FLO) should consider the need to inform the NHS Forth Valley Board, the Counter Fraud Champion (CFC), the Chief Internal Auditor, External Audit, the Police and CFS, of the reported incident. In doing so, cognisance should be taken of the following guidance:

- Inform and consult the Director of Finance and the Chief Executive at the first opportunity, in all cases where the loss may exceed the delegated limit (or such lower limit as NHS Forth Valley may determine) or where the incident may lead to adverse publicity.
- In all cases where fraud, embezzlement, bribery, corruption or systematic thefts are suspected, it is essential that there is the earliest possible consultation with CFS, who should be contacted immediately by the FLO. CFS will then advise if Police Scotland need also be involved.
- In any event, CFS should be contacted before any overt action is taken that may alert suspects and precipitate the destruction or removal of evidence. This includes taking action to stop a loss or tighten controls.
- If a criminal act is suspected, particularly fraud or corruption, it is essential that there is the earliest possible consultation with the Police. The Police should be contacted before any overt action is taken which may alert suspects and precipitate the destruction or removal of evidence. This includes taking action to stop a loss or tighten controls.
- At the stage of contacting the Police, the FLO should contact the Director of Human Resources to consider whether/when to initiate suspension of the employee pending an enquiry.

7.10 All such contact should be formally recorded in the Log. It should be noted that staff who wish to raise concerns about unprofessional behaviour or decisions (where fraud, theft, embezzlement, bribery or corruption are not suspected) should do so by following

the guidance contained in the NHS Forth Valley Whistleblowing Policy. Following investigation of the complaint, if improper practices or criminal offences are suspected, the matter should be referred by the investigating officer to the FLO.

8. Managing the investigation

8.1 The decision on whether a referral is progressed by CFS as a criminal investigation is usually taken following correspondence between the FLO and CFS and usually involves an initial meeting to consider the available evidence. If the referral involves an employee of the Board then HR involvement in any initial meeting is crucial to avoid any conflict with ongoing or future disciplinary processes. The officer leading the criminal investigation will be Counter Fraud Specialist from CFS. The circumstances of each case will dictate who will be involved and when.

8.2 The manager overseeing the investigation (referred to hereafter as the "investigation manager") should initially:

- initiate a diary of events to record the progress of the investigation.
- if possible, determine the nature of the investigation i.e. whether fraud or another criminal offence. In practice it may not be obvious if a criminal event is believed to have occurred. If this is established the Police, External Audit and the Chief Executive should be informed if this has not already been done.

8.3 CFS staff, acting on behalf of the Director of Finance on any matters related to the investigation of fraud) are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case they shall have a duty to safeguard that confidentiality), within the confines of the data protection act;
b) Access at all reasonable times to any land, premises or employees of the Board;
c) The production or identification by any employee of any cash, stores or other property of the Board under an employee's control; and
d) Explanations concerning any matter under investigation.

8.4 If after initial CFS enquiries it is determined that there are to be no criminal proceedings then an internal investigation by NHS Forth Valley may be more appropriate. In this instance, all information/evidence gathered by CFS will be passed to NHS Forth Valley. The internal investigation will then be taken forward as appropriate in line with Employment Law, Once for Scotland policies and relevant HR policies such as the Management of Employee Conduct Policy.

8.5 Any formal internal investigation to determine and report upon the facts, should establish:

- the extent and scope of any potential loss.
- if any disciplinary action is required.
- the criminal or non-criminal nature of the offence (if not yet established).
- what can be done to recover losses.
- what may need to be done to improve internal controls to prevent any recurrence.

8.6 Where the report confirms a criminal act, and notification to the Police has not yet been made, then a formal report should be submitted to Police Scotland at that point.

8.7 This report should form the basis of any internal disciplinary action taken. The conduct of internal disciplinary action will be assigned to the Director of People or delegated officer within the Directorate, who shall gather such evidence as necessary.

8.8 Where recovery of a loss to NHS Forth Valley is likely to require a civil action, arising from any act (criminal or non-criminal), it will be necessary to seek legal advice through the Central Legal Office (CLO), which provides legal advice and services to NHS Scotland.

9. Disciplinary/dismissal procedures

9.1 Consideration should be made in conjunction with CFS/CFC/FLO on whether/when to suspend the employee(s) who are subject to any investigation, pending the results of the investigation.

9.2 In any disciplinary action taken by the NHS Forth Valley toward an employee, the Once for Scotland disciplinary procedures have to be followed (including dismissal). This may involve the person in charge of the investigation recommending a disciplinary hearing to consider the facts, reflect on the results of the investigation and recommendations on any further appropriate action, to the employee's line manager. Where the fraud involves, e.g. a regulated health professional, and/or a Primary Care Services Practitioner the Board should pass the matter over to the relevant professional body for action.

9.3 In every case where it is proposed to proceed to a disciplinary hearing whilst there is a criminal case pending based on the same or related allegations, the advice of Central Legal Office/external equivalent is to be sought before proceeding. There is no requirement under the criminal law for staff to be retained on full pay pending the criminal case. However, it may be considered inappropriate to proceed with a disciplinary hearing if the individual concerned declines to attend. In every such case, CLO will advise on whether the evidence is in itself sufficiently strong and compelling to justify dismissal in absentia, if necessary. In practice, such action will be the exception rather than the rule.

10. Gathering evidence

10.1 This policy cannot cover all the complexities of gathering evidence. Each case must be progressed based on the individual circumstances of the case, taking professional advice as necessary (including advice from CLO where deemed appropriate). Where CFS decides not to pursue a criminal investigation, for whatever reason, the recommended next steps may involve an internal, Board-level investigation. In these circumstances it is important that the gathering of evidence is carried out in a methodical and consistent way.

10.2 If a witness to the event is prepared to give a written statement, it is best practice for an experienced member of staff, preferably from the HR Directorate, to take a chronological record using the witness's own words. The witness should sign the statement only if satisfied that it is a true record of his or her own words. In

circumstances where the witness is the Fraud Liaison Officer then the "role" of Fraud Liaison Officer moves to the next most senior member of staff.

10.3 At all stages of the investigation, any discussions or interviews should be documented and where feasible agreed with the interviewee.

10.4 Physical evidence should be identified and gathered together in a secure place at the earliest opportunity. An inventory should be drawn up by the investigating officer and held with the evidence. To prevent any changes being made to the original evidence, where possible, a replacement or alternative record should be implemented for business continuity. It is essential that the evidence is kept intact. If evidence consists of several items, for example a number of documents, each one should be tagged with a reference number corresponding to the written record. Care with evidence gathering is important, as that which may initially be treated as a discipline case could become a criminal prosecution at a later stage.

10.5 Where evidence is believed to be held on: individual computers; laptops; smartphones; tablets; camera systems; or on a business network, CFS will provide advice in the first instance to the Board on developing a plan to secure digital evidence. Great care should be taken where there is a need to secure copies of files, emails and logs, and strict procedures must be followed to allow this type of evidence to be admissible in prosecution proceedings. Accessing this information prior to securing a forensic image may be considered by a Court as tampering with the evidence and it may be ruled inadmissible.

11. Disclosure of loss from fraud

11.1 Guidance on the referring of losses and special payments is provided in CEL 10 (2010) – Revised Scottish Financial Return (SFR) 18: Enhanced Reporting of NHS Frauds and Attempted Frauds. This includes reporting of all forms of irregular activity which suggest that fraud may have taken place, even if the evidence is not of a standard that can be used for prosecution. Scottish Financial Return (SFR) 18.0 on Losses and Compensation Payments is submitted annually to the Audit and Risk Committee as part of the Annual Accounts. SFR 18 should include all losses, with appropriate description, aligned within the standard categories specified by the SGHSCD. External Audit should be notified of any loss as part of their statutory duties.

11.2 Management must take account of the permitted limits on writing off losses for "Category 2 Boards", as outlined in Annex C of CEL 10 (2010).

11.3 It will be important for the Director of Finance to consider actions to be taken to minimise the risk of a potential repeat of the incident. The actions could include a review of lessons learnt and completion of a risk assessment by internal audit or consideration of a Fraud Risk Assessment by CFS. Any lessons learned should for example, be disseminated to the Service through the internal audit network or by using the CFS bulletins.

12. Police Involvement

12.1 It is expected that, wherever a criminal act is suspected, but which falls out-with the remit of Counter Fraud Services, the matter will be notified to Police Scotland as follows:

- During normal working hours, it will be the decision of the Director of Finance as to the stage that the Police are contacted. If the Director of Finance is unavailable, this decision will be delegated to the FLO.
- Outwith normal working hours, the manager on duty in the area where a criminal act is suspected should always report the matter to the Senior Manager and Executive Director On Call. It will be the decision of the Executive Director On Call as to the stage that the Police are contacted. In any case the manager on duty in the area where a criminal act is suspected should always report the matter to the Director of Finance and the FLO at the earliest possible time.

12.2 The nominated officer (the FLO) and investigating manager should informally notify the Police of potential criminal acts, to seek advice on the handling of each investigation at an early stage in the investigation.

12.3 Formal notification of a suspected criminal act will normally follow completion of the investigating manager's report and formal disciplinary action. It is important that the internal report is carried out in a timely manner to avoid delaying the Police investigation.

13. Press Release

13.1 To avoid potentially damaging publicity to the NHS and/or the suspect, NHS Forth Valley should prepare at an early stage, a Press release, giving the facts of any suspected occurrence and any actions taken to date e.g. suspension. The Communications Team within CFS, the CLO and the Police should agree the release where applicable.

13.2 Under no circumstances should a member of staff speak or write to representatives of the press, TV or radio, about a suspected fraud without the express authority of the Chief Executive.

13.3 The Officer in Charge of the criminal case, whether from CFS or Police Scotland, will be responsible for collaborating with the Board's communications department in relation to preparing and agreeing the timing and content of an appropriate press release.

14. Resourcing any internal investigation

14.1 The Director of Finance will determine the type and level of resource to be used in investigating any suspected fraud. The choices available will include:

- Staff from within NHS Forth Valley
- Internal Audit
- Specialist Consultant
- Police

14.2 In making a decision, the Director of Finance, should consider independence, knowledge of the organisation, cost, availability and the need for a speedy investigation. Any decision must be shown in the Log held by the Nominated Officer (the FLO). A decision to take "No action" will not normally be an acceptable option unless exceptional circumstances apply.

14.3 In any case involving a suspected criminal act, it is anticipated that Counter CFS involvement will be in addition to NHS Forth Valley resources. In any case involving other suspected criminal acts, it is anticipated that Police involvement will be in addition to NHS Forth Valley resources.

15. The law and its remedies

15.1 Criminal Law - The Board shall refer all incidences of suspected fraud/criminal acts to CFS or the Police for decision by the Procurator Fiscal as to any prosecution.

15.2 Civil Law - The Board shall refer all incidences of loss through proven fraud/criminal act to the CLO for opinion, as to potential recovery of loss via Civil Law action.

15.3 Criminal Law may impose sanctions on the suspect for causing loss, while civil law may assist the Board to recover its loss.

Annex 1 – Key Contacts

Board Key Contacts

Role	Name	Designation	Contact Details
Fraud Liaison Officer	Anne Marie Machan	Regional Audit Manager	annemarie.machan@nhs.scot
Deputy Fraud Liaison Officer	Scott Urquhart	Director of Finance	01786 457245 scott.urquhart@nhs.scot
Counter Fraud Champion	Robert Clark	Non-Executive Member and Employee Director	01786 457226 robert.clark4@nhs.scot
Whistleblowing Champion	Gordon Johnston	Non-Executive Member and Whistleblowing Champion	Gordon.johnston@nhs.scot

External Contacts

Counter Fraud Hotline (Crimestoppers) – 08000 15 16 28

Counter Fraud Services – 01506 705200 (general enquiries)
www.nss.nhs.scot/departments/counter-fraud-services/

Independent National Whistleblowing Officer - 0800 008 6112
https://inwo.spso.org.uk/whistleblowing

SECTION E

Scheme of Delegation

1. INTRODUCTION

1.1. The Scheme of Delegation is a reference document which summarises the responsibilities and accountabilities of Forth Valley NHS Board and confirms the decision-making authority delegated by the NHS Board to standing committees, individual NHS Board members and NHS Board employees.

1.2. The Scheme of Delegation should be read in conjunction with the NHS Board's Code of Corporate Governance and Financial Operating Procedures.

1.3. The Scheme of Delegation is a key part of the NHS Board's governance framework and is designed to support timely and effective decision making across the organisation. As a minimum, the Scheme of Delegation is subject to an annual review by the NHS Board. However, the scheme may be reviewed more frequently where appropriate (for example following a change in the management or organisational structure that is likely to impact on the scheme's effectiveness).

1.4. The NHS Board has delegated authority to the Director of Finance to lead the routine review and maintenance of the Scheme of Delegation.

2. PRINCIPLES UNDERPINNING DELEGATION AND DECISION MAKING

2.1. All members and officers of the NHS Board are expected to familiarise themselves with the Scheme of Delegation.

2.2. In accordance with Financial Operating Procedure 03, all budget holders are required to formally agree their annual budgets and are accountable for budgetary performance. It is essential that expenditure levels do not exceed the agreed budget. Budget holders must therefore ensure that all decisions taken within the scope of their delegated authority are affordable within the available budget.

2.3. Where an employee of a Local Authority is either a budget holder or is granted authority to approve expenditure, the Director of Health and Social Care (IJB Chief Officer) must ensure that this individual is familiar with the NHS Board's policies and procedures and has the necessary access to relevant IT systems.

2.4. Where authority is delegated to Directors and members of the Senior Management Team, further delegation to deputies and other staff may be permitted through the Authorised Signatory process. However, the Directors and members of the Senior Management Team named in the Scheme of Delegation ultimately remain accountable for the actions of any individuals they have delegated to and for all transactions within their remit. Note that there are certain transactions and activities that may not be delegated any further (these items can only be approved by the named Director or member of the Senior Management Team in the Scheme of Delegation).

2.5. All values quoted in the Scheme of Delegation are inclusive of VAT, unless otherwise stated.

3. MATTERS RESERVED FOR THE NHS BOARD

3.1. The NHS Board is ultimately responsible for the protection and improvement of the health of Forth Valley's resident population and for the delivery of local frontline healthcare services.

3.2. The Standing Orders contained in the Code of Corporate Governance sets out the written rules on the business conduct and proceedings of the NHS Board. In accordance with section A, paragraph 6 and annex C of the Standing Orders, decision making on the following matters is reserved exclusively for the NHS Board and these matters may NOT be delegated:

3.2.1. The establishment and terms of reference of all its committees, and appointment of committee members.

3.2.2. Organisational Values.

3.2.3. The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.

3.2.4. The Delivery Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Delivery Plan, the Board should receive it at a public Board meeting).

3.2.5. Corporate objectives or corporate plans which have been created to implement its agreed strategies.

3.2.6. Risk Management Policy.

3.2.7. Financial plan for the forthcoming year, and the opening revenue and capital budgets and medium-term financial planning (3 – 5 year plans).

3.2.8. Standing Financial Instructions and the Scheme of Delegation.

3.2.9. Annual accounts and report. (Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts, or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly, the Board cannot publish the report of the external auditors of their annual accounts in this period).

3.2.10. Approval of local business cases with a revenue or capital value of in excess of £250k.

3.2.11. Endorsement of any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval (the current delegated limit set by the Scottish Government for NHS Forth Valley is £1.5m as per the Scottish Capital Investment Manual and CEL(2010)32).

3.2.12. The Board shall approve the content, format, and frequency of performance reporting to the Board.

3.2.13. The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment).

3.2.14. Acquisition and disposal of any land and property in excess of £250,000.

3.2.15. NHS Board Members' Register of Interests.

3.2.16. Approval of NHS Board Annual Report and Annual Accounts.

3.2.17. Financial and Performance Management Reporting Arrangements.

3.2.18. Arrangements for approval of policies required as a result of national guidelines with the exception of Human Resource policies (see Staff Governance Committee remit).

3.2.19. Recommendations to the Scottish Government relating to the closure or change of use of hospitals.

3.2.20. Appointment of Executive Directors of Forth Valley NHS Board.

3.2.21. Appointment of Management Consultants/Advisors where contract value exceeds £100,000.

3.2.22. Approval of delegation of any function to an agency out with the National Health Service.

4. MATTERS DELEGATED TO STANDING COMMITTEES AND GROUPS

4.1 In accordance with section A, paragraph 7 of the Standing Orders, the NHS Board may delegate decision making to standing committees and various groups as appropriate. The following standing committees and groups have delegated responsibility for decision making on behalf of the NHS Board.

4.2 **Matters delegated to standing committees:**

4.2.1. **Audit and Risk Committee** (Executive Lead: Director of Finance). Decision making by this Committee is focused on matters relating to risk management, governance and internal control as part of the Committee's key role to provide assurance that the organisation is being managed effectively and resources are safeguarded appropriately.

4.2.2. **Clinical Governance Committee** (Executive Leads: Medical Director and Executive Nurse Director). Decision making by this Committee primarily relates to service quality assurance, continuous service improvement and clinical risk management as part of the Committee's role to ensure effective Clinical Governance arrangements are in place throughout the local NHS system (including services that are commissioned from independent providers and other partner agencies)

4.2.3. **Strategic Planning, Performance and Resources Committee** (Executive Lead: Director of Finance). Decision making by this Committee is linked to all aspects of performance management (both financial and non-financial) and securing best value in the use of resources (including approval of property transactions).

4.2.4. **Pharmacy Practices Committee** (Executive Lead: Medical Director). This Committee will consider and approve or reject applications for inclusion in the Pharmaceutical List in accordance with the NHS (Pharmaceutical Services) (Scotland) Regulations 2009 and the NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 (SSI 2011 No. 32) and 2014 (SSI 2014 No. 148).

4.2.5. **Remuneration Committee** (Executive Lead: Director of People). Decision making by this Committee is focused on the application and implementation of fair and equitable pay systems on behalf of the NHS Board, as determined by Ministers and Scottish Government.

4.2.6. **Staff Governance Committee** (Executive Lead: Director of People). Decision making by this Committee primarily relates to implementation of the NHS Scotland staff governance standard.

4.3 Further information on the specific role and remit of each of the standing committees referred to above is contained in section A, annex B of the NHS Board's code of corporate governance.

4.4 **Matters delegated to Groups:**

4.4.1. **Senior Leadership Team** (SLT) - the SLT is the whole system decision making group for the implementation of the NHS Board's strategy. SLT has accountability through the Chief Executive to the NHS Board and reports to the NHS Board.

4.4.2. The role and remit of the SLT is:

Role and Remit of the Senior Leadership Team
Providing exemplary leadership and direction to the organisation, modelling the principles, behaviours and values set out in the NHS Forth Valley Code of Conduct.
The development, implementation and co-ordination of operational plans, policies, procedures and resources that underpin the delivery of the Board's strategic aims, particularly complex whole system decisions.
The oversight and monitoring of the whole system and its performance across all strands of delivery, holding each other to account through effective performance accountability structures.
Prioritising and allocating resources through transparent processes. For example, the group will consider for approval all business cases seeking capital and revenue investment in excess of £50k that have been endorsed by the Strategic Prioritisation Review & Implementation Group (SPRIG).

Assessing and mitigation of risk, in conjunction with active horizon scanning for opportunities.
Ensuring that the regulatory and statutory requirements are met for the Board.

5. MATTERS DELEGATED TO INDIVIDUALS

5.1 The Chief Executive:

5.1.1. The Chief Executive, as the Accountable Officer of the NHS Board in line with Part 2, Section 15 of the Public Finance and Accountability (Scotland) Act 2000, is personally answerable to the Scottish Parliament in respect of the NHS Board's policies, actions and conduct. Financial Operating Procedure 02 and the NHS Board's Standing Financial Instructions provide further detail on the specific responsibilities of the Chief Executive.

5.1.2. The full range of responsibilities arising from the NHS Board's Standing Orders and Standing Financial Instructions in relation to financial, corporate and clinical governance, risk management and other operational activities are delegated to other specific individuals as summarised in the following tables.

5.2 Delegated Powers Arising from Standing Orders

Ref	Area of responsibility	Delegated to	Further delegation permitted	Limits applying £	Comments
Delegated powers arising from Standing Orders					
5.2.1	Maintenance of a register of NHS Board members interests.	Board Secretary	N/A	N/A	As per section 1.6 of the NHS Board's Standing Orders. As a minimum, the register is updated on an annual basis and this is published online.
5.2.2	Execution of documents on behalf of Scottish Ministers relating to property transactions.	Chief Executive and/or Director of Finance	N/A	N/A	As per section 8.1 of the NHS Boards Standing Orders. Also see the NHS Scotland Property Transactions Handbook for further information.
5.2.3	Sealing of documents with the NHS Board Seal	Chief Executive and/or Director of Finance	N/A	N/A	Use of the NHS Board seal must be accompanied by the signatures specified in the Standing Orders.

5.3 Delegated Powers Arising from Standing Financial Instructions:

Ref	Area of responsibility	Delegated to	Further delegation permitted	Limits applying £	Comments
Delegated powers arising from Standing Financial Instructions					
ALLOCATIONS, BUSINESS PLANNING, BUDGETS & BUDGETARY CONTROL					
5.3.1	Design, implement & monitor systems of financial control & related procedures (including establishment & maintenance of financial planning & the budgetary control system).	Director of Finance	N/A	N/A	In accordance with section 1.1.4 of the NHS Board's Standing Financial Instructions & Statutory Instrument (1974) no 468 & NHS circular 1974 (GEN) 88.
5.3.2	Preparation of revenue and capital financial plans.	Director of Finance	N/A	Revenue Resource Limit & Capital Resource Limit	Approval of the annual financial plan is initially required by the Strategic Planning, Performance & Resources Committee, followed by the NHS Board. The financial plan will normally be approved by SPP&R committee in February & the NHS Board in March, (ie the plan must be approved in advance of the financial year to which it relates).
5.3.3	Calculation of the annual payment to Integration Joint Boards (IJBs)	Director of Finance	N/A	As per approved financial plan	Forms part of the annual financial plan & must be approved by the NHS Board in line with the timescales indicated in the relevant Integration Scheme. See 5.3.84 re approvals.
5.3.4	Annual budget setting & allocation of **non-delegated** revenue healthcare service budgets to budget holders.	Director of Finance	Deputy Director of Finance	As per approved financial plan	Also referred to as NHS Core Service budgets. As per Financial Operating Procedure (FOP) 03 all budget holders are required to formally agree their annual budgets, together with any in year changes, through an authorised Budget Control Amendment schedule.
5.3.5	Annual budget setting & allocation of **delegated** set aside & integrated revenue healthcare service budgets to budget holders in the Health & Social Care Partnership (HSCP).	Chief Finance Officer	N/A	As per approved IJB financial plan	Integrated budget is also referred to as Operational and Universal HSCP service budgets. Budgets must reconcile to IJB Directions & confirmation from Chief Finance Officer (CFO).

5.3.6	In year management of revenue **non-delegated** budgets at individual budget level (pay & non-pay) and overall service level.	Nominated budget holders/ relevant Director	Named Deputies	Within approved budget	All budget holders have a responsibility to ensure expenditure is contained within agreed budgeted levels. A list of budget holders in maintained by the Director of Finance.
5.3.7	Budget virement within or between **non-delegated** revenue healthcare service budgets.	Relevant Director	Deputy Director of Finance	< £100k	Any proposed virement must be in support of agreed NHS Board strategy. Virement over £100k requires approval from the Director of Finance.
5.3.8	Authority to commit expenditure for which no provision has been made in approved financial plans/budgets.	Chief Executive	Director of Finance	£500k	Limit applies to both revenue and capital expenditure.
5.3.9	Authority to commit expenditure for which no provision has been made in approved financial plans/budgets.	Director of Finance	N/A	£250k	Limit applies to both revenue and capital expenditure.
5.3.10	Budget virement within or between **non-delegated** revenue healthcare budgets in respect of items where no provision has been made in approved financial plans/budget.	Director of Finance	Deputy Director of Finance	£100k	In general budgets should only be used for the purposes originally intended & agreed. Any virement (regardless of value) to fund an item that is not provided for or agreed via the financial plan or budget requires approval from the Director of Finance.
5.3.11	In year management of revenue **delegated** set aside & integrated healthcare budgets at individual budget level and overall service level.	HSCP Nominated budget holders/Chief Officer/ Director of Acute Services	Named Deputies	Within approved budget	All budget holders have a responsibility to ensure expenditure is contained within agreed budgeted levels. Budget management processes and risk sharing arrangements are outlined in the extant Integration Schemes.
5.3.12	Budget virement within or between **delegated** integrated revenue healthcare service budgets.	Chief Officer	N/A	< £100k	Any proposed virement of HSCP operational or universal budgets must be in support of agreed IJB strategy. See IJB Scheme of Delegation for further information.

5.3.13	Budget virement to/from **delegated** Set Aside revenue healthcare service budgets or virement between Set Aside & the Integrated budget.	Director of Finance & Chief Officer	Deputy Director of Finance & Chief Finance Officer	< £100k	Any proposed virement within Set Aside budgets, or transfers to/from Set Aside & integrated budgets be in support of agreed IJB strategic plans.
5.3.14	Annual budget setting & allocation of Capital budgets to budget holders.	Director of Finance	Deputy Director of Finance	As per of approved financial plan	Capital budgets are allocated based on the NHS Board approved 5-year capital plan.
ANNUAL ACCOUNTS & REPORTS					
5.3.15	Submission of Financial Performance Returns to Scottish Government.	Director of Finance	Deputy Director of Finance	N/A	Monthly in line with the Scottish Government reporting timetable.
5.3.16	Signatories to Annual Report & Accounts/Financial Statements.	Chief Executive and Director of Finance	N/A	N/A	Draft accounts to be submitted to the Scottish Government by 31 May followed by final audited accounts no later than 30 June as per the NHS Scotland Annual Accounts Manual and Public Finance & Accountability (Scotland) Act 2000. Formal approval of the audited Annual Report & Accounts is via the NHS Board.
5.3.17	Preparation of Annual Governance Statement.	Director of Finance	Deputy Director of Finance	N/A	The Annual Governance Statement forms part of the Accountability Report section of the Annual Report & Accounts. See NHS Scotland Annual Accounts Manual for further information.
AUDIT					
5.3.18	Appointment of External Auditor.	Auditor General	N/A	N/A	The External auditors of the NHS Board are appointed by the Auditor General on a five-year cycle in order to maintain auditor independence. The majority of external audits are undertaken by Audit Scotland with the balance carried out by private firms of auditors appointed by the Auditor General. See Audit Scotland code of Audit Practice & International Standard on Auditing (IAS) 315 for further information.
5.3.19	Appointment of Chief Internal Auditor.	NHS Board	N/A	N/A	As per section 6.2 of the NHS Board's Standing Orders.

5.3.20	Provision of an adequate Internal Audit Service.	Director of Finance	N/A	N/A	As per section 15 of the Standing Financial Instructions and Public Sector Internal Audit Standards (PSIAS).
5.3.21	Preparation of annual audit certificate	External Auditor	N/A	N/A	The Annual Audit Report (ISA 260) & annual audit certificate are prepared by External Audit & presented to those charged with governance (via the Audit & Risk Committee) in June of each year.
BANKING ARRANGEMENTS					
5.3.22	Opening of bank accounts in the NHS Board's name	Director of Finance	N/A	N/A	Cash balances in non-GBS accounts held with commercial banks must not exceed £50k as per HDL(2001)49.
5.3.23	Notification to Bankers of authorised signatories on bank accounts	Director of Finance	Deputy Director of Finance	N/A	The Accounting Services Manager will maintain a list of authorised signatories for all banking services.
5.3.24	Transfers to/from Government Banking Service (GBS) accounts to commercial accounts	Director of Finance	Deputy Director of Finance	N/A	Working capital and cash flow is managed by the Treasury team under the direction of the Director of Finance. Temporary cash surpluses shall only be held in accordance with the Scottish Public Finance Manual (SPFM).
5.3.25	Authorisation of BACS, CHAPS, SWIFT, faster payments	2 signatories from list of bank authorisers	N/A	N/A	As per authorised signatory list referred to in 5.3.23. • Bankers Automated Clearing System (BACS), • Clearing Houses Automated Payment System (CHAPS) • Society for World-wide Interbank Financial Telecommunication (SWIFT)
5.3.26	Authorisation of Direct Debits and Standing Order mandates	Director of Finance	Deputy Director of Finance	N/A	
5.3.27	Authorisation of corporate credit card transactions.	Deputy Director of Finance	Accounting Services Manager	N/A	Transactions must be pre-approved by the relevant budget holder (and/or Director of Finance depending on value) before being processed by the Treasury Team.

SERVICE LEVEL AGREEMENTS & CONTRACTS REALTING TO THE PROVISION OF HEALTHCARE					
5.3.28	Signing of Service Level Agreements (SLAs) & contracts for the provision of healthcare	Director of Finance & relevant Director	N/A	Within approved budget	All SLAs & provision of service contracts for healthcare, regardless of the value, must be jointly signed by the Director of Finance and relevant service Director on behalf of the NHS Board.
5.3.29	Setting of fees & charges in respect of private patients, overseas visitors, income generation/mutual aid and other patient related services.	Director of Finance	Deputy Director of Finance	N/A	Applies in respect of fees that are locally determined and are not set by Scottish Government/statute.
5.3.30	Submission of grant applications and funding bids	Director of Finance & relevant Director	N/A	N/A	All grant applications and funding bids must be approved by the Director of Finance in advance of submission to the awarding body.
5.3.31	Signing of Patient Access Scheme (PAS) & Primary Care Rebate Scheme (PCRS) approval letters	Director of Pharmacy	N/A	N/A	PAS & PCRS are confidential pricing agreements between the NHS Board & pharmaceutical companies designed to enable patients to gain access to drugs or other treatments that may not be considered to be cost-effective based on published list price. NHS National Services Scotland maintain a PAS and PCRS register on behalf of all NHS Boards.
PAY EXPENDITURE					
5.3.32	Preparation of contracts of employment	Director of People	Yes	N/A	Contacts must comply with relevant legislation & national and/or locally agreed terms & conditions as advised by HR. The post must form part of the budgeted establishment.
5.3.33	Approval of hours worked & leave/absence recording	Budget holder	Line Manager	Within approved budget	Hours worked and absence for all staff groups must be within budget, in line with relevant Terms & Conditions & recorded via the appropriate HR & payroll systems eg Scottish Standard Time System (SSTS), electronic Employee Support System (eESS) and eRoster/Allocate.

5.3.34	Engagement of supplementary staffing & other external contractors/workers	Executive Nurse Director/ Medical Director	Nurse Director/ Associate Medical Director	N/A	See agreed approval processes/protocols for the use of supplementary medical & dental and Nursing, Midwifery & Allied Health Professionals (NMAHP). The recruiting manager must conduct IR35/off payroll working checks in advance of engaging certain external contractors and workers as appropriate.
5.3.35	Approval of new and/or redesigned posts or regraded posts	Director of People/ Director of Finance	N/A	Within approved budget	Professional advice and approval must be confirmed in relation to any skill mix change or regrading (see section 5 of the Recruitment Authorisation Form). The post must form part of the budgeted establishment.
5.3.36	Responsibility for implementing changes to terms & conditions of service	Director of People	Named Deputies	N/A	As per national guidance & policy.
5.3.37	Approval of severance and/or settlement agreements/exit packages	Chief Executive	Director of People	≤ £95k	Packages in excess of £95k require to be approved by the Scottish Government in line with DL(2019)15 and the SPFM.
5.3.38	Settlement of employment litigation claims	Director of People	N/A	≤ £100k	In conjunction with advice from the Central Legal Office (CLO). Values in excess of £100k require Scottish Government Approval.
NON-PAY EXPENDITURE (REVENUE)					
5.3.39	Development & oversight of Procurement Strategy	SPP&RC	Head of Procurement	N/A	Procurement activity must be conducted in accordance with the requirements of the SPFM and all relevant procurement legislation and regulations as they apply to the NHS in Scotland.
5.3.40	Maintenance of a non-pay contract register	Head of Procurement	N/A	N/A	
5.3.41	Approval & authorisation of non-pay revenue expenditure, including supplier invoices, employee expense claims etc	Relevant Budget Holder	Named deputies	Within approved budget	Limits for each budget holder are contained in the authorised signatory list maintained by the Accounting Services Team. Expenditure authorised by the budget holder must be contained within the available budget.

					Approval of employee expense claims must be in line with agreed Terms & Conditions of service and within the available budget.
5.3.42	Management & control of stock – including issue of stores recording & operating procedures.	Head of Procurement/ Digital Director/ Pharmacy Director	N/A	N/A	Stock security arrangements also fall under this item (including management of controlled drugs see item 5.5.8)
5.3.43	Amendments to the Unitary Charge in relation to PFI/PPP contracts as a result of a variation request where the associated revenue costs are less than £20k	Director of Facilities & Director of Finance	N/A	≤ £20k	See contract variation request process – if the variation request is cost neutral or the additional revenue costs are less than £20k, acceptance of the response to the variation request requires to be approved by both the Director of Facilities and the Director of Finance.
5.3.44	Amendments to the Unitary Charge in relation to PFI/PPP contracts as a result of a variation request where the associated revenue costs are in excess of £20k	Strategic Planning, Performance & Resources Committee.	N/A	>£20k	See contract variations process. Where the additional revenue costs of the variation request are greater than £20k, a business case should be presented to the Strategic Planning, Performance & Resources Committee for approval (this may require NHS Board approval if costs exceed £250k).
NON-PAY EXPENDITURE (CAPITAL)					
5.3.45	In year management of capital budgets at individual project level & Directorate level.	Budget holder/ Director	Named deputies	Within approved budget	All budget holders have a responsibility to ensure expenditure is contained within agreed budgeted levels.
5.3.46	Virement of capital budget between projects (per item/event)	Digital Director/ Director of Facilities	DDOF	≤ £150k	Subject to affordability. Proposed virement in excess of £150k requires approval by the Director of Finance (Chief Exec where value is over £250k & NHS Board where value is in excess of £500k).
5.3.47	Management of capital contingency budget	Director of Finance	DDOF	Within approved budget	All budget holders have a responsibility to ensure expenditure is contained within agreed budgeted levels. Virement permitted within agreed levels.

5.3.48	Approval of non-pay capital expenditure, including supplier invoices etc.	Relevant Budget Holder	Named Deputies	Within approved budget	As per 5.3.41 above re authorised signatory.
5.3.49	Amendments to the Unitary Charge in relation to PFI/PPP contracts as a result of a variation request where the associated capital costs are in excess of £20k	Strategic Planning, Performance & Resources Committee	N/A	>£20k	As per 5.3.43 & 5.3.44 above. Variations with a capital cost below £20k can be approved by the Director of Facilities and Director of Finance (both signatures are required on the variation acceptance). Where capital costs exceed £20k approval is via the SPPRC.
ORDERS, QUOTATIONS & TENDERS					
5.3.50	Responsibility for ensuring that all expenditure is processed via official purchase orders (PO)	Budget holders	Yes	Within approved budget	NHS Forth Valley POs are subject to our standard terms of business unless otherwise agreed in writing. “No PO no pay” policy applies (ie all supplier invoices must quote a valid PO number).
5.3.51	Requisitioning & ordering of goods & services: Where an order exceeds a 12-month period	DDOF	No	Within approved budget	Subject to total expenditure remaining within the approved budget.
5.3.52	Requisitioning & ordering of goods & services (**revenue**): With an annual value up to £250k	Relevant Director	DDOF	≤ £250k	Subject to total expenditure remaining within the overall budget allocated to the Directorate.
5.3.53	Requisitioning & ordering of goods & services (**revenue**): With an annual value over £250k	Chief Executive	Director of Finance	≥ £251k	Subject to total expenditure remaining within the overall approved NHS Board budget.
5.3.54	Requisitioning & ordering of goods & services (**capital**): With an annual value over £500k	Chief Executive	Director of Finance	≥ £500k	Subject to NHS Board approval of the associated business case (including confirmation that all capital & revenue consequences are affordable) and/or the NHS Board approved capital plan.
5.3.55	Requisitioning & ordering of goods & services (**capital**): With an annual value up to £499k	Digital Director/ Director of Facilities	Deputy Director of Finance	£250k to £499k	Subject to NHS Board approval of the associated business case (including confirmation that all capital & revenue consequences are affordable) and/or the NHS Board approved capital plan.

5.3.56	Requirements for quotations & tenders: Where the value of the expenditure is between £5,000 toto £10,000 a minimum of 1 written quotation should be sought.	Budget holders	No	Within approved budget	The written quotation can be via hard copy or electronic. Consider use of "Quick Quote" where appropriate. This is an online quotation facility via the Public Contracts Scotland website which enables NHS Boards to obtain competitive quotes electronically for low value requirements.
5.3.57	Requirements for quotations & tenders: Where the value of the expenditure is between £10,001 to £19,999 a minimum of 2 written quotations should be sought.	Budget holders	N/A	Within approved budget	As above.
5.3.58	Requirements for quotations & tenders: Where the value of the expenditure is between £20,000 to £50,000 a minimum of 3 written quotations should be sought.	Budget holders	N/A	Within approved budget	As above.
5.3.59	Requirements for quotations & tenders: Where the value of the expenditure is greater than £50,000 a competitive tender process is required.	Budget holders	N/A	Within approved budget	As per the Procurement Reform (Scotland) 2014 Act 2014, any contracts over £50k (for goods and services) or £2m (for works) must be formally advertised on the Public Contracts Scotland website. These thresholds are exclusive of VAT. Contact the Head of Procurement for further advice on the competitive tender process.
5.3.60	Maintenance of tender register	Head of Procurement	N/A	N/A	
5.3.61	Approval of Tender Waivers	Director of Finance	Deputy Director of Finance	N/A	As per Tender Waiver form.
5.3.62	Maintenance of tender waiver register	Director of Finance	Deputy Director of Finance	N/A	A summary of all tender waivers approved by the Director of Finance approved during the financial year is reported on an annual basis to the Audit & Risk Committee.
CAPITAL INVESTMENT & RELATED TRANSACTIONS					

5.3.63	Approval of Business Cases	NHS Board	N/A	≥ £250k	Business cases with a capital value in excess of £1.5m also require formal approval by the Scottish Government.
5.3.64	Approval of the acquisition or disposal of land & property where the sales proceeds or Net Book Value is in excess of £250k	NHS Board	N/A	≥ £250k	For disposals, the land or property must be formally declared surplus to requirements. Note that all land & property transactions must be endorsed by the Strategic Planning, Performance & Resources Committee (SPPRC) to provide assurance that the requirements of the NHS Scotland Property Transactions Handbook have been met.
5.3.65	Approval of the acquisition or disposal of land & property where the sales proceeds or Net Book Value is less than £250k	Director of Finance	N/A	≤ £250k	As above
5.3.66	Approval to condemn & dispose of assets (excluding land & property) where the current/estimated purchase price is in excess of £250k	Chief Executive	Director of Finance	≥ £250k	This applies to items that are obsolete, redundant, irreparable or cannot be repaired cost effectively.
5.3.67	Approval to condemn & dispose of assets (excluding land & property) where the current/estimated purchase price is £20k to £250k	Director of Finance	Deputy Director of Finance	£20k to £250k	As above
5.3.68	Approval to condemn & dispose of assets (excluding land & property) where the current/estimated purchase price is up to £20k	Relevant Director	Deputy Director of Finance	£20k	As above
5.3.69	Approval to enter into lease/rental agreements where the NHS Board is the lessee/tenant (including concessionary leases)	NHS Board	N/A	N/A	Requires endorsement by the Strategic Planning, Performance & Resources Committee (SPPRC) to provide assurance that the requirements of the NHS Scotland Property Transactions Handbook have been met. All lease/rental agreements require approval by the NHS Board.
5.3.70	Approval to enter into lease/rental agreements where the NHS Board is the lessor/landlord (including	NHS Board	N/A	N/A	Subject to formal tenancy/occupancy agreements being in place as prepared by the Director of Facilities & approval of rent by Deputy

	concessionary leases granted to voluntary, community or social enterprise groups)				Director of Finance. All lease/rental agreements require approval by the NHS Board.
ENDOWMENT FUNDS (FORTH VALLEY GIVING)					
5.3.71	Approval of the annual budget in respect of both restricted & unrestricted funds.	Endowment Trustees	N/A	N/A	As recommended/endorsed by the Endowment subcommittee.
5.3.72	Approval of expenditure from endowments funds (including both restricted & unrestricted funds)	Endowment Trustees	N/A	Within approved budget	As recommended/endorsed by the Endowment subcommittee.
5.3.73	Maintenance of Accounts & associated records	Director of Finance	Deputy Director of Finance	N/A	Note that the endowment funds are subject to an annual external audit. The external auditors are formally appointed by the Endowment Trustees.
5.3.74	Access to share and stock certificates and property deeds	Director of Finance	Deputy Director of Finance	N/A	
5.3.75	Opening and amendment of bank accounts in name of the NHS Forth Valley Endowment Fund, a registered charity administered under the terms of sections 82, 83 and 84A of the National Health Service (Scotland) Act 1978.	Director of Finance	Deputy Director of Finance	N/A	The opening & amendment of such bank accounts is to be reported to the Endowment Trustees.
5.3.76	Acceptance and banking of endowment funds	Director of Finance	Deputy Director of Finance	N/A	Funds may only be accepted where they are in line with the charitable purpose of the endowment fund as per the NHS Forth Valley Health Board Endowment Fund Charter.
5.3.77	Investment of Endowment Funds	Endowment Trustees	N/A	As per Strategy	As per Investment Strategy approved by the Endowment Trustees.
5.3.78	Nominee for grants of probate or letters of administration for an estate.	Director of Finance	N/A	N/A	Where appropriate to obtain a legacy left to the Endowment Fund under the terms of a will.
FAMILY HEALTH SERVICES (FHS)					

5.3.79	Preparation, issue & agreement of 17J & 17C General Medical Services (GMS) Contracts	Director of Falkirk Health & Social Care Partnership	Primary Care Contracts Manager/ Deputy Director of Finance	N/A	Operationally managed on behalf of the NHS Board by the Director of Health & Social Care (Falkirk). Note that this is not a delegated service for the purposes of Health & Socia Care integration as IJBs cannot hold contracts.
5.3.80	Monitoring of FHS contracts	Director of Falkirk Health & Social Care Partnership	Primary Care Contracts Manager	N/A	As above in terms of operational management. Monitoring of contracts for all FHS contractor streams is undertaken by the FHS Performance Review Group. Reports on issues arising (including potential fraud) are received by the Audit & Risk Committee.
5.3.81	Additions & removals from NHS Forth Valley FHS performer lists	Primary Care Contracts Manager	Deputy Director of Finance	N/A	As per the National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004.
5.3.82	Pre & post payment verification (PV) of payments made to all FHS contractors.	Practitioner & Counter Fraud Services NHS NSS on behalf of NHS Forth Valley	N/A	As per PV protocol	In line with the national PV protocol DL(2023)24
HEALTH & SOCIAL CARE INTEGRATION					
5.3.83	Delegation of Functions to Integration Joint Boards (IJBs)	NHS Board	N/A	N/A	In accordance with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.
5.3.84	Approval of payments to IJBs	NHS Board	N/A	Within approved budget	As per NHS Board approved financial plan.
FRAUD, LOSSES, LEGAL CLAIMS & SPECIAL PAYMENTS					
5.3.85	Ex-gratia payments: • Extra-contractual payments • Compensation payments (Clinical)	Director of Finance	N/A	≤£15K ≤£250k	Ex-gratia payments above these limits requires approval from the Scottish Government. See Scottish Financial Return (SFR) 18.1a "Details of Delegated Authority of NHS Boards

	• Compensation payments (Non-Clinical) • Compensation payments (Financial Loss) • Other payments			≤£100k ≤£25k ≤£2k	for Losses and Special Payments" for Category 2 Boards.
5.3.86	Legal claims – clinical	NHS Board	Chief Executive (for urgent decisions between Board meetings)	≤ £250k	Scottish Government approval is required for clinical claims in excess of £250k together with clinical approval by the Medical Director as per SFR 18.1a.
5.3.87	Legal claims – non-clinical	Chief Executive	Director of Finance	≤ £100k	Both NHS Board and Scottish Government approval is required for non-clinical claims in excess of £100k as per SFR 18.1a.
5.3.88	Theft/Arson/Wilful Damage: • Cash • Stores / procurement • Equipment • Contracts • Payroll • Buildings & Fixtures • Other	Director of Finance	N/A	≤£15k ≤£30k ≤£15k ≤£15k ≤£15k ≤£30k ≤£15k	Losses or payments relating to Theft, Arson or Wilful Damage above these limits requires approval from the Scottish Government as per SFR 18.1a.
5.3.89	Fraud, Embezzlement & other irregularities (including attempted fraud): • Cash • Stores / procurement • Equipment • Contracts • Payroll • Other	Director of Finance	N/A	≤£15k ≤£30k ≤£15k ≤£15k ≤£15k ≤£15k	Losses or payments relating to Fraud, Embezzlement & other irregularities (including attempted fraud) above these limits requires approval from the Scottish Government as per SFR 18.1a.
5.3.90	Nugatory & Fruitless Payments	Director of Finance	N/A	≤£15k	Nugatory & Fruitless Payments above this limit requires approval from the Scottish Government as per SFR 18.1a.

5.3.91	Claims Abandoned: • Private Accommodation • Road Traffic Acts • Other	Director of Finance	N/A	≤£15k ≤£30k ≤£15k	Claims Abandoned above these limits requires approval from the Scottish Government as per SFR 18.1a.
5.3.92	Stores losses due to: • Fire • Flood • Accident • Deterioration in Store • Stocktaking Discrepancies • Other Causes		N/A	≤ £30k	Stores losses above this limit requires approval from the Scottish Government as per SFR 18.1a.
5.3.93	Losses of Furniture & Equipment and Bedding & Linen in circulation due to: • Fire • Flood • Accident • Disclosed at physical check • Other Causes	Director of Finance	N/A	≤ £15k	Losses of Furniture & Equipment and Bedding & Linen in circulation above this limit requires approval from the Scottish Government as per SFR 18.1a.
5.3.94	Damage to Buildings & Fixtures due to: • Fire • Flood • Accident • Other Causes	Director of Finance	N/A	≤ £30k	Damage to Buildings & Fixtures above this limit requires approval from the Scottish Government as per SFR 18.1a.
5.3.95	Gifts in cash or in kind	Director of Finance	N/A	≤ £15k	Gifts in cash or in kind above this limit requires approval from the Scottish Government as per SFR 18.1a.
5.3.96	Other losses not included in the categories above	Director of Finance	N/A	≤ £15k	Other losses above this limit require approval from the Scottish Government as per SFR 18.1a.

5.4 Delegated Powers Arising from Other Areas of Corporate Governance:

Ref	Area of responsibility	Delegated to	Further delegation permitted	Limits applying £	Comments
Delegated powers arising from other areas of corporate governance					
CLINICAL GOVERNANCE					
5.4.1	Approval of Clinical Governance Strategy	NHS Board	Clinical & Care Governance Committee	Within approved budget	Executive Lead: Medical Director
5.4.2	Approval of research & development studies, including associated clinical trials & indemnity agreements in respect of commercial studies	Medical Director	N/A	Within approved budget	Initial approval is through the Research & Ethics Committee (this group will prepare an annual report for the Clinical & Care Governance Committee).
5.4.3	Approval of Quality Strategy	NHS Board	Clinical & Care Governance Committee	Within approved budget	See FV-Quality-Strategy-2021-2026.pdf Executive Lead: Medical Director
5.4.4	Approval of patient complaints handling policy & procedures	Clinical & Care Governance Committee.	Executive Nurse Director	N/A	As per Patient Rights Act & Patient Rights Directions.
5.4.5	Monitoring & reporting of patient complaints (including key themes, trends & learning)	NHS Board	Clinical & Care Governance Committee	N/A	As per Patient Rights Act & Patient Rights Directions. Executive Lead: Executive Nurse Director
5.4.6	Monitoring of compliance & adherence to national standards relating to Healthcare Acquired Infection (HAI)	Clinical & Care Governance Committee	Director of Public Health	N/A	Also forms part of routine performance monitoring reporting to the NHS Board.
5.4.7	Monitoring of compliance & adherence to national standards relating to decontamination	Director of Facilities	N/A	N/A	Also forms part of routine performance monitoring reporting to the NHS Board.
5.4.8	Development of policies & procedures in relation to the safe &	Director of Pharmacy	N/A	N/A	The Director of Pharmacy is the NHS Board's Controlled Drugs Accountable Officer as per the Controlled Drugs

	secure management of Controlled Drugs				(Supervision of Management and Use) Regulations 2013. See 5.5.11.
STAFF GOVERNANCE					
5.4.9	Implementation of the NHS Scotland staff governance framework & associated action plan	Director of People	N/A	N/A	Monitored via the Area Partnership Forum & the Staff Governance Committee.
5.4.10	Compliance with equality legislation	NHS Board	Director of People	N/A	See NHS Forth Valley Equality & Inclusion Strategy 2021-25
5.4.11	Approval of a Workforce Strategy (& supporting recruitment & retention policies)	NHS Board	Staff Governance Committee	Within available resources	Engagement required with Area Partnership Forum. Workforce strategy should align with the Delivery Plan & the Financial Plan.
5.4.12	Monitoring & operation of whistleblowing policy	Staff Governance Committee	Area Partnership Forum	N/A	Executive Lead: Executive Nurse Director
5.4.13	Oversight of safe staffing legislation	Staff Governance Committee	Director of People	Within available resources	Clinical & Care Governance Committee
RISK MANAGEMENT					
5.4.14	Oversight of risk management framework	Audit & Risk Committee	Chief Executive	N/A	See NHS Forth Valley Risk Management Strategy 2022-25
5.4.15	Oversight of strategic risk register	Audit & Risk Committee	Director of Strategic Planning & Performance	N/A	Review of the Strategic Risk Register is a standing agenda items at the Audit & Risk Committee and NHS Board meetings.
5.4.16	Development of prescribing policies	Area Drug & Therapeutic Committee	Director of Pharmacy	N/A	Executive Lead: Medical Director
PLANNING					
5.4.17	Development & approval of a local population health & care strategy	NHS Board	Director of Public Health	As per approved financial plan	As per National Clinical Strategy & DL(2024)31 "a renewed approach to population based planning across NHS Scotland".
5.4.18	Approval of Annual Delivery Plan	NHS Board	Director of Strategic Planning & Performance	As per approved financial plan	As per Scottish Government Annual Delivery Plan guidance (draft plans to be submitted in January with final plans in March).

5.4.19	Preparation & maintenance of a comprehensive Civil Contingency Plan	Director of Strategic Planning & Performance	Head of Strategic Planning	N/A	As per the Civil Contingencies Act 2004 & regulations. Executive Lead: Director of Public Health
5.4.20	Preparation & maintenance of a Business Continuity Plan	Director of Strategic Planning & Performance	Head of Strategic Planning	N/A	Oversight via Audit & Risk Committee. Executive Lead: Director of Public Health
5.4.21	Nominated representative in local Community Planning Partnerships	Director of Public Health	N/A	N/A	Clackmannanshire community planning partnership Falkirk community planning partnership Stirling community planning partnership
INFORMATION GOVERNANCE					
5.4.22	Oversight of information management systems & strategy, including monitoring delivery of the Digital & eHealth plan.	Strategic Planning, Performance & Resources Committee	Director of Digital	As per approved financial plan	As per national Digital Health & Care Strategy and local Health & Care in the digital age: a digital strategy for NHS Forth Valley 2023-2027 Executive Lead: Director of People. Clinical Lead: Medical Director.
5.4.23	Responsibility for Freedom of Information publication scheme & associated publication plan	Medical Director	Head of Information Governance	N/A	As per the Freedom of Information (Scotland) Act 2002 (FOISA). The publication scheme requires approval by the Information Commissioner's Office (ICO). See model publication scheme.
5.4.24	Responsibility for corporate records management plan	Medical Director	Head of Information Governance	N/A	In conjunction with the Senior Information Risk Owner (SIRO).
PERFORMANCE MANAGEMENT					
5.4.25	Approval of performance management framework	Strategic Planning, Performance & Resources Committee	Director of Strategic Planning & Performance	N/A	NHS Forth Valley performance management framework
5.4.26	Oversight of performance & performance reporting arrangements.	Strategic Planning, Performance & Resources Committee	Director of Strategic Planning & Performance	Within approved budget	Performance is a standing agenda item at every Strategic Planning, Performance & Resources Committee and NHS Board meeting.

5.5 Delegated Powers Arising from Other Operating Activities and Statutory Requirements:

Ref	Area of responsibility	Delegated to	Further delegation permitted	Limits applying £	Comments
Delegated powers arising from other operating activities & statutory requirements					
COMMUNICATION					
5.5.1	Develop & maintain a public facing access policy	Chief Executive	Head of Communications	N/A	In line with the NHS Scotland national access policy which sets out how NHS Boards should ensure equitable, safe, clinically effective and efficient access to services for their patients.
5.5.2	Develop & maintain a Communications Framework	Chief Executive	Head of Communications	N/A	See NHS Forth Valley Communications Framework 2023 - 2028
PATIENTS PRIVATE FUNDS & PROPERTY					
5.5.3	Develop detailed procedures for the safe custody & management of patients' funds & property	Director of Finance	Deputy Director of Finance	N/A	See Financial Operating Procedure (FOP) 17.
5.5.4	Approval of Patient Funds Annual Accounts	NHS Board	N/A	N/A	Patients fund accounts are subject to external audit.
STATUTORY REQUIREMENTS					
5.5.5	Nominated Lead Executive Director for Person Centred Care & engagement	Executive Nurse Director	N/A	N/A	
5.5.6	Responsibility for all aspects of Health & Safety	Chief Executive	Director of Facilities & Director of People	N/A	The Staff Governance Committee will consider the overall approach to staff safety & performance in relation to the precision of a safe and healthy working environment.
5.5.7	Implementation of Adult & Child support & protection policy	Chief Executive	Executive Nurse Director/ Directors of Health & Social Care	N/A	Adult Support & Protection (Scotland) Act 2007 national-guidance-child-protection-scotland-2021-updated-2023.pdf
5.5.8	Caldicott Guardian	Medical Director	Director of Public Health	N/A	This is an advisory role aligned with the Caldicott principles
5.5.9	Senior Information Risk Owner (SIRO)	Director of Finance	Chief Executive	N/A	The SIRO is the overall owner of information risk within the organisation & acts as the focal point for information

					risk management in the organisation including resolution of any pan-organisation or other escalated risk issues raised by Information Asset Owners. The SIRO will provide written advice to the Chief Executive on the content of the Governance Statement regarding information risk.
5.5.10	Nominated Fraud Liaison Officer	Regional Internal Audit Manager	Director of Finance	N/A	The role and responsibilities of the Fraud Liaison Officer is set out within Annex B of CEL11(2013) "Strategy to Combat Financial Crime in NHS Scotland".
5.5.11	Controlled Drugs Accountable Officer (CDAO)	Director of Pharmacy	N/A	N/A	As per the Controlled Drugs (Supervision of Management and Use) Regulations 2013.
OTHER					
5.5.11	Compliance with guidelines on chaplaincy & spiritual care	Executive Nurse Director	N/A	N/A	See national NHS Scotland Spiritual Care and Chaplaincy guidance.

SECTION F

Standing Financial Instructions

SECTION 1: INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the financial directions issued by the Scottish Government Health and Social Care Directorate under the provisions contained in regulation 4 of the National Health Service (Financial Provisions) (Scotland) Regulations 1974, together with the subsequent guidance and requirements contained in NHS Circular No.1974 (GEN) 88 and NHS Circular MEL (1194) 80, and shall have the effect as if incorporated in the Standing Orders of Forth Valley NHS Board. The purpose of the SFIs is to provide a sound basis for the control of Forth Valley NHS Board's financial affairs and for the regulation of the conduct of Forth Valley NHS Board, its directors, officers, and agents in relation to all financial matters in line with the Health Boards (Membership and Procedure) Regulations 2001. NHS Forth Valley is the common name of Forth Valley NHS Board. The Board's formal, legal title remains Forth Valley NHS Board and it will be identified as such in certain legal and financial documents.

1.1.2 These SFIs outline the financial responsibilities, policies, and procedures to be adopted by Forth Valley NHS Board. They are designed to ensure that Forth Valley NHS Board financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency, and effectiveness. The SFIs do not provide detailed procedural advice and should therefore be read in conjunction with all relevant Financial Operating Procedures, departmental instructions and the Scheme of Delegation adopted by the Board.

1.1.3 All Board members, officials, staff and agents of Forth Valley NHS Board shall observe these SFIs. The Chief Executive, Directors and Members of the Executive Leadership Team shall be responsible for ensuring that all staff and agents of the Board are aware of, and adhere to, the SFIs.

1.1.4 Statutory Instrument (1974) No.468 requires Directors of Finance to design, implement and supervise systems of financial control and NHS circular 1974 (GEN) 88 requires the Director of Finance to:

(a) approve the financial systems.
(b) approve the duties of officers operating these systems.
(c) maintain a written description of such approved financial systems, including a list of specific duties.

1.1.5 Should any difficulties arise regarding the interpretation or application of any aspect of the SFI's then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the Provisions of the Board's Standing Orders.

1.1.6 Failure to comply with SFIs is a disciplinary matter, which could result in dismissal.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in directions made under the Acts, shall have the same meaning in these instructions; and:

(a) "Board" means the Board of Forth Valley NHS Board or such Committee of the Board to which powers have been delegated.
(b) "Budget" means an allocation of resources, expressed in financial terms, proposed by Forth Valley NHS Board for the purpose of carrying out, for a specific period, any, or all of the functions of Forth Valley NHS Board.
(c) "Chief Executive" means the chief officer of Forth Valley NHS Board and who is directly accountable to the Board.
(d) "Director of Finance" means the chief financial officer of Forth Valley NHS Board.
(e) "Budget Holder" means the director or officer of Forth Valley NHS Board who has the delegated authority to manage finances (income and expenditure) for a specific operational area of Forth Valley NHS Board.
(f) "Legal Adviser" means the properly qualified person appointed by Forth Valley NHS Board to provide legal advice.

1.2.2 Wherever the title Chief Executive, Director of Board, or other nominated officer is used in these instructions, it shall be deemed to include such other officers and agents who have been duly authorised to represent them.

1.2.3 References in these instructions to "officer" shall be deemed to include all employees of Forth Valley NHS Board, including nursing and medical staff, and consultants who practice upon Forth Valley NHS Board premises, as well as the staff of any agency contracted to Forth Valley NHS Board and/or performing financial functions on behalf of Forth Valley NHS Board.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board shall exercise financial supervision and control by:

(a) requiring the submission and approval of financial plans and budgets within approved allocations/overall income to a pre-determined timetable
(b) defining and approving essential features of financial arrangements in respect of important procedures and financial systems (including the need to obtain value for money)
(c) defining specific responsibilities placed on directors and officers as indicated in the Scheme of Delegation document

1.3.2 Within the SFIs it is acknowledged that the Chief Executive and Director of Finance shall have joint responsibility for ensuring that the Board meets its obligation to perform its functions within the financial resources available. The Chief Executive has overall responsibility for the Board's activities and is responsible to the Board for ensuring containment within the Board's Revenue Resource Limit, Capital Resource Limit and Cash Requirement Limit.

1.3.3 The Chief Executive is also the Accountable Officer for Forth Valley NHS Board as defined under the Public Finance and Accountability (Scotland) Act 2000 and is personally responsible to the Scottish Parliament. The specific responsibilities of the Chief Executive as Accountable Officer are set out in Section 2.

1.3.4 Forth Valley NHS Board shall delegate executive responsibility for the performance of its functions to the Chief Executive and the Senior Leadership Team (SLT). Members of the SLT will exercise financial supervision and control by requiring the submission and approval of financial plans within approved allocations, by defining and approving essential features of financial arrangements in respect of important procedures and financial systems, including the need to obtain value for money and by defining specific responsibilities placed on our officers.

1.3.5 So far as is possible, the Chief Executive and Director of Finance will delegate their detailed responsibilities but retain their overall accountability. The extent of delegation will be kept under review by the Board.

1.3.6 Without prejudice to any other functions of officers of Forth Valley NHS Board, the Director of Finance shall be responsible for:

(a) provision of financial advice to the Board and its officers
(b) setting the Board's accounting policies consistent with Scottish Government and Treasury guidance and generally accepted accounting practice
(c) supervising the implementation of the Board's financial strategies and for coordinating any corrective action necessary to further these strategies
(d) ensuring that sufficient records are maintained to show and explain Forth Valley NHS Board transactions, in order to disclose, with reasonable accuracy, the financial position of Forth Valley NHS Board at any time
(e) the design, implementation, and supervision of systems of financial control incorporating the principles of segregation of duties and internal checks
(f) the preparation and maintenance of such accounts, certificates, estimates, records, and reports as the Board may require for the purpose of carrying out its statutory duties and responsibilities

1.3.7 All directors and officers of Forth Valley NHS Board, severally and collectively, are responsible for:

(a) the security of Forth Valley NHS Board property
(b) avoiding loss
(c) exercising economy and efficiency and securing best value in the use of Forth Valley NHS Board resources; complying with the requirements of:

- Standing Orders (including the Scheme of Delegation)
- Standing Financial Instructions
- Financial Operating Procedures
- the NHS Scotland conduct policy and the Board's local business code of conduct policy.

1.3.8 The form in which financial records are kept and the manner in which duties are discharged by all directors and officers of Forth Valley NHS Board who carry out a financial function must be to the satisfaction of the Director of Finance and in line with

the Public Records Scotland Act 2011, data protection legislation (consisting primarily of the UK-GDPR and Data Protection Act 2018), the Freedom of Information (Scotland) Act 2002, and the Board's Information Governance policies and procedures.

1.3.9 Any contractor, agent or employee of a contractor who is empowered by Forth Valley NHS Board to commit Forth Valley NHS Board to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

SECTION 2: RESPONSIBILITIES OF HEALTH BOARD CHIEF EXECUTIVE AS ACCOUNTABLE OFFICER

2.1 INTRODUCTION

2.1.1 In accordance with part 2 section 15 of the Public Finance and Accountability (Scotland) Act 2000, the Principal Accounting Officer for the Scottish Government has designated the Chief Executive of Forth Valley NHS Board as Accountable Officer.

2.1.2 Accountable Officers must comply with the terms of annex 2 of the Scottish Public Finance Manual (SPFM), and any updates issued to the manual by the Principal Accountable Officer for the Scottish Government.

2.2 GENERAL RESPONSIBILITIES

2.2.1 The Accountable Officer is personally answerable to the Scottish Parliament for the propriety and regularity of the public finances for NHS Forth Valley. The Accountable Officer must ensure that Forth Valley NHS Board takes account of all relevant financial considerations, including any issues of propriety, regularity, or value for money, in considering policy proposals relating to expenditure, or income.

2.2.2 It is incumbent upon the Accountable Officer to combine their duties as Accountable Officer with their duty to the Forth Valley NHS Board, to whom they are responsible, and from whom they derive their authority. The Forth Valley NHS Board is in turn responsible to the Scottish Parliament in respect of its policies, actions, and conduct.

2.2.3 The Accountable Officer has a personal duty of signing the Annual Accounts of Forth Valley NHS Board and for their proper presentation as prescribed in legislation and/or in the relevant Accounts Direction issued by the Scottish Ministers. Consequently, they may also have the further duty of being a witness before the Audit Committee of the Scottish Parliament and be expected to deal with questions arising from the Accounts, or, more commonly, from reports made to Parliament by the Auditor General for Scotland.

2.2.4 The Accountable Officer must ensure that any arrangements for delegation promote good management, and that they are supported by the necessary staff with an appropriate balance of skills. This requires careful selection and development of staff and the sufficient provision of, or access to, specialist skills and services. The Accountable Officer must ensure that staff are as conscientious in their approach to costs not borne directly by NHS Forth Valley (such as costs incurred by other public bodies, or financing costs, e.g., relating to banking and cash flow) as they would be where such costs directly borne.

2.3 SPECIFIC RESPONSIBILITES

2.3.1 The Accountable Officer must:

(a) ensure that from the outset, proper financial systems are in place and applied, and that procedures and controls are reviewed from time to time to ensure their continuing relevance and reliability, especially at times of major changes.

(b) sign the Annual Accounts and the associated governance statement, and in doing so accept personal responsibility for their proper presentation as prescribed in legislation and/or relevant Accounts Direction issued by Scottish Ministers.

(c) ensure that proper financial procedures and systems of internal control are followed and that accounting records are maintained in a form suited to the requirements of management as well as in the form prescribed for published Accounts as per the NHS Scotland Annual Accounts Manual.

(d) ensure that the public funds for which the Accountable Officer is responsible are properly managed and safeguarded, with independent and effective checks of cash balances in the hands of any official.

(e) ensure that the assets for which the Accountable Officer is responsible, such as land, buildings, or other property, including stores and equipment, are controlled, and safeguarded with similar care, and with checks as appropriate.

(f) ensure that, in the consideration of policy proposals relating to expenditure, or income, for which the Accountable Officer has responsibility, all relevant financial considerations, including any issues of propriety, regularity or value for money, are considered, and where necessary brought to the attention of the Board.

(g) ensure that any delegation of authority is accompanied by clear lines of control and accountability, together with reporting arrangements.

(h) ensure that any procurement activity is conducted in accordance with the requirements in the procurement section of the SPFM and all relevant procurement legislation and regulations as they apply to the NHS in Scotland.

(i) ensure that effective management systems appropriate for the achievement of the organisation’s objectives, including financial monitoring and control systems have been put in place.

(j) ensure that risks, whether to achievement of business objectives, regularity, propriety, or value for money, are identified, that their significance is assessed and that systems appropriate to the risks are in place in all areas to manage them.

(k) ensure that arrangements have been made to secure best value as set out in the SPFM.

(l) ensure that managers at all levels have a clear view of their objectives and the means to assess and measure outputs or performance in relation to these objectives.

(m) ensure managers at all levels are assigned well defined responsibilities for making the best use of resources (both those assumed by their own commands and any made available to third parties) including a critical scrutiny of outputs, outcomes, value for money and compliance with any conditions of funding awards/grants.

(n) ensure that managers at all levels have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

(o) ensure that the common seal of the Board is held securely by the Corporate Business Manager who shall be responsible for its safe custody and for recording its use.

(p) Ensure that any document or proceeding requiring authentication by the Board by affixation of its common seal shall be subscribed by the Chief Executive and Director of Finance.

(q) to ensure where a document requires for the purpose of any enactment or rule of law relating to authentication of documents under the Law of Scotland, or otherwise requires to be authenticated on behalf of the NHS Board, it shall be signed by an Executive Director of the NHS Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the provisions of the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the NHS Board procedures have been received. A document executed by the NHS Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

2.4 REGULARITY AND PROPRIETY OF EXPENDITURE

2.4.1 The Accountable Officer has a particular responsibility for ensuring compliance with parliamentary requirements in the control of expenditure. A fundamental requirement is that funds should be applied only to the extent and for the purposes authorised by Parliament in Budget Acts (or otherwise authorised by section 65 of the Scotland Act 1998).

2.4.2 Parliament's attention must be drawn to losses or special payments by appropriate notation of the Board's Accounts. In the case of expenditure approved under the Budget Act, any payments must be within the scope and amount specified in that Act. In cases not covered by the Budget Act, e.g. in connection with a service not contemplated when the Budget Bill was presented; the Accountable Officer must ensure that the Scottish Government Health and Social Care Directorate is informed in order that appropriate advice can be given, and if necessary parliamentary procedures followed.

2.4.3 The Accountable Officer will advise the Forth Valley NHS Board, as appropriate, on all matters of financial probity and regularity, on prudent and economical administration; efficiency and effectiveness and, in particular, will provide assurance that expenditure by NHS Forth Valley complies with Parliamentary requirements, relevant legislation and relevant guidance issued by the Scottish Ministers in particular the SPFM. In meeting these requirements, the Accountable Officer must:

- Not exceed the revenue resource limit (RRL) (taking one year with another).
- Draw the attention of Parliament to losses or payments by appropriate notation of the statutory accounts.
- Obtain approval from the Scottish Government Health and Social Care Directorate for any expenditure which exceeds the Board's RRL or is not covered by standing delegated authorities e.g. losses and special payments in excess of specific delegated limits or expenditure which is considered novel, contentious or repercussive.
- Ensure that all items of expenditure, including payments to staff, fall within the legal powers of the Forth Valley NHS Board, are exercised responsibly and with due regard for probity and value for money.
- Comply with guidance issued by the Scottish Government Health and Social Care Directorate on classes of payments and authorise personally, such payments as termination payments to other Chief Officers.

SECTION 3: ALLOCATIONS, BUSINESS PLANNING, BUDGETS AND BUDGETARY CONTROL

3.1 GENERAL

3.1.1 The Board is required by statutory provisions made under Section 85 of the National Health Service (Scotland) Act (1978), as amended by the Health Services Act 1980, to perform its functions within the total funds allocated by the Scottish Ministers. All plans and financial approval systems shall be designed to meet this obligation.

3.2 ALLOCATIONS

3.2.1 The Director of Finance of the Board will review, as a minimum annually, the bases and assumptions used for distributing allocations to ensure such allocations are fair, realistic, and secure the Board's entitlement to funds.

3.3 BUSINESS PLANNING AND BUDGETS

3.3.1 The Chief Executive will prepare, and submit to the board for approval, an Annual Delivery Plan. The delivery plan will reflect financial targets and forecast limits of available resources and will describe the planning assumptions and the necessary changes in workload, delivery of services or resources required to achieve the plan.

3.3.2 The Director of Finance shall, on behalf of the Chief Executive, prepare and submit to the Board, an annual financial plan. The financial plan will incorporate both revenue and capital expenditure within the limits of available funds as determined by the notified allocations and will align to the annual delivery plan. The financial plan will be submitted to the Board for approval in March, in advance of the financial year to which it relates.

3.3.3 The Director of Finance shall ensure that the delivery plan and the financial plan are reconcilable to budgets and reflect t h e outcome of discussions and consultation with the ELT, the Performance and Resources Committee and other stakeholders. As a consequence, the Director of Finance shall have right of access to all budget holders on all and any budgetary related matters.

3.4 BUDGETARY CONTROL

3.4.1 The Board shall delegate the management of the Financial Plan to the Chief Executive. The Chief Executive within limits approved by the Board, can delegate responsibility for a budget or part of a budget to individual Senior Managers. The terms of delegation shall include, in writing, a clear definition of individual responsibilities for control of expenditure, exercise of virement, achievement of performance levels and the provision of regular reports on the discharge of these delegated functions. The delivery of this delegation shall be included within the performance review of appropriate officers.

3.4.2 In performance of their duties:

(a) The Chief Executive will not exceed the budgetary or virement limits or exclusions set by the Board or by the Scottish Government Health and Social Care Directorate.

(b) Senior Managers will not exceed the budgetary or virement limits set by the Board and Chief Executive.

(c) The Chief Executive may exercise virement or vary the budgetary limit of a Senior Manager within the Chief Executives own budgetary limit.

3.4.3 The Board shall approve and review annually a Scheme of Delegation that will form part of the Standing Orders of the Board. The Scheme of Delegation shall specify: -

(a) areas of responsibility

(b) nominated officers

(c) financial value

(d) virement levels

3.4.4 Expenditure for which no provision has been made in approved plans and budgets and outwith delegated virement limits may only be incurred after authorisation by the Chief Executive or the Director of Finance acting on their behalf, or the NHS Board dependent on the nature and level of expenditure. There shall be a financial limit of £500,000 in respect of the delegated authority of the Chief Executive on a non-recurring basis (no individual item shall exceed £100,000). The Director of Finance shall have authority within the Chief Executive's limit of £250,000.

3.4.5 The Director of Finance, on behalf of the Chief Executive, shall monitor the financial performance against the plan, the use of delegated budgets to ensure that financial control is maintained, and that the Board's plans and policies are implemented.

3.4.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget-holders to help them to manage successfully.

3.4.7 The Director of Finance shall ensure that:

(a) the system of internal financial controls is sufficient and adequate to ensure the achievement of objectives and compliance with standards and regulations.

(b) adequate statistical and financial systems are in place to monitor and control all agreements for patients' services and facilitate the compilation of estimates, forecasts and investigations as may be required.

(c) reports provide all financial, statistical, and other relevant information as necessary for the compilation of estimates and forecasts.

(d) the Chief Executive and the Board are informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets or projections and shall advise on the financial and economic aspects of future plans and projects.

(e) the issue of timely, accurate and comprehensible advice, and monthly financial reports to each budget holder, covering the areas for which they are responsible.

(f) The provision of financial information as per the requirements of extant Integration Schemes to support Chief Finance Officers in their role as section 95 Officers for the Integration Joint Board.

3.4.8 The Director of Finance shall provide the Board with regular financial reports including, but not limited to, the following details: -

- analysis of all income and expenditure to date and a forecast year-end position;
- progress in delivering agreed cost improvement plans & efficiency savings;
- movements in working capital;
- capital project spend and projected outturn against plan;
- explanation of significant variances from plan plus corrective action if appropriate, including an assessment as to whether such actions are sufficient to correct the situation;
- monitoring of management action to correct variances; cash spending to date and forecast year-end position;
- report on budgetary transfers and virement.

SECTION 4: HEALTH AND SOCIAL CARE INTEGRATION

4.1 GENERAL

4.1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 established the framework for the integration of adult health and social care services in Scotland. Two Integration Joint Boards (IJBs) have been established in Forth Valley under the body corporate arrangement. The approved Integration Schemes set out the detail of the integration arrangement, including those functions delegated by NHS Forth Valley to the IJBs.

4.2 FINANCIAL ARRANGEMENTS

4.2.1 Each partner will agree an annual payment to the IJB in advance of financial year to which it relates as per the requirements of the extant Integration Schemes. The value of the annual payment will be informed by Scottish Government policy and the preparation of a business case by each IJB. The business case will summarise the funding requirements and financial planning assumptions of the IJB and will form the basis of initial negotiations with the NHS Board and Local Authority as to level of payment/funding contributions for the forthcoming financial year.

4.2.2 In subsequent financial years the NHS Board will evaluate the case for the Integrated Budget against its other priorities and will agree its contributions accordingly. The business case put forward by the IJB will be evidenced based and will detail assumptions made.

4.2.3 Following agreement of the payment to the IJB by the NHS Board and Local Authority, the IJB Chief Officer and Chief Finance Officer will prepare a financial plan to support achievement of the IJB's approved Strategic Plan. To deliver the strategic plan, the IJB will commission services from the NHS Board and Local Authority by issuing a Direction.

4.2.4 In line with the provisions of sections 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014, Directions are the mechanism by which the IJB's strategic commissioning plan is actioned and they represent the legal basis for the NHS Board and Local Authority to deliver services which are under the control of the IJB. The Direction from the IJB must set out how services are to be delivered and funded (including details of the funding source, distinguishing between sums Set Aside or a payment from the IJB to the NHS Board via the integrated budget).

4.2.5 Following receipt of a Direction from the IJB (assuming paragraph 4.2.6 below does not apply), the NHS board will adjust the relevant Set Aside or Health and Social Care Partnership (HSCP) operational or universal budget and will inform budget holders accordingly. HSCP budget holders are responsible for ensuring all transactions processed by the NHS Board comply with these SFIs and any associated detailed procedural NHS guidance deemed relevant to the transaction.

4.2.6 If the NHS Board does not believe the direction can be achieved for the payment being offered, then it shall notify the IJB as soon as possible that additional funding would be necessary to comply with the direction.

4.3 DELEGATED AUTHORITY

4.3.1 Where a manager has delegated authority for integrated health and social care expenditure, they must ensure the VAT treatment is in line with the guidance issued by the Integrated Resource Advisory Group and HMRC. If in doubt they should seek advice from the Director of Finance and/or IJB Chief Finance Officer.

4.3.2 Where a Local Authority employee has been given delegated authority for an integrated budget that includes NHS transactions, a signed declaration confirming that they have received and will comply with these SFIs is required. This should also be signed by the IJB Chief Officer, who will further undertake to pursue any breaches of the NHS SFIs through the Local Authority line management structure if required.

4.3.3 The Integration Scheme includes further detailed guidance on the financial governance and financial management arrangements for IJBs.

SECTION 5: COMMISSIONING OF HEALTHCARE

5.1 FINANCIAL TARGETS

5.1.1 The Scottish Government sets 3 budget limits at a Health Board level on an annual basis. These limits are:

(a) Revenue Resource Limit: a resource budget for ongoing operations;
(b) Capital Resource Limit: a resource budget for net capital investment;
(c) Cash requirement: a financing requirement to fund the cash consequences of the ongoing operations and net capital investment.

5.1.2 Health Boards are required to contain their net expenditure within these limits and will report on any variation from the limits as set.

5.1.3 The Director of Finance shall be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Board to fulfil its statutory responsibility while achieving its financial targets.

5.2 GENERAL - HEALTH NEEDS ASSESSMENT

5.2.1 The Director of Public Health, on behalf of the Chief Executive, is responsible for the production of Health Needs Assessments and for the monitoring of Health Status and overall population health.

5.2.2 The Health Needs Assessment Reports incorporate historical and projected financial information. The Director of Finance is responsible for the provision of historical financial details and for the financial impact/implication of each Needs Assessment.

5.3 GENERAL - HEALTH PLANNING

5.3.1 The Chief Executive is responsible for the production of the Corporate Plan (Healthcare Strategy). The Corporate Plan will be informed amongst others by

(a) plans arising from Health Needs Assessments

(b) socio-demographic trends

(c) public consultation

(d) resource availability

(e) Business unit pressures

5.3.2 Planning groups may be established to prepare health strategies or develop plans for individual care groups or non-delegated service areas that are not part of integrated health and social care services. The Director of Finance has responsibility for ensuring that where appropriate the remit of such groups outlines the financial parameters within which the group may operate. On occasion these groups may also

cover non-delegated Local Authority services. In this instance the parameters should be agreed with the appropriate individuals within Local Authorities.

5.3.3 The Director of Finance is responsible for the provision of financial advice and plans in respect of the affordability of the Corporate Plan.

5.4 PRIMARY HEALTH CARE

5.4.1 Primary Health Care Services include:

(a) all Family Health Services

(b) Staff employed by NHS Forth Valley that are attached to specific GP Practices eg District Nursing

(c) General Medical Services (GMS) IT

(d) Services provided as part of the Primary Care Improvement Plan

5.4.2 Primary Healthcare Services fall within the scope of Integration Authorities and are hosted by Falkirk IJB. Resources are allocated from both IJBs to the NHS Board via Direction in line with IJB Strategic Commissioning Plans. Any variations proposed to budgets must be approved by the IJB Chief Finance Officer.

5.5 COMMUNITY SERVICES

5.5.1 Community Services include:

(a) mental health (inclusive of elderly, frail elderly, long-stay, and community)

(b) learning disability

(c) palliative hospice care

(d) community health services

(e) drugs and alcohol

(f) healthcare in prisons

5.5.2 The vast majority of local Community Health Care Services fall within the scope of integration authorities and are operationally managed by IJB Chief Officers through their role as Director of the Health and Social Partnership. Any variations proposed to budgets relating to IJB delegated services must be approved by the relevant IJB Chief Finance Officer.

For community services that are not delegated to IJBs , resources are transferred on a monthly basis in accordance with the annual financial plan and any subsequent agreed variations. Any approved budget adjustments are processed through the Service Agreement Variation (SAV) process in year. Such variations must be approved by the Director of Finance of Forth Valley NHS Board.

5.5.3 NHS Boards outwith the Forth Valley area may also provide Community services to local residents. In such instances service level agreements will be prepared. Resources are transferred on a monthly basis in accordance with the annual financial plan and any subsequent agreed variations. Such variations must be signed by both the Director of Finance of the Forth Valley NHS Board and the Director of Finance of the appropriate Health Board.

5.6 INPATIENT AND OTHER HOSPITAL BASED SERVICES

5.6.1 These include:

(a) Emergency and urgent care

(b) Acute inpatients and Community Hospital beds

(c) Ambulatory Care and Day Surgery

(d) Outpatient Services

(e) Cancer Services

(f) Allied Health Professionals

(g) Diagnostic Services

(h) Women and Children Services

5.6.2 Inpatient and other hospital-based services are operationally managed by the Director of Acute Services. However, an element of this budget is “set aside” by NHS Forth Valley to be included as part of the total resources within the scope of the IJB Strategic Plans as per the extant Integration Schemes.

5.6.3 Set aside, also referred to as Large Hospital Services, is defined as services which are carried out in a hospital setting and provided for the areas of two or more Local Authorities. They typically include services relating to emergency and unscheduled care and whilst operational management and financial risk for the Set Aside budgets remains with NHS Forth Valley, the IJBs have a strategic planning role in relation to these services.

5.6.4 Resources for Inpatient and other hospital-based services which are categorised as set aside are allocated from the Integration Authority via direction in line with their Strategic Commissioning Plans. Any variations proposed to set aside budgets must be approved by the Director of Finance of Forth Valley NHS Board and the relevant IJB Chief Finance Officer.

5.6.5 Resources in respect of Inpatient and other hospital based services that are not part of set aside are operationally managed by the Director of Acute Services. Resources for these service areas are transferred on a monthly basis in accordance with the annual financial plan and any subsequent agreed variations. Any approved budget adjustments are processed through the Service Agreement Variation (SAV) process in year. Such variations must be approved by the Director of Finance of Forth Valley NHS Board.

5.6.6 NHS Boards outwith the Forth Valley area may also provide these services to local residents. In such instances service agreements will be prepared. Resources are transferred on a monthly basis in accordance with the annual financial plan and any subsequent agreed variations. Such variations must be signed by both the Director of Finance of the Forth Valley NHS Board and the Director of Finance of the appropriate Health Board.

SECTION 6: CASH AND BANKING

6.1 INTRODUCTION

6.1.1 The Director of Finance is responsible for managing Forth Valley NHS Board's banking arrangements and for advising Forth Valley NHS Board on the provision of banking services and the operation of bank accounts. This advice will take into account such guidance and directions as may be issued by the Scottish Government Health and Social Care Directorate.

6.2 CASH HANDLING

6.2.1 The Director of Finance is responsible for:

(a) Ensuring a process is in place for the timely banking of cash receipts;
(b) Preparing procedures on the use of petty case, and
(c) Ensuring controls are in place for secure handling of cash.

6.2.2 Staff, on appointment, shall be informed in writing by the appropriate departmental or Senior Manager, of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc and must familiarise themselves with the relevant Financial Operating Procedure.

6.3 SECURITY

6.3.1 All receipt books, tickets, agreement forms or other means of officially acknowledging or recording amounts received or receivable shall be in a form approved by the Director of Finance. Such stationery shall be ordered and controlled by the Director of Finance and subject to the same precautions as are applied to cash.

6.3.2 All employees with an official duty to collect or hold cash must have access to a secure safe and lockable cash box. Safes will normally be accessible to authorised individuals by combination code. For key access safes and cash boxes spare keys must be held securely and recorded on a register, with only authorised staff allowed to gain access. Any loss of keys must be reported immediately to the Finance Department.

6.3.3 All cash, cheques, postal orders, and other forms of payment received by someone other than the cashier shall be entered immediately in an approved form of register. The remittances must be passed to the cashier and a signature obtained to evidence the handover.

6.3.4 The opening of coin operated machines (including telephones) and the counting and recording of takings shall be undertaken by two officers together, at frequent intervals,

and the coin box keys shall be held by a nominated officer. A reconciliation of monies collected should be carried out.

6.3.5 The Director of Finance shall prescribe the system for the transporting of cash and uncrossed pre-signed cheques and shall approve, where appropriate, the use of the services of a specialist security firm.

6.3.6 Official money must not, under any circumstances, be used to cash private cheques.

6.3.7 All cheques, postal orders, cash etc. shall be promptly banked. Disbursements must not be made from cash received except under arrangements approved by the Director of Finance.

6.3.8 Those with access to safes must not accept unofficial funds for depositing in their safes.

6.3.9 During the absence (e.g. due to annual leave) of the individual responsible for the safe and cash box, the employee who acts in their place shall be subject to the same controls as the normal safekeeper. Handover of the safe and/or cash box contents must be recorded and signed by both individuals upon the transfer of responsibilities. The signed document must be retained for audit purposes.

6.3.10 Cheque books will be controlled by officers approved by the Director of Finance and are subject to the same security precautions as are applied to cash. New books will be ordered as required via online banking by approved officers and must be stored in a secure safe.

6.3.11 Any loss or shortfall of cash, cheques, or other items, regardless of how it occurred, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 12 on Condemnations, Losses and Special Payments).

6.4 BANK ACCOUNTS

6.4.1 The Director of Finance is responsible for:

(a) Establishing exchequer bank accounts as directed by Scottish Government Health and Social Care Directorate;
(b) establishing separate bank accounts for Forth Valley NHS Board non exchequer funds;
(c) ensuring funds are drawn down from Scottish Government for approved expenditure but that excess funds are not drawn in advance of need;
(d) ensuring payments made from accounts do not exceed the amount credited to the account except where arrangements have been made;
(e) reporting to the Board all arrangements made with Forth Valley NHS Board bankers for accounts to be overdrawn, and
(f) The opening and operation of Project Bank Accounts when required for construction contracts in line with Scottish Government guidance.

6.4.2 Bank accounts will be operated in accordance with the HM Treasury Government Banking Services (GBS) contract, the Scottish Government Banking Services Framework for commercial accounts, and guidance in the Scottish Public Finance Manual.

6.4.3 All funds shall be held in accounts in the name of Forth Valley NHS Board. No officer other than the Director of Finance plus one other approved signatory shall open or close any bank account in the name of Forth Valley NHS Board.

6.4.4 The Director of Finance will advise the Bankers in writing of the conditions under which each account shall be operated.

6.5 BANKING PROCEDURES

6.5.1 The Director of Finance shall prepare procedural instructions on the operation of accounts. These instructions must include:

(a) the conditions under which each account is to be operated;

(b) ensuring that funds held in commercial accounts are kept to a minimum and do not exceed £50,000 in total, with excess funds being transferred to the GBS account;

(c) those authorised to sign cheques or other payments on Forth Valley NHS Board accounts, and

(d) the required controls for online banking.

6.5.2 The Director of Finance shall ensure appropriate arrangements and controls are in place for debit/credit card transactions.

6.5.3 The Accounting Services Manager shall advise the bankers of the officers authorised to release money from or make electronic payment from each bank account.

6.5.4 The Accounting Services Manager shall notify the bankers promptly of the cancellation of any authorisation to draw on Forth Valley NHS Board accounts

6.5.5 Where an agreement is entered into with a Health Board or other body for payment to be made on behalf of Forth Valley NHS Board from bank accounts maintained in the name of that Health Board or other body, or by electronic funds transfer via the Bankers' Automated Clearing System (BACS), the Director of Finance shall ensure that satisfactory security regulations of the Health Board or other body relating to any such accounts exist and are observed.

SECTION 7: CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

7.1 CAPITAL INVESTMENT

7.1.1 The overall control of all capital investment and fixed assets shall be the responsibility of the Chief Executive, as advised by the Director of Finance.

7.1.2 Whilst the Board reserves decision making with regard to the medium term Capital Plan and the Annual Capital Plan, the Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital investment priorities and the effect of each proposal on the Board Health Strategy and Annual Delivery Plan in accordance with the guidance contained in the Scottish Capital Investment Manual (SCIM).

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost.

(c) will ensure that capital investment is not undertaken without confirmation of the availability of resources to finance all revenue consequences.

7.1.3 The Chief Executive will also ensure that, for every capital expenditure proposal:

(a) where required, a business case is prepared setting out an option appraisal of potential benefits compared with known costs to determine the option with the most favourable ratio of benefits to costs in accordance with the guidance contained in the Scottish Capital Investment Manual (SCIM).

(b) the Director of Finance has certified professionally to the costs and revenue consequences.

(c) appropriate project management and control arrangements are set in place.

7.1.4 On approval of a capital investment scheme in accordance with the Scheme of Delegation, the Director of Finance shall issue written communication to the manager responsible for the capital investment project confirming the following**:**

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) authority to accept a successful tender.

7.1.5 The Director of Finance shall ensure that procedures are in place for the regular reporting of actual expenditure against authorisation of capital expenditure.

7.1.6 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the Scottish Capital Investment Manual (SCIM).

7.1.7 The Chief Executive will issue a scheme of delegation for capital investment management which will be in accordance with:

(a) SCIM guidance

(b) Forth Valley NHS Board Standing Orders

(c) the schedule of financial limits

7.1.8 Competitive tendering processes as per Section 8 must be followed with the exception being when the supply is proposed under special arrangements negotiated by the Scottish Government in which event the said special arrangements must be complied with. This is applicable to processes under the auspices of nationally approved procurement programmes, including Frameworks Scotland and Hub Company, where the formal tendering process has been deemed to have been completed in arriving at the principal supply chain partners.

7.1.9 The Director of Finance will issue procedures governing the financial management of capital investment projects, including variations to contract and valuation for accounting purposes.

7.2 PRIVATELY FINANCED INFRASTRUCTURE INVESTMENT

7.2.1 When Forth Valley NHS Board proposes to use finance, which is to be provided other than through NHS Finances (as determined by its Capital Allocation), the following procedures shall apply:

(a) the Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

(b) where the sum involved exceeds the limits of approval delegated to the Board, a business case must be prepared, and approved by the Board;

(c) the Business case must then be referred to the Scottish Government Health and Social Care Directorate for approval.

7.3 FIXED ASSET REGISTERS

7.3.1 The Chief Executive who has overall control of fixed assets will delegate responsibility for ensuring the maintenance of registers of assets and for prescribing the form and content of any register and the method of updating.

7.3.2 The minimum data set to be held within these registers shall be as specified in the NHS Scotland Capital Accounting Manual as issued by the Scottish Government Health and Social Care Directorate.

7.3.3 A fixed asset control procedure shall be approved by the Director of Finance. This procedure shall make provision for:

(a) recording the managerial responsibility for each asset

(b) identification of additions and disposals

(c) physical security of assets

(d) periodic verification of the existence of condition of and title to assets

7.3.4 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices, and other documentary evidence in respect of purchases from third parties

(b) stores requisitions and wages records for own materials and labour including appropriate overheads

(c) lease agreements in respect of assets held under a finance lease and capitalised

7.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

7.3.6 The value of each asset shall be indexed to current values in accordance with the methods specified in the NHS Scotland Capital Accounting Manual as issued by the Scottish Government Health and Social Care Directorate.

7.3.7 The value of each asset shall be depreciated using methods and rates as specified in the NHS Scotland Capital Accounting Manual as issued by the Scottish Government Health and Social Care Directorate.

7.3.8 Registers shall also be maintained by responsible nominated officers and receipts retained for:

(a) equipment on loan; and
(b) all contents of furnished lettings.

7.3.9 On the closure of any facility, a check shall be carried out and a responsible officer will certify an inventory of items held pending eventual disposal.

7.3.10 The Director of Finance shall approve a procedure for the calculation and payment of capital charges as specified in the NHS Scotland Capital Accounting Manual issued by the Scottish Government Health and Social Care Directorate.

7.4 SECURITY OF ASSETS

7.4.1 The Chief Executive is responsible for the overall control of the fixed assets of Forth Valley NHS Board, but all staff have a responsibility for the security of property of the Board. It shall be the responsibility of senior staff in all disciplines to apply appropriate routine security practices in relation to NHS property. Persistent breach of agreed security practices should be reported to the Chief Executive.

7.4.2 Wherever practicable, items of equipment shall be indelibly marked as Forth Valley NHS Board property.

7.4.3 The Director of Finance shall prepare procedural instructions on the security and checking and disposal of assets (including cash, cheques, and negotiable instruments, and also including donated assets). This procedure shall make provision for:

(a) recording managerial responsibility for each asset

(b) identification of additions and disposals

(c) identification of all repairs and maintenance expenses

(d) physical security of assets

(e) periodic verification of the existence of condition of, and title to, assets recorded

(f) identification and reporting of all costs associated with the retention of an asset

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments

7.4.4 Any damage to Forth Valley NHS Board premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors, Heads of Service or employees in accordance with the procedure for reporting losses.

SECTION 8: PURCHASING OF SUPPLIES AND SERVICES

8.1 DELEGATION OF AUTHORITY

8.1.1 The Forth Valley NHS Board will approve the total level of non-pay expenditure on an annual basis and the Director of Finance will determine the level of delegation to budget holders.

8.1.2 The Director of Finance will set out:

(a) the list of managers who are authorised to approve requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the process for authorisation above that level;

(c) the procedures to be adopted for the seeking of professional advice regarding the supply of goods and services.

8.1.3 All non-pay expenditure will be incurred within the limits of the non-pay budgets delegated to budget holders.

8.1.4 Section 21 sets out Standards of Business Conduct, which must be adhered to by members and officers of Forth Valley NHS Board.

8.2 SYSTEMS AND PROCEDURES FOR REQUISITIONING, ORDERING AND RECEIVING GOODS AND SERVICES

8.2.1 Supplies and services must be purchased through national contracts including framework agreements in accordance with CEL 05 (2012) where these are available. Only in exceptional circumstances and only with the authority of the Head of Procurement and the Director of Finance shall supplies and services available on contract be ordered outwith national contracts.

8.2.2 All formal contract arrangements must meet Information Governance requirements including appropriate patient confidentiality, information security, data protection and Freedom of Information requirements. The Head of Information Governance should be contacted for clarification in terms of use of standard wording and to resolve any queries that arise. The Caldicott Guardian has overall responsibility for Patient Information security.

8.2.3 Standard wording for inclusion within contracts has been prepared and the Head of Procurement should be contacted to confirm/advise on standard clauses. The Head of Procurement is responsible for compliance with this component of SFIs and ensuring compliance with CEL 05 (2012).

8.2.4 In line with the Procurement Reform (Scotland) Act 2014 competitive tenders for the supply of all goods and services not available to the Board through national or regional contracts will be invited by advertising on the Public Contracts Scotland website unless:

(a) the estimated value of the contract is (exclusive of VAT):

- less than £50,000 for building and engineering works
- less than £50,000 for other supplies
- less than £1,000 for disposals

(b) the supply or disposal is for goods or services of a special nature or character in respect of which it is not possible or desirable to obtain competitive tenders;

(c) in cases of emergency where it is not practicable or where the delay would result in further expense to the NHS Board. Such cases must be reported immediately to the Chief Executive.

8.2.5 A minimum of 3 written quotations shall be obtained from firms on approved lists (where possible) where the expenditure will be more than £5,000 but less than £50,000.

8.2.6 Where competitive tenders have been obtained, the lowest cost shall normally be accepted or, for disposals, the highest sales price. If other than the lowest (highest for disposals) is being recommended, the approval of the Chief Executive or the Director of Finance shall be obtained before acceptance and the reasons entered in the Register of Tenders.

8.2.7 Any Board Member or Officer concerned with a contract who has a pecuniary interest in that contract shall declare his interest in writing to the Chief Executive who shall maintain a register of all such declarations. The NHS Board Member or Officer concerned must withdraw from the decision-making process of the purchasing/contracting arrangements concerning that item. (See Section 21 – Standards of Business Conduct).

8.2.8 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for Forth Valley NHS Board. In so doing, the advice of Forth Valley NHS Board's sourcing adviser on supply shall be sought.

Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted before any order is placed.

8.2.9 The Director of Finance shall:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds must be incorporated in Forth Valley NHS Board Standing Financial Instructions and regularly reviewed; and

(b) prepare procedural instructions on the obtaining of goods, services and works, incorporating the thresholds set by the Board.

8.2.10 No order may be placed for any item, or items, for which there is no budget provision unless authorisation is provided by the Director of Finance on behalf of the Chief Executive.

8.2.11 All goods, services, or works must be ordered on an official order through the Board's electronic purchase to pay system ie the Professional Electronic Commerce Online System (PECOS) except for works and services executed in accordance with a contract and purchases from petty cash. Suppliers/Contractors shall be notified that they should not accept orders unless they are generated through PECOS.

8.2.12 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with European Commission (EC) and General Agreement on Tariffs and Trade (GATT) rules and comply with other such legislation relating to public procurement;

(c) where consultancy advice is being obtained, the procurement of such skills must be in accordance with guidance issued by the Scottish Government Health and Social Care Directorate;

(d) where eHealth and IT systems and/or software are being obtained, procurement of these items must be approved and processed through the Digital Directorate;

(e) in accordance with Section 21 – Standards of Business Conduct, no order is issued for any item, or items, to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than:

- isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars
- conventional hospitality, such as lunches in the course of working visits

(f) verbal orders are only issued in exceptional circumstances, in cases of emergency or urgent necessity, and only by an officer designated by the Chief Executive; these must be confirmed by an official order no later than the next working day, and clearly marked “Confirmation Order;”

(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit Forth Valley NHS Board to a future uncompetitive purchase;

(i) changes to the list of directors/employees authorised to certify invoices are notified to the Accounting Services Manager;

(j) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(k) petty cash records are maintained in a form as determined by the Director of Finance.

8.2.13 All tenders shall be addressed to the Chief Executive.

8.2.14 Official orders must:

(a) be consecutively numbered

(b) be in a form approved by the Director of Finance

(c) include such information concerning prices or costs as may be appropriate

(d) incorporate an obligation on the contractor to comply with the conditions printed thereon as regards delivery, carriage, documentation, variations, etc.

8.2.15 The Chief Executive must ensure that Forth Valley NHS Board Standing Orders and SFIs are compatible with guidance issued by the Scottish Government Health and Social Care Directorate in respect of building and engineering contracts (PROCODE) and land and property transactions (ESTATECODE). The technical audit of these contracts shall be the responsibility of the relevant Director. The Director of Finance shall ensure that the arrangements for financial control and audit of building and engineering contracts and property transactions comply with the guidance contained within these codes.

8.2.16 In accordance with Scottish Procurement Policy Note SPPN 2/2010 any contractor or sub-contractor performing security industry services will be required to be registered with the SIA Approved Contractors Scheme for the category of security service being provided/performed under the contract.

SECTION 9: INCOME, FEES AND CHARGES

9.1 INCOME SYSTEMS

9.1.1 The Director of Finance shall be responsible for designing and maintaining systems for the proper recording and collection of all monies due, including income due under service agreements for the provision of patient care services. The Director of Finance shall also be responsible for establishing reliable systems for financial coding to properly record all transactions.

9.2 FEES AND CHARGES

9.2.1 Forth Valley NHS Board shall follow the guidance and advice of the Scottish Government Health and Social Care Directorate in setting prices for Service Agreements.

9.2.2 The Director of Finance is responsible for setting prices for chargeable services including non-contracted activity (cross-border) and unplanned activity (UNPACS) cross health board boundary, in accordance with national guidance.

9.2.3 The Director of Finance is responsible for approving and regularly reviewing the level of fees and charges other than those determined by the Scottish Government Health and Social Care Directorate or by Statute.

9.2.4 All employees have a responsibility to inform the Accounting Services Manager of money due to Forth Valley NHS Board arising from transactions which they initiate, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.3 DEBT RECOVERY

9.3.1 The Director of Finance is responsible for taking appropriate recovery action on all outstanding debts.

9.3.2 Income not received will be dealt with in accordance with losses procedures.

9.3.3 All staff dealing with income transactions are responsible for ensuring that underpayments against sums due are prevented, but where these occur, recovery action as determined by the Director of Finance should be initiated.

9.3.4 The Director of Finance shall establish procedures for the write-off of debts after all reasonable steps have been taken to secure payment.

SECTION 10: TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND STAFF

10.1 REMUNERATION AND TERMS OF SERVICE

10.1.1 The Board shall establish a Remuneration Committee whose composition and remit will be set out in the Forth Valley NHS Board's standing orders contained in the code of Corporate Governance.

10.1.2 The Remuneration Committee will operate within the Terms of Reference described in the Forth Valley NHS Board's standing orders contained in the code of Corporate Governance.

10.1.3 The remuneration of the Chairperson and Non-Executive Directors will be set in accordance with the instructions issued by the Scottish Ministers.

10.1.4 The Committee shall report in writing to the Board the bases for its recommendations. The Board shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of executive directors.

10.2 FUNDED ESTABLISHMENT

10.2.1 The establishment plans incorporated within the annual budget will form the funded establishment of the Forth Valley NHS Board.

10.2.2 The Director of Finance shall be responsible for designing a system of funded establishment control. The funded establishment of any department may only be varied in accordance with the approved establishment control system. As part of this, any changes in the funded establishment will require approval from the relevant professional lead, particularly in relation to skill mix changes.

10.3 STAFF APPOINTMENTS

10.3.1 No director or officer may engage, re-engage or re-grade staff, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration unless

(a) so authorised by the Chief Executive; and

(b) within the limit of the approved budget and funded establishment.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service, job evaluation etc. for employees.

10.3.3 A certified appointment form and such other documents as may be required shall be sent to HR connect for approval immediately upon the employee commencing duty. It is the responsibility of the Manager who is receiving the new team member to complete any paperwork or input information to the electronic employee support systems (eESS) as appropriate.

10.4 CONTRACT OF EMPLOYMENT

10.4.1 Each employee shall be issued with a Contract of Employment by the Director of Human Resources, which shall comply with current employment legislation and be in a form approved by the Board.

10.4.2 The Director of Human Resources shall be responsible for dealing with variations to, or termination of, contracts of employment, including appropriate record-keeping.

10.5 STAFF CHANGES

10.5.1 A variation to contract of employment shall be issued in all cases of changes to existing contract.

10.5.2 Confirmation of a change in the status of employment shall be completed and submitted electronically via eESS.

10.5.3 Termination of employment must be processed via eESS immediately upon the effective date of an employee's resignation, retirement or termination being known. Where an employee fails to report for duty in circumstances which suggest they have left without notice, the Director of Human Resources and the Payroll Manager shall be informed as soon as possible.

10.6 PAYROLL

10.6.1 All pay records, related electronic records and their notification shall be in a form approved by the Director of Finance and shall be certified and submitted in accordance with their instructions.

10.6.2 The Director of Finance shall be responsible for the final determination of any pay including verification that the rate of pay and relevant conditions of service are in accordance with current agreements, the proper compilation of the payroll and for payments made.

10.6.3 The Director of Finance shall determine the dates on which the payment of salaries and wages are to be made, having regard to the general rule that it is undesirable to make payments in advance.

10.6.4 All employees shall be paid monthly by BACS (with the exception of any enhancements, extra hours or overtime which are paid one month in arrears) unless otherwise agreed by the Director of Finance.

10.6.5 All staff have a responsibility to ensure they are being paid correctly. Staff must report immediately to the Payroll Manager any irregular payment which has been made from funds for payroll purposes.

10.7 TRAVEL AND OTHER STAFF EXPENSES

10.7.1 The Board will reimburse reasonable expenses which have been necessarily and exclusively incurred by employees while engaged on approved NHS Forth Valley business in accordance with the relevant terms and conditions of employment.

10.7.2 All expenses claims must be submitted via the NHS Scotland electronic expenses system, or where this is not possible, on the relevant NHS Scotland expenses claim form (there are separate forms for Medical & Dental staff, Agenda For Change staff and leased car users). Claims must be submitted within a maximum of 3 months of the expenses being incurred by the employee. Claims submitted outwith this period will not be reimbursed unless there are exceptional circumstances which must be notified to the Payroll Team in writing by the Service Manager of the Department. A final decision on whether the claim should be reimbursed will rest with the Director of Finance.

10.7.3 The Director of Finance shall reimburse all expenses claimed by employees of the Board or outside parties in line with the relevant Agenda For Change regulations, General Whitley Council regulations, Hospital, Medical and Dental Whitley Council regulations and His Majesty's Revenue & Customs (HMRC) regulations, as appropriate. Arrangements for the certification of such claims by the appropriate Head of Department shall be subject to the approval of the Director of Finance.

10.7.4 The Director of Finance shall ensure that HMRC regulations with regard to travel and other staff expenses are complied with.

SECTION 11: ACCOUNTS PAYABLE

11.1 RESPONSIBILITIES FOR NOTIFYING AND MAKING PAYMENTS

11.1.1 All employees must comply with the approved scheme of delegation contained in the Board's Standing Orders when initiating all non-pay transactions.

11.1.2 The Director of Finance shall be responsible for the prompt payment of all properly authorised invoices and claims. Payment of contract invoices shall be undertaken promptly in accordance with contract terms, or otherwise, in accordance with the Scottish Government prompt payment policy.

11.1.3 All Directors, officers and agents shall inform the Director of Finance promptly of all monies payable by Forth Valley NHS Board arising from transactions which they initiate, including contracts, leases, tenancy agreements and other transactions.

11.1.4 Payments to independent Family Health Service Practitioners and all associated administration has been delegated to NHS National Services Scotland (NSS) under a Partnership Agreement. NSS will act as agents of the Board in accordance with the Partnership Agreement.

11.2 SYSTEMS AND PROCEDURES FOR MAKING PAYMENTS

11.2.1 The Director of Finance shall be responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by Forth Valley NHS Board. The system shall provide for:

(a) a list of officers authorised to certify invoices, together with specimens of their signatures (the authorised signatory database)

(b) certification that:

- goods have been received or services supplied as agreed;
- where contracts are based on measurement of time, materials, or expenses, that each are in accordance with the appropriate independent certified measures;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the invoice or claim is arithmetically correct;

- the invoice or claim is not a duplicate and has not been paid previously, and

- the VAT treatment is correct.

(c) a timetable for payments to be made; provision shall be made for the early submission of accounts where cash discounts can be obtained or for those accounts which otherwise require early payment;

(d) instructions to employees regarding the handling and payment of accounts by the Accounts Payable team;

(e) a process which ensures that payment for goods and services is only made once the goods and services have been received by Forth Valley NHS Board (except as allowed for below), and

(f) appropriate segregation of duties.

11.2.2 In the case of contracts for building or engineering works, which require payment to be made on account during progress of the works, the Director of Finance shall make payment on receipt of a certificate from the appropriate technical consultant. Without prejudice to the responsibility of any consultant or works officer appointed to a particular building or engineering contract, a contractor's account shall be subject to such financial examination by the Director of Finance and such general examination by a works officer as may be considered necessary, before the person responsible to Forth Valley NHS Board for the contract, issues the final certificate.

11.2.3 Where a contract is based on the measurement of time, materials or expenses, the checks to be carried out must provide confirmation that:

(a) the time charged is in accordance with the time sheets

(b) the rates of labour are in accordance with the appropriate rates

(c) the materials have been checked as regards quantity, quality, and price

(d) the charges for the use of vehicles, plant and machinery have been examined

11.2.4 Where an officer certifying accounts or claims relies upon other officers to do preliminary checking, they shall, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

11.2.5 Payment in advance may also be approved for items such as courses, conferences and travel where payment is required to secure the booking, or where it is necessary to use corporate credit card.

11.3 OTHER

11.3.1 All employees must comply with the NHS Scotland Conduct policy and the local standards of business conduct policy. Any query on the application of the standards must be raised with the Director of Human Resources.

SECTION 12: CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

12.1 FRAUD POLICY AND RESPONSE PLAN

12.1.1 The Director of Finance shall prepare a Fraud Policy and Response Plan which shall be approved by the Board.

12.2 DISPOSALS AND CONDEMNATIONS

12.2.1 The Director of Finance shall prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

12.2.2 When it is decided to dispose of an asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

12.2.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the condemning officer in a form approved by the Director of Finance, which will indicate whether the articles are to be converted, destroyed, or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

12.2.4 The condemning officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report such evidence to the Director of Finance who will take the appropriate action.

12.3 LOSSES AND SPECIAL PAYMENTS

12.3.1 The Director of Finance shall prepare procedural instructions on the recording of and accounting for losses and special payments.

12.3.2 Any officer discovering or suspecting a loss of any kind shall forthwith inform their Head of Department, who shall immediately inform the Chief Executive and Director of Finance.

12.3.3 Where a criminal offence is suspected, the Board's Fraud Policy and Response Plan will be implemented.

12.3.4 The Director of Finance shall notify the Scottish Government Health and Social Care Directorate of all losses and special payments, including those arising from fraud in accordance with CEL (2010) 10 and report this via Scottish Financial Return (SFR) 18.0 to 18.2.

12.3.5 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance shall immediately notify:

(a) the Forth Valley NHS Board

(b) the Statutory Auditor

12.3.6 All reported instances of fraud (including any relating to independent Family Health Services Practitioners) and other cases as may be determined by Scottish Government Health and Social Care Directorate, will be referred to the NHS Scotland Counter Fraud Service in accordance with guidance received from Scottish Government Health and Social Care Directorate.

12.3.7 All legal claims brought against the Board must be directed to the Central Legal Office who will manage them on the Board's behalf under the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). An updated register of ongoing cases and expected losses will be issued to the Board periodically by the CNORIS Team.

12.4 WRITING OFF OF LOSSES

12.4.1 The Board has delegated authority to write-off losses and make special payments up to certain limits as detailed in the Scheme of Delegation. Prior approval must be obtained from SGHSCD for amounts exceeding this.

12.4.2 The Director of Finance shall maintain a losses and compensation register in which details of all losses shall be recorded, as they are known. Write-off action shall be recorded against each entry in the register.

12.4.3 The Director of Finance shall be authorised to take any necessary steps to safeguard Forth Valley NHS Board interest in bankruptcies and company liquidations.

12.4.4 No special payments exceeding the delegated limits determined by the Board shall be made without the prior approval of the Director of Finance.

12.4.5 Losses are classified in accordance with the relevant SFRs as outlined in the NHS Scotland Accounts Manual issued by the Scottish Government Health and Social Care Directorate.

12.4.6 The delegated limits of authority for each type of loss are contained in the Scheme of Delegation included in the Board's Code of Corporate Governance.

12.4.7 A statement of Losses and Special Payments requires to be reported within the Annual Report and Accounts. Individual losses or special payments exceeding £300,000 must be reported separately.

SECTION 13: ENDOWMENTS AND TRUST FUNDS (NON-EXCHEQUER FUNDS)

13.1 INTRODUCTION

13.1.1 Endowment and Trust Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the National Health Service, the objects of which are for the benefit of the National Health Service in Scotland. They are administered by the Board acting as trustees or by Special Trustees appointed by the Scottish Ministers or by other persons under a trust. An Endowments Committee will be responsible for the management of Forth Valley NHS Board Endowment and Trust Funds.

13.1.2 The discharge of the Board's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence, and propriety.

13.1.3 These Standing Financial Instructions shall apply equally to Non-Exchequer Funds as to other funds except that expenditure from Non-Exchequer Funds shall be restricted to the purpose(s) of the appropriate Fund.

13.1.4 The Director of Finance shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of Forth Valley NHS Board as trustees of non-exchequer funds, including an Investments Register.

13.1.5 All share and stock certificates and property deeds shall be deposited either with Forth Valley NHS Board Bankers or Investment Advisers, or in a safe, or a compartment within a safe, to which only a designated responsible officer will have access.

13.1.6 The Director of Finance shall prepare detailed procedural instructions concerning the receiving, recording, investment, and accounting for endowment funds.

13.1.7 The Director of Finance shall be required to advise the Board on the financial implications of any proposal for fund raising activities, which Forth Valley NHS Board may initiate, sponsor, or approve.

13.1.8 The Director of Finance shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. After the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of Forth Valley NHS Board by the Director of Finance who alone shall be empowered to give an executor a good discharge.

13.1.9 Endowment and Trust Funds shall be invested by the Director of Finance in accordance with Forth Valley NHS Board policy and subject to statutory requirements. The Director of Finance shall have authority to obtain professional advice on investments.

13.1.10 Where it becomes necessary for Forth Valley NHS Board to obtain Grant of Probate, or to make application for grant of letters of administration, in order to obtain a legacy due to Forth Valley NHS Board under the terms of a Will, the Director of Finance shall be Forth Valley NHS Board nominee for the purpose.

SECTION 14: INFORMATION MANAGEMENT

14.1 RESPONSIBILITIES

14.1.1 The Chief Executive shall be responsible for ensuring the maintenance of archives for all documents required to be retained under the direction contained in CEL (31)2010 and the requirements of the Freedom of Information Act 2002 and the Public Records (Scotland) Act 2011.

14.1.2 The documents held in archives shall be capable of retrieval by authorised persons. Stirling University provides archive services for the Board.

14.1.3 Documents held shall only be destroyed at the express instigation of the Chief Executive in line with approved retention schedules.

14.1.4 The Director of Finance will act as Senior Information Risk Officer (SIRO) for NHS Forth Valley. The SIRO is a mandatory role for public sector organisations and has oversight of information risks within the organisation. The SIRO will inform and advise the board on how to mitigate these risks in accordance with the organisation's risk appetite.

14.1.5 The Director of Finance shall be primarily responsible for the accuracy and security of the computerised financial data of Forth Valley NHS Board and will formally record this is part of the Board's Information Asset Register.

14.2 FINANCIAL SYSTEMS MANAGEMENT

14.2.1 The Board's financial system (eFinancials) is a national single instance financial system operated and maintained by NHS Ayrshire and Arran on behalf of all NHS Boards in Scotland. The eFinancials software is supplied and supported by OneAdvanced and interfaces with a number of NHS Scotland's procurement, payroll and payment systems. An annual service audit is commissioned by NHS Ayrshire and Arran to provide assurance to all NHS boards that appropriate and effective system controls are in place.

14.2.2 The Director of Finance shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of Forth Valley NHS Board and individuals from inappropriate use or misuses of any financial and other information held on computer files, for which he is responsible after taking into account relevant legislation (including UK-GDPR and the Data Protection Act 2018), the Network and Information Systems Regulations 2018, the Freedom of Information (Scotland) Act 2002, and the Computer Misuse Act 1990.

(b) ensure that adequate data controls exist over data entry, processing, storage, transmission, and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system, including the use of any external agency arrangement.

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance, and amendment.

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out.

(e) ensure that contingency planning is undertaken and that adequate contingency arrangements are in place.

14.2.3 The Director of Finance shall satisfy themself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.2.4 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as the Digital Healthcare Strategy

(b) data produced for use with financial systems is adequate, accurate, complete, timely and in a form determined by the Director of Finance, and that a management (audit) trail exists

(c) finance staff have access to such data

(d) such computer audit reviews as are considered necessary are being carried out

SECTION 15: INTERNAL AND EXTERNAL AUDIT

15.1 AUDIT AND RISK COMMITTEE

15.1.1 In accordance with Standing Orders (and as set out in DL (2019) 02 and the Blueprint for good governance in NHS Scotland 2nd edition published in Nov 2022), the Board shall establish an Audit and Risk Committee which will provide an independent and objective view of when considering the following;

(a) Internal control and corporate governance

(b) Internal Audit including the approval of the Strategic Audit Plan

(c) External Audit

(d) Standing Orders and Standing Financial Instructions

(e) Accounting Policies

(f) Annual Accounts (including the schedule of losses and compensations)

(g) Risk Management

15.1.2 Where the Audit and Risk Committee consider there is evidence of ultra-vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chairperson of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Scottish Government Health and Social Care Directorate.

15.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided to Forth Valley Health Board and that this is reviewed regularly by the Audit Committee. The Audit Committee should be consulted on any decision to change the internal audit service provider and shall participate in the selection process for any new service provider.

15.2 DIRECTOR OF FINANCE

15.2.1 The Director of Finance shall be responsible for ensuring that internal audit is adequate for the needs of NHS Forth Valley and meets the NHS mandatory audit standards. The Director of Finance will ensure that there are arrangements to measure, evaluate and report on the effectiveness of internal control and efficient use of resources by the establishment of an adequate internal audit function headed by a Chief Internal Auditor of sufficient status.

15.2.2 It shall be the responsibility of the Director of Finance to review, appraise, and to report to management upon the adequacy of follow-up action to Audit Reports in accordance with the policy approved by the Audit Committee, which shall be reviewed at least biennially.

15.2.3 The Director of Finance shall ensure that an annual internal audit report is prepared by the Chief Internal Auditor and presented to the Audit Committee, in accordance with its timetable which contains:

(a) a clear statement on the adequacy and effectiveness of internal control

(b) details of major internal control weaknesses discovered

(c) a summary of progress against plan in the previous year

(d) quality measures as defined within the service specification

15.2.4 The Director of Finance shall be notified immediately whenever any matter arises which involves, or is thought to involve, irregularities involving cash, stores, other property of Forth Valley Health Board, or any suspected irregularity in the exercise of any function of a financial nature and shall inform the Chief Internal Auditor. The Director of Finance shall comply with the requirements of the Scottish Government Health and Social Care Directorate and of the Board's Fraud Policy in the resolution of these matters.

15.3 INTERNAL AUDIT

15.3.1 The Chief Internal Auditor shall be responsible directly to the Director of Finance for the provision of a professional and comprehensive Internal Audit Service to Forth Valley Health Board. In carrying out this responsibility the Chief Internal Auditor shall normally attend the meetings of the Audit and Risk Committee and will have the right of direct access to the Chief Executive, the Chairperson, or other members of the Audit and Risk Committee.

15.3.2 The objectives and scope of Internal Audit are set out in the Public Sector Internal Audit Standards (PSIAS) and the Board's approved audit charter. Internal Audit will review, appraise, and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures

(b) the adequacy and application of financial and other related management controls

(c) the suitability of financial and other related management data

(d) the extent to which Forth Valley Health Board assets and interests are accounted for and safeguarded from loss of any kind, arising from:
- fraud and other offences
- waste, extravagance, or inefficient administration
- poor value for money
- other causes.

15.3.3 The Chief Internal Auditor shall be entitled, without necessarily giving prior notice, to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case he shall have a duty to safeguard the confidentiality);

(b) access to any land, premises, or employee of the Board;

(c) the production or identification by any employee of any Board cash, stores, or other property under the employee's control;

(d) explanations concerning any matter under investigation or review.

15.3.4 Where a matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property of the Board, or any suspected irregularity in the function of a pecuniary nature, officers shall act in accordance with the provisions of Section 12 of the SFIs, the Board's Fraud Policy, relevant Financial Operating Procedures and the requirements of the Scottish Government Health and Social Care Directorate.

15.3.5 The Chief Internal Auditor shall report in accordance with the reporting protocol approved by the Audit Committee which shall be reviewed at least biennially.

15.3.6 Counter Fraud Service (CFS) staff acting on the Director of Finance's behalf may require and receive access to:

- All records, documents and correspondence relating to transactions relevant to an investigation.

- At all reasonable times to any premises or land of NHS Forth Valley.

15.4 EXTERNAL AUDIT

15.4.1 The External Auditors for Forth Valley Health Board are appointed by the Auditor General for Scotland. The audit appointments are rotated on a five year cycle in order to maintain External Auditors' independence.

15.4.2 The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000 and these are undertaken from a wider perspective than audits conducted in the private sector.

15.4.3 The External Auditor is concerned with providing an independent assurance of the Board's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. However they will also consider additional aspects or risks in financial management, financial sustainability, vison, leadership and governance and the use of resources to improve outcomes.

15.4.4 The appointed External Auditor has a general duty to satisfy themself that:

(a) The Board's accounts have been properly prepared in accordance with the directions given under the Public Finance and Accountability (Scotland) Act 2000

(b) Proper accounting practices have been observed in the preparation of the accounts

(c) The Board has made proper arrangements for securing best value in the use of its resources

15.4.4 Additionally, Audit Scotland's Code of Audit Practice which covers the conduct of the audit, requires the appointed External Auditor to consider whether the statement of accounts represents a true and fair view of the financial position of the Board.

15.4.5 The External Auditor is required to provide an Audit Certificate and opinion to Forth Valley Health Board, Scottish Ministers and Audit Scotland. They are also required to submit a final report to members of Forth Valley Health Board, which summarises significant matters arising during the statutory audit. The auditor will also normally issue management letters to the Chief Executive and the Director of Finance highlighting any significant matters during the course of the audit.

15.4.6 The appointed External Auditor has special duties to report directly to the Auditor General should he have reason to believe that a Board decision would involve unlawful expenditure or would be unlawful and cause a loss or deficiency.

SECTION 16: ANNUAL REPORT AND ACCOUNTS

16.1 GENERAL

16.1.1 Forth Valley NHS Board is required under the terms of Section 86(3) of the National Health Service (Scotland) Act 1978 to prepare and submit Annual Accounts to Scottish Ministers.

16.1.2 The Director of Finance, on behalf of the Forth Valley NHS Board, shall prepare, certify, and submit annual accounts to the Chief Executive in such a form as directed by the Scottish Ministers and in accordance with the guidance and timetable laid down by the Scottish Government Health and Social Care Directorate.

16.1.3 The annual accounts are a public report on the financial and governance affairs of the NHS Board during the financial year and are laid before the Scottish Parliament. The annual accounts are comprised of the financial statements together with an annual report which consist of a performance report and accountability report.

16.1.4 The Annual Report and Accounts must comply with the accounting and disclosure requirements of the Government Financial Reporting Manual (FReM) as issued by HM Treasury for the year being reported on. Guidance in this NHS Board Annual Accounts Manual for the relevant year must also be followed.

16.1.5 The Board's Annual Accounts must be independently audited by an auditor appointed by the Auditor General for Scotland under the terms and provisions of the Public Finance and Accountability (Scotland) Act 2000.

16.1.6 On receipt of the audited Annual Accounts and the associated Management Letter, the Director of Finance shall:

(a) present the proposed management response for consideration by the Audit and Risk Committee;
(b) ensure that the accounts are presented to and approved by the Board at a Board meeting
(c) submit by the 30th of June each year to the Scottish Government to be laid before Parliament before being published.

16.1.7 The Director of Finance shall prepare and submit annually a financial report to the Board detailing the overall performance for the preceding financial year.

SECTION 17: STORES AND RECEIPT OF GOODS

17.1 GENERAL RESPONSIBILITIES

17.1.1 The Chief Executive shall delegate to an officer of Forth Valley NHS Board the responsibility for the overall control of stores.

17.1.2 The Director of Finance shall be responsible for design and implementation of the systems of control.

17.1.3 The day to day management of stores may be delegated to departmental officers and Stores Managers/Keepers, subject to such delegation being entered in a record available to the Director of Finance.

17.2 SECURITY ARRANGEMENTS

17.2.1 The responsibility for security arrangements and the custody of keys for all stores locations shall be clearly defined in writing by an officer delegated by the Chief Executive and agreed with the Director of Finance.

17.3 SYSTEMS AND STORES CONTROL

17.3.1 All stores' records shall be in such form and shall comply with such system of control as the Director of Finance shall approve.

17.3.2 The Director of Finance shall set out procedures and systems to regulate stores transactions including records for receipt of goods from store and returns to store.

17.3.3 Wherever practicable stocks shall be marked as health service property.

17.3.4 Controlled stores and department stores established for immediate use should be:

(a) maintained at the minimum practicable store levels related to operational requirements
(b) subject to a regular stock takes (either as part of a rolling programme or a full annual stock take)
(c) valued at the lower of cost or net realisable value

17.3.5 The nominated manager/pharmaceutical officer shall be responsible for a system, approved by the Director of Finance, for a review of slow moving and obsolete items and for the condemnation, disposal, and replacement of unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (See Section 12). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

17.3.6 Stock levels should be kept to a minimum consistent with operational efficiency.

17.3.7 Stocktaking arrangements shall be agreed with the Director of Finance, with either an agreed physical rolling programme of stock takes throughout the year or a full

annual stock take. However, depending on the value and marketability of some items, a system of perpetual inventory checking may be applied.

17.3.8 Those stores designated by the Director of Finance as comprising more than 7 days of normal use should be:

(a) subjected to annual or continuous stock-take
(b) valued at the lower of cost and net realisable value

SECTION 18: PATIENTS' PROPERTY

18.1 GENERAL

18.1.1 Forth Valley NHS Board has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

18.1.2 The Chief Executive shall be responsible for informing patients or their guardians, as appropriate, before or at admission, that the Board will not accept responsibility or liability for patient's property brought into health service premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

18.1.3 The Director of Finance shall provide detailed written instructions for the receipt, custody, recording, safekeeping, and disposal of patient's property (including instructions on the disposal of the property of deceased patients and patients transferred to other premises) for all staff who have responsibility for the property of patients. The Director of Finance will also have procedures in place to deal with the loss of patients' property.

18.1.4 Where Scottish Government Health and Social Care Directorate instructions require the opening of separate accounts for patients' monies as part of Corporate Appointee duties, these shall be opened and operated under arrangements agreed by the Director of Finance.

18.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18.1.6 The Director of Finance will ensure there are instructions and guidance for managing the funds of patients with incapacity who are unable to manage their own financial affairs. Funds may be managed either through DWP Appointeeship, or where necessary, powers delegated to ward managers by NHS Forth Valley under part 4 of the Adults with Incapacity (Scotland) Act 2000.

18.1.7 Staff should be informed on appointment, by the appropriate departmental or senior manager, of their responsibilities and duties for the administration of the

property of patients. Staff will be expected to familiarise themselves with the relevant financial operating procedures in respect of patients property.

18.1.8 Where patients' property or income is received for specific purposes and held for safekeeping, the property of income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18.1.9 The Director of Finance shall prepare an abstract of receipts and payments of patients' private funds in the form laid down in the Board Accounts Manual. This abstract shall be audited independently and presented to the Audit Committee annually, with the auditor in attendance at the meeting.

SECTION 19: RISK MANAGEMENT

19.1 GENERAL

19.1.1 The Chief Executive shall ensure that Forth Valley NHS Board has a risk management strategy which sets out the principles and approaches to risk management that will be followed in relation to risks that could threaten achievement of business objectives. The risk management strategy will be approved and monitored by the Forth Valley NHS Board.

19.1.2 The programme of risk management shall include, inter alia:

a) a process for identifying and quantifying risks and potential liabilities including those arising from the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS)
b) engendering among all levels of staff a positive attitude towards the control of risk
c) management processes to ensure that all significant risks and potential liabilities are mitigated as far as possible, including effective systems of internal control and decisions on the acceptable level of retained risk
d) contingency plans to offset the impact of adverse events
e) audit arrangements including external and internal audit, clinical audit, health, and safety review
f) arrangements to review the risk management programme
g) development of a financial risk management strategy to cope with possible in-year variations to the initially set budget

19.1.3 The existence, integration and evaluation of the above elements will provide a basis for the Audit and Risk Committee to make a statement on the effectiveness of internal control and corporate governance to Forth Valley NHS Board.

SECTION 20: PRIMARY CARE CONTRACTORS

20.1 GENERAL

20.1.1 The Practitioner and Counter Fraud Services Division (PCFS) of NHS National Services Scotland (NSS) is the payment agency for all Family Health Service (FHS) contractor payments due to:

(a) General Practitioners
(b) Dentists
(c) Community Pharmacists
(d) Optometrists

20.1.2 The Director of Finance shall conclude a "Partnership Agreement" with the PCFS division covering validation, payment, monitoring, reporting and the provision of an audit service by the NSS service auditors. The agreement will be signed off by the Chief Executive of NHS Forth Valley.

20.1.3 The Board will approve additions to, and deletions from, the approved performers list of FHS contractors in line with the National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004 and other applicable guidance and regulations, including consideration of the health needs of the local population and access to existing services. All applications and resignations received will be dealt with equitably, within any time limits laid down in the relevant contractors' NHS terms and conditions of service.

20.1.4 The Director of Finance will:

(a) ensure that lists of all contractors are maintained and kept up to date; and
(b) ensure that systems are in place to deal with applications, resignations, inspection of premises, etc. within the appropriate contractor's terms and conditions of service.

20.1.5 The Director of Finance shall ensure that NSS systems are in place to provide assurance that:

(a) only contractors who are included on the Board's approved lists receive payments;
(b) all valid contractors' claims are paid correctly, and are supported by the appropriate documentation and authorisations
(c) any payments to third parties are notified to the Independent Contractors on whose behalf payments are made
(d) ensure that regular independent pre and post payment verification of claims is undertaken to confirm that:

- payment criteria/eligibility rules have been correctly and consistently applied
- overpayments are prevented wherever possible; if, however, overpayments are detected, recovery measures are initiated
- fraud is detected and instances of actual and potential fraud are followed up

(e) exceptionally high/low payments are identified and escalated
(f) payments made via NSS are reported to NHS Forth Valley as appropriate
(g) local payments made on behalf of the Board by NSS are pre-authorised
(h) payments made by NSS are reconciled with the cash draw-down reported by the Scottish Government Health and Social Care Directorate to the Board

20.1.6 The Director of Finance shall prepare operating procedures to cover all payments made by NSS (both payments made directly, or payments made on behalf of the Board and/or Contractors).

20.1.7 Payments made to all FHS independent contractors shall comply with their appropriate contractor regulations.

SECTION 21: STANDARDS OF BUSINESS CONDUCT

21.1 GENERAL

21.1.1 Detailed information is available in the NHS Scotland Conduct policy and the local NHS Forth Valley Policy on Standards of Business Conduct.

21.1.2 MEL (1994) 80 also provides details of the principles for standards of conduct and accountability in situations when there is potential conflict between the private interests of NHS staff and their duties.

21.1.3 It will be the responsibility of the Chief Executive to:

(a) ensure that the NHS Scotland conduct policy, any local conduct policy and all Scottish Government Health and Social Care Directorate guidelines on standards of business conduct for NHS staff as per MEL (1994) 48 are brought to the attention of all staff, and are effectively implemented
(b) develop local conflict of interest policies and the machinery to implement them, in consultation with staff and local staff representatives
(c) ensure that such policies and procedures are kept up to date
(d) ensure that a full operational policy on the Standards of Business Conduct is developed and communicated to staff

21.1.4 The business of the Board will be conducted in accordance with the Ethical Standards in Public Life etc (Scotland) Act 2002. All members of staff have a duty to maintain strict ethical standards in the conduct of their business as an employee of Forth Valley NHS Board.

21.1.5 It is the responsibility of all staff when acting on NHS Forth Valley's behalf to:

- conduct the business of the organisation professionally, with honesty, integrity, free from bribery and maintain the organisations reputation
- if staff are in any doubt as to what they can or cannot do they must seek advice from their line manager or from the Human Resources Department.
- Note that breaches may lead to disciplinary action or to dismissal.

21.2 BRIBERY ACT 2010

21.2.1 The Bribery Act 2010 is one of the strictest pieces of legislation on bribery and makes it a criminal offence for any individual (employee, contractor, agent) associated with NHS Forth Valley to give, promise or offer a bribe or to request, agree to receive or accept a bribe (section 1,2 and 6 offences). This can be punishable for an individual by imprisonment of up to 10 years.

21.2.2 In addition, the Act introduces a corporate offence (section 7 offence) which means that NHS Forth Valley can be exposed to criminal liability, punishable by an unlimited fee if it fails to prevent bribery by not having adequate preventative procedures in place that are robust, up-to-date, and effective. The corporate offence is not a standalone offence and would follow a bribery/corruption offence committed by an individual associated with NHS Forth Valley in the course of their work.

21.2.3 If a bribery offence is proved to have been committed by an outside body corporate with the consent or connivance of a Director or Senior Officer of NHS Forth Valley, under the Act the Director or Senior Officer would be guilty of an offence (Section 14 offences) as well as the body corporate which paid the bribe.

21.2.4 Whilst the exact definition of bribery and corruption is a statutory matter, the following working definitions are given:

- Bribery is an inducement or reward offered, promised, or provided to gain any commercial, contractual, regulatory, or personal advantage.

- Broadly, the Act defines bribery as giving or receiving a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith.

- Bribery does not have to involve cash, or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event.

- Corruption relates to a lack of integrity or honesty including the use of trust for dishonest gain. It can broadly be defined as the offering or acceptance of inducements, gifts, favours, payments, or benefits in kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly however they may be unreasonably using their position to give some advantage to another.

21.2 GIFTS, HOSPITALITY, AND INDUCEMENTS

21.2.1 The policy on the Standards of Business Conduct applies to all members of staff at all times.

21.2.2 Officers of Forth Valley NHS Board should not accept business gifts, but articles of a low intrinsic value such as chocolates, biscuits, business diaries or calendars, need not necessarily be refused. No gifts of alcohol should be accepted. Acceptance of gifts over £25 but under £200 require to be authorised by Line Management. Gifts over £200 require to be authorised by Head of Service or Director.

21.2.3 Care should be taken when accepting hospitality. All hospitality offered, such as lunches and dinners, corporate hospitality events, etc should be reported to the officer's superior before acceptance.

21.2.4 Any inducements offered should be reported to the officer's superior.

21.2.5 Visits at suppliers' expense to inspect equipment etc should not be undertaken without the prior approval of the Chief Executive and in the case of the Chief Executive by the prior approval of the Chairperson.

21.2.6 A register to record all gifts received by staff with a value over £25 is maintained by the Corporate Services Department and it is the responsibility of the recipients of such gifts to report all such items received. The form 'Declaration of Staff interests and Gifts/Hospitality' (Annex 2 of the Policy on Standards of Business Conduct' should be used for this purpose). This register will be published on the NHS Forth Valley website.

21.3 ACQUISITION OF GOODS AND SERVICES

21.3.1 If officers are involved in the acquisition of goods and services, they should adhere to the ethical code of the Institute of Purchasing and Supply.

21.3.2 Officers should ensure that acceptance of commercial sponsorship will not influence or jeopardise purchasing decisions.

21.4 DECLARATION OF INTERESTS

21.4.1 To avoid conflicts of interest and to maintain openness and accountability all directors, members of staff and non-executive board members have a responsibility to promptly declare relevant interests and any changes to those interests that may arise from time to time.

21.4.2 Employees are required to register all interests that may have any relevance to their duties/responsibilities. These include any financial interest in a business or any other activity or pursuit that may compete for an NHS contract to supply either goods or services to the NHS or in any other way that could be perceived to conflict with the interests of NHS Forth Valley. The test to be applied when considering appropriateness of registration of an interest is to ask whether a member of the public acting reasonably might consider the interest could potentially affect the individual's responsibilities to the organisation and/or influence their actions. If in doubt the individual should register the interest or seek further guidance from the Corporate Services Department.

21.4.3 Interests that it may be appropriate to register include:-

(i) Other employment including self-employment

(ii) Directorships including Non-Executive Directorships held in private companies or public limited companies whether remunerated or not

(iii) Ownership of, or an interest in private companies, partnerships, businesses, or consultancies

(iv) Shareholdings in organisations likely or possibly seeking to do business with the NHS (the value of shareholdings need not be declared)

(v) Ownership of or an interest in land or buildings which may be significant to, of relevance to, or bear upon the work of NHS Forth Valley

(vi) Any position of authority held in another public body, trade union, charity, or voluntary body

(vii) Any connection with a voluntary or other body contracting for NHS services

(viii) Any involvement in joint working arrangements with Clinical or other Suppliers

21.4.4 This list is not exhaustive and should not preclude the registration of other forms of interest where these may give rise to a potential conflict of interest upon the work of NHS Forth Valley. Any interests of spouses, partner or civil partner, close relative or associate or persons living with the individual as part of a family unit will also require registration if a perceived or actual conflict of interest exists.

21.4.5 Forth Valley NHS Board will maintain a Register of Interests and publish this on the Board's website

SECTION 22: SUSPECTED THEFT, FRAUD & OTHER FINANCIAL IRREGULARITIES

22.1 INTRODUCTION

22.1.1 The following procedures should be followed, as a minimum, in cases of suspected theft, fraud, embezzlement, corruption or other financial irregularities to comply with the NHS Scotland Counter Fraud Service Strategy and the Board's local fraud policies and protocols. This procedure also applies to any non-public funds.

22.2 THEFT, FRAUD, EMBEZZLEMENT, CORRUPTION AND OTHER FINANCIAL IRREGULARITIES

22.2.1 The Chief Executive has the responsibility to designate an officer within the Board with specific responsibility for co-ordinating action where there are reasonable grounds for believing that an item of property, including cash has been stolen.

22.2.2 It is the designated officer's responsibility to inform as they deem appropriate the police, the Counter Fraud Services (CFS), the appropriate director, the Appointed Auditor, and the Chief Internal Auditor where such an occurrence is suspected.

22.2.3 Where any officer of the Board has grounds to suspect that any fraud related activities has occurred, their line manager should be notified without delay. Line managers should in turn immediately notify the Board's Director of Finance, who should ensure consultation with the CFS, normally via the Chief Internal Auditor. It is essential that preliminary enquiries are carried out in strict confidence and with as much speed as possible.

22.2.4 If, in exceptional circumstances, the Director of Finance and the Chief Internal Auditor are unavailable the line manager will report the circumstances to the Chief Executive who will be responsible for informing the CFS. As soon as possible thereafter the Director of Finance should be advised of the situation.

22.2.5 Where preliminary investigations suggest that prima facie grounds exist for believing that a criminal offence has been committed, the CFS will undertake the investigation, on behalf of, and in co-operation with, the Board. At all stages the

Director of Finance and the Chief Internal Auditor will be kept informed of developments on such cases. All referrals to the CFS must also be copied to the Appointed Auditor.

22.3 REMEDIAL ACTION

22.3.1 As with all categories of loss, once the circumstances of a case are known the Director of Finance will require to take immediate steps to ensure that so far as possible these do not recur. However, no such action will be taken if it would prove prejudicial to the effective prosecution of the case. It will be necessary to identify any defects in the control systems, which may have enabled the initial loss to occur, and to decide on any measures to prevent recurrence.

22.4 REPORTING TO THE SCOTTISH GOVERNMENT HEALTH AND SOCIAL CARE DIRECTORATE

22.4.1 While normally there is no requirement to report individual cases to the Scottish Government Health and Social Care Directorate, there may be occasions where the nature of scale of the alleged offence, or the position of the person or persons involved, could give rise to national or local controversy and publicity. Moreover, there may be cases where the alleged fraud appears to have been of a particularly ingenious nature or where it concerns an organisation with which other health sector bodies may also have dealings. In all such cases the Scottish Government Health and Social Care Directorate must be notified of the main circumstances of the case at the same time as an approach is made to the CFS.

22.5 RESPONSES TO PRESS ENQUIRIES

22.5.1 Where the publicity surrounding a particular case of alleged financial irregularity attracts enquiries from the press or other media, the Chief Executive should ensure that the relevant officials are fully aware of the importance of avoiding issuing any statements, which may be regarded as prejudicial to the outcome of criminal proceedings.

APPENDIX A: TENDERING AND CONTRACT PROCEDURES

1. TENDERING PROCESS

1.1 The Chief Executive shall prescribe standard terms and conditions of contract appropriate to each class of supplies and services and for the execution of all works. All contracts entered into shall incorporate the appropriate set of terms and conditions.

1.2 All invitations to potential contractors to tender shall include a notice, warning tenderers of the consequences of engaging in any corrupt practices involving Board employees.

1.3 In the event of tenders being required, notification should be sent to the Corporate Business Manager (Chief Executive's Office) providing details of the tender request sent out, specification, closing date and time and the number of anticipated submissions.

1.4 A record will be maintained of all invitations to tender.

1.5 Tenders shall be invited in plain sealed envelopes addressed to the Chief Executive. The envelope shall be marked 'Tender for ……' but shall not bear the name or identity of the sender.

1.6 Unopened tenders shall be date stamped and stored unopened in a secure place until after the closing date or time.

1.7 Tenders shall be opened as soon as possible after the stated closing date or time by the officer nominated by the Chief Executive, in the presence of an independent witness, normally from the Finance Directorate.

1.8 Details of each tender received should be entered into a register or record of tenders and will be signed by both officers. Tender documents shall also be date stamped and signed on the front page and all priced pages initialled by both officers.

1.9 Where it is in the interests of the Board, late, amended, incomplete, qualified, or not strictly competitive tenders may be considered. In such circumstances a full report shall be made to the Chief Executive who may admit such tenders. This approval must be given in writing by the Chief Executive. Where a Company invited to tender requests a delay in the submission, deferment, if approved, shall be notified to all the Companies concerned. A record of all delays requested, and the outcome of the request shall be maintained.

1.10 The examination of the tenders received shall include a technical assessment, and a written report on the result, containing a recommendation should be made to the Chief Executive. At the same time, staff responsible for making this recommendation shall declare in writing that they have no pecuniary interest in the recommended Company.

1.11 The Chief Executive may accept the tender provided it is the lowest cost (or for disposals the highest sales price) and has been recommended for acceptance, and that on the advice of the Director of Finance, financial provision is available within the overall Board resource. If it is proposed to accept a tender other than the lowest cost,

the Chief Executive will record the reason for this decision. e.g., best overall lifetime cost.

1.12 All officers shall follow any relevant guidance issued by the Scottish Government Health and Social Care Directorate.

1.13 Payment under the contract shall be made by the Director of Finance who shall have the right to carry out such financial examinations and checks as considered necessary before making payment.

1.14 Approval for increases in prices allowed under an appropriate variation of prices clause in a contract for supplies and services shall be given by the Chief Executive.

1.15 No contract for the purchase of computer equipment or software outwith the eHealth Department shall be entered into without the Director of Finance's prior written approval.

1.16 Post-tender negotiation may be undertaken where it is anticipated that such action will reduce cost to the Board and where such negotiation has specially been approved in advance by the Chief Executive and Director of Finance. In such circumstances the negotiation must take place with not less than two employees of the Board present both of whom must be approved for the purpose by the Chief Executive. A record of the names of those present at the negotiation must be kept along with a record to the final prices and conditions agreed.

1.17 Where post-tender negotiation is undertaken with some but not all of the companies who submitted tenders a record of criteria for the selection must be kept by the managers concerned. Companies invited to post-tender negotiation must include those in the following categories:

(a) Companies who, following analysis of the original tender offers, are one of the cheapest three for each product item.

(b) The two companies “winning” the highest number total value of business following analysis of the original tender offers.

1.18 In addition to complying with the sections above officers involved in post-tender negotiation should familiarise themselves with the guidance produced by the Central Unit on Purchasing issued by HM Treasury.
(See: www.hm-treasury.gov.uk/pub/html/docs/cup/guidance.html)

1.19 For the period between opening of tenders and completion of the post-tender negotiation the tender documents shall be stored in a secure place when not actively under analysis.

1.20 Consultants appointed by the Board to be responsible for the supervision of a contract on its behalf shall comply with these Standing Financial Instructions as though they were officers of the Board.

1.21 In circumstances where the need for additional work is identified or a variation to an existing contract is required, the Head of Procurement should be consulted first to ensure that this does not represent a material change to the contract which would require a new procurement and tender process. All Variations must be approved by the Director of Finance or designated Deputy, or in their absence, the Chief Executive. Variations shall include not only contract cost but contract term.

1.22 A contract and framework agreement may be modified without a new procurement procedure:

(a) where the modifications, irrespective of their monetary value, have been provided for in the initial procurement documents in clear, precise and unequivocal review clauses, which may include price revision clauses or options, provided that such clauses:

I. state the scope and nature of possible modifications or options as well as the conditions under which they may be used; and

II. do not provide for modifications or options that would alter the overall nature of the contract or framework agreement.

(b) to provide for additional works, supplies or services by the original contractor that have become necessary and were not included in the initial procurement, where a change of contractor:

I. cannot be made for economic or technical reasons such as requirements of interchangeability or interoperability with existing equipment, services or installations procured under the initial procurement; and

II. would cause significant inconvenience or substantial duplication of costs for the contracting authority, provided that any increase in price does not exceed 50% of the initial contract value;

(c) where all of the following conditions are fulfilled:

I. the need for modification has been brought about by circumstances which a diligent contracting authority could not have foreseen;
II. the modification does not alter the overall nature of the contract or framework;

III. any increase in price does not exceed 50 % of the initial contract value or framework agreement.

Guidance within Section 72 of the Public Contracts Regulations 2015 should be followed.

SECTION G

Risk Management

1. Introduction

The Risk Management Strategy sets out the principles and approaches to risk management which are to be followed throughout NHS Forth Valley in relation to risks that could threaten the achievement of business objectives. Its aim is to achieve a consistent and effective application of risk management and enable it to be embedded into all core processes, forming part of the day-today management activity of the organisation. Risk Management, when deployed effectively, should add value by supporting day-to-day activities as opposed to being seen as a separate, self-contained process and this Strategy supports this approach.

1.1. What is a Risk?

A risk can be defined as 'the effect of uncertainty on objectives' (*ISO31000)*. It is essentially any uncertain event which can have an impact upon the achievement of an organisation's objectives – either reducing the likelihood of achievement or stopping it altogether.

Not every perceived problem or adverse event is a risk. An important distinction must be made between what is a risk and what is an issue – or in other words, an uncertainty and a certainty. A risk is an event that may or may not happen. An issue or adverse event is something that is currently happening or has already happened. Issues and adverse events should therefore not be recorded and treated as risks – we want to adopt a proactive rather than reactive stance.

1.2. What is Risk Management?

Risk management is a systematic way of dealing with that uncertainty which involves the identification, analysis, control and monitoring of risk. Risk Management activities are designed to achieve the best possible outcomes and reduce the uncertainty. An effective system of risk management will draw together all types of risks and enable an interrelated view of the organisation's risk profile.

1.3. Why do we need Risk Management?

An effective system of risk management will deliver a range of outputs:

- Ensuring that decision making is informed and risk-based, to maximise the likelihood of achieving key strategic objectives and effective prioritisation of resources
- Ensuring compliance with legislation, regulations, and other mandatory obligations
- Providing assurance to internal and external governance groups that risks are being effectively controlled
- Supporting organisational resilience
- Raising awareness of the need for everyone to adopt consistent risk management behaviours and actions in our everyday business
- Empowering all staff to make sound judgements and decisions concerning the management of risk and risk taking – fostering a "risk aware" rather than "risk averse" culture
- Achievement of effective and efficient processes throughout the organisation

- Anticipating and responding to changing political, environmental, social, technology and legislative requirements and / or opportunities
- Preventing injury and / or harm, damage and losses.

Effective risk management will be achieved by:

- Clearly defining roles, responsibilities and governance arrangements for individuals, teams and assurance committees within NHS Forth Valley
- Incorporating risk management in all Executive Leadership Team, Health Board, Integration
  Joint Board and Assurance Committee reports and when taking decisions
- Maintaining risk registers at all levels that are linked to the organisation's strategic objectives, primarily using risk management software to capture key risk data
- Staff at all levels understanding risk management principles, and consistently applying them through their everyday activities, confidently identifying risks and taking actions to bring them within the organisation's risk appetite
- Monitoring and reviewing risk management arrangements on a regular basis
- Seeking assurance that controls relied on to mitigate risks are effective
- Communication and engagement with stakeholders to maintain awareness, build trust, encourage buy-in and embedding of risk management activities.

2. Risk Architecture

The arrangements for communication, governance, reporting, roles and responsibilities forms the organisation's overarching risk architecture. Defining a consistent approach to how and where risk information is communicated is essential to developing a positive risk culture and to ensuring risk management is appropriately implemented to support NHS Forth Valley activities.
Risks, once identified, are captured on risk registers. Each Department and Specialty will hold a risk register for its area – these form the bottom level of risk registers. There are four main levels of risk register and an escalation route exists for risks that cannot be fully mitigated at the Department / Speciality level. This risk register hierarchy is detailed below.

Risk Register Hierarchy

Strategic Risk Register

Risks contained in the Strategic Risk Register (previously known as the Corporate Risk Register) are the high-level risks that could impact the delivery of longer-term strategic objectives of the organisation. Risks are not escalated/de-escalated from lower-level risk registers to the Strategic Risk Register. Instead, risk identification for the Strategic Risk Register is facilitated through twice yearly review and horizon scanning sessions led by the Executive Leadership Team.

Organisational/System-wide Risk Register

Risks contained in the Organisational/System-wide Risk Register are top level, cross cutting risks that present a significant short-medium term threat to multiple Directorates or the Health and Social Care Partnerships (HSCPs). Risks are escalated and de-escalated via the Directorate and HSCP Risk Register(s).

Directorate Risk Registers

Each Directorate holds a risk register that contains a cut of the most significant risks from its component Departments / Specialties. Risks are escalated to the Directorate level via the individual Department / Specialty risk registers.

Department Risk Registers

Each Department and Specialty will hold a risk register for its area – these form the bottom level of risk registers.

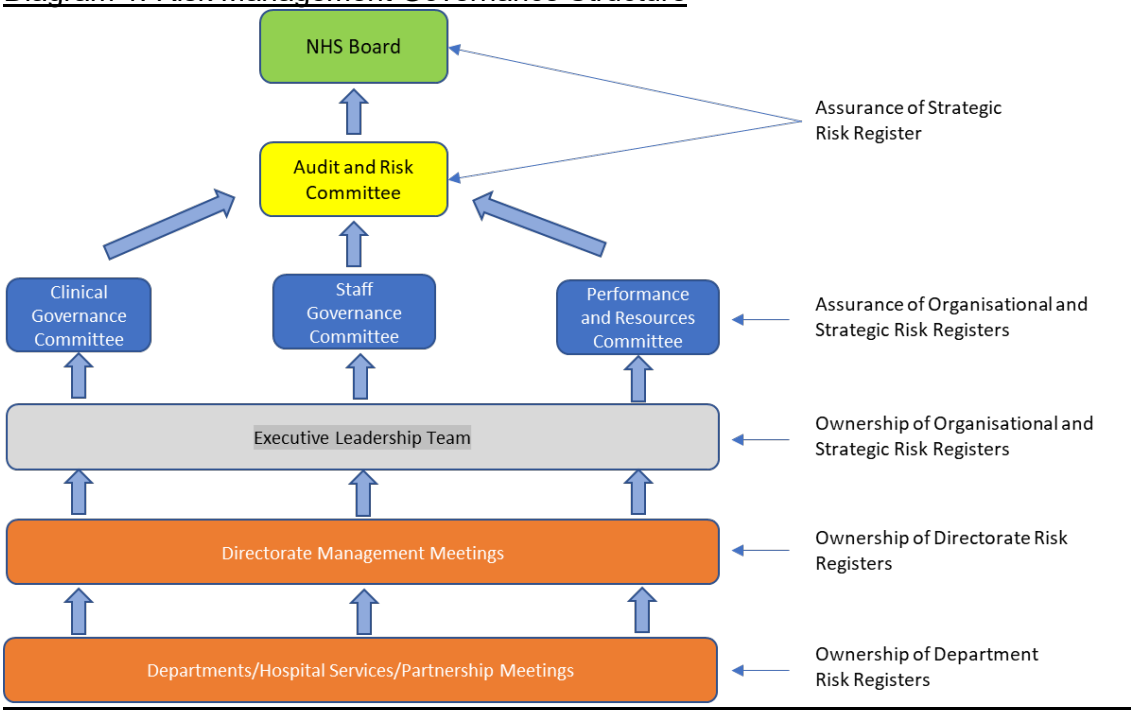
2.1. Governance & Reporting

The Board of NHS Forth Valley is corporately responsible for the Risk Management Strategy and for ensuring that significant risks are adequately controlled. To support

the Board a number of formal committees have been established and are responsible for various aspects of risk management, principally these are the Audit and Risk, Performance & Resources, Clinical Governance and Staff Governance Committees. All Health Board Committees are responsible for providing assurance on the effective management of risks relevant to their area of responsibility. In addition, the Audit and Risk Committee has a responsibility for overseeing the operation of the Risk Management Strategy, taking assurance from the Executive Leadership Team.

Diagram 1 illustrates NHS Forth Valley's risk management governance structure.

Diagram 1: Risk Management Governance Structure



2.2. Roles & Responsibilities

Risk Management Roles & Responsibilities
NHS Board

- Provide Oversight and Scrutiny of NHS Forth Valley's risk management arrangements to seek assurance on their effectiveness

- Approve risk appetite within NHS Forth Valley

Chief Executive

- To have overall accountability for the management of risk across NHS Forth Valley

Executive Leadership Team

- Set risk appetite within NHS Forth Valley
- Ensure risk management processes are supported to provide them with adequate information and assurance related to strategic and organisational/system-wide risks

Audit and Risk Committee

- To evaluate and recommend approval of the strategies and frameworks in respect of risk management to the NHS Board, and provide assurance on the effectiveness of the risk management arrangements, systems and processes
- To approve updates and provide direction in respect of risks held within the strategic and organisational/system-wide risk registers
- To review the organisation's risk culture and maturity and direct action in pursuit of continuous improvement in this area
- To formally approve the strategic risk register for onward reporting to the NHS Board

Assurance Committees

- To ensure that an appropriate approach is in place to deal with risk management across the system working within the NHS Forth Valley Risk Management Strategy, and consider and endorse the assurance provided by the Executive Leadership Team and Senior Management regarding the effective management and escalation of risks

Executive and Non Executive Directors

- To ensure that risk management processes are providing appropriate information and assurances relating to risks in Directorates
- Promote the importance of risk management and foster a good risk culture within their area of responsibility
- Approve escalation of Directorate level risks where appropriate

Corporate Risk Manager

- Responsible for the implementation of the Risk Management Strategy
- Ensure risks are properly identified, understood and managed across all levels within the organisation
- Report on the organisation's risk profile at Assurance and Audit Committees and NHS Board, and oversee reporting to Directorates
- Periodically review the Risk Management Strategy and arrangements, identifying areas for potential improvement
- Drive an improving risk culture through risk education, awareness and embedding into day-today management

- Assist the Corporate Risk Manager with the development and implementation of the Risk Management Strategy
- Act as a key point of contact for Risk Management, providing expert advice and guidance and supporting the Directorates and Partnerships
- Assist the Corporate Risk Manager with reporting on the organisation's risk profile, providing Risk Management representation at various levels
- Support an improving risk culture through delivery of training, awareness and supporting

Directorates and Partnerships to embed risk considerations into day-to-day management

Risk Owner

- Accountable for ensuring the effective management of a risk, and providing assurance that key controls are operating effectively
- While the Chief Executive owns all risks, ownership and therefore accountability is delegated to an appropriate level
- At Strategic and Organisational/system-wide Level, the risk owner is the relevant Director/Chief Officer
- At Directorate and Departmental Level the risk owner is the relevant Head of Service/Department or equivalent

Risk Lead

- Responsible for managing a risk on a day-to-day basis, assessing the risk score and updating the management plan, reviewing the risk on a regular basis and identifying sources and levels of assurance regarding control effectiveness, to allow risk owners to provide assurance

Risk Champion

- Responsible within an individual speciality, department or Directorate area for maintaining lines of communication with the risk function, administering the risk register and co-ordinating all risk activities

Integrated Risk Management: Health & Social Care Partnerships

In order to ensure strong risk management partnership arrangements, it will be necessary to agree how some emerging risks have an impact on more than one partner at a strategic level. Risks will be discussed and agreed across partners, with particular focus on:

- Where the risk was first identified
- Date of identification
- Nature of emerging risk
- Impact areas (e.g. service delivery, performance, strategic commissioning intentions etc)
- Mitigation required
-

Risks with the potential to impact more than one partner will be identified for inclusion in one or more of the following risk registers:

- NHS Forth Valley Strategic Risk Register or Organisational/System-wide Risk Register
- Clackmannanshire and Stirling IJB Strategic Risk Register
- Falkirk IJB Strategic Risk Register
-

Any such emerging risks will be submitted to the NHS Forth Valley Executive Leadership Team to approve inclusion on the Strategic Risk Register.

Operational risks will continue to be managed by partner bodies, with relevant risk specialists working together to ensure consistent practice, and that respective Risk Management strategies are aligned. The IJBs will also have a defined risk appetite to determine the target score range for strategic risks. It is recognised that partners may not have the same appetite, however these variances will be taken into consideration when the risks are being managed and reported.

Reciprocal assurances on the operation of the Risk Management arrangements and of the adequacy and effectiveness of key controls will be provided to/from partners. Receipt/provision of assurance will be facilitated by risk specialists from partner bodies, who will attend regular meetings to discuss risks and provide relevant advice.

3. Risk Appetite

Utilising risk appetite principles can help the organisation identify and set appropriate thresholds for risks, whereby the Board establishes the level of risk they are willing and able to absorb in pursuit of objectives.
The delivery of public services can be inherently high risk and the concept of applying risk appetite can be challenging. However, the application of risk appetite, particularly in a resource-finite environment, is essential to avoid over or under management of risk. Deployed effectively, risk appetite can act as an enabler to the delivery of key services.

Risk Appetite:
The amount and type of risk we, as an organisation, are willing to seek or accept in the pursuit of our objectives.

Key considerations when applying risk appetite:

- It is not always possible to manage every risk down the minimum or most desirable level and maintain service delivery
- It is not always financially affordable or manageable to fully remove risk and uncertainty from decision making and service delivery
- Risk management is concerned with balancing risk and opportunity (or downside risk and upside risk)

When a risk increases to a point where it is no longer within risk appetite, it may initially fall within a range which is not desirable, but the organisation has the capacity to tolerate. This is known as the risk tolerance range.

Risk Tolerance:
The maximum level of risk the organisation can tolerate regarding each type of risk before it is significantly impacted.

If a risk is out of appetite and falls within the tolerance range, this indicates that close monitoring and corrective action is required to bring the risk back within appetite. A risk with a current score out with the tolerance range requires escalation and immediate corrective action.

There are benefits to the practical application of Risk Appetite:

- supports decision making (resources can be allocated to risks further away from the desired appetite level)
- allows further prioritisation (if you have several risks with the same score, mitigate those further from appetite first)
- subjectivity is taken away from the setting of target scores (the appetite range becomes the target score)

Risk appetite is also useful when budget setting or considering approval of business cases, such as those relating to innovation activity. Identifying associated risks and their appetite levels allows focus on activities which mitigate the risks furthest from the organisation's desired risk appetite/tolerance levels.

3.1. Risk Appetite Levels

There are four levels of risk appetite within NHS Forth Valley. Each risk category in the risk assessment matrix is assigned one of the risk appetite levels described below. The risk appetite levels and their application to each risk category is set and approved by the NHS Board. Risk appetite may vary depending on internal and external circumstances; therefore the levels will be reviewed on an annual basis.

Averse:
- Very little appetite for this type of risk
- Avoidance of risk and uncertainty is a key organisational objective
- Exceptional circumstances are required for any acceptance of risk

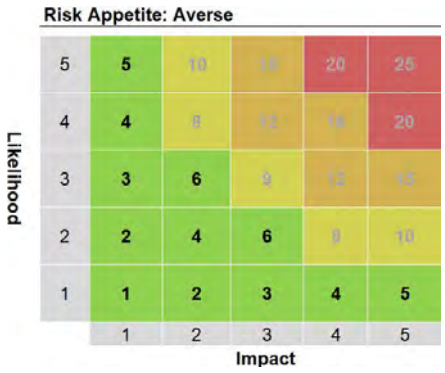
Cautious:
- Minimal appetite for this type of risk.
- Preference for ultra-safe delivery options that have a low degree of inherent risk and only reward limited potential.

Moderate:
- Acceptance that a level of risk will be required to pursue objectives, or that a greater level of risk must be tolerated in this area.
- Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward.

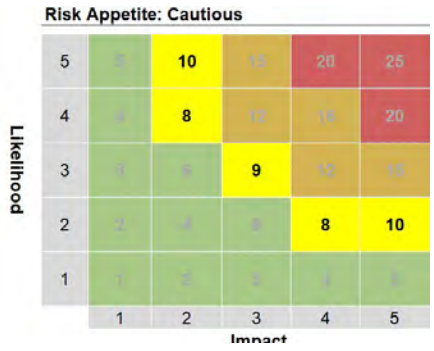
Open:
- Acceptance that risk must be more actively taken in the pursuit of transformation or that a high level of risk must be tolerated.

- Willing to consider all potential delivery options and choose the one most likely to result in successful delivery while also providing an acceptable level of reward (and Value for Money).
- Eager to be innovative and confident in setting high level of risk appetite as controls are robust.

Each risk appetite level correlates with risk score levels on our risk assessment matrix as shown below. Refer to the NHS Forth Valley Risk Appetite Statements (Appendix E) for details on risk appetite levels for each risk category.

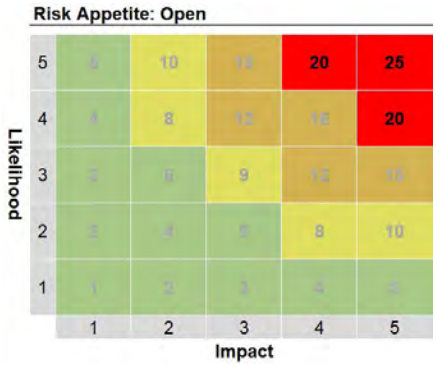


Demonstrates that if the risk appetite is 'Averse', a risk score of between 1-6 and the range of associated outcomes is within appetite



Demonstrates that if the risk appetite is 'Cautious', a risk score of between 8-10 and the range of associated outcomes is within appetite

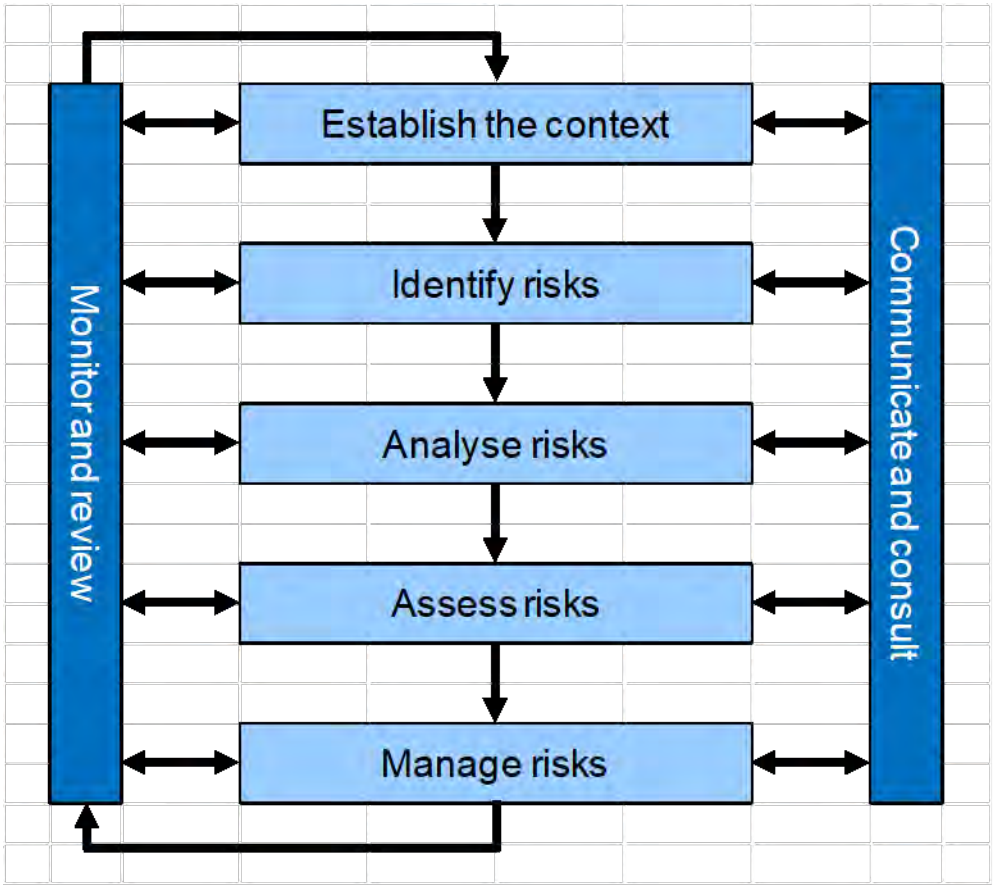
Demonstrates that if the risk appetite is 'Moderate', a risk score of between 12-16 and the range of associated outcomes is within appetite



Demonstrates that if the risk appetite is 'Open', a risk score of between 20-25 and the range of associated outcomes is within appetite

4. Approach to Risk Management

4.1. Risk Management Process – ISO31000



The above diagram demonstrates the whole process and cycle of risk management under the international standard ISO 31000.

The standard as outlined above makes clear that risk management is a dynamic process, with frequent review of existing risks and monitoring of the environment necessary to ensure the risks captured represent the current profile of the organisation.

Continual communication of risks within the organisation is essential to allow for informed decisionmaking. Communication to the Health Board and other stakeholders is also imperative to allow effective scrutiny and provide assurance that our risk profile is being effectively managed. It is also imperative to consult with and receive information from other departments within the organisation and our stakeholders to inform the management of our risks.

4.2. Step 1: Establish Context

The purpose of establishing context is to customise the risk management process, enabling effective risk analysis and appropriate risk treatment. In order to identify risks, we need to understand what we are assessing risk *against.* We must set risks within the context of the team, specialty, department and overall organisation. In addition, we need to recognise the internal and external drivers that could create risk.

Risks should be set against what we are trying to achieve as an organisation – our strategic objectives. In this stage it is important to ensure there is a common understanding of what those objectives mean at a team, specialty, department and organisational level in order that risk identification is not based on an inconsistent set of assumptions.

4.3. Step 2: Identify Risks

Once a clear, common set of objectives are agreed, the next step of the process is to identify potential risks that will prevent us from achieving them.

A range of techniques can be used for risk identification. Some prompts to consider:

- What might impact on your ability to deliver your objectives?
- What does our performance data tell you?
- What do our audit and scrutiny reports and external reviews tell us?
- Do you have experience in this area? Do you know or do you need to involve others?
- Should you involve partners or specialists in your risk identification?
- Lessons learned – what happened before?

Risk can be identified in a multitude of ways, through focused identification sessions or as a product of other work:

Focused Identification Methods	Other Identification Opportunities

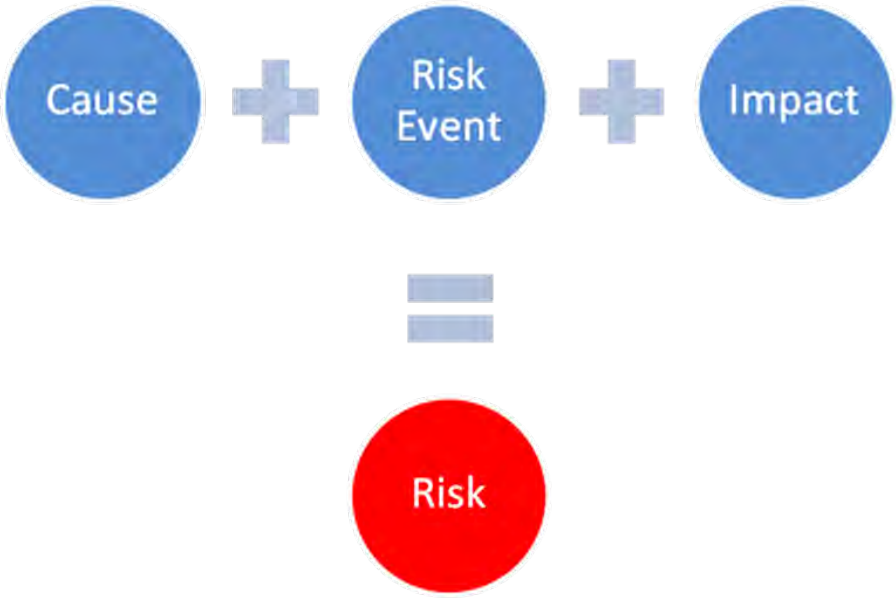
• Risk Identification Workshops • Risk Questionnaires • Review & refresh of existing risk registers • Interviews	• Horizon scanning • Board meetings / working groups / management meetings • Audit & scrutiny reports • Performance data • Risk Management training

The Risk Management function facilitates risk identification workshops with Departments to direct an in-depth review of new or emerging risks.

It is important to note that just because a risk cannot be fully mitigated by the organisation alone does not mean that it should not be captured. If the risk exists to the organisation, then it should be captured, managed as far as practicable and then monitored. Ongoing management of the risk may well be in conjunction with partner agencies or influence can be exerted over those capable of mitigating the risk to within an acceptable level.

4.4. Step 3: Analyse Risks

Once a risk has been identified it must be described in a certain way in order to effectively understand, manage and mitigate it. The risk description should contain three essential components:



These three components can be included within the description as follows:

"If [insert cause here], there is a risk that

[a certain event that may happen], resulting in

[describe impact this will have if it manifests]"

An example of an effective risk description might be:

If there is insufficient in external funding and continued uncertainty over our cost base there is a risk that NHS FV will be unable to achieve financial sustainability, resulting in Scottish Government intervention and a detrimental impact on service delivery.

Without understanding the underlying causes of the risk and all the potential impacts, it would be very difficult to design and implement effective controls.

4.5. Step 4: Assess Risks

The assessment, or scoring, of risk allows for prioritisation by severity. Determining the likelihood and impact of a risk and utilising a standardised assessment criteria to assign a score based on these factors allows us to understand and prioritise which risks to mitigate first. Three scores must be assigned to cover the full trajectory and lifespan of the risk:

Untreated Score

This is the inherent risk score, that is the score with no controls applied. This score represents the "reasonable worst case scenario" for the risk. If there were no controls, mitigation or contingency plans in place, how likely is it the risk would materialise and what would the impact be?

Current Score

Considering any controls that are currently in place to manage the risk, how does the risk score compare to the untreated score? This is the current score. Current risk score is assessed on a regular basis to establish the effectiveness of the controls applied to the risk. It is also the current score that is the key indicator used to determine if the risk should be considered for escalation.

Target Score

The target risk score is the optimum position for the risk. Once all controls have been adequately implemented, what will the residual risk score be? Target risk scores should reflect the organisation's risk appetite and align with the amount and type of risk NHS Forth Valley is willing to accept (refer to section 3 on Risk Appetite). Risk controls should be designed to actively reduce the risk score towards the target level.

Risk Assessment Matrix

The risk assessment matrix is a 5x5 scoring mechanism which will identify a score between 1 (1x1) at the lowest and 25 (5x5) at the highest possible score.

When utilising the impact criteria on the assessment matrix, a score must be applied for every category of impact applicable to that risk. For example, one risk may have a financial impact, an impact to patient experience and public confidence implications. The impact category with the highest scoring criteria will identify the overall impact score for that risk.

Assessment of likelihood is considered on a sliding scale from 1 to 5, with 1 representing 'very unlikely' and 5 'very likely.'

Once both scores have been identified, they are multiplied giving the overall score at *untreated, current* and *target* levels.

A full copy of the Risk Assessment matrix is included at Appendix B.

Categorisation

All risks, once identified, must be categorised into one of the recognised impact categories in order to understand the overall risk profile for the organisation. Categorisation of a risk is based upon the impact score, with the impact category which has the highest scoring criteria for that particular risk determining the risk category.

For example, a risk scoring a 3 for impact in Patient Experience but scoring a 5 in Finance will categorise that risk as Finance overall. Risk categories are outlined in the risk assessment matrix:

- Patient Harm
- Patient Experience
- Transformation/Innovation
- Health and Safety
- Service Delivery / Business interruption
- Workforce
- Financial
- Inspection / audit
- Public Confidence
- Health Inequalities
- Environmental Sustainability / Climate Change

Where more than one category has the same impact score, select the category which has the lower risk appetite level. For example, if Patient Experience and Finance both score 5, but Patient Experience has an averse appetite but Finance has a cautious appetite, select Patient Experience. If both categories have the same risk appetite level, use professional judgement (see Appendix D for current levels).

4.6. Risk Escalation/De-escalation

Risk escalation is a process that ensures significant risks that cannot be managed by a local team, department or specialty are escalated appropriately following the risk register hierarchy and line management arrangements. Risks are escalated in accordance with the agreed risk appetite and tolerance for that category of risk.

If a current risk score is above the agreed risk appetite for that risk category and falls into the tolerance range, the departmental/service management or equivalent should closely monitor the risk and undertake corrective action by amending existing controls or applying new controls. If the risk remains in tolerance after 6 months, the risk should be escalated to Directorate level for oversight and direction of mitigating action.

If a current score exceeds both appetite *and* tolerance, it should be escalated to Directorate level straight away for enhanced oversight and direction of action.

The risk appetite and tolerance levels (escalation criteria) are set out in Appendix D.

At Directorate level, consideration can be given as to whether further escalation to the Organisational/System-wide Risk Register is required, meaning additional scrutiny and direction of action by the Executive Leadership team as a collective, and reporting to the standing assurance committees.
The following questions should be asked when deciding whether to further escalate a risk to the Organisational/system-wide risk register:

- Does the risk have a widespread impact beyond a local area, e.g. does it affect multiple Departments, Directorates or HSCPs, or does it have dependencies on multiple Departments, Directorates or HSCPs to mitigate?
- Does the risk present a significant cost/decision making beyond the scope of the budget holder, or require change driven at an organisational/system-wide level?

Risks can be de-escalated to the appropriate level (Directorate or Departmental) once back within risk appetite.

4.7. Step 5: Manage Risks

The purpose of this step is to select and implement the appropriate action to respond to the risk. There are four broad ways we can respond to risk, known as the 4 Ts:

- Tolerate: this is the decision to accept the risk at its current level (usually after treatment). The ability to do anything may be limited, or the cost of taking action may be disproportionate to the benefit gained. Generally, it is risks that are within appetite that are tolerated.
- Treat: this is the decision to retain the activity or process creating the risk and to take action to implement risk controls that reduce either the likelihood of the risk occurring or minimising the impact. Risks which are out of appetite or tolerance will have to be treated.
- Transfer: this is the decision to transfer the impact of the risk either in full, or in part, to a third party. The most common form of risk transfer is insurance.
- Terminate: this is the decision to stop doing the activity associated with the risk. This may not always be possible and may create risks elsewhere as a result.

Risk Controls

Risk controls are management measures put in place to effectively manage a risk to within acceptable levels (i.e. to target score range). It is essential that the controls put in place to manage a risk are effective. The identification of effective controls is the most important part of the whole risk management process as without this element we would simply be identifying risks and doing nothing to manage them.

To assess whether the controls we identify are or will be effective, it is important to consider the following:

- What do you already have in place to manage the cause and / or impact of the risk? e.g. policies, procedures, projects, training courses, business continuity plans etc
- Do they work and what evidence do you have of the effectiveness? A policy which is in place but never complied with is not an effective one.
- Are there any gaps in your controls?

- Do you have all the information that you need about this risk or do you need to find out more?
- What more should you do?
- If several activities are required to manage the risk, how will you prioritise these?
- Are these controls within the remit of your department? If not, you will need to liaise with stakeholders to ensure that appropriate controls are put in place.
- If you implement the controls you have identified, will this manage the risk to within acceptable levels for that risk category? If the answer is no, further controls are required.

There are two main types of control measure that can be put in place to manage a risk:

- *Preventative Controls:* These are mitigating actions which will work to control the cause of the risk and prevent it happening in the first place.
- *Contingency Controls:* These are actions that can be put in place to reduce the impact of the risk if it does materialise. Contingency controls are often aligned to the business continuity plans of an organisation.

As an example, consider fire safety measures. Segregation of flammable materials and sources of ignition is a control which prevents the risk of fire. Smoke detectors, sprinkler systems and fire evacuation plans are contingency controls should the risk of fire materialise.

If a risk has been effectively analysed (see section 4.4), it will be much easier to identify appropriate preventative and/or contingency controls.

4.8. Monitor and Review

Risk Review

Once the process of identifying, analysing and assessing a risk are complete, it is imperative that it is subject to regular review. Ongoing management and review of a risk is the most important part of the process, as maintaining or reducing the risk score to within an acceptable range assures the overall management of the organisation's risk profile.

Required risk review timescales are outlined below:

Out of Tolerance	Monthly
In Tolerance	Every 2 months
In Appetite	Every 6 months

These are the minimum review timescales – if there are changes in the operating environment which could affect the severity of a risk, it can be reviewed and reported more frequently.

During a risk review, the risk score must be re-assessed. If it is identified that the risk continues to exist, the list of current controls and further controls required must be checked and added to where necessary. On the basis of progress with controls and

an assessment of the risk environment (i.e. are there any significant changes to the internal/external context), a re-assessment of the current score must be made using the risk assessment matrix. This will show whether the risk is decreasing, increasing or remaining static, and whether or not the risk requires escalation. Depending on its escalation level, a change to risk score will be reported at the appropriate assurance committee.

Review of the Risk Management Process

In addition to review of the risks themselves, the Risk Management team also reviews the whole system of risk management – are the right risks being escalated at the right time? Are the tools we provide sufficient to allow staff to effectively identify, analyse, assess and manage their risks? This enables learning and improvement and ensures that risk management adds value to the organisation's activities.

Assurance

A fundamental component of any risk management framework is the expert and objective assessment of risk controls to ensure they are well designed and operate effectively. Implementing a process to critically review risk controls provides the Board with assurance on the effective management of key strategic risks. To facilitate the provision of assurance, NHS Forth Valley utilises the "three lines of defence" model.

Operating as the first line, operational management has ownership, responsibility and accountability for directly assessing, controlling and mitigating risks, understanding what the key controls are, and how effectively and consistently those controls are operating, in order to provide assurance to the Board. The second line is provided by governance/compliance functions such as Risk Management, who will assist the first line in developing an approach to fulfilling their assurance responsibilities. Internal Audit forms the third line, (providing independent assurance, and checking that the risk management process and framework are effective and efficient).

The levels of assurance and associated system and control descriptors are shown below:

Overall Risk Assurance Assessment		
Level of Assurance	**System Adequacy**	**Controls**
Substantial Assurance	Robust framework of key controls ensure objectives are likely to be achieved.	Controls are applied continuously or with only minor lapses
Reasonable Assurance	Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance

Limited Assurance	Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.	Controls are applied but with some significant lapses
No Assurance	High risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls

Assurance should be provided to the relevant committees for their consideration on an ongoing basis. Any papers submitted as a source of assurance for the committee should explicitly reference the related strategic risk and should provide a conclusion as to whether performance indicates that controls are operating effectively and as intended. At the start of the year, assurance mapping principles will be used to determine the assurance requirements, and this will be set out in the committee assurance workplan. Assurance provision over the course of the financial year will be tracked and managed utilising the Pentana system.

Risks on the strategic risk register are subject to a rolling programme of 'deep dives' considered by the relevant assurance committee. Deep dive reviews are facilitated by the Risk Owner/Lead and Corporate Risk Manager and provide expert, objective assessment of the following key areas:

- Comparison of current risk score and target risk score
- Requirements to achieve the target risk score – success criteria for managing the risk
- Assessing the importance and effectiveness of implemented controls
- Assessing the proportionality of further controls required – i.e. will they help to achieve target score?
- Reviewing the assurance activity aligned to the risk controls in order to establish an overall assurance statement for the risk
-

Refer to Appendix C for guidance on risk controls assurance.

4.9. Communicate and Consult

Communication at all levels is important to allow for informed decision making, and provision of assurance that our risk profile is effectively managed – this is achieved through risk reporting.

Risk Reporting

A quarterly risk management report is presented to the Health Board which reports on our strategic risks. In addition, Assurance Committees are provided with a regular risk management report on strategic and organisational/system-wide risks assigned to their area of scrutiny.
The Executive Leadership Team acts as the Risk Management Steering Group and provides recommendations to the Board on the status of strategic level risks. Directorates and Departments are expected to carry out regular review, monitoring and

reporting on their risk registers (supported by the risk management function) to ensure that risks are identified and escalated to the appropriate level at an early stage.

The risk management reporting in place includes a range of risk management KPIs and trend analysis that enhances oversight and assurance for the Health Board. An annual report on risk management is also produced for the Health Board.

The Health and Social Care Integration Schemes for both Falkirk Integration Joint Board (IJB) and Clackmannanshire and Stirling IJB, detail the requirements and responsibilities regarding Risk Management for the IJBs and constituent parties. The IJBs will establish a Risk Management Strategy including a risk monitoring framework. Risks to delegated services which are identified will require to be communicated across partner organisations with clear responsibilities, ownership and timescales, and with mechanisms to ensure that assurance can be provided to the relevant Boards. Risk specialists from all parties will work together to ensure that Risk Management strategies are aligned to facilitate effective escalation of risks and provision of assurance.

5. Training, Learning and Development

A key part of developing a positive risk management culture in support of improving the overall risk maturity is the delivery of risk management training.

There are two levels of training available to staff within NHS Forth Valley and the two Health and
Social Care Partnerships. The first level is an online module hosted on TURAS, “Introduction to Corporate Risk Management”, and is aimed at all staff within the organisation/partnerships.

The second level is the “NHS Forth Valley Corporate Risk Management Training”, aimed at staff who have specific responsibilities involving the management of risk within their service areas, for example Risk Champions and Risk Leads. The course enhances knowledge and understanding of corporate risk management methodology and processes used within the NHS Forth Valley and the partnerships.

Eligibility for Level 2 training can be confirmed by contacting the mailbox at fv.corporateriskmanagement@nhs.scot

6. APPENDIX A: GLOSSARY

Assurance. Stakeholder confidence in our service gained from evidence showing that risk is well managed, achieved by risk owners and leads confirming that significant risks are being adequately managed, that critical controls have been identified, implemented and are effective.

Contingency. An action or arrangement that can be implemented to minimise impact and ensure continuity of service when things go wrong.

Current Risk Score: The risk score identified taking into account any controls that are currently in place to manage the risk.

Governance. The system by which organisations are directed and controlled to achieve objectives and meet the necessary standards of accountability, probity and openness in all areas of governance.

Internal Control. Corporate governance arrangements designed to manage the risk of failure to meet objectives.

Issue: Something that has happened and is currently affecting the organisation in some way and needs to be actively dealt with and resolved.

Likelihood. Used as a general description of probability or frequency which can be expressed quantitatively or qualitatively.

Risk: An uncertain event, or set of events, which, should it occur, will have an effect on the organisation's ability to achieve its objectives.

Risk Appetite. The level of risk that an organisation is prepared to accept in pursuit of its objectives.

Risk Architecture: All of the Risk Management arrangements within an organisation – sets out lines of communication and reporting, delegation and roles / responsibilities.

Risk Assessment. The scoring of a risk to allow prioritisation. Determining the likelihood and impact of a risk.

Risk Champion: The person / role with responsibility within an individual department or business area for maintaining lines of communication with the Risk Management team, administering the risk register and co-ordinating all risk activities.

Risk Control: Management measures put in place to effectively manage a risk to within an acceptable level. Can be preventative or contingency in nature and will reduce the likelihood or impact of consequence.

Risk Culture: The reflection of the overall attitude of every part of management of an organisation towards risk.

Risk Target Score: An acceptable level of risk based on the category of risk and risk appetite.

Risk Escalation. The process of delegating upward, ultimately to the Board, responsibility for the management of a risk deemed to be impossible or impractical to manage locally.

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Risk Lead: The person / role responsible for managing a risk on a day-to-day basis, assessing the risk score and updating the management plan, reviewing the risk on a regular basis.

Risk Management: The integrated approach (culture, processes, structures) to the identification, analysis, control and monitoring of risk.

Risk Management Policy: Statement outlining the objectives of the risk management practices within the organisation.

Risk Management Strategy**:** Sets out the basis for the principles, processes and approaches to risk management to be followed in order to achieve a consistent and effective application of risk management and allow it to be embedded into all core processes.

Risk Matrix: A scoring mechanism used to identify the severity of a risk, using a multiplication of likelihood and impact, across pre-set categories.

Risk Maturity: The level of risk management capability within an organisation.

Risk Owner: The person / role with accountability for ensuring the effective management of a risk

Risk Register: A tool used to capture and monitor risks. Includes all information required about that particular risk and is intended to be used both as a management tool and conduit for risk reporting.

Risk Tolerance. The maximum level of risk the organisation can tolerate regarding each type of risk before the organisation is significantly impacted.

Threat: A negative scenario which could give rise to risks.

Untreated Risk Score: The risk score identified by assessing the risk with no controls, mitigation or contingency plans in place.

7. APPENDIX B: RISK ASSESSMENT MATRIX

Impact – What could happen if the risk occurred?

Assess for each category and use the highest score identified.

Category	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Patient Harm *(through delivery or omission of care, risk results in unintended/unexpected but avoidable physical or psychological harm to a patient)*	Adverse event Negligible effect on patient	Minor episode of harm not requiring intervention	Harm which requires intervention but doesn't trigger organisational Duty of Candour response	Harm, such as sensory, motor, or intellectual impairment which has lasted or is likely to last at least 28 days OR Pain or psychological harm which lasts, or is likely to last, at least 28 days And triggers organisational Duty of Candour	Severe harm such as death or permanent disability, either physical or psychological (e.g., removal of wrong limb/organ or brain damage) And triggers organisational Duty of Candour

Patient Experience *(risk could impact on how a patient, their family or carer feels during the process of receiving care)*	Reduced quality patient experience Locally resolved verbal complaint or observations	Unsatisfactory patient experience directly related to care provision – readily resolvable Justified written complaint peripheral to clinical care	Unsatisfactory patient experience/clinical outcome with potential for short term effects Justified written complaint involving lack of appropriate care Themes emerging – readily or locally resolvable	Unsatisfactory patient experience /clinical outcome with potential for long-term effects Multiple justified complaints Serious problem themes emerging, informed from more than one source	Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects Complex Justified complaints Confirmed serious problem themes from more than one source Involvement of Scottish Public Services Ombudsman
Transformation/Innovation *(risk could impact on ability to successfully adapt and transform)*	Barely noticeable reduction in scope/quality/ schedule Negligible impact on achievement of intended benefits	Minor reduction in scope/quality/ schedule Minor impact on achievement of intended benefits	Reduction in scope/quality/project/programme objectives or schedule Some intended benefits will not be achieved	Significant project/programme over-run Significant proportion of intended benefits will not be achieved	Failure to deliver project/programme Failure to achieve sustainable transformation
Health and Safety *(risk could impact on staff/public, or a patient out with delivery of care)*	Adverse event leading to minor injury not requiring first aid No staff absence	Minor injury or illness, first aid treatment required Up to 3 days staff absence	Agency reportable, e.g., Police (violent and aggressive acts) Significant injury requiring medical treatment and/or counselling RIDDOR over 7- day absence due to injury/dangerous	Major injuries/long term incapacity /disability (e.g., loss of limb), requiring, medical treatment and/or counselling RIDDOR over 7- day absence due to major injury/dangerous occurrences.	Incident leading to death(s) or major permanent incapacity RIDDOR Reportable/FAI

			occurrences		

Service Delivery/ Business Interruption *(risk could impact on ability to efficiently and effectively deliver services)*	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service with minor impact on patient care/ quality of service provision	Some disruption in service with unacceptable impact on patient care Resources stretched Prolonged pressure on service provision	Sustained loss of service which has serious impact on delivery of patient care Contingency Plans invoked Temporary service closure	Permanent loss of core service/ facility Major Contingency Plans invoked Disruption to facility leading to significant "knock on" effect Inability to function as an organisation
Workforce *(risk could impact on staff wellbeing, staffing levels and competency)*	Negligible impact on staff wellbeing Temporary reduction in staffing levels/skills mix Individual training/competency issues	Minor impact on wellbeing, requires peer support Short-term reduction in staffing levels/skills mix (<6 months) Small number of staff unable to carry out training or maintain competency levels Increased usage of supplementary staff	Moderate impact on staff wellbeing, requires line manager support Medium-term reduction in staffing levels/skills mix (>6 months) Moderate number of staff unable to carry out training or maintain competency levels Reliance on supplementary staff in some areas	Serious impact on staff wellbeing, requires referral to support services Long-term reduction in staffing levels/skills mix (>9 months) Significant number of staff unable to carry out training or maintain competency levels Reliance on supplementary staff in multiple areas	Critical impact on staff wellbeing, co-ordinated response and referral to support services Loss of key/high volumes of staff Critical training and competency issues throughout the organisation Unsustainable reliance on supplementary staff across organisation.

Financial *(risk could impact through unplanned cost/reduced income/loss/non-achievement of intended benefit of investment)*	Some adverse financial impact but not sufficient to affect the ability of the service /department to operate within its annual budget	Adverse financial impact affecting the ability of **one or more** services/ departments to operate within their annual budget	Significant adverse financial impact affecting the ability of **one or more** directorates to operate within their annual budget	Significant adverse financial impact affecting the ability of the organisation to achieve its annual financial control total	Significant aggregated financial impact affecting the long-term financial sustainability of the organisation
Inspection/Audit *(risk could impact on outcome during/after inspection by internal/external scrutiny bodies)*	Small number of recommendations which focus on minor quality improvement issues	Recommendations made which can be addressed by low level of management action	Challenging recommendations that can be addressed with appropriate action plan	Mandatory improvement required. Low rating. Critical report. High level action plan is necessary	Threat of prosecution. Very low rating. Severely critical report. Board level action plan required
Public Confidence *(risk could impact on public/stakeholder trust and confidence, and affect organisation's reputation)*	Some discussion but no impact on public confidence No formal complaints or concerns	Some concerns from individuals, local community groups and media – shortterm Some impact on public confidence Minor impact public perception and confidence in the organisation	Ongoing concerns raised by individuals, local media, local communities, and their representatives - long-term Significant effect on public perception of the organisation	Concerns raised by national organisations/scrutiny bodies and short-term national media coverage Public confidence in the organisation undermined Use of services affected	Prolonged national/international concerns and media coverage Issues raised in parliament Legal Action/ /Public Enquiry/FAI/Formal Investigations Critical impact on staff, public and stakeholder confidence in the organisation
Health Inequalities *(risk could increase health inequalities, particularly those that are healthcare generated)*	Negligible impact on health inequalities such as morbidity/mortality and healthy life expectancy No impact on services	Minor impact on health inequalities such as morbidity/mortality and healthy life expectancy Some services experience increased pressures	Moderate impact on health inequalities such as morbidity/mortality and healthy life expectancy Causes short term increased pressures across the system	Serious exacerbation of health inequalities such as morbidity/mortality and healthy life expectancy Causes long term pressures in system/affects ongoing viability of a service	Critical exacerbation of health inequalities such as morbidity/mortality and healthy life expectancy Affects whole system stability/sustainability

Environmental Sustainability / Climate Change (*risk could impact on environment, ability to comply with legislation/targets or environmentally sustainable care)*	Limited damage to environment, to a minimal area of low significance Negligible impact on ability to comply with climate legislation/targets or ability to reach net zero Negligible impact on ability to provide environmentally sustainable care	Minor effects on biological or physical environment Minor impact on ability to comply with climate legislation/targets or ability to reach net zero Minor impact on ability to provide environmentally sustainable care	Moderate short-term effects but not affecting eco-system Moderate impact on ability to comply with climate legislation/targets or ability to reach net zero Moderate impact on ability to provide environmentally sustainable care	Serious medium term environmental effects Serious impact on ability to comply with climate legislation/targets or ability to reach net zero Serious impact on ability to provide environmentally sustainable care	Very serious long term environmental impairment of eco-system Critical non-compliance with climate legislation/targets or ability to reach net zero Critical impact on ability to provide environmentally sustainable care

Likelihood – What is the likelihood of the risk occurring? Assess using the criteria below.

Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
It is assessed that the risk is very unlikely to ever happen.	**It is assessed that the risk is not likely to happen.**	**It is assessed that the risk may happen.**	**It is assessed that the risk is likely to happen.**	**It is assessed that the risk is very likely to happen.**
Will only occur in exceptional circumstances	**Unlikely to occur but potential exists**	**Reasonable chance of occurring - has happened before on occasions**	**Likely to occur - strong possibility**	**The event will occur in most circumstances**

Risk Assessment Table – Multiply likelihood score by impact score to determine the risk rating (score).

	5	**Low 5**	**Medium 10**	**High 15**	**Very High 20**	**Very High 25**

LIKELIHOOD						
	4	Low 4	Medium 8	High 12	High 16	Very High 20
	3	Low 3	Low 6	Medium 9	High 12	High 15
	2	Low 2	Low 4	Low 6	Medium 8	Medium 10
	1	Low 1	Low 2	Low 3	Low 4	Low 5
		1	2	3	4	5
		IMPACT				

8. APPENDIX C: RISK CONTROLS ASSURANCE GUIDANCE – NHS Forth Valley

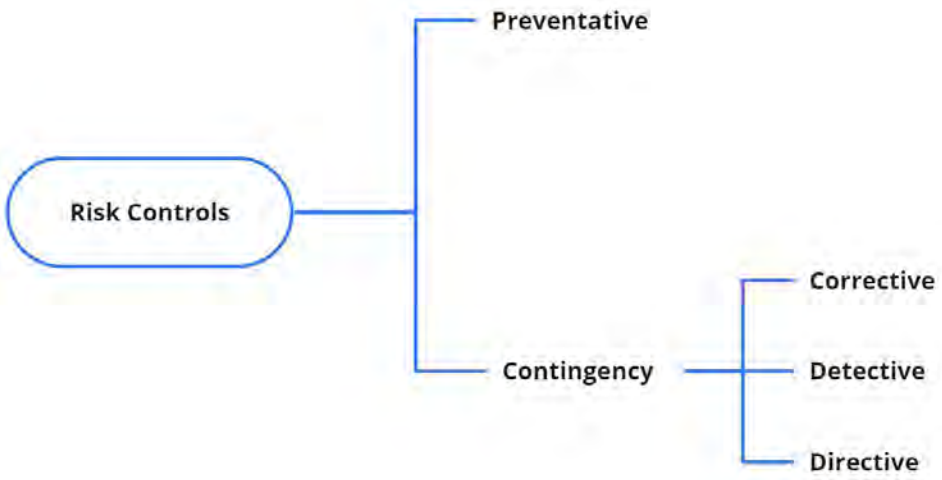
Risk Controls Assurance Guidance – NHS Forth Valley

Overall Risk Assurance Assessment		
Level of Assurance	**System Adequacy**	**Controls**
Substantial Assurance	A sound system of governance, risk management and control, with internal controls operating effectively and being consistently applied to support the achievement of objectives.	Controls are applied continuously or with only minor lapses

Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, noncompliance or scope for improvement identified which may put at risk the achievement of objectives.	Controls are applied frequently but with evidence of non-compliance
Limited Assurance	Significant gaps, weaknesses or non-compliance identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives.	Controls are applied but with some significant lapses
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives.	Significant breakdown in the application of controls

Control Types		
Type	**Description**	**Examples**
Preventative	Activity to control the underlying risk cause and prevent it happening in the first place	• Removal / substitution of a hazard • Employee vetting / checks • Segregation of duties / authorisation levels to reduce fraud • Restricting access to assets (physical / information) • Password protection • Policies, standards, processes for planning

Contingency (Reactive)	Corrective – limits the scope for loss, reduced undesirable outcomes Directive – direct activity to ensure a particular outcome is achieved Detective – designed to identify occasions when undesirable outcomes have been realised	• Policies, standards, processes to provide direction as to steps required in a certain situation • Budget review / reconciliation process • Performance review – budget-to-actual comparison to identify variance, Key Risk Indicators • Reporting • Inventories • Business Continuity / Disaster Recovery Plans • Whistleblowing / Fraud Detection



Risk Control Effectiveness Assessment

Effectiveness Score	Description
Fully effective: 100% Review and monitor existing controls	Nothing more to be done except review and monitor the existing control. Control is well designed for the risk, and addresses root causes. Management believes it is effective and reliable at all times. Full compliance with statutory requirements, comprehensive procedures in place, no other controls necessary, ongoing monitoring only Control is likely to be of a preventative nature (for example, prevents the risk from occurring) and be systematic or automatic (for example, electronic banking authorisation process)
Mostly Effective: 80-99% Most controls are designed correctly and are in place and effective.	Control is designed correctly and largely in place, effective and regularly reviewed. Some more work to be done to improve operating effectiveness or management has doubts about operational effectiveness and reliability.
	Control is likely to be of a preventative nature (for example, prevents the risk from occurring) but may not be automated and require manual intervention / review

Partially effective: 50-79% Some controls poorly designed or not effective	While the design of control may be largely correct in that it treats the root of the risk, it is not currently very effective. **or** While it operates effectively, the control does not seem correctly designed in that it does not treat root causes. Reasonable compliance with statutory requirements established, some preventative measures in place, controls can be improved Control is likely to be either reactive (for example, business continuity plan) or of a deterrent nature (for example corporate policy, training) and as such would not be considered as effective as a purely preventative control
Not effective: <50% Significant control gaps due to poor control design or very limited operational effectiveness	Significant control gaps. Either control does not treat root causes or does not operate at all effectively. Virtually no credible control. Management has no confidence that any degree of control is being achieved due to poor control design or very limited operational effectiveness Insufficient control, weak procedures, limited attempt made to implement preventative measures Control is either not in place or not working as intended

Effectiveness of Controls – Questions to Ask:

- Do the controls in place already work – have they prevented the risk materialising or mitigated its effects?

- Are there any gaps in controls?
- Is further information required about the cause and impact of the risk in order to design and implement appropriate controls?
- If several controls are required for mitigation, how are they prioritised?
- Are there any dependencies or critical points of failure in implementing the controls?
- Will planned controls be sufficient to bring the risk to target score?

Risk Control Criticality Assessment	
Control Rating	**Description**
Low Importance	The control is of negligible importance in effectively mitigating the risk. Failure of the control will not result in an increase in the likelihood or impact of the risk.
Moderately Important	The control is of moderate importance in effectively mitigating the risk. Failure of the control will result in an increase in the likelihood or impact of the risk, but the risk score will remain within appetite.
Important	The control is important in effectively mitigating the risk. Failure of the control will result in an increase in the likelihood and impact of the risk beyond risk appetite, but within tolerance. Additional controls will be required to mitigate the risk if this control cannot be executed.
Very Important	The control is very important in effectively mitigating the risk. Failure of the control will result in an increase in the likelihood and impact of the risk beyond risk appetite and tolerance. Significant additional controls will be required to mitigate the risk if this control cannot be executed.
Absolutely Critical	The risk control is an essential component of the mitigation plan for the risk. If the control is not in place and working effectively the risk cannot be successfully mitigated to within risk appetite or tolerance.

1st Line of Defence: The function that owns and manages the risk

Under the first line of assurance, operational management has ownership, responsibility and accountability for directly assessing, controlling and mitigating risks.

2nd Line of Defence: Functions that oversee or specialise in risk management, compliance and governance

The second line of assurance consists of activities covered by several components of internal governance (compliance, risk management, quality, IT and other control departments). This line of defence monitors and facilitates the implementation of effective risk management practices by operational management and assists risk owner in reporting adequate risk related information up and down the organisation.

3rd Line of Defence: Functions that provide independent assurance – e.g. Internal and External Audit

Internal audit forms the organisation's third line of assurance. An independent internal audit function will, through a risk based approach to its work, provide assurance to the organisation's board of directors and senior management. This assurance will cover how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence. It encompasses all elements of an institution's risk management framework (from risk identification, risk assessment and response, to communication of risk related information) and all categories of organisational objectives: strategic, ethical, operational, reporting and compliance.

Examples of Assurance Activity

- Training
- Policies and Procedures
- Communication, Consultation and Information
- Executive Management / Assurance Committee Oversight
- Management Review and Reporting (1st Line of Defence)
- Independent Review (2nd Line of Defence) – e.g. internal compliance functions such as Finance, Legal, Risk Management, Procurement, Information Governance, Infection Control, Emergency Planning / Resilience etc etc
- Internal and External Audit (3rd Line of Defence)

APPENDIX D: RISK APPETITE AND TOLERANCE LEVELS

Impact Category	Appetite	Tolerance
Health and Safety	**Averse**	**No Tolerance**
Service/Business Interruption	**Averse**	**Cautious**
Workforce	**Averse**	**Cautious**
Patient Harm	**Cautious**	**No Tolerance**
Patient Experience	**Cautious**	**Moderate**
Financial	**Cautious**	**Moderate**
Adverse Publicity / Reputation (Public Confidence)	**Cautious**	**Moderate**
Inspection / Audit	**Cautious**	**Moderate**
Health Inequalities	**Cautious**	**Moderate**
Transformation/Innovation	**Moderate**	**Open**
Environmental Sustainability and Climate Change	**Moderate**	**Open**

APPENDIX E: RISK APPETITE STATEMENTS

Impact Category	Appetite Level/Statement	Tolerance Statement
Patient Harm	Cautious: NHS Forth Valley exists to deliver safe, effective, person-centred care to its population. We recognise that to meet patient care objectives where the benefit exceeds the risk, there are occasions where we must operate with a **CAUTIOUS APPETITE** for risks which could result in patient harm.	There is no tolerance for this type of risk.
Patient Experience	Cautious: NHS Forth Valley has a sustained focus on improving care and experience of patients, families, and carers. We have a **CAUTIOUS APPETITE** for risk, reflecting our desire for positive patient experience and quality clinical outcomes, but recognising that it is not possible to avoid all risk and uncertainty in this area, particularly in the current operating environment.	Moderate: We are prepared to operate in the **MODERATE TOLERANCE** range for Patient Experience for a defined period, to ensure that essential health and social care needs are quickly and effectively met, and while mitigation plans are being actively developed.

Transformation/Innovation	Moderate: NHS Forth Valley has a **MODERATE appetite** for innovation, accepting that a greater degree of risk is required to maximise innovation and opportunities to improve patient experiences and outcomes, transform services and ensure value for money.	Open: We will operate with an **OPEN TOLERANCE for innovation** to allow the scoping of innovation projects to provide the detail of the case for change. This would be for a defined period while all potential delivery options are considered. Once in the initiation and planning stage for the innovation project to be implemented, the appropriate appetite level would be reconsidered in line with organisational process for initiating a new project.
Health and Safety	Averse: Any injury, illness or loss of life as a result of NHS FV failing to comply with Health and Safety obligations would be unacceptable. Therefore, there is an **AVERSE APPETITE** for risks that may compromise the Health and Safety of patients, staff, visitors and public and others accessing NHS FV services/venues.	There is no tolerance for this type of risk, but we recognise that on some occasions we will have to accept risks that have been reduced as low as reasonably practicable, and these are likely to fall into the cautious range.

Service/Business Interruption	Averse: NHS Forth Valley has an **AVERSE APPETITE** for risks which could result in Service/Business Interruption. Delivery of Health and Social Care is a priority, and while it may not be possible to eliminate risk, there is a focus on ensuring that essential health and social care needs are met quickly and effectively.	Cautious: We are prepared to operate in the cautious tolerance range for Service/Business Interruption for a defined period of time while mitigation plans are being actively developed.
Workforce	Averse: NHS Forth Valley is committed to recruiting and retaining a confident, flexible, trained workforce. We have an **AVERSE APPETITE** for risks to staffing, competence and wellbeing, particularly those which could result in contravention of relevant Professional Standards. It may not always be feasible to reach the desired range of outcomes, but nonetheless this is an area which we will prioritise until risks are ALARP*.	Cautious: NHS Forth Valley will operate with a **CAUTIOUS TOLERANCE,** to support staff to innovate and improve their workplace, balancing the risk against the reward to be gained from the significant staff knowledge and experience which is available. This will be for a defined period while mitigation plans are implemented. The priority will remain adherence to professional standards, and staff should continue to work within the limits of their competence, exercise “duty of candour” and raise concerns when they come across situations that put patients or public at risk.

Financial	Cautious: NHS Forth Valley's strategic aim is high quality and sustainable clinical services. We wish to achieve financial sustainability by spending well and making the most of our resources. Therefore, we have a **CAUTIOUS APPETITE** for Financial risk as budgets are constrained and unplanned / unmanaged budget variance could affect our ability to achieve statutory financial targets, potentially increases reputational risk and places pressure on divisions and departments. Well informed risks can be taken but budget variances are to be minimised and VFM is the primary concern.	Moderate: We will operate with a **MODERATE TOLERANCE** for a defined period while mitigation plans are implemented. We are prepared to accept the possibility of limited unplanned / unmanaged budget variance. VFM is the primary concern but we are willing to consider other benefits for a limited budget variance.
Inspection/Audit	Cautious: NHS Forth Valley has a **CAUTIOUS APPETITE** for risks impacting on Inspection/Audit. We are prepared to take informed risks which could result in recommendations, improvement notices or criticism, provided that the benefit outweighs the negative outcome.	Moderate: NHS Forth Valley has a **MODERATE TOLERANCE** for risks impacting on Inspection/Audit. Due to constraints in the current operating environment, we are prepared to take informed risks, for a defined period, which could result in recommendations, improvement notices or criticism, even where the benefits/negative impacts are balanced.

Public Confidence	Cautious: NHS Forth Valley has a **CAUTIOUS APPETITE** for risks impacting on public confidence which flow from informed decision-making, in order that achievement of strategic objectives is not hindered.	Moderate: We are prepared to operate within a **MODERATE TOLERANCE** range for Public Confidence for a defined period of time while mitigation plans are being actively developed.
Health Inequalities	Cautious: NHS Forth Valley has a **CAUTIOUS APPETITE** as there is a need to take a degree of balanced risk to achieve potential rewards from undertaking costeffective prevention activities and addressing health inequalities. We are focused on reducing healthcare generated inequalities.	Moderate: Recognising that tackling health inequalities requires integrated working across the whole health and care system, NHS Forth Valley has a **MODERATE TOLERANCE** to allow partners to actively collaborate to develop mitigation plans.
Environmental Sustainability and Climate Change	Moderate: NHS Forth Valley has a **MODERATE APPETITE** for risks impacting on Environmental Sustainability and Climate Change, being mindful of our commitment to reaching net zero, and of the negative impact on the health of our population.	Open: It would not be appropriate to have an open appetite due to the effect of climate change on the long-term health of the population we serve. However, we will operate in the **OPEN TOLERANCE** range while we actively seek mitigations which provide value and sustainability.

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

15. Progress Update: NHS Forth Valley Blueprint for Good Governance Board Development Plan 2024/25 and Plan for 2025/26
For: Approval

Executive Sponsors: Ms Kerry Mackenzie, Acting Director of Strategic Planning and Performance
Author: Jack Frawley, Board Secretary

Executive Summary
This report provides an update on the position against the Board Development Plan 2024/25 and sets out an initial Plan for the coming year which carries over actions still in progress and new actions identified in 2024/25.

Recommendation
The Forth Valley NHS Board is asked to:

- **approve** the 2024/25 Board Development Plan outcome;
- **approve** the draft 2025/26 Board Development Plan, and
- **note** that the 2025/26 Plan is an iterative document and **provide comment** on further areas to be considered for inclusion.

Key Issues to be considered
Appendix 1 sets out the Board Development Plan for 2024/25 with updates provided under each high-level action. The majority of action points specified in the Plan have been completed with any in progress actions proposed for carry over into the 2025/26 Plan, set out at Appendix 2.

Current Position
The recommendations from the External Review of Governance received in October 2023 were mapped against outputs from the Board Self-Assessment conducted in September 2023. To reflect upon the results of the Survey and capture any additional actions, two Board Development sessions have taken place (5 December 2023 and 1 February 2024). The mapping exercise was a significant piece of work to carefully review all current actions, ensure any gaps were filled, and to avoid duplication of remaining or additional actions. This was reviewed by External Audit during their year-end work with NHS Forth Valley with no gaps identified.

The Board Self-Assessment Development workshops identified areas for enhancement which were incorporated into the Board Development Plan for 2024/25.

The Plan set out high-level actions against a number of Blueprint Functions: Setting Direction; Engaging Stakeholders; Influencing Culture; Diversity, Skills & Experience; Assurance Framework, and Integrated Governance.

Next Steps

- It is proposed that the Board approves the outcomes of the 2024/25 Board Development Plan with significant progress made and a number of actions closed.
- It is proposed to carry over to the 2025/26 Plan actions under:
  (i) Equality, Diversity & Inclusion;
  (ii) Active Governance – Data and Triangulation;
  (iii) Undertaking a review (identified through the active governance session) of the Board's management of risk, including risk appetite and tolerance, and
  (iv) Influencing culture.
- Other areas for inclusion in the 2025/26 Board Development Plan will be developed through discussion with Board members; appraisal processes with Non-Executive Board members; priorities for the organisation 2025/26; national priorities, and follow on actions from Board development activities.

Implications

Financial Implications
There are no direct financial implications in respect of this paper.

Workforce Implications
There are no direct workforce implications in respect of this paper however the improvement actions identified under the headings of Culture, Leadership and Governance will support our workforce.

Infrastructure Implications including Digital
There are no direct infrastructure implications in respect of this paper.

Sustainability Implications
There are no direct Sustainability Implications in respect of this paper.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process. (A policy for NHS Scotland on the climate emergency and sustainable development)

☒ Yes
☐ *N/A*

Where applicable, the climate change, environmental and sustainability impacts and any mitigating measures are noted above/contained in the supporting papers.

Quality / Patient Care Implications
All the actions set out in the Assurance and Improvement Plan are intended to support improvements in service quality and patient experience. The links between good leadership, governance and culture are well evidenced most recently, in the Blueprint for Good Governance[1]'*For NHS Scotland to be successful in delivering quality healthcare, good governance is necessary but not sufficient if NHS Boards are to meet or exceed the expectations of their principal stakeholders. To do that, the organisation must also excel at day-to-day management of operations and the implementation of change*.'

Information Governance Implications
There are no direct information governance implications in respect of this paper.
Risk Assessment / Management
There are no direct risk management implications in respect of this paper however, to ensure good governance, it is important that actions against the 2025/26 Development Plan are delivered timeously.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:
- Paper is not relevant to Equality and Diversity

Communication, involvement, engagement and consultation
Engagement has been undertaken with the Board/Senior Leadership team members to get their input and feedback.

Appendices
- Appendix 1: Board Development Plan 2024/25
- Appendix 2: Board Development Plan 2025/26

Progress Report: NHS Forth Valley Blueprint for Good Governance Board Development Plan 2024-25

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Delivery Actions	Intended Good Governance Outcome	Status
Functions	**Setting Direction**	Ensure the Board influences and is fully engaged in the shaping and development of the new Population Health and Care Strategy	Board strategic vision / corporate objectives.	Medical Director / Director of Public Health	By end of March 2025	• Ensure the Board understands and supports the whole system, integrated and collaborative approach being taken to develop the strategy • Consideration is taken of the connections between the strategy and work required on strengthening engagement to inform decision making at a Board level • Develop clear Board oversight of delivery mechanisms, key milestones and the linkages to other strategies	The Board exercises its primary role to set strategic direction, hold executives to account for delivery, manage risk, engage stakeholders and influence organisational culture.	Complete

Progress to date

- To ensure a whole system collaborative approach, a Strategy Steering Group was established in 2024 to develop the Population Health and Care Strategy. The Group had whole system representation from NHS Forth Valley Public Health, Planning, Quality and Communications, as well as representation from the two Health and Social Care Partnerships, Primary Care and Staff Side Partnership.
- Population Health Care Strategy Board Seminars were held to shape timeline/content/the engagement plan.
- A review of Board Governance committees was undertaken and a new Strategic Planning, Performance & Resources Committee (SPPRC) established to provide a strategic thinking space for early oversight and influence of all strategies before being considered by the Board. The development of the Population Health Strategy is a standing item at SPPRC.
- A Non-Executive Director chaired Task and Finish group has been established to provide oversight of the development of the strategy, linking into the SPPRC prior to Board decisions on agreeing priorities, key milestones, the content of the strategy and the engagement plan.
- Strategic Board seminars are now scheduled in the annual Board Plan to consider linkages to other strategic imperatives e.g. Equality, Diversity & Inclusion / Value Based Health & Care
- The Board has had the opportunity to influence the refresh of the Board's Vision and Corporate Objectives, aligned with being a Population Health Organisation.

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Delivery Actions	Intended Good Governance Outcome	Status
Functions	**Engaging Stakeholders**	Develop the Board's collective understanding of NHS Forth Valley's stakeholders and what this means for more effective engagement to help shape the Board's decision making	Communications Framework 2023-2028	Head of Communications	By end of March 2025	• Ensure the Board understands its different stakeholders and has better oversight of engagement activity across the organisation and partners • Ensure the Board understands the difference between statutory consultation and engagement and how to use ongoing engagement to shape decision making • Maximise opportunities to learn from feedback • Consider how Board meetings could be more transparent and accessible to the wider public	The Board has a clear understanding of who its stakeholders are and the approach to engagement Stakeholders are meaningfully involved and account is taken of their views and feedback to shape the Board's plans and priorities Improved transparency and openness of the Board	Complete

Progress to date

- Alongside the development of the Population Health & Care Strategy a review of the Communications and Engagement Framework was considered at the February SPPR Committee and is being submitted to the Board for decision March 2025.
- The revised communication and engagement framework clearly illustrated the difference between statutory consultation and ongoing engagement with our staff, communities and partners.
- Feedback from the engagement of the Population Health & Care Strategy will be considered by the Board before the Strategy is finalised and approved.
- Engagement with Ethnic Diversity Network by Chair and Chief Executive through attendance at Network meetings and forming closer relationships with office bearers.
- Development of the Population Health & Care Strategy builds strongly on learning from the engagement so far, including IJB Strategic Planning and Locality Groups and Third Sector Organisations.
- Opportunities for Board members to hear from and act on feedback from patients, service users, carers and staff are considered at Board meetings through the presentation of patient/staff stories.
- The Board reflects and learns from reporting to Governance Committees such as: the Person Centred Care Report, raising of complaints and concerns, Care Opinion, feedback from the Area Clinical Forum, Area Partnership Forum and iMatter.
- To support the transparency of board meetings: the dates and location of Board meetings are published on the website to the public. The website provides information on how members of the public can attend meetings either in person or through remote means. Board papers are published online on the morning of the Board meeting and hard copies are made available at the meeting for any public observers attending in person. The Head of Communications issues a summary of key items considered/decisions taken at each board meeting on the Intranet for staff after every board meeting.

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Delivery Actions	Intended Good Governance Outcome	Status
Functions	**Influencing Culture**	Develop mechanisms for bringing together all aspects of Culture work for the Board to have clear oversight of performance metrics and delivery.	Staff Governance Committee / Area Partnership Forum	Director of HR	By end of March 2025	• Continue to deliver the Culture Change and Compassionate Leadership Programme and gain assurance on the impact this is having • Enhance current approaches to engaging with staff, including diversity networks, and continue to develop mechanisms which enable open and transparent communication. • Enhance the visibility and profile of Board Members/Senior Leaders within the organisation and consider how else the Board can establish their role in setting the tone and influencing culture. • Consider which metrics will provide a comprehensive and consistent approach to improving Board oversight of culture • Ensure Board oversight of iMatter and follow through of how it leads into culture work	Staff treated fairly and consistently, with dignity and respect, in an environment where diversity is valued. A continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.	In Progress

Progress to date

- Updates on the Culture & Compassionate Leadership Programme (CCLP) are provided regularly to the Staff Governance Committee and the Board and detailed discussion took place during the year through a Board Seminar.
- CCLP Workstreams and priorities are being developed and led by staff through a 'bottom up' approach.
- To enhance engagement with staff, the Chair, Chief Executive and other Senior Directors have engaged with and attended meetings of the Ethnic Diversity Network, Area Partnership Forum and Area Clinical Forum. The Vice Chair of the Ethnic Diversity Network participated in the Board's development session on Equality, Diversity & Inclusion.
- To enhance the visibility of Board members and Senior leaders, a number of initiatives have been introduced or strengthened including – 'Step into my Shoes', where Senior Leaders shadow staff on the front line; communication to all staff by the Chief Executive and Senior Directors through videos; service visits and Patient Safety Conversation Visits by Non-Executive Directors and other Senior Leaders; attendance by Board members at key strategic events and learning opportunities including the Safer Together Collaborative, SIM Safety Club and Organ Donation Week.
- Staff are encouraged to present at Board and Committee meetings.
- Non-Executive Directors are undertaking a spotlight interview on their background and their role in the staff newsletter on the Net.
- Non-Executives shadowed other Boards and take part in national forums such as the Board Vice Chair Group, IJB Chairs and Vice Chairs Group, Organ Donation Collaborative.

To be carried forward 2025/26

- Metrics to provide a comprehensive and consistent approach to improving Board oversight of culture are still in development and will be carried forward to the 2025/26 Plan, taking account of national work also underway in this area.

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Delivery Actions	Intended Good Governance Outcome	Status
Enablers	**Diversity, Skills and Experience**	Develop a shared understanding of equality, diversity and inclusion, building on expertise internally and externally to embed a culture of inclusion and enhance the Board's decision making	Staff Governance Committee and staff equality networks	Director of HR	By end of March 2025	• Build on the Board's understanding of diversity and how this should be taken account of in relation to decision making and relationships with stakeholders • Create opportunities for the Board to hear and learn from staff equality networks and diverse stakeholder views • Consider initiatives to enhance recruitment from diverse communities, both to the Board and to the organisation • Review skills and expertise of Board Members through the use of a skills matrix, sharing of skills sets across the Board and Board Member appraisals to identify and respond to development needs • Develop arrangements for succession planning for the Board to ensure future recruitment considers diversity of thought around the Board table and what skillsets/expertise is needed to support delivery of the Board's priorities.	A Board that consists of a diverse group of people with the necessary skills, experience, values, behaviours and relationships. Better decision making of the Board by taking account of EDI impacts	In Progress

Progress to date

- An Equality, Diversity & Inclusion (EDI) Board seminar was held on 6 February 2025, which covered the vision at NHS Forth Valley; Challenging Current Mindsets; Key EDI Objectives; Equality Outcomes; development of the Anti-Racism Plan development, enhancing the Board's understanding of diversity and their responsibilities I this area.
- The Board is reviewing its Equality, Diversity & Inclusion Strategy.
- Equality Impact Assessments processes have been discussed by the Board and this is being refreshed as part of the review of Board and Committee papers, to ensure that they inform the Board's decision making.
- Work is underway with the Ethnic Diversity Network to enhance understanding of racism and issues affecting our minority ethnic staff.
- Engagement with the Ethnic Diversity Network has taken place with the Chair, Chief Executive and Director of People.
- The Vice Chair of Ethnic Diversity Network participated in the Board Development Seminar on EDI and further work is taking place on developing the Board's Anti-Racism Action Plan.
- The Chair of the Ethnic Diversity Network participated in the Chief Executive recruitment process and plans are underway to consider input into the Area Partnership Forum.

- To ensure that the Board consists of a diverse group of people with appropriate skills and expertise to meet the organisation's current priorities, a new skills matrix was developed and completed by all Board members to inform succession planning and the recruitment of new Non-Executive Directors.
- Succession planning was discussed with Board members/Senior Leadership Team with an opportunity for all colleagues to input their views and ideas in cognisance of strategic priorities and skill gaps within the Board.
- In the recent recruitment of Non-Executive Members an online information session with a Q&A was held along with a personalised letter being issued to wider networks to broaden interest in the positions.
- An appraisal process is being undertaken to identify and respond to individual development needs of Board members.

To be carried forward 2025/26

(i) The need for the Board to understand how it can enhance the diversity of the wider workforce including its initiatives on international recruitment
(ii) The need for the Board to hear and learn from its wider staff equality networks and diverse stakeholders
(iii) The Board will review its EQIA processes and embed this within its decision making

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Delivery Actions	Intended Good Governance Outcome	Status
Delivery	**Assurance Framework**	Complete the work on the Board Assurance Framework, ensuring it is aligned to the Scottish Government NHS Blueprint for Good Governance and that it is fit for purpose.	Code of Corporate Governance, Corporate Objectives, Risk Management Strategy, Strategic Planning Framework, Performance Management Framework, Audit arrangements.	Board Secretary	By end of March 2025	• Benchmark with other NHS boards to learn from good practice • Continue to work with non-executive colleagues to review reports received by assurance committees to ensure that reporting is adequate to support effective decision making and scrutiny. • Engage Board Members to reflect on and understand how the Board Assurance Framework should be used to provide assurance • Provide further support around active governance development to enhance understanding of data, skills in challenging and triangulating information for assurance • Review operations/working of committees to ensure they are fit for purpose and are providing the right assurance to the Board	An assurance framework that aligns strategic planning and change implementation with the organisation's purpose, aims, values, corporate objectives and operational priorities.	Complete

Progress to date

- The Code of Corporate Governance has been reviewed and will be submitted to the March 2025 Board meeting for approval, with work undertaken to align the Code with the Model Code.
- Benchmarking has been completed against other Boards in relation to their Board Assurance Frameworks (BAF).
- A Board Seminar on Active Governance was held on 3 December 2024 facilitated by NES and with an input from Tom Steele, Chair of Scottish Ambulance Service, covering an understanding of active governance; the use of data; how to gain assurance through Board and Committee reports and the use of the BAF; the format of reports and the need for intelligence and triangulation. Discussions also took place on the need to review the Board template and a further understand on the use of data.
- The Board Assurance Framework coming to the Board for approval in March 2025.
- Non-Executive Director only sessions are scheduled for the year and to date have reflected on improvements required in governance to enhance oversight, scrutiny and constructive challenge.
- A review has taken place of Governance Committees, the portfolios of Non-Executive Directors and associated governance processes i.e. minutes/action logs/workplans/revised membership/annual reporting/ToR of Committees. This has facilitated the golden thread of how Committees and their Chairs report to the Board to provide assurance and pull through key governance issues.
- A report on progress and changes around strengthening of governance arrangements will be to the Board in May 2025.

To be carried forward 2025/26

(i) A refresher session to be held on understanding data and triangulation.
(ii) Undertake further development work on the use of the BAF to provide assurance

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Delivery Actions	Intended Good Governance Outcome	Status
Delivery	**Integrated Governance**	Ensure Integrated whole system working continues at pace and that assurance provided to the Board is cognisant of the whole system approach	Integration Joint Boards, HSCPs, Local Authority Leadership Teams and the NHS Board Executive Leadership Team	Chief Executive	By end of March 2025	• Review the Integration Schemes for both Falkirk and Clackmannanshire & Stirling Health and Social Care Partnerships (HSCP) • Build on existing business processes and decision-making matrix to deliver effective governance across and between Integration Joint Boards, HSCP Leadership Teams, Local Authority Leadership Teams and the NHS Board Executive Leadership Team.	Clear governance and accountability processes and whole system decision making for prioritisation, supporting improved integrated working. Clarity around operational and professional decision making. A collaborative approach that ensures the organisation's systems are integrated or aligned with the governance arrangements of key external stakeholders.	Complete

Progress to date

- A Review Group comprising of senior governance/finance officers from NHS Forth Valley; Clackmannanshire Council; Falkirk Council; Stirling Council, and both HSCPs undertook a review of the Integration Schemes.
- Board seminars were held on 8 October 2024 and 5 November 2024 to enhance understanding of the integration landscape and to provide an opportunity to influence the revised content of the proposed Integration Schemes with a particular focus on risk share and finances.
- Discussion took place at the Board Seminar on 19 November 2024, SPPR Committee 17 December 2024 and the subsequent board meeting on 28 January 2025 on inclusion of Falkirk Council's Children and Justice services into the Falkirk Integration Scheme.
- The Integration Schemes Review is now complete and both schemes have been approved by the NHS Forth Valley Board.
- A collaborative approach between all 4 Chief Executives in relation to Chief Officer performance is now in place and there is clarity on whole system decision making processes.
- Board membership on 3 Community Planning Partnerships has been confirmed and clarified to ensure senior level representation
- A Join Integration Board Development Session across both IJBs was held on Primary Care and future joint sessions are planned.
- The NHS Forth Valley Board has revised its assurance reporting and now receives whole system reporting on Urgent and Unscheduled Care and other areas delegated to Integration Joint Boards such as Primary Care.

DRAFT NHS Forth Valley Blueprint for Good Governance Board Development Plan 2025-26

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Delivery Actions	Intended Good Governance Outcome
Functions	**Influencing Culture**	Develop mechanisms for bringing together all aspects of Culture work for the Board to have clear oversight of performance metrics and delivery.	Staff Governance Committee / Area Partnership Forum	Director of People	By end of March 2026	• Consider metrics to provide a comprehensive and consistent approach to improving Board oversight of culture, taking account of national work also underway in this area. • Measure change by SMART metrics and incorporate into performance reporting. • Consider Board oversight, through the Staff Governance Committee, of an evaluation of the Culture & Compassionate Leadership Programme to date and any changes which are required going forward.	Staff treated fairly and consistently, with dignity and respect, in an environment where diversity is valued. A continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

Enablers	**Diversity, Skills and Experience**	Develop a shared understanding of equality, diversity and inclusion, building on expertise internally and externally to embed a culture of inclusion and enhance the Board's decision making	Staff Governance Committee and staff equality networks	Director of People	By end of March 2026	• Continue to build on the Board's understanding of diversity and how this should be taken account of in relation to decision making and relationships with stakeholders. • Develop the Board's EQIA processes and embed this within its decision making and development of strategies. • Create further opportunities for the Board to hear and learn from staff equality networks and diverse stakeholder views • Develop the Board's understanding of initiatives to enhance recruitment from diverse communities, both to the Board and to the organisation.	A Board that consists of a diverse group of people with the necessary skills, experience, values, behaviours and relationships. Better decision making of the Board by taking account of EDI impacts

Delivery	**Assurance Framework**	Complete the work on the Board Assurance Framework, ensuring it is aligned to the Scottish Government NHS Blueprint for Good Governance and that it is fit for purpose.	Code of Corporate Governance, Corporate Objectives, Risk Management Strategy, Strategic Planning Framework, Performance Management Framework, Audit arrangements.	Board Secretary	By end of March 2026	• Provide further support around active governance development to enhance understanding of data, skills in challenging and triangulating information for assurance • Undertake further development work on the use of the BAF to provide assurance. • Undertake a mapping exercise of local strategies to understand interdependencies and any gaps.	An assurance framework that aligns strategic planning and change implementation with the organisation's purpose, aims, values, corporate objectives and operational priorities.
Functions	**Managing Risk**	Review of Risk Framework and Board's Risk appetite/ tolerance and approach to Risk	Audit & Risk Committee / Code of Corporate Governance	Chief Executive	By end of March 2025	• The Board will review its Risk Framework, Risk appetite and tolerance to strengthen oversight and scrutiny in this area through a Board development session	A more active approach to governance to make more timely, well informed and strategic decisions. A clearer understanding of the Board's risk appetite and tolerance being evident at Committee and Board level.

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

16. Board Schedule of Business 2025/26
For: Approval

Executive Sponsor: Ms Kerry Mackenzie, Acting Director of Strategic Planning and Performance
Author: Jack Frawley, Board Secretary

Executive Summary
This paper presents the Draft Board Schedule of Business (SoB) 2025/26 for review and approval, enclosed at Appendix 1.

Recommendations
The Forth Valley NHS Board is asked to:

- **approve** the Draft Board Schedule of Business 2025/26.
- **note** that the Schedule of Business will be a standing item on Board agendas.

Key Issues to be considered
The SoB is presented to Board on an annual basis and has been reviewed. The approved SoB will be used throughout the year to inform the preparation of Board agendas. Ad-hoc items can still be included and as matters develop during the year the SoB will be updated to reflect any changes to reporting.

The SoB will be included on all ordinary Board meeting agendas going forward.

Implications

Financial Implications
There are no direct financial implications in respect of this paper.

Workforce Implications
There are no direct workforce implications in respect of this paper.

Infrastructure Implications including Digital
There are no direct infrastructure implications in respect of this paper.

Sustainability Implications
There are no direct Sustainability Implications in respect of this paper.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process. (A policy for NHS Scotland on the climate emergency and sustainable development)

☒ Yes

☐ *N/A*

Where applicable, the climate change, environmental and sustainability impacts and any mitigating measures are noted above/contained in the supporting papers.

Quality / Patient Care Implications
There are no specific quality / patient care implications in respect of this paper.

Information Governance Implications
There are no direct information governance implications in respect of this paper.

Risk Assessment / Management
There are no direct risk management implications in respect of this paper.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity

Communication, involvement, engagement and consultation
None carried out in the development of the report.

Appendices

- Appendix 1: Board Workplan 2025/26

Forth Valley NHS Schedule of Business 2025/26							
	27 May	**17 June (Private)**	**29 July**	**30 Sept**	**25 Nov**	**27 Jan**	**31 Mar**
Standing Items							
Minute of previous meeting	☑	☑	☑	☑	☑	☑	☑
Action Log	☑		☑	☑	☑	☑	☑
Chair's Update	☑		☑	☑	☑	☑	☑
Board Executive Team Report	☑		☑	☑	☑	☑	☑
Strategic Risk Register	☑		☑	☑	☑	☑	☑
Patient/Staff Story	☑		☑	☑	☑	☑	☑
Finance Report	☑		☑	☑	☑	☑	☑
Performance Report	☑		☑	☑	☑	☑	☑
HAIRT	☑		☑	☑	☑	☑	☑
Quality & Safety Report	☑		☑	☑	☑	☑	☑
Schedule of Business	☑		☑	☑	☑	☑	☑
Minutes							
Assurance Committee Minutes							
Audit & Risk Committee	☑		☑	☑	☑	☑	☑
Clinical Governance Committee	☑		☑	☑	☑	☑	☑
Staff Governance Committee	☑		☑	☑	☑	☑	☑
Strategic Planning, Performance & Resources Committee	☑		☑	☑	☑	☑	☑
Advisory Committees Minutes							
Area Clinical Forum	☑		☑	☑	☑	☑	☑
Area Partnership Forum	☑		☑	☑	☑	☑	☑
IJB Minutes							
Clackmannanshire & Stirling IJB	☑		☑	☑	☑	☑	☑
Falkirk IJB	☑		☑	☑	☑	☑	☑
Strategy							
Access Policy	☑						
Anchor and Community Planning Partnership Update			☑			☑	
Annual Delivery Plan 2025/2026 (including Workforce Plan)	☑						
Anti-Racism Strategy – tbc							

Climate Emergency & Sustainability Strategy and Action Plan 2023-2026 – Annual Update				☑			
Communications Priorities							☑
Communications Update			☑			☑	
Development Plan Against Self-Assessment Progress Report							☑
Digital and eHealth Plan	☑						
Equality Outcomes and Mainstreaming Annual Report - tbc							
Innovation Plan Annual Update			☑				
Mental Health & Wellbeing Strategic Commissioning Plan			☑				
Model Hours for Pharmacy	☑						
Participation & Engagement Strategy Update							☑
Population Health & Care Strategy	☑			☑			
Quality Strategy Annual Update			☑				
Whole System Plan – tbc							
Winter Plan					☑		
Performance & Finance							
Annual Accounts		☑					
Draft Financial Plan 2025/2026							☑
HSCP Annual Performance Reports					☑		
Person Centred Complaints Feedback Annual Report				☑			
Safe Staffing Annual Report							☑
Whistleblowing Annual Report	☑						
Whistleblowing Standards and Activity Report	☑			☑		☑	
Governance							
Board Assurance Framework – Annual Review (including Performance Framework)							☑
Code of Corporate Governance – Annual Review							☑
Corporate Objectives							☑
Dates of Meetings				☑			
Advisory Committee Annual Reports 2024/25 – tbc							

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

17. Population Health and Care Strategy Development
For: Assurance

Executive Sponsor: Mr Andrew Murray, Medical Director

Author: Ms Kerry Mackenzie, Acting Director of Strategic Planning and Performance

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1. Executive Summary

1.1 At the NHS Board Meeting on 28 January 2025, the proposed plan for developing the strategy and the indicative timeline were approved by the Board. It was anticipated that the Population Health and Care Strategy, setting the direction of travel for the next ten years, would be published by the end of August 2025.

2. Recommendations

2.1 The Forth Valley NHS Board is asked to:

- **note** that development of the Population Health & Care Strategy continues with support from the Task and Finish Group.
- **note** the advice from the Task and Finish Group that the Strategy development requires further work.
- **support and accept** the advice from the Task and Finish Group that further work is required in the development of the Strategy and accept the delay to the originally approved timeline.
- **note** that the Task and Finish Group will meet on 10 April 2025 to review progress ahead of further discussion at a Board Development Session on 15 April 2025.

3. Key Issues to be considered

3.1 Following the NHS Board meeting on 28 January, two papers were taken to the Strategic Planning Performance and Resources Committee (SPPRC) for consideration on 25 February 2025, with a view to receiving approval by the NHS Board in March ahead of a planned period of engagement.

3.2 The draft Population Health and Care Strategy (the Strategy) was presented for review and discussion by the SPPRC. Comments were welcomed at the meeting with feedback requested thereafter to inform an updated version of the Strategy, with further input from the Task and Finish Group on 6 March 2025.

3.3 The second paper brought for consideration by SPPRC was the Strategy Engagement Plan. Feedback was received with an updated version considered at the Task and Finish Group.

3.4 The Task and Finish Group acknowledged the work undertaken thus far in the development of the Strategy and confirmed that the content was broadly aligned with expectations. However, in light of comments received the Task and Finish Group agreed that further work was required including bringing into focus key themes, aims and aspirations and ensuring read across with other current key documents. It was agreed that the Strategy would be redrafted as narrative only ahead of work around the design of the document.

3.5 In addition, work is underway to engage with a key third sector organisation to refine and enhance the questions to be included as part of the engagement process.

3.6 The timeline approved by the Board in January highlights that draft Population Health and Care Strategy and engagement plan would be brought to the Board for approval in March. After discussion at the Task and Finish Group, it was agreed that additional time would be required to ensure the Strategy continues to develop in line with the agreed changes, with a short delay proposed, and that support for this additional work and delay would be sought at the March 2025 Board meeting.

3.7 A meeting of the Task and Finish Group is scheduled for 10 April 2025 to review progress, followed by a Board Seminar on 15 April 2025, where further discussions will take place with the Board and Senior Leadership Team providing an opportunity to provide feedback on the Strategy.

3.8 Thereafter, the draft Population Health and Care Strategy, along with the engagement plan, will be presented to the NHS Board for approval. This will allow for the start of additional engagement over a 6-week period.

3.9 A revised timeline is yet to be agreed however it is estimated that there will be about a 1-month delay to the agreed timeline.

Implications

4 Financial Implications

4.1 Whilst there are no financial implications associated with developing the Population Health and Care Strategy, there is input to the Strategy preparation, development, and engagement in terms of a time commitment from senior leaders in Strategic Planning, Public Health, Patient Relations, HSCPs and other services and departments. Financial implications will be determined alongside implementation.

5 Workforce Implications

5.1 There are no direct workforce implications associated with developing the Population Health and Care Strategy. These will be determined alongside implementation.

6 Infrastructure Implications including Digital

6.1 There are no direct infrastructure implications associated with developing the Population Health and Care Strategy. These will be determined alongside implementation.

7 Sustainability Implications

7.1 There are no direct sustainability implications arising from this paper. Climate Change and Sustainability initiatives across the five priority areas for NHS Scotland (i.e. Sustainable Buildings & Land; Sustainable Travel; Sustainable Goods & Services; Sustainable Care; and Sustainable Communities) will be important considerations when considering the Population Health and Care Strategy implementation.

7.2 **Sustainability Declaration**

Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process A policy for NHS Scotland on the climate emergency and sustainable development. *(please tick relevant box)*

□ *Yes*

* *N/A*

Where applicable, the climate change, environmental and sustainability impacts, and any mitigating measures are noted above/contained in the supporting papers.

8 Quality / Patient Care Implications

8.1 It is imperative that quality of care and overall service provision is integral to implementation of the Population Health and Care Strategy, taking a value-based health and care approach.

9 Information Governance Implications

9.1 There are no direct information governance implications arising from this paper.

10 Risk Assessment / Management

10.1 Addressing health inequalities is a strategic risk, recently added to the risk register. There are some risks associated with the development of the Population Health and Care Strategy, and these include meeting key milestones within the proposed timeline, a potential lack of engagement or not reaching the desired breadth of engagement and responding appropriately to the feedback from the engagement.

11 Relevance to Strategic Priorities

11.1 It is essential that the Board has a Population Health and Care Strategy in order to shape how the Board will improve population health in the future.

12 Equality Declaration

12.1 The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process. The Population Health and Care Strategy approach recognises that tackling health inequalities, in conjunction with strategic partners, is one of the key aims. The Strategy Steering Group membership includes leads for equality and diversity, person centred care and children and young people. The proposed engagement will seek input and feedback from wide representation across Forth Valley. A draft Equality Impact Assessment for the Population Health and Care Strategy will be completed for approval alongside the draft Strategy and will be finalised as the Strategy is developed.

13 Communication, involvement, engagement, and consultation

13.1 This paper was prepared following the Task and Finish Group meeting on 6 March.

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

18. Out of Hours Update Including Patient and Staff Story
For: Assurance

Executive Sponsor: Ms Gail Woodcock, Chief Officer Falkirk HSCP
Author: Mr Andrew McCall, Out of Hours Service Manager

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1. Executive Summary

1.1 The purpose of this paper to give the Forth Valley NHS Board an overview of and showcase the work of the Out of Hours (OOH) service. This includes both a staff (appendix 3) and patient story sharing their experience of working within and using the OOH service.

1.2 In 2022 Sir Lewis Ritchie, author of the National Review of OOH Services in Scotland (2015) and appointed representative of the Scottish Government raised concerns regarding the resilience of OOH services in Forth Valley. This led to the creation of a service redesign and sustainability project which included securing input from Sir Lewis and his team agreeing an improvement plan to address the concerns identified. This was approved and commenced in November 2022.

1.3 OOH was required to provide a monthly update report outlining the progress being made on each action.

1.4 The OOH service was formally transferred to Falkirk HSCP in line with the Integration Scheme in December 2023.

1.5 Following a review in March 2024 Sir Lewis acknowledged the improvements that had been achieved along with the plans in place to complete the outstanding actions. This led to the monthly updates moving to quarterly updates. In December 2024 Sir Lewis advised that OOH had achieved substantive and significant improvements and as such he formally wrote to NHS Forth Valley confirming that all further scrutiny of the service would be stood down.

1.6 A further letter was received by NHSFV CEO from Rebecca Charmers, OOH unit head at Scottish Government confirming that their role in the 2022 review had come to end.

2. Recommendations:

2.1 The Forth Valley NHS Board is asked to:

- **note** the significant improvements OOH has achieved between November 2022 and December 2024. These include:
  - Successful recruitment to full salaried staff establishment
  - Increased engagement with local GPs
  - Dedicated management structure appointed
  - Consistent high rota fill
  - Increased positive impact on staff wellbeing
- **recognise** the positive developments which have taken place in the service, exemplified by the Patient Story (video item) and Staff Story (appendix 3).
- **note** the formal notification lifting the Scottish Government escalation measures & the reasonable assurance level proposed.
- **note** that, based on the formal notification from Scottish Government; the Clinical Governance Committee approved the closing of OOH Strategic Risk SR16 at its January 2025 meeting.

3. Key Issues to be Considered:

3.1 In response to concerns raised by Scottish Government (SG) regarding the resilience of OOH services in Forth Valley, an OOH Service Redesign & Sustainability Plan Project Initiation document was developed in June 2022 with the final action plan agreed November 2022.

3.2 The project was led by the previous OOH Service Manager who was supported by the clinical Lead, Lead ANP and other specialist colleagues including communications and operational managers within the Acute and HSCP services. The purpose of the redesign was to ensure resilient, high quality and safe OOH services providing the best urgent and emergency care for the people of Scotland on a 24/7 basis.

3.3 The key actions included strengthening of senior team with the appointment of permanent service manager, establishing enhanced MDT, development of OOH as a learning environment and establishing strategic partnerships with other OOH services including SAS.

3.4 An assessment of progress took place in a series of on-site meetings with SG officials and Professor Sir Lewis Ritchie, author of the National Review of OOH services in Scotland in 2015 and the officer responsible for completing a review of NHS Forth Valley's services following escalation on the Support and Intervention Framework.

3.5 A review of the action plan and the service was conducted by Sir Lewis and the SG team in March 2024. The key areas of development and successes achieved presented and noted during this review were:

- OOH was fully delegated to IJBs, in line with existing Integration Schemes, in December 2023 with Falkirk IJB hosting the service who are responsible for overseeing the performance of the service ensuring its continues to meet the agreed performance indicators.
- Dedicated and permanent leadership structure was put in place consisting of Service Manager, Clinical Lead, Lead ANP and Deputy Clinical Lead focussing on GP training and development.
- Clear accountability and decision-making pathways established.
- Rota fill % increased with service now consistently operating at >90%
- Strong team of 8A ANPs to support running of service including the introduction of an paediatric ANP to enhance the service provision for children and further develop the skills of whole ANP team in respect of treating children
- Good career progression for ANPs within OOH including hybrid role being established.
- Increased engagement from sessional GPs contributing to greater stability in service development.
- Further development of multidisciplinary team within OOH
- Reduction in times service operating at Purple/Red Opel levels.
- Significant reduction in the strategic risk register bringing it into NHSFV appetite and tolerance levels.
- Strengthened or established new working relationships across NHSFV and FHSCP

3.6 The improvements outlined above were acknowledged and welcomed by Sir Lewis and the SG team and this led to the monthly reports moving to quarterly reports. The service continued to further develop the service with further improvements including:

- Devised and implemented new GP salary structure resulting in all previous GP vacant hours being successfully recruited.
- Established and implemented structure for monthly governance meetings and quarterly business meetings.
- Agreed new partnership working with SAS.
- Further developed and strengthened working partnership with Pharmacy team leading to a pilot for increased Sunday opening times.
- Established a SLWG with representatives across the whole team to create a vision and mission statement for the service and outline the operating values the team will adopt. These are planned to be published in due course.

3.7 Communication from Sir Lewis was received in December 2024 (appendix 1) acknowledging the excellent progress against the 2022 improvement plan the service has continued to achieve and that solid evidence of building resilient had been identified through the number of follow up review assessments along with the monthly and latterly quarterly update reports.

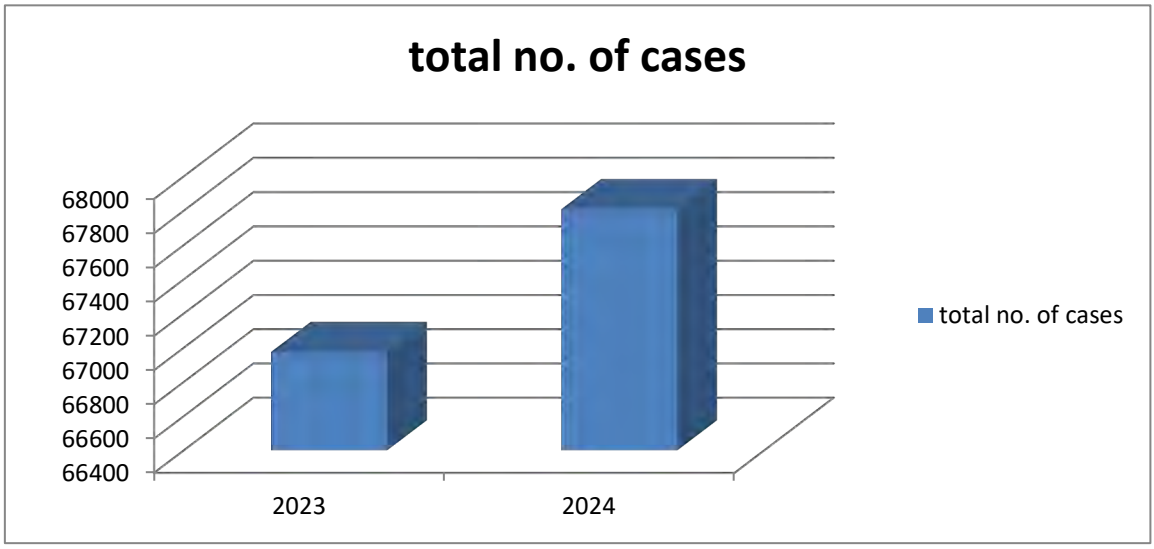
3.8 Sir Lewis concluded that based on the substantive and satisfactory progress achieved for OOH services all further scrutiny arising following the report of 1 November 2022 would be stood down.

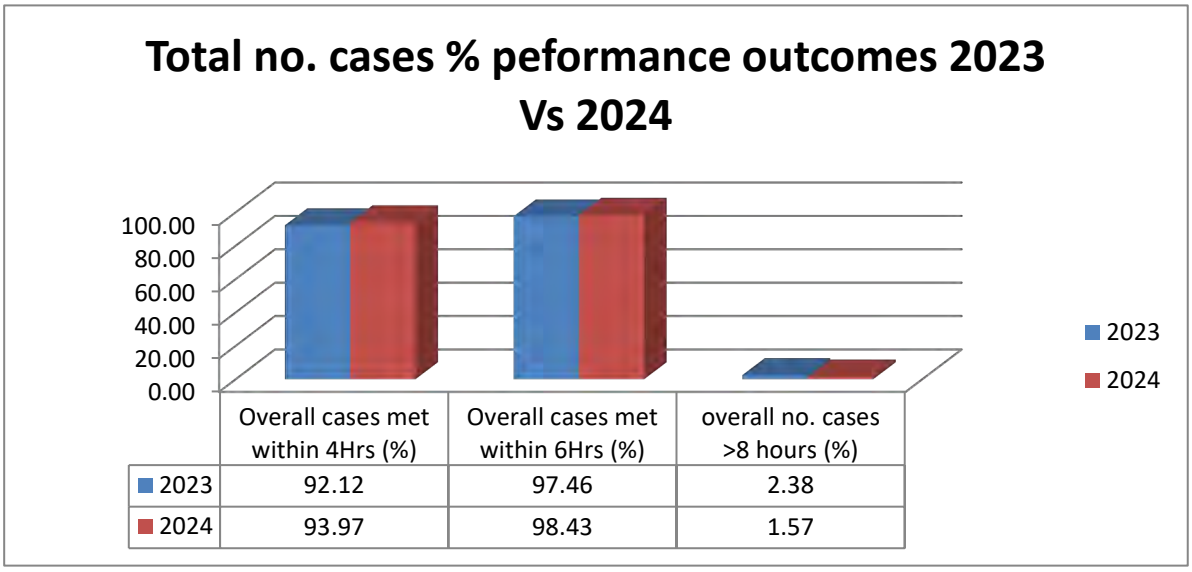
3.9 Further communication with NHSFV CEO from Scottish Government (appendix 2) in January 2025 supports the conclusions of Sir Lewis, confirming that Scottish Government will formally be ending their ongoing review of the service.

4. Improvements

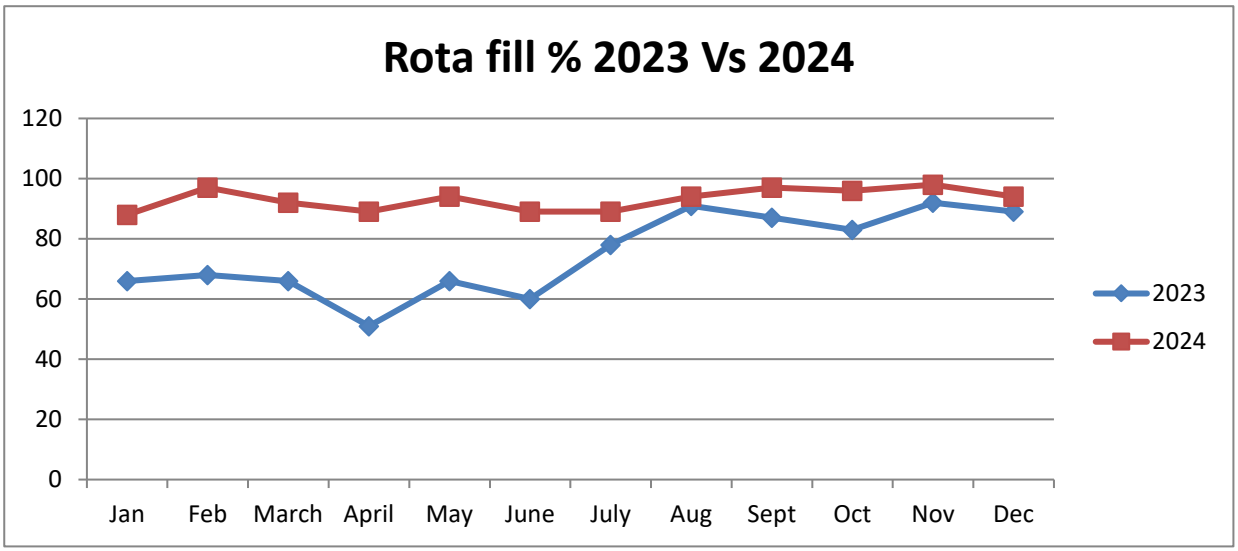
4.1 As outlined in the section above the service has made significant improvements from November 2022 working through and completing the improvement plan.

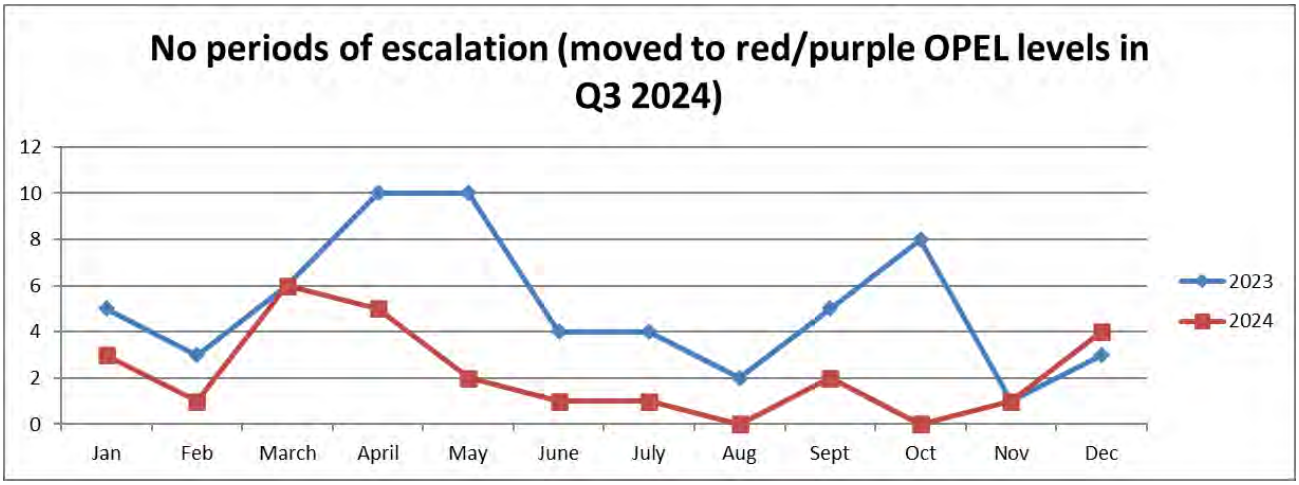
4.2 These improvements have resulted in the service becoming a fully staffed, stable, robust and resilient service. The improvements include consistent high rota fill, consistently achieving 98% of patient journeys within a 6-hour period and significantly reducing the number of occasions the service operates within Red and Purple OPEL level. These are outlined below:





	Overall cases met within 4Hrs (%)	Overall cases met within 6Hrs (%)	overall no. cases >8 hours (%)
2023	92.12	97.46	2.38
2024	93.97	98.43	1.57





4.3 This success is a result of strong leadership and the whole team working together with a shared vision and commitment to provide a high-quality, person-centred service within a work environment based on continuous and shared learning. This is supported by the **Patient story - OOH Service** and staff story (appendix 3).

4.4 The improvements now form the strong foundations that the team will continue to build on. The service is currently working to finalise its objectives for the year ahead and will include the following:

- Further develop clinical pathways with specialties, including joint training to ensure efficient patience experiences
- Further develop and improve service based on principles of realistic medicine.
- Working in partnership with other OOH services to scope and design a fully integrated whole system OOH service to ensure the people of Forth Valley receive the right care by the right person at the right time in the right location.

Financial Implications
There are no finance implications or approvals required

Workforce Implications
OOH has successfully recruited and established a stable and resilient multidisciplinary team

Risk Assessment
The improvements that have been implemented have helped reduce the previously identified risks from both a patient and organisational perspective. This is evidenced by the fact that the service is consistently completing patient journeys within 6 hours and the recommendation to close the strategic risk assessment has been approved by the NHS Clinical Governance Committee

Relevance to Strategic Priorities
The delivery of OOH is a key part of Primary Care provision aligned with NHSFV and IJB strategic objectives in providing the right care at the right time by the right person.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.

Further to an evaluation it is noted that: *(please tick relevant box)*
X **Paper is not relevant to Equality and Diversity**
□ Screening completed - no discrimination noted
□ Full Equality Impact Assessment completed – report available on request.

Consultation Process
Not applicable

Appendices
Appendix 1 – Letter from Sir Lewis D Ritchie OBE FRSE
Appendix 2 – Letter from Primary Care Directorate
Appendix 3 – Staff Story
Please note that this item is supported by a Patient Story Video.

UNIVERSITY OF ABERDEEN

James Mackenzie Professor of General Practice
Sir Lewis D Ritchie OBE FRSE

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17 December 2024

Dr Andrew Murray
Executive Medical Director
NHS Forth Valley
Headquarters
Carseview House
Castle Business Park
Stirling
FK9 4SW

Dear Andrew

Many thanks for your letter of 12 December. It is timely, in that I was about to write to congratulate the Administrative and Clinical Leadership of Out-of-Hours (OOH) services in Forth Valley and all front-line staff for their excellent progress and steadfast endeavours to achieve that. In that letter, I would also have signalled discontinuation of any further scrutiny of NHS Forth Valley OOH services arising from my original Review Report of 1 November 2022.

By way of context, I attach a copy of my original Review Report which sets out context (including antecedents), major findings, assessment of OOH service resilience and 12 recommendations.

A number of follow up assessments including further visits have taken place since. We requested and received regular monthly updates of progress, latterly quarterly. These updates provided encouraging and solid evidence of building resilience of NHS FV OOH services.

I welcomed the strategic governance heft accorded by NHS Forth Valley to my Review Report and for the steadfast commitment of you and your colleagues to bring my recommendations to fruition. As you clearly set out in the detailed points in your letter, all actions arising from my recommendations have now been evidenced as completed and risk registration re-calibrated accordingly. As you will gather, my Scottish Government colleagues and I had separately come to the same position from our own observations. I therefore agree with the recommendation of your Corporate Risk Manager as presented to the NHS Forth Valley Clinical Governance Committee.

Our review process sat alongside, but separate from the NHS Forth Valley Assurance Board, chaired by Christine McLaughlin, Co-Director Population Health, Scottish Government I shall ensure that relevant colleagues within Scottish Government are made aware of this correspondence, of the substantive and satisfactory progress achieved for OOH services and

of our intention to stand down further scrutiny arising following my report of 1 November 2022. In turn, I would be grateful if you would kindly communicate these positive findings to Health and Social Care Partnership and NHS Forth Valley leadership for OOH services.

I am conscious also of the approaching challenges of the festive season and of winter - wishing colleagues well in all they do to help the public of Forth Valley.

In closing, I would like to commend you and your colleagues for your heartening achievements and to indicate our willingness to offer further advice and support should any future need or request for assistance arise.

Best wishes

Lewis D Ritchie

Primary Care Directorate
Rebecca Chalmers, Unit Head,
SAS, NHS24 Sponsorship, Out Of Hours

E: Rebecca.Chalmers@gov.scot

a b c d

Mr Ross McGuffie
Chief Executive
NHS Forth Valley
Carseview Castle Business Park
Stirling
FK9 4SW

January 2025

Dear Mr McGuffie

REVIEW OF THE OUT OF HOURS SERVICE

Following a period of ongoing difficulties in the service, in October 2022, Sir Lewis Ritchie, Scottish Government Advisor and Scottish Government officials were invited to conduct a review of the NHS Forth Valley Out of Hours service.

As you may be aware, the review consisted of an initial visit and assessment in October 2022 with a report including recommendations being issued shortly thereafter in early November 2022. Sir Lewis and the team then undertook a number of follow up assessments spanning across 2023 into 2024 during which time the Senior Management Team at Forth Valley provided monthly progress update reports. The final visit took place on 19 June 2024 where it was clear that the service had improved significantly and the reporting cycle was at that time then reduced to quarterly.

We are aware through the Board's reporting and additional dialogue with the team at Forth Valley that the service is now operating well and our role in the review process has now come to an end. We will of course be available to provide any ongoing guidance and support going forward should the service require it.

Further to the recent communication issued to the Board from Sir Lewis, we would like to take this opportunity to express our sincere thanks to the entire team at Forth Valley for their hard work, dedication and commitment towards making the improvements that have shaped Out of Hours into a more robust and resilient service.

With kindest regards

Rebecca Chalmers
Unit Head
SAS, NHS 24 Sponsorship & OOH

OOH staff story – Angela Rae, Paediatric ANP

My career started in 2004 as a staff nurse in Yorkhill Children Hospital Accident and Emergency Department in Glasgow. I developed skills on all aspects of emergency care: trauma, medical, surgical, ENT, dermatology, burns, wound management and emergency resuscitation.
Within 3 years I was promoted to Senior Staff nurse taking responsibility and prioritising patient flow through the department. The role also incorporated teaching and developing staff skills in keeping in line with evidence base practice.
I then completed the Emergency Nurse Practitioner course along with my prescribing certificate. This enabled me to independently see, treat & diagnose all injuries and trauma.

Main Clinical Skills as Emergency Nurse Practitioner

- Assessment of burns and all wounds
- Closure with sutures of full thickness lacerations
- Interpret all X-ray.
- Manipulation of bone dislocations
- ENT: Foreign body removal from ears and skin
- Working in the resuscitation team.
- Working with major trauma team.

After a few years I wanted to further develop my skills. I went on to complete a Masters in Advance Practice. I was the first Paediatric nurse Practitioner within the GGC to have obtained a dual role.

I went on to work in the Flow Navigation centre to help establish Paediatric virtual consultations. This involved staff training and implementing Paediatrics pathways. Although after 8 months I missed clinical interaction with patients I was becoming de-skilled. I thrived to work in a clinical area again with patients to keep my skills up to date. Therefore, I applied and was successful in the Senior Paediatric Advance Nurse Practitioner position in FVRH Out Of Hours.

My job role is clinical and educational.
Within the first few months working in OOH I knew I had made the right decision to leave Glasgow. I was extremely impressed with the variety of services that the OOH working in partnership with the Urgent Care Centre offer.
All staff bring different individual experiences and knowledge to create a robust team.
Before my arrival, staff were seeing, treating, and discharging children along with teaching trainees ANP. However, with my experience I was able to offer a more structured approach of teaching and development with the implementation of a Paediatric competence pack. The pack allows individual shared learning needs to enhance a more in-depth knowledge base in the assessment and diagnostics skills of paediatric patients.
On completion of the pack the ANP will be confident and competent to independently assess and treat children safely and efficiently.

I mentor and support staff from all grades. Whilst worki in collaboration with Stirling University for clinical decision making, assisting with academic assessment, and teaching.

The aims and objectives of my role are:

• To empower families to self-manage their children's conditions through provision of health education, advice.
• To provide specific interventions to attempt to reduce presentation to accident and emergency and if possible, avoid hospital admission.
. Asses, treat, diagnose, and discharge high volumes of paediatric patients safely and effectively.
• Providing the right care, right place, right time approach. This will overall improve and enhance patient and staff experiences.

Overall, I absolutely love my Job working within GP OOH. I am so grateful for this opportunity.I feel so privileged to be part of an amazing team of people. The team have been so supportive of me and I have learned so much within my first year working there.

As well as doing the job I love I now have an opportunity to assess adult' patients and develop my skills in adult medicine.

Thank you to Cheryl Johnston my lead for having faith and believing in me. I have a job for life. Not to mention having support from all my peers. I am looking forward to my future within the urgent care centre.
Thank you!

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

19. GP Primary Care Sustainability Update Report
For: Assurance

Executive Sponsor: Gail Woodcock, IJB Chief Officer, Director of Falkirk HSCP
Author: Louise McCallum, Interim Primary Care Senior Service Manager

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Executive Summary
The Primary Care Medical Services (Scotland) Act 2004 requires NHS Boards to provide primary medical services.

In 2014, the Public Bodies (Joint Working) (Scotland) Act was passed, delegating services, with Primary Care remaining 'Hosted' by NHS Forth Valley until 2023.

In October 2022, responsibility for Primary Care strategic planning and operational management was transferred to Falkirk Health & Social Care Partnership for both Clackmannanshire & Stirling IJB and Falkirk IJB, including GP Out of Hours/Urgent Care Services. This transfer was completed in February 2023.

General Practice plays a key role in healthcare, supporting patients at home and managing a wide range of health concerns. It provides around 5,471 daily appointments, mostly face-to-face. Some practices report GPs managing over 25 patients daily, in addition to non-patient-facing tasks like prescribing and reviewing clinical correspondence.

This paper highlights challenges in General Practice, such as recruitment, financial sustainability, rising public expectations, and growing demand, exacerbated by the pandemic. It also addresses these challenges in the context of sustainability and health improvement, with examples of progress detailed in the Assurance Section.

Recommendations
The Forth Valley NHS Board is asked to:
- **note** the report and the recommendations below.
- **note** the challenges to sustainability for GP Practices across Forth Valley.
- **consider** the actions being taken to support GP Practices
- **discuss** the activity to clarify and mitigate the risks within Primary Care in the assurance section.

Background and Context
General Practice plays a key role in the health of citizens, handling undifferentiated presentations, long-term condition management, and coordinating wider NHS interventions.

Recent national challenges, including economic factors and changing demands, have raised concerns about the sustainability of General Practice. Key challenges include:
- GP practice sustainability, with most practices as independent businesses facing recruitment difficulties
- Challenges in community health and care recruitment
- Premises and infrastructure limitations
- Limited support from the Primary Care Improvement Plan (PCIP)
- Rising demand, compounded by the pandemic
- GP practices returning Enhanced Service Contracts and reduced uptake of new services

Broader issues, like escalating prescribing costs, affect the entire sector, not just Forth Valley.

This paper focuses on GP Contractor challenges and their impact on the wider system. The Scottish Government's focus is on GP access, but understanding capacity is equally important.

Key Issues Affecting General Practice Sustainability
Notable trends indicate GP practice sustainability is at risk:

- The Forth Valley population is around 305,570, with 330,328 registered GP patients. Aging populations, multi-morbidities, and long secondary care waiting lists increase primary care demand.
- Recruitment and retention of GPs, nurses, and multidisciplinary team members remain a challenge. While the GP headcount is higher (236 in 2024 vs. 220 in 2019), full-time equivalent (FTE) figures have only marginally increased (169.8 in 2024 vs. 165 in 2019).
- Most practices are independent businesses with funding linked to staffing, which impacts business sustainability. Practices have merged, reduced service areas, or returned contracts due to these pressures.

GP practices are spread geographically to ensure access to core services, as required by the Primary Care Medical Services (Scotland) Act 2004. NHS Forth Valley must manage sustainability within existing resources and national GMS arrangements.

Primary Care Improvement Plan
The Primary Care Improvement Plan (PCIP) and Memorandums of Understanding (MOUs) aim to address these challenges. However, full implementation of the GMS Contract requires more resources than the current PCIP funding allows. As of April 2023, GP practices are no longer responsible for Pharmacotherapy or Community Treatment and Care Services, with NHS Boards now assuming responsibility. Challenges remain in staffing, accommodation, and collaboration within multidisciplinary teams.

The Forth Valley Primary Care Improvement Plan was agreed upon in 2018, with subsequent updates detailing progress. A recent summary of national PCIP implementation by the Scottish Government provides further background.

The PCIP's implementation in Forth Valley has been largely successful, thanks to the diligent efforts of those involved. Although the plan was formulated in 2018, its full realisation has taken time due to the introduction of new roles, requiring job descriptions, recruitment and specialised training to integrate these new roles within General Practice.

Recruitment challenges have stabilised over the past year, with teams now well-integrated into practices. Any absence or vacancy is acutely felt, highlighting the integral role of PCIP teams. Workforce stabilisation has also presented financial challenges within the PCIP budget.

The PCP SG allocation is **£10.006m** (before any AFC pay award funding announced) and other funding sources such as CAMHS, Diabetes, Action 15 and Prescribing Support totalling £1.107m (these are subject to change once the MH Outcomes Framework bundle reduction has been spilt).

The PCIP programme is over committed against existing allocations made by Scottish Government, a position that has been tolerated given the level of slippage seen since the programme inception. For noting, as many staff are now at top of scale, there may be further pressure on this position. This is a complex matter given the contractual commitments set out in the MOU and tripartite planning decisions made on local implementation plans.

PCIP Data
Over 200 staff have been recruited, increasing capacity by approximately 6,350 appointments and over 8,500 medicines-related activities. The LIST team has developed high-quality dashboards to monitor PCIP activities, making them invaluable for tracking and enhancing performance.

Area	No. Of Staff (WTE funded)	Average Volume of Activity per Week
Pharmacotherapy	72	8500 activities
Community Treatment and Care (CTAC)	41	3500 appointments 2310 bloods taken
Mental Health	29	1030 appointments
Advanced Physiotherapy Practitioners	17	675 appointments
Urgent Care	36	1150 appointments
Vaccinations	17	TBC
Community Link Workers	4	TBC

There are a number of opportunities that are currently being explored to maximise the capacity and impact delivered through PCIP. Specifically, some of the opportunities being explored are:

- Development of Community Diagnostic Hubs – Currently exploring what could be delivered within these hubs and how bookings would be managed.
- Using Feedback to Inform Improvement – A number of PCIP services are in the process of seeking feedback from practices on the services they deliver and what practices want to prioritise going forwards. There is also regular dialogue between PCIP leads and practices to ensure any issues are resolved quickly.
- Improved Data Collection –the development of the new Vision system should reduce the need for manual data collection and therefore optimise patient facing time for PCIP staff.
- Improved Training Opportunities – Continue with the success of the ANP training hub and develop further training opportunities and support for PCIP staff.
- PCIP teams are also following the progress of the national demonstrator sites and will take learning from these as they develop.

Quantifying the Risk of General Practice Sustainability
Significant work has been done over the last year in fully articulating and defining Risks associated with Primary Care and General Practi This includes the primary risk to Forth Valley that it fails to meet the legal requirement outlined in the ‘Primary Care Medical Services (Scotland) Act 2004’ which places a duty on NHS Boards to provide or secure 'primary medical services' for their populations.

Recognising the complexity of the General Practice delivery model, with its dependency on independent contractors and current challenges, the Risk and associated scoring required further attention to ensure it is recognised, reported and reviewed appropriately recognising the complexity and pace of change within Primary Care. On this basis a further focussed review of the Primary Care Sustainability Risk SRR018 has taken place following an ask at Staff Governance Committee in September 24, with a revised description of the risk as follows:

- "If we do not have adequate resources to support and implement a Primary Care framework, there is a risk that we don't have effective measures to ensure delivery of primary care across Forth Valley, resulting in a failure to meet our statutory responsibilities with reputational impact."
- It is felt this more accurately reflects the responsibilities of the organisation to deliver Primary Care services and the implications should that not be possible in accordance with this risk.

Further assessment has also been carried out on the previous set of controls, their descriptions and the gap analysis associated with each. In line with the themes raised in this paper, four key pressures on sustainability have been identified: **Recruitment & Retention, Capacity & Demand, Finance and Premises.** In reviewing the controls previously recorded, it was identified that a number address more than one of these pressures, reflecting the complexity of the Primary Care environment and the challenge that exists in identifying and securing effective mitigations.
On review, several controls were deemed no longer appropriate, effective or measurable due to the limited impact and therefore were removed. Further narrative has also been included in the gap analysis to clarify and indeed quantify Criticality assessment and Control Effectiveness where possible. This additional detail aims to articulate where controls may have a strategic impact on the whole service or where a control may have an impact for individual independent contractors only. For the latter, these are considered "Not Effective" in service wide terms.

As part of the focussed review, associated actions have been identified that would positively increase the effectiveness of each control. These reflect the further work needed to provide greater assurance on the Primary Care Sustainability Risk.

Current Risk Mitigations
These include:

- A revised Primary Care Governance Framework. Since the transfer of responsibility for Primary Care Hosting moved to Falkirk HSCP, work has been undertaken in relation to governance and decision making and a proposal is under consultation with a view to implementation as soon as feasible.
- The NHS Forth Valley Population Health and Care Strategy currently being worked on is inclusive of Primary Care and with that will promote greater coherence and collaboration between Acute, Secondary Care and Primary Care to reduce the, at times, disconnect in the patient journey that can be impactful on the patient, as well as General Practice.
- The Interim position of Head of Primary Care assisted in the relationship management with colleagues across GP Practices and has assured them that they have a direct connectivity to the HSCP Senior Leadership Team, and by extension the IJB, for their issues and ideas. Further to the recent Falkirk Health and Social Care Partnership senior management changes, the Head of Strategic Planning and Transformation now has Primary Care within their remit
- A process of engagement, both at formal processes such as Practice Manager Forums and informally through practice visits and discussions, has been undertaken to promote ideas and innovation to assist Practices. This includes discussions about supporting 'tests of change' within the 'Cluster' environment to promote opportunities for sharing capacity and providing local support networks.
- As can be seen within the Quality / Patient Care section significant progress is being made to improve the patient experience for citizens of Forth Valley, and this progress is fully supported by the Primary Care Team, the PCIP Lead and the GP Sub Committee, a representative body of Forth Valley GP's.

- Improved access to Primary Care data remains a focus building on the GP Capacity and Weekly activity and PCIP dashboards with work underway to agree additional resource to support improved access to information including whole system data and analysis of key indicators.

Quality/Patient Care Experience
In terms of sustainability of the current model for delivering PC services to every citizen, the risks of patient care availability and quality are fundamentally impacted by the continued availability and easy access to patient services through GP Practices.

Progress to improve the patient journey and experience:
- Interface and Chronic Disease Management - secondary care/interface working agreement has been introduced and additional diabetes care through CTAC is expanding capacity for this patient cohort.
- Enhanced Services (ES) – a review and refresh of Local ES is underway including GPPS and Anti-coagulation with a recommendation and associated plan to conduct a full review being taken through governance routes. The review will seek to re-affirm secondary care and Board responsibilities where Practices may choose not to provide these for registered patients.
- Annual health checks for Adults with Learning Disabilities – a pilot programme has been running for 18 months to inform a mainstream model within Primary Care. Programme delivered collaboratively between General Practice, Learning Disabilities Nursing team and Keep Well health improvement nursing team.
- Clinical Care & Governance work – a revision of the Quality Improvement and Clinical Governance Group Terms of Reference and increased reporting using the Vincent Framework is underway.
- Cluster Working – a cornerstone of the re-modelled GP Contract, all Forth Valley Practices are engaged in quality improvement through the Cluster Quality and Practice Quality Lead structure.

Funding and Financial Implications
Much of the funding and financial structures around General Practice including the Primary Care Improvement Plan are determined nationally either under the General Medical Services Contract or associated Statement of Financial Entitlements. Local decisions can be taken on the scope for additional funding streams to invest in Primary Care and General Practice services and local rates can be determined for contracts and services such as Local Enhanced Services, Whole Systems Working activity and Prescribing Improvement Projects.

Total PMS allocation (not including the 6.5% global sum uplift recently announced) £52.02m. Use of brought forward PC reserves that cover Capacity Assessments and Adults with Learning Disabilities Annual Health checks.

The most visible PC-related financial challenge relates to the escalating Prescribing costs. This issue, whist substantially Primary care related is also a matter connected to wider systems, such as Acute and Secondary Care, and so will be detailed in a separate report for the board.

Infrastructure Implications Including Digital
Seventeen of 48 Forth Valley Practices own their premises, facing financial pressures from rising maintenance and utility costs. GP Sustainability Loans, available through the Scottish Government for Tranche 1 applicants, are currently open, but further tranches are paused with no reopening date, limiting opportunities for premises improvements.

Significant premises work, including projects referred to locally as the 'Appendix F' programme which delivered GP premises improvements within 9 Medical Practices in 2021/22 and large-scale capital investments, has created additional capacity, but ongoing funding for further upgrades is restricted.

A national project is transitioning Forth Valley's GP IT system from EMIS PCS to Vision. The situation with INPS (Vision software provider) is being monitored, with plans progressing for implementation once more clarity is available.

Some GP Practices are piloting the Consultant Connect programme, providing a dedicated phone service for easier access to Specialty Consultants for improved patient care.

Sustainability Declaration
There are no direct environmental sustainability issues in respect of the issues raised in this paper however it's recognised if services in the community, including General Practice, are reduced this may have an impact through increased travel for staff and patients.
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process. (A policy for NHS Scotland on the climate emergency and sustainable development) (please tick relevant box)

☒ Yes
☐ N/A

Where applicable, the climate change, environmental and sustainability impacts and any mitigating measures are noted above/contained in the supporting papers.

Quality / Patient Care Implications
As detailed in the main body of the report

Information Governance Implications
Not applicable

Risk Assessment / Management
As detailed in the main body of the report

Relevance to Strategic Priorities

Community-Based Services
Enhance services to improve the 'flow' through hospital settings, prevent admission, and promote independent living. General Practice is a vital preventative service to ensure that the majority of care and support is provided within individuals home or a homely setting. Any risk to General Practice sustainability would compromise that.

Accessible Care
Improve the way people access services – enabling everyone to access the right care, at the right time, in the right place. Accessibility to GP Services is critical to achieving this objective. Any risk to General Practice sustainability would compromise that.

Early Intervention & Prevention
Minimise the harm of long-term health conditions, ill/ mental health, substance use, or neglect through early action. General Practice is critical to supporting individuals at the earliest possible opportunity. Any risk to General Practice sustainability would compromise that.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that: (please tick relevant box)
☒ Full Equality Impact Assessment completed – report available on request

An EPIA is noted on the Falkirk Council system in relation to Primary Care Sustainability. EPIA (reference 00565) covering GP Practice sustainability was commenced in June 2023. This assesses the likely impacts of reduced services on specific groups of patients. It's recognised that specific sustainability challenges affecting individual Practices or areas may impact on different patient cohorts to a greater or lesser extent depending on the location and registered patient demographics. On this basis, a more individualised EPIA may be required in response to specific service sustainability challenges.

Communication, involvement, engagement and consultation
The report has been co-written in collaboration with Deputy Medical Director for Primary Care, Head of Strategic Planning and Transformation- Falkirk Health and Social Care Partnership and Transformational Programme Manager, Falkirk Health and Social Care Partnership. The issues raised within the report have been highlighted with support from the GP Sustainability Group and GP Clinical Leads from each of the local authority areas within Forth Valley.

Additional Information
A Joint IJB Workshop providing a General Practice Update took place on 17th January 2025 providing a valuable opportunity to raise awareness of the Forth Valley General Practice model.

Appendices
NA

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

20. Power Outage – Forth Valley Royal Hospital 24 January 2025
For: Assurance

Executive Sponsor: Professor Ross McGuffie, Chief Executive
Authors: Mr Garry Fraser, Director of Acute Services
Mrs Nicola Watt, Emergency Planning & Resilience Manager

1. Executive Summary

1.1 On the 24th January 2025 at 14:45 there was a full loss of power to the Forth Valley Royal Hospital site which resulted in a Major Infrastructure Failure being declared. At this time the telephone exchange was offline due to weather which coincidently resulted in a complete loss of communication, lighting and running water in areas where it requires electrical power to function, such as wave taps on the site. The site had to implement a process of contingency plans to enable the site to function and care for the patients and staff. There was already a command structure in place due to the red weather warning for Storm Eowyn and within minutes a structure was in place to manage the situation.

1.2 The immediate response of staff on site was exceptional with teams working and willing to do whatever was required to support patients and each other at this very challenging time.

1.3 A Black Start test took place on the FVRH site on the 26th November 2024 prior to the Major Infrastructure Failure; at that time everything was tested and was working as normal. There was no patient harm recorded as a result of the infrastructure failure, however a small number of patients who were being prepared for theatre had to have their procedures rescheduled.

1.4 Staff engagement has been undertaken to understand what worked well, what could be improved and suggestions for the future.

2. Recommendations

2.1 The Forth Valley NHS Board is asked to:

(i) **note** the findings of the review report and details of the root cause of the power loss.
(ii) **acknowledge** that learning will be shared through the local, regional and national resilience partnerships.
(iii) **take assurance** that lessons have been learned and actions taken to prevent and enhance our response.
(iv) **discuss** and **comment** on any additional actions and learning required.

3. Key Issues to be Considered

3.1 The process for undertaking parallel running of generators with grid power, when there is a potential of a power surge has been reviewed. There is a list of recommendations and actions outlined below and within the paper to change local processes and response to a power outage going forward.

- Serco has carried out a review and updated their Standard Operating Procedures to incorporate additional checks linked to the circuit breakers and switch as part of the manual reset procedures for the generators.
- Serco has updated local operating procedures to avoid parallel running of the generators during periods when there is an unstable mains supply, with consideration given instead to enacting full generator power only.

- Serco has carried out training for manual reset processes to ensure local site staff are aware of the updated operating procedures.
- Pre-agreed actions and communication for future red weather warnings affecting the local area are being developed to ensure that decisions on the level of activity that can be maintained and what should be rescheduled are taken at an earlier stage.
- Local business continuity plans are being reviewed and updated and checklists prepared to help improve preparations for any potential disruption to local systems during a red weather alert.
- Additional training in contingency arrangements for major infrastructure failures is planned to ensure staff, particularly those who have joined the organisation recently, are aware of the arrangements and actions required.
- Potential solutions to improve the resilience of local telecommunication systems are being explored.
- Serco will develop a protocol in collaboration with NHS Forth Valley to support earlier decision making and intervention in advance of a red weather warning.

Financial Implications
The financial impact has not been fully estimated as yet. There were many surgical procedures and appointments on the day which had to be rescheduled. Pharmacy protocols along with attention to detail avoided hundreds of thousands of pounds of medications being lost. There will be estates adjustments around the site to be explored along with additional equipment procured.

Workforce Implications
The team work experienced on the day did have a positive impact on those involved. A review of the planned activity and communications ahead of a red warning is being re-evaluated.

Infrastructure Implications including Digital
This is being reviewed through the debrief outcomes.

Sustainability Implications
The learning from this event very much falls into the Sustainable Buildings; Sustainable Care; and Sustainable Communities. We must have a hospital that can function during a power loss from the National Grid supply. This is the aim of the lessons learned, to understand why this happened and put new processes in place to resolve for this.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process. *(A policy for NHS Scotland on the climate emergency and sustainable development) (please tick relevant box)*

☐ *N/A*

Quality / Patient Care Implications
This has been outlined in the paper.

Information Governance Implications
There are information governance issues to be reviewed through this process. There is no conclusion to that yet. This is a NIS reportable incident. Information Governance is taking this forward.

Risk Assessment / Management
This type of event is a top risk for NHSFV and we aim to ensure that we mitigate this as much as possible

Relevance to Strategic Priorities
Business continuity and a fully functioning hospital are at the core of how we deliver patient care. There is nothing more relevant to the strategic priorities of the hospital functioning correctly.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

☒ Paper is not relevant to Equality and Diversity
Screening completed - no discrimination noted
Full Equality Impact Assessment completed – report available on request

Communication, involvement, engagement and consultation
Staff engagement was carried out to gather feedback which informed a site wide debrief and individual departmental debriefs, ELT, SLT and the acute management team.

Additional Information
None

Appendices

- Appendix 1: Update on Power Outage at Forth Valley Royal Hospital on 24 January 2025

Update on Power Outage at Forth Valley Royal Hospital on 24 January 2025

Situation
Forth Valley Royal Hospital experienced a power outage due to significant power fluctuations during Storm Eowyn, resulting in the loss of power at 14.45 for a total period of 70 minutes (power was restored after an hour followed by a short manual restart process which took approximately 10 mins).

Background
Storm Eowyn was categorised as a Red Weather Warning by the Met Office on 23 January 2025 with effect from Friday 24 January 2025, 10:00 until 17:00, across southern Scotland and the Central Belt with a high likelihood of high impact. Predictions were expected winds gusting to 80-90mph across inland areas of southern Scotland and the Central Belt, bringing the potential for significant damage and disruption.

Forth Valley Royal Hospital has four generators, with three required to power 100% capacity of the hospital and on-site fuel stocks able to support three days of continued use.

The monthly generator testing schedule was up to date, and the annual full on-load black start was undertaken on 26 November 2024, with no significant issues identified. In addition, there is weekly off load testing and monthly on-load testing. This is in accordance with SHTM 06 requirements. The generators are subject to six-monthly servicing in line with manufacturers recommendations, with the last taking place on 19 December 2024.

Several meetings took place on Thursday 23 January 2025 with a Gold Command structure in place, Operational/Silver Command site meetings and Local Resilience Partnership (LRP) to discuss and agree how to prepare for the anticipated weather-related issues. Meetings were scheduled throughout Thursday 23rd and Friday 24th January to monitor the situation and respond to any emerging issues.

Throughout the morning and early afternoon of Friday 24 January, the extreme weather resulted in disturbances on the electricity grid transmission and distribution networks. This, in turn, caused some disruption to the hospital's mains power supply. Whilst this was not significant enough for the back-up generators to deploy automatically, it did cause some local disruption with power dips causing lights to flicker and several circuits and systems having to be reset.

As a result, a decision was taken by the Serco team to set the hospital's generators to parallel run alongside the mains power supply to help minimise the impact of more frequent power dips as the storm progressed.

At 14:45, all areas within the hospital experienced a loss of power because of a major power surge which tripped the connections for both incoming mains and generator power supplies. This power outage was compounded by other weather-related issues which impacted on fixed and mobile network infrastructure across the local area and made communication extremely challenging.

The onsite Serco team immediately commenced the Standard Operating Procedures in place for all manual and digital resets but were unable to reinstate mains or generator supplies. The Serco Authorising Electrical Engineer, who had been contacted at the onset of the outage, attended the site and working with the local site team was able fully restore the power.

This full site power loss was managed via our Incident Command structure, reported to Scottish Government and the Local Resilience Partnership with support requested from the

Scottish Ambulance Service and neighbouring NHS Boards, if required. It was declared as a Major Infrastructure Failure and the response plan for this was enacted.

The main aims and priorities were to:

- avoid any loss of life or potential harm to patients
- restore power as quickly as possible
- return the hospital and systems to normal operations

Critical medical equipment, including ventilators, were plugged into a network of blue sockets which are part of the Isolated Power Supply (IPS). These are powered from the UPS system, a separate battery-operated Uninterruptible Power Supply (UPS). Checks were undertaken to ensure that vital equipment was functioning appropriately and expected battery life was reported back to Silver Command (ventilators can continue to operate on battery power for 3 – 4 hours and other ITU equipment for up to 8 hours). No identified risks were highlighted with no interruption to the continuity of care, with staff working together to support patients and each other during this very challenging time. Contrary to some initial media reports – no patients required to be manually ventilated as a result of the power loss. There was no patient harm recorded as a result of the infrastructure failure, however a small number of patients who were being prepared for theatre had to have their procedures rescheduled.

After power was restored, IT systems were brought back online in a prioritised, planned manner along with the phone system and Wi-Fi communications.

The immediate response to the power loss by staff on site was exceptional with staff working and willing to do whatever was required to prevent loss of life or harm to local patients. We have also received positive feedback from patients in hospital during the power outage who got in touch to praise staff for their care and ongoing communication during the incident.

Debrief

A full site debrief into the power outage was held on 31 January 2025 at Forth Valley Royal Hospital to review feedback and identify learning from departments, wards and services across the hospital site. Key themes and issues were discussed along with feedback on what worked well and what could be improved.

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Key Actions & Recommendations

- Serco has carried out a review and updated their Standard Operating Procedures to incorporate additional checks linked to the circuit breakers and switch as part of the manual reset procedures for the generators
- Serco has updated local operating procedures to avoid parallel running of the generators during periods when there is an unstable mains supply, with consideration given instead to enacting full generator power only
- Serco has carried out training for manual reset processes to ensure local site staff are aware of the updated operating procedures
- Pre-agreed actions and communication for future red weather warnings affecting the local area are being developed to ensure that decisions on the level of activity that can be maintained and what should be rescheduled are taken at an earlier stage

- Local business continuity plans are being reviewed and updated and checklists prepared to help improve preparations for any potential disruption to local systems during a red weather alert
- Additional training in contingency arrangements for major infrastructure failures is planned to ensure staff, particularly those who have joined the organisation recently, are aware of the arrangements and actions required
- Potential solutions to improve the resilience of local telecommunication systems are being explored
- Serco will develop a protocol in collaboration with NHS Forth Valley to support earlier decision making and intervention in advance of a red weather warning

Recommendations

Review and implement lessons learned to ensure the risk of this incident is mitigated and plans are updated. Share learning from this Major Infrastructure Failure through the local, regional and national resilience partnerships.

Garry Fraser
Director of Acute Services
NHS Forth Valley

Nicola Watt
Emergency Planning and Resilience Manager
NHS Forth Valley

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

21(a). Quality Assurance and Improvement Report
For: Assurance

Executive Sponsors: Mr Andrew Murray, Medical Director. Professor Frances Dodd, Executive Nurse Director.
Authors: Mrs Susan Bishop, Head of Efficiency, Improvement, and Innovation. Mr Ashley Calvert, Head of Clinical Governance, Mrs Eilidh Gallagher, Head of Person-Centred Care & Mrs Lucy Atalla, Quality Improvement and Patient Safety Lead

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Executive Summary
The purpose of this paper is to describe the Board's quality assurance position, give an update on progress with key quality improvements across NHS Forth Valley and use of evidence to plan for quality. In doing so, it also provides an update on implementation of the NHS Forth Valley Board Quality Strategy (QS) and the way that we manage quality.

Recommendations
The Forth Valley NHS Board is asked to:
- **note** overall delivery of quality assurance, quality improvement and using evidence to plan for quality
- **note** the current quality assurance position and quality improvements being made in relation to specific quality measures and compliance with national safety standards and targets
- **note** the level of assurance being given.
- **support** the progress and further development of the quality management system

Key Issues to be Considered.

1. Introduction

Our vision for quality is 'To improve the experiences of health & care for the people of Forth Valley by working together to deliver quality care and support that is recognisable and meaningful'.

Progress with implementation of the QS is monitored, reported, and reviewed at the NHS Forth Valley Quality Programme Board. see Appendix 1

The delivery of the Clinical Governance Strategic Implementation Plan is a key objective of the QS and progress on the implementation of this is reported to the Clinical Governance Working Group and up to the Clinical Governance Committee.

2. Assurance of Quality

2.1 Data and measurement

A significant level of work to improve use of data and maximise use of existing data systems, Safeguard in particular, is continuing. Data quality review, risk identification and redesign of use of data continues via the Quality Strategy Using Data Effectively Group, the NMAHP Quality Management Board and the Safer Together Dashboard project group.

This includes the use of the QI Data Visualisation and Interpretation Guide V1, run chart and statistical process control tools and upskilling of the QI Team and Information Services colleagues.

Work continues into having robust quality data for assurance of quality, as well as for improvement. The NMAHP Quality Management Board has focussed on improving NMAHP data quality and standards and is developing an assurance measurement framework.

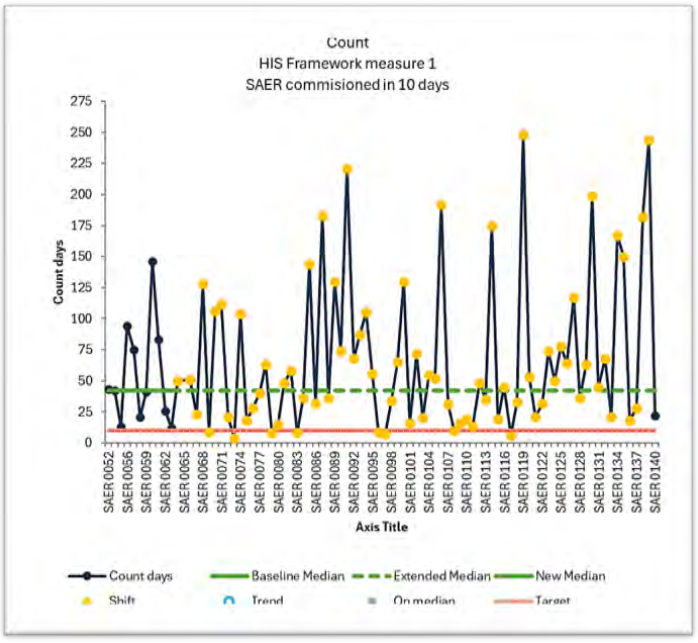
In February 2025 an updated Healthcare Improvement Scotland (HIS) Framework for Adverse Events and Significant Adverse Event Review management was published and disseminated to all Boards and responsible officers. Work on improving the use of the Safeguard adverse event reporting and risk management system for adverse events continues. Alongside developing standardised adverse event (AE) escalation pathways within all Directorates and developing a measurement plan to provide assurance for the Board in relation to NHS Forth Valley's compliance with the timescales set out within Framework for Adverse Events and Significant Adverse Event Review management. Reviewing and ensuring alignment to national dataset requirements of the AE category and subcategory lists within the Safeguard system is an ongoing piece of work.

There are key performance indicators (KPI) within the framework for completing the reviews:

- Time to Commissioning the SAER - 10 working days from reporting on incident management system.
- SAER report submission due 90 working days from date SAE was commissioned.
- Final approval of SAER report no later than 30 working days from report submission.
- Develop an improvement plan within 10 working days from report being approved.

A review of current performance in relation to each of these measures has been undertaken, and an improvement plan and supporting measures drafted for implementation

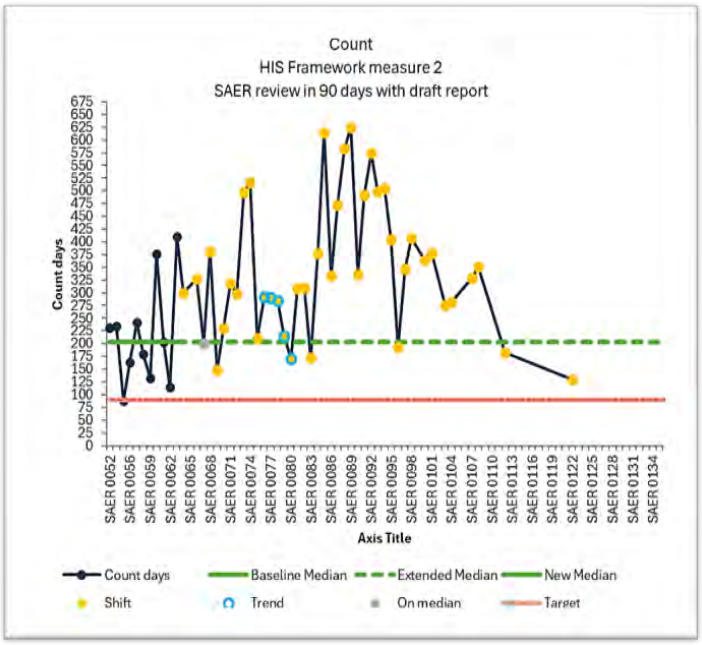
Chart 1: HIS Framework process measure 1: Time to Commissioning the SAER - 10 working days from reporting on incident management System.



From the data reviewed from all SAER commissioned from 2020-2024, the current NHSFV commissioning average = 42 days.

The initial improvement aim is to reduce commissioning days average by 50% by December 2025.

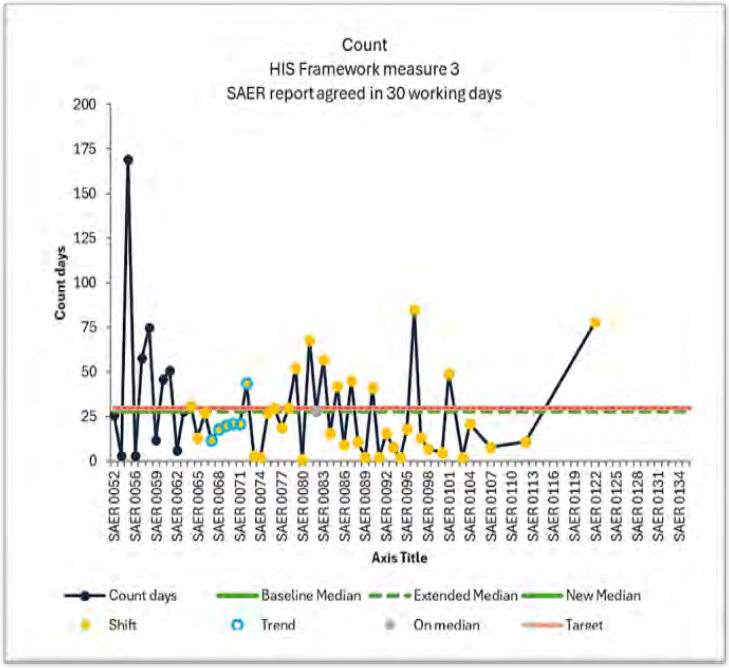
Chart 2: HIS Framework process measure 2: SAER report submission due -90 working days from date SAE was commissioned.



From the data reviewed from all SAERs commissioned from 2020-2024, the current NHSFV draft report submission average = 203 days.

The initial improvement aim is to reduce SAER draft report submission average by 50% by December 2025, with the full aim of meeting 90-day process by December 2026.

Chart 3. HIS Framework process measure 3: Final approval of SAER report -no later than 30 working days from report submission.



From the data reviewed from all SAER commissioned from 2020-2024, the current NHSFV report agreed days = 28 days

NHSFV currently meet this HIS timeframe.

HIS Framework process measure 4: Develop an improvement plan within 10 working days from report being approved.
We are currently unable to provide meaningful data at present. This measure has not historically been recorded in NHSFV and will be a new measure as part of improvement plan.

Appendix 3 and Appendix 4 of this paper describe the measurement plan and high-level driver diagram relating to the SAER process.

A further measurement plan for adverse event management will be submitted to the CGWG in April 2025 as part of the ongoing AE improvement work stream.
Detailed workplans for Adverse events management and SAER management have been developed by the corporate CG team and will be tracked and monitored through the CGWG, with assurance provided to the CGC.

2.2. Setting standards of care
The delivery of the ST collaborative will contribute to higher quality care and support quality assurance.

3. Quality Improvement

3.1 Safer Together Collaborative (ST)
The aim of the ST collaborative is to improve patient safety across several areas through implementing evidence-based practice using improvement science methodology, standard setting through clinical policy review, coordination of improvement support and improvement of data and measurement processes.

There is a focus on identifying and addressing key areas of patient safety concern, such as data quality and system reporting capability, pressure ulcers incidence, safer mobility and falls risk reduction, cardiac arrest and deteriorating patient, catheter care and ageing & frailty.

63 teams across the whole system are currently in Action period 1(AP1) and LS2 is set for 18th March 2025.

3.2 Knowledge, skills and capacity for improvement
Overall work to build knowledge, skills and capacity for improvement across NHS Forth Valley and the Health and Social Care Partnerships continues as part of the QS implementation.

The “Capacity, Capability and Culture for Continuous Learning and Quality Improvement – Implementation Plan” was approved by the Quality Programme Board in November 2024. The evidence-based plan was developed as one of the objectives of the Forth Valley Quality Strategy.

There are three high level priorities:
Priority 1: All NHS Forth Valley and Health and Social Care Partnership workforce will have access to quality improvement education
Priority 2: Create a robust and accessible quality improvement learning infrastructure that supports a culture for continuous learning and improvement
Priority 3: Create a culture which supports continuous learning and quality improvement where ‘failure’ is viewed as a learning gift.

3.3 Key metrics progress

3.3.1 Pressure Ulcer

Aim: ***Reduce grade 2-4 pressure ulcers by 30% by Nov 2025***

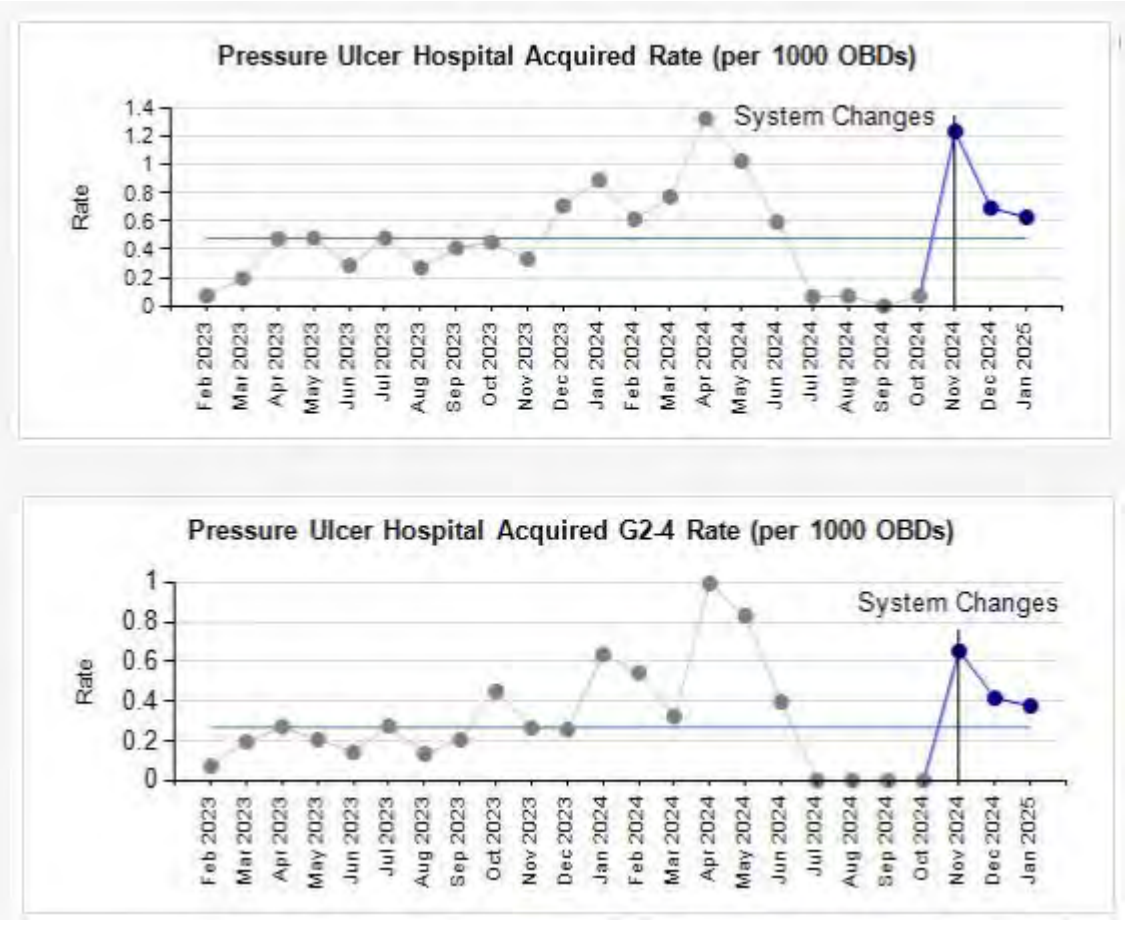
Background:

Forth Valley's historic data demonstrated a deterioration in pressure ulcer incidence with 11 data points above the median. There are reliability issues with reporting due to the previous measurement framework, therefore an increase in occurrence is expected as reporting improves, and data quality is improved through review of process via the Safeguard system. Improvement efforts will be based on Healthcare Improvement Scotland's pressure ulcer standards, improvement change package and measurement plan. The Pressure Ulcer Policy is complete and reflects contemporary practice, the reporting mechanisms are being refined to align with the policy.

Current position:

There are currently **11** active test teams focusing on pressure ulcers in line with QI methodology following the quality improvement journey.

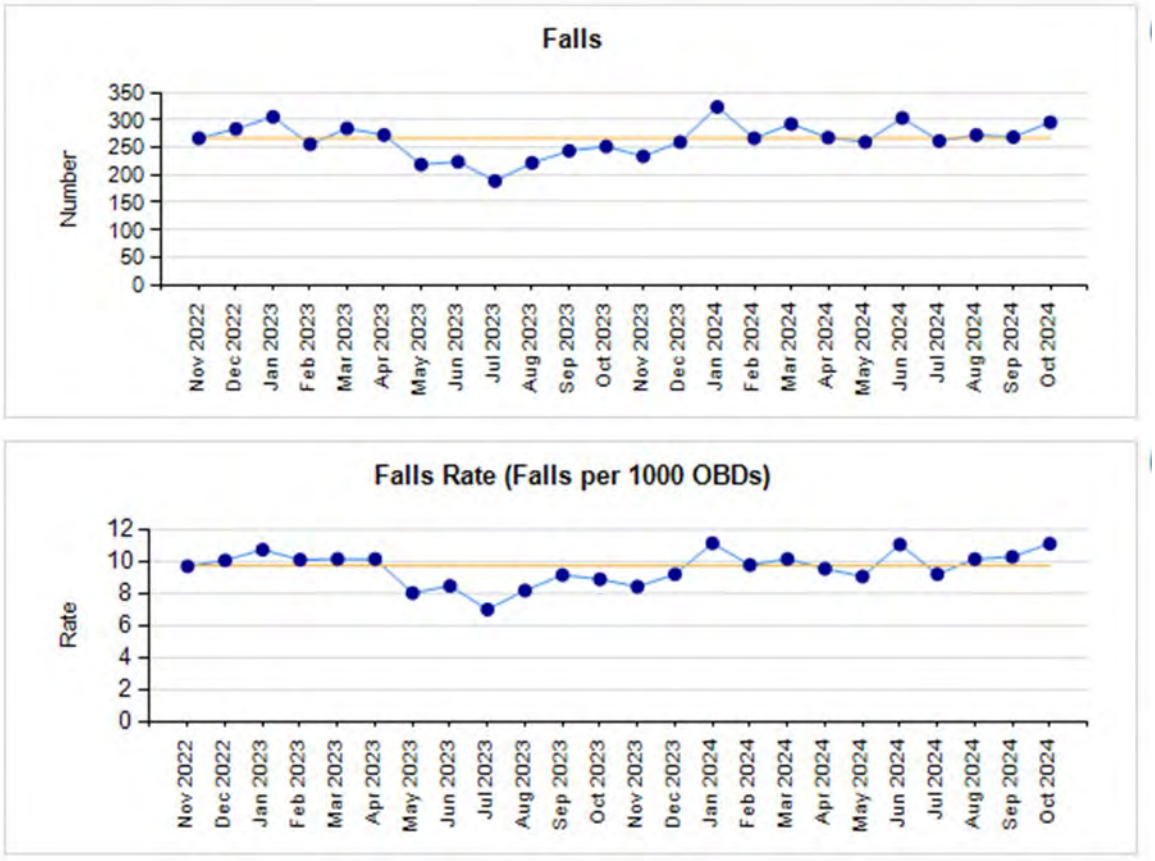
Work is underway to look at reporting and data quality, system changes have been in place since November 2024 which has had some impact on the data seen below.



3.3.2 Safer Mobility/Falls

Aim: ***Reduce total falls and falls with Harm (moderate to severe) by 30% by Nov 2025***

Background: Our baseline median was 10 with a static rate from April 22. We currently have limited ability to understand categorisation of falls in term of harm at organisational level. The local measurement plans reflect the national SPSP falls change package. Current Data displaying random variation Nov 22 - Oct 24.

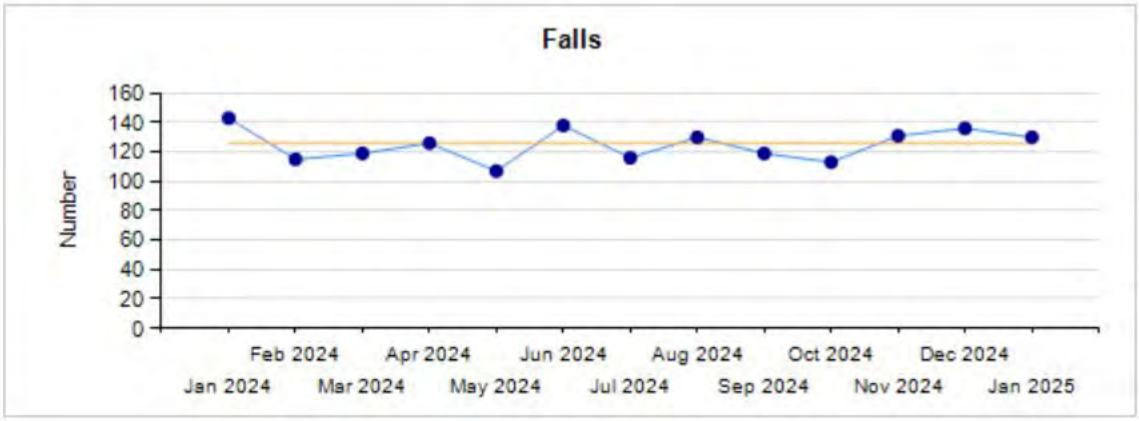


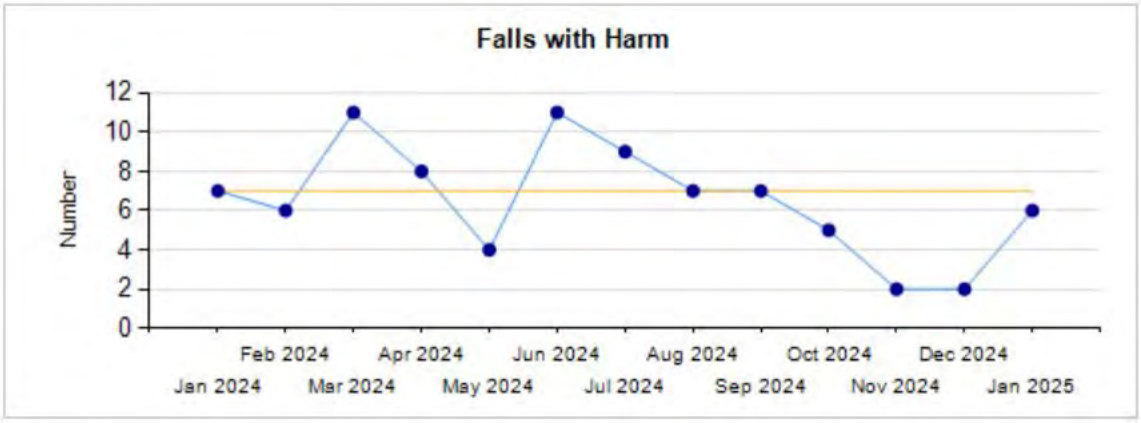
Current Position:

There are currently **12** active test teams focusing on Safer Mobility in line with QI methodology following the quality improvement journey.

The NMAHP Quality Management Board subgroups interdependencies are currently reviewing and redesigning the front-end reporting mechanism of Safeguard to support data extraction to provide harm intelligence and support improvement planning.

Falls



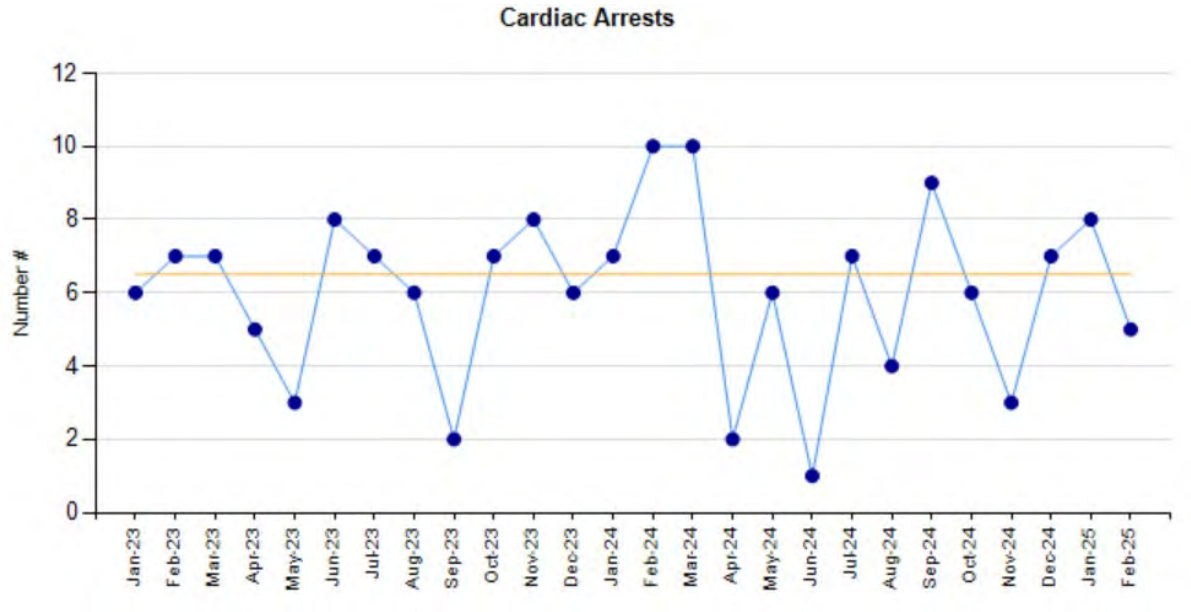


3.3.3 Cardiac Arrest

Aim: ***Reduce Cardiac Arrest rate by 40% by Nov 2025 (NCAA) while improving cardiac arrest reporting via safeguard. (National Cardiac Arrest Audit)***

Background: NHS Forth Valley is part of the National Cardiac Arrest Audit (NCAA). Our position on the caterpillar plot comparing FVRH to all participating hospitals demonstrates that we are in the upper range for Cardiac arrest rate. Cardiac arrest data reporting is undergoing review to ensure cardiac arrests are captured through our risk system as a clinical event. Treatment and escalation planning (TEP) as a process will have an impact on outcome data and will be a focus of the safety collaborative.

Current Position:
There are currently **10** active test teams focusing on deteriorating patients (Cardiac arrests and TEP) in line with QI methodology following the quality improvement journey.



3.3.4 Catheter Associated Urinary Tract Infection (CAUTI)

Aim: ***Reduce Catheter Usage by 30% by Nov 2025***

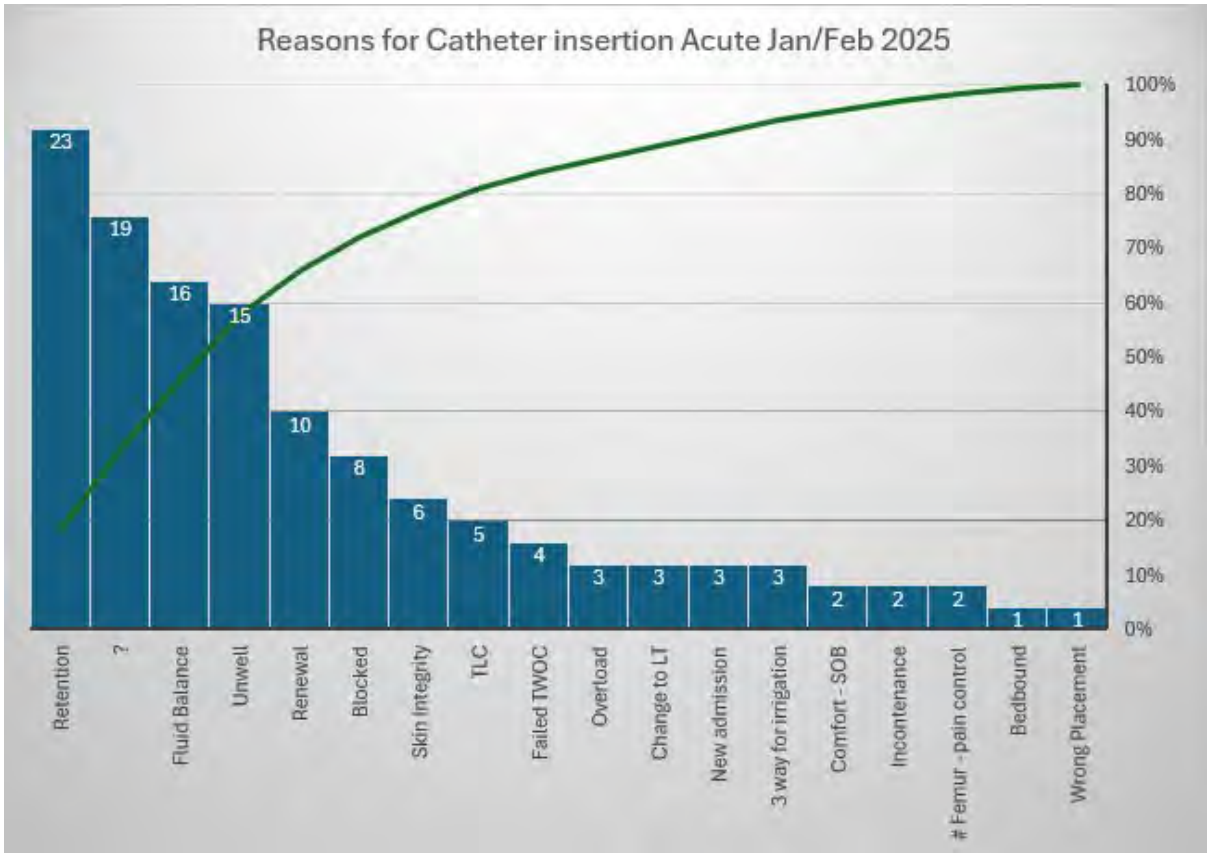
Background:

The safety collaborative will focus on catheter usage and care across Forth Valley to understand usage and potential for process improvement where opportunities exist to deliver evidence-based catheter care and appropriate usage.

Current Position:

There are currently **14** active test teams focusing on Catheter Care in line with QI methodology following the quality improvement journey.

Urinary Catheter Policy review group have been established and improvement work within these test teams will run parallel to this group and feed in to influence the new Urinary Catheter Policy. Planned transformative simulation is in place for acute and non-acute test teams on techniques, HOUDINI (daily catheter review criteria) & continence assessment. Daily collection of data has commenced as of January 2025 on *'number of catheters inserted daily' awaiting* monthly visualisation of data. Manual data collection is in place using the safety cross methodology.



4. Quality planning

4.1.1 Clinical guidelines review

The development of a new Clinical Policy and Guidelines Group will ensure greater assurance of standardised and aligned processes for the development, review and approval of clinical policies and guidelines within the Board, along with a strategic risk having been developed to further enhance visibility and mitigation. This workplan is being taken to the CGWG in April 2025 for further engagement and support.

4.1.2 Learning from feedback and complaints

There has been a sustained increase in the volume of complaints received which is reflective of the increase in healthcare interactions that have, and continue to, take place across the organisation. The volume of complaints is reflective of a ratio of 0.21% of interactions. The upheld ratio remains.

Combined performance across the organisation has remained between 60 – 70% since April 2024, a 10% increase in comparison with 23/24 data.

The patient relations department continues to implement service improvements to further improve performance in line with high level service objectives.

1) **To achieve a 25% Stage 2 performance rate by the end of March 2025.**
Target achieved in August, September and October (performance in excess of 28%). Performance reduced below 20% in December and January, largely impacted by planned and unplanned leave. Recruitment ongoing to mitigate this, although this target is unlikely to be achieved within the timeframe due to the reasons stated previously.

2) **To achieve a 20% reduction in the volume of complaints by the end of March 2025 in comparison with 23/24 statistics.**
11% reduction achieved in November / December in comparison with 2024 monthly averages. Ongoing risk of deterioration attributed to the increase in healthcare interactions.

3) **To increase the patient relations workforce in line with national averages by the end of March 2025.**
Recruitment ongoing, base budget profile re-established to meet national averages for the next 12 months without the ask for any additional financial investment. It is predicted that the department will recruit to the realigned skill mix but may be beyond the March 2025 deadline.

4) **To manage 65% of complaints under Stage 1, local resolution, processes by the end of December 2024.**
Target achieved and sustained since March 2024, indicative of a 15 – 20% increase in management of complaints under S1 processes.

We continue to share learning via local service units and clinical governance forums to enhance patient care across the organisation. Deep dives into high prevalence complaint areas are reported at regular intervals.

Work is ongoing to enable complaint avoidance practices through the development of robust learning environments with collaborative working between the business units.

Financial Implications
There are no direct financial implications arising from the recommendations of this paper other than the time commitment of the faculty and the test teams in the delivery of the collaborative as part of the Board's approach to patient safety and quality improvement.

Workforce Implications
There are no direct workforce implications arising from the recommendations of this paper, except the opportunity to support staff to participate in the faculty and the test teams to strengthen care provision and improve outcomes for patients.

Infrastructure Implications including Digital
There are no immediate infrastructure implications arising from this paper.

Sustainability Implications
There are no immediate sustainability implications arising from this paper.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process. *(A policy for NHS Scotland on the climate emergency and sustainable development) (please tick relevant box)*

☐ *Yes*

☒ *N/A*

Where applicable, the climate change, environmental and sustainability impacts, and any mitigating measures are noted above/contained in the supporting papers

Participation, leadership, and support
The Executive Director of Nursing and the Medical Director are the executive sponsors for the STC. The STC will contribute to building improvement in clinical and care knowledge, skills, and practice and to workforce development.

Patient, service users and family representatives and Third Sector colleagues will be invited to contribute to and participate in the STC.

Forth Valley Quality's Innovation Lead will be a member of STC Faculty to lead and support identification of other innovation opportunities as part of implementation of NHS Forth Valley's Innovation Plan.

Demonstrating impact
A measurement plan for the programme has been developed to outline outcome, process and balancing measures aligned to improvement aims. Data and measurement support is crucial to the STC to be able to deliver a standard of reporting that drives improvement, through intelligence and data that measures and accurately reflects harms and the impact that implementation of tested change ideas produces.

An evaluation plan is being developed, including scoping of economic evaluation and collaboration with the University of Stirling via our University College NHS Partnership.

A knowledge management plan is also being developed via the FVQ team to contribute to learning throughout the STC and to wider learning within the organisation and with partners and other external bodies such as Healthcare Improvement Scotland.

Information Governance Implications
There are no immediate information governance implications arising from this paper.

Risk Assessment / Management
Each risk either explicitly or implicitly identified within this paper is reviewed by the corporate risk manager and head of clinical governance to ensure it is captured on the appropriate risk register (if applicable) and mitigations are in place.

Relevance to Strategic Priorities
- The Forth Valley Board Quality Strategy***.***
- NHS Forth Valley Clinical Governance Implementation plan
- Leadership: Develop individual and collective responsibility to enable a collaborative approach to system leadership.
- Culture: Model behaviours and a culture where staff and patients feel valued, safe, and empowered
- Transformational Change: Reimagine and redesign the way we work to improve the health of the population of Forth Valley.
- Performance: Progress incremental and sustainable improvements in our system wide performance.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:

☒ Paper is not relevant to Equality and Diversity
☐ Screening completed - no discrimination noted
☐ Full Equality Impact Assessment completed – report available on request

Communication, involvement, engagement, and consultation

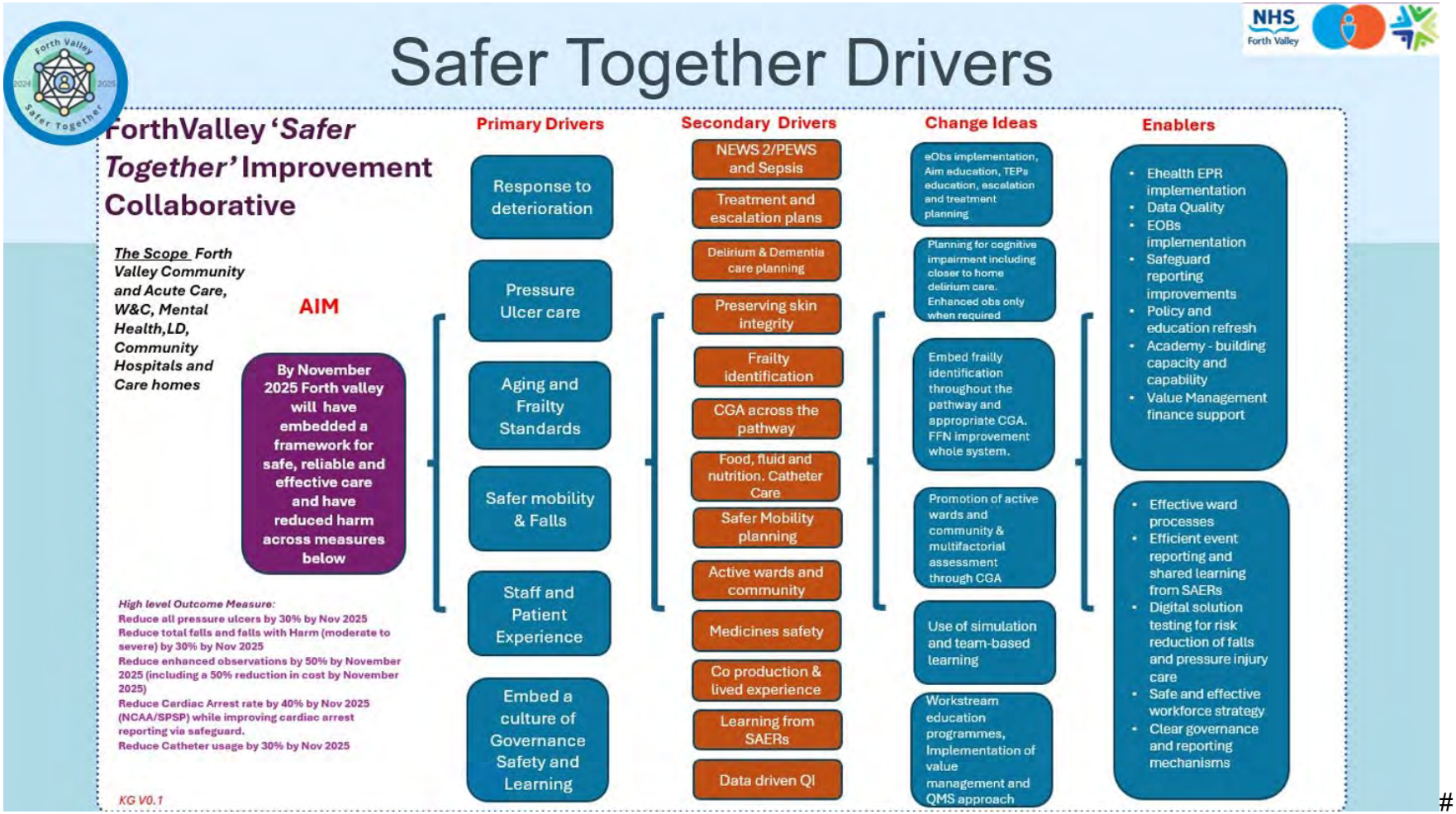
- Safer Mobility Leadership Group,
- Deteriorating Patient Leadership Group
- Pressure Ulcer Improvement Group
- NHS Forth Valley Directorate Level Clinical Governance meetings
- Clinical Governance Working Group
- Clinical Governance Committee
- NHS Forth Valley Safer Together Collaborative

Appendices

- Appendix 1: Quality Management System Overview
- Appendix 2: STC high level driver diagram
- Appendix 3: high level driver diagram SAER process
- Appendix 4: Measurement plan SAER process

Appendix 1: Quality Management System Overview

Appendix 2: STC Driver Diagram (High level)



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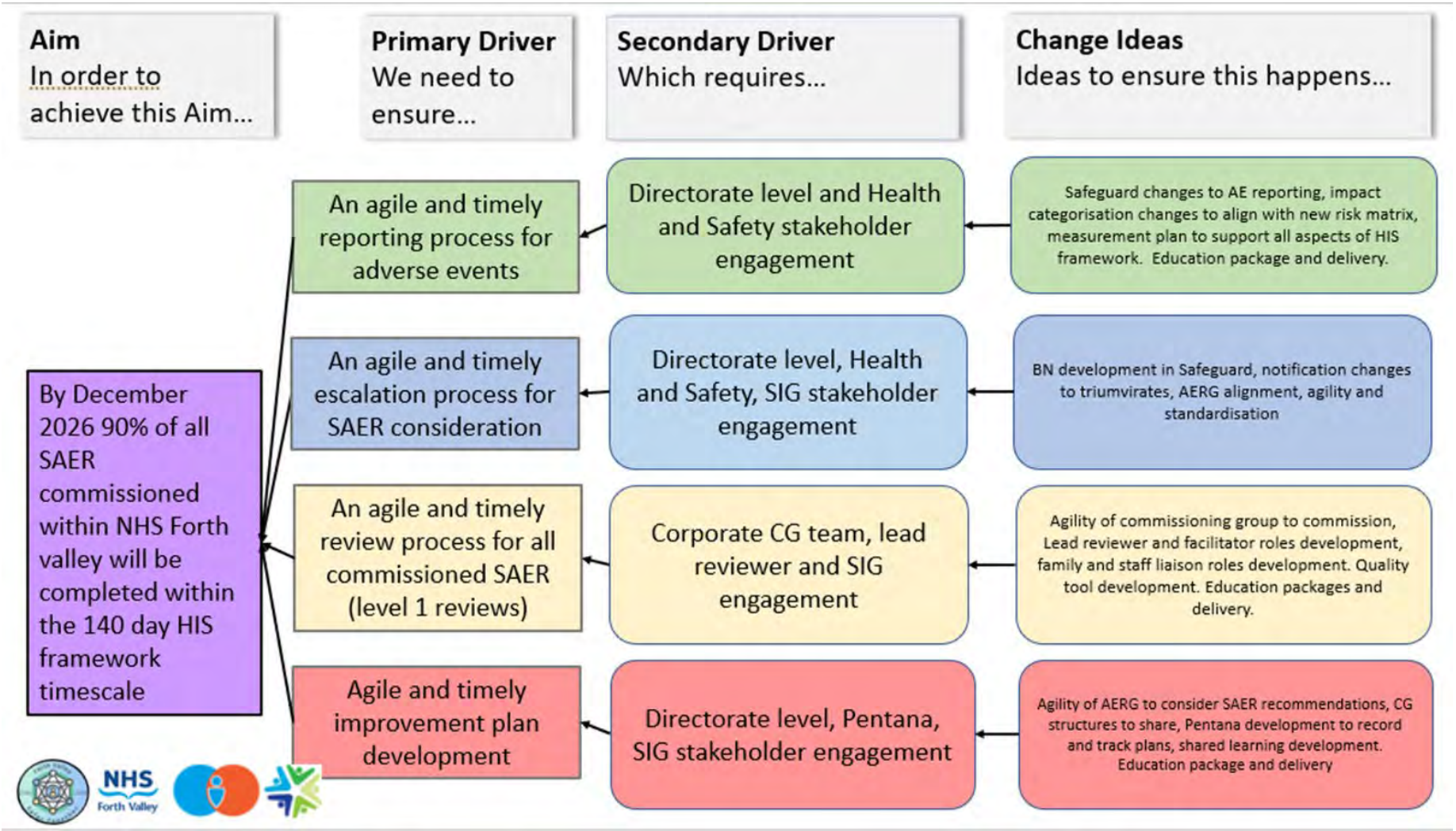
Appendix 3: Driver diagram SAER process



Appendix 4: Measurement plan SAER process

Name of measure Specify type of measure (e.g., percentage / count / rate / variable (e.g. time, volume etc) / days or cases between) and what you are measuring. Indicate underneath whether it is an Outcome (O), Process (P) or Balancing (B) measure	**Concept being measured and why it is important to look at this.** What is the purpose of this measure? i.e., what questions do you want answered in relation to your improvement efforts? What goals are you trying to achieve?	**Operational definition** Clear, precise definition of the measure and how it is calculated. Include numerator and denominator if it is a % or rate. What / who is included or excluded?	**Data collection** Who is collecting it? How often and when? Where is the data coming from? What is the sampling method and sample size (if used)?	**What type of Shewhart (control) chart will you use?** (when enough data points become available)
HIS SAER 1 **Count** of SAER commissioned within 10-day commissioning timescale Process C measure Then calculate percentage for reports over a specified time period	To ensure a timely commissioning process is taking place on all relevant AE.	Determine the numerator: the total number of adverse events that are commissioned for SAER within 10 working days from the date reported on Safeguard 1. Determine the numerator: the total number of adverse events that are commissioned for SAER within 10 working days from the date reported on Safeguard 2. Determine the denominator: the total number of SAER in your sample for the time period 3.Calculate the actual percent of SAER commissioned within timescale by dividing the numerator by the denominator and then multiplying the resulting proportion by 100	Safeguard system- record adverse event reported date and commissioning date. Report per SAER Report per time period (IE 50% of SAER were commissioned within 10 working days for time period…)	Run chart initially, then move to SPC C chart (once 24 data points to establish baseline mean)

HIS SAER 2 **Count** of SAER reports at draft submission stage within 90 working days Process C measure Then calculate percentage for reports over a specified time period Process P measure	To ensure timely SAER review and draft report process is in place	Determine the numerator: the total number of SAER reports submitted to SIG for approval within 90 working days from reported date on safeguard 1.Determine the numerator: the total number of SAER reports submitted to SIG for approval within 90 working days from date reported on safeguard 2. Determine the denominator: the total number of SAER commissioned for time period 3. Calculate the actual percent of reports submitted for approval within 90 working days by dividing the numerator by the denominator and then multiplying the resulting proportion by 100	Safeguard system- record adverse event reported date and draft report submitted to SIG for approval (1st draft submission) date. Report per SAER Report per time period (IE 50% of SAER reviews were completed to draft report stage within 90 working days for time period…)	Run chart initially, then move to SPC C chart (once 24 data points to establish baseline mean)
HIS SAER 3 **Count** of SAER reports approved at commissioning body (SIG) within 30 working days Process C measure Then calculate percentage for reports over a specified time period Process P measure	To ensure timely report acceptance and to allow timely improvement plan formation.	Determine the numerator: the total number of SAER reports accepted within 30 working days from date event reported on safeguard 1. Determine the numerator: the total number of SAER reports accepted within 30 working days from date event reported on safeguard 2. Determine the denominator: the total number of SAER reports submitted to SIG for approval 3. Calculate the actual percent of SAER reports accepted within 30 working days by dividing the numerator by the	Safeguard system- record adverse event reported date and date SIG approves report. Report per SAER Report per time period (IE 50% of SAER reports were approved within 30 working days for time period…)	Run chart initially, then move to SPC C chart (once 24 data points to establish baseline mean)

		denominator and then multiplying the resulting proportion by 100		
HIS SAER 4 **Count** of SAER improvement plans developed within 10 working days Process C measure Then calculate percentage for reports over a specified time period Process P measure	To ensure timely action/improvement plan development	Determine the numerator: the total number of SAER reports with a fully developed action plan on Pentana within 10 working days from accepted report date 1. Determine the numerator: the total number of SAER reports with a fully developed action plan on Pentana within 10 working days from accepted report date 2. Determine the denominator: the total number of SAER reports submitted to the relevant AERG 3. Calculate the actual percent of SAER improvement plans developed within 10 working days by dividing the numerator by the denominator and then multiplying the resulting proportion by 100	Safeguard system- record SAER report approval date and improvement plan on Pentana date (recorded in Safeguard) Report per SAER Report per time period (IE 50% of completed SAER (with a final accepted report) had an improvement plan developed within 10 working days for time period…)	Run chart initially, then move to SPC C chart (once 24 data points to establish baseline mean)
HIS SAER 5 **Count** of SAER completed within 140-day process Count O measure Then calculate percentage for reports over a specified time period O measure percentage	To ensure timely SAER process in line with HIS Framework	Determine the numerator: the total number of SAER with an improvement plan recorded on Pentana within 140 working days from adverse event date to developed improvement plan date 1. Determine the numerator: the total number of SAER with an improvement plan recorded on Pentana within 140 working days from adverse event date to developed improvement plan date	Safeguard system- record adverse event reported date and improvement plan on Pentana date (recorded in Safeguard) Report per SAER Report per time period (IE 50% of SAER were fully completed within 140 working days for time period…)	Run chart initially, then move to SPC C chart (once 24 data points to establish baseline mean)

		2. Determine the denominator: the total number of SAER commissioned from reported date for original AE 3. Calculate the actual percent of SAER completed within 140 working days by dividing the numerator by the denominator and then multiplying the resulting proportion by 100		

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

21(b). Healthcare Associated Infection (HAI) Reporting Template February 2025
For: Assurance

Executive Sponsor: Professor Frances Dodd, Executive Nurse Director
Author: Jonathan Horwood, Infection Control Manager & Clinical Lead

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1. Executive Summary

1.1 The Healthcare Associated Infection Reporting Template (HAIRT) is mandatory reporting tool for the Board to have oversight of the HAI targets (Staph aureus bacteraemias (SABs), Clostridioides difficile infections (CDIs), device associated bacteraemias (DABs), incidents and outbreaks and all HAI other activities across NHS Forth Valley.

2. Recommendation

2.1 The Forth Valley NHS Board is asked to:

- **note** the HAIRT report.
- **note** the performance in respect for SABs, DABs, CDIs & ECBs.
- **note** the detailed activity in support of the prevention and control of Health Associated Infection.

3. Key Issues to be Considered

- Total SABS remain within control limits. There were two hospital acquired SABs in February.
- Total DABs remain within control limits. There was one hospital acquired DAB in February.
- Total CDIs remain within control limits. There were two hospital acquired CDIs in February.
- Total ECBs remain within control limits. There was one hospital acquired ECB in February.
- There have been no deaths with MRSA or *C.difficile* recorded on the death certificate.
- There were no mandatory surgical site infections in February.
- There was one outbreak reported in February.

Implications

Financial Implications
None.

Workforce Implications
None.

Infrastructure Implications including Digital
None.

Sustainability Implications
None.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process A policy for NHS Scotland on the climate emergency and sustainable development.
□ *Yes*
√ *N/A*

Quality / Patient Care Implications
Healthcare associated infections (HAI) can result in poor outcomes for patients in terms of morbidity and mortality, increased length of stay and necessitate additional diagnostic and therapeutic interventions.

Information Governance Implications
None.

Risk Assessment / Management
Work is on trajectory to reduce all reducible SABs, DABs, ECBs and CDI infections across NHS Forth Valley to meet both national and local standards/expectations.

Relevance to Strategic Priorities
AOP Standards in respect of SABs, ECBs & CDIs.

- No targets have been set currently although it is anticipated interim targets will be set later this year.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that: (*please tick relevant box)*
□ Paper is not relevant to Equality and Diversity

Communication, involvement, engagement and consultation
Infection Prevention & Control Team, Infection Control Committee and Clinical Governance Committee

Additional Information
- None.

Appendices
- None

NHS Forth Valley

Healthcare Associated Infection Reporting Template (HAIRT)

February 2025

NHS Forth Valley

Infection Prevention
& Control Team

Glossary of abbreviations

Following feedback from stakeholders below is a list of abbreviations used within this report:

HAI	Healthcare Acquired Infection
SAB	*Staphylococcus aureus* Bacteraemia
DAB	Device Associated Bacteraemia
CDI	*Clostridioides* Infection
ECB	Escherichia Coli Bacteraemia
AOP	Annual Operational Plan
NES	National Education for Scotland
IPCT	Infection Prevention & Control Team
HEI	Healthcare Environment Inspectorate
SSI	Surgical Site Infection
SICPs	Standard Infection Control Precautions
PVC	Peripheral Vascular Catheter

Definitions used for *Staph aureus*, device associated and *E coli* bacteraemias

Definition of a bacteraemia
Bacteraemia is the presence of bacteria in the blood. Blood is normally a sterile environment, so the detection of bacteria in the blood (most commonly accomplished by blood cultures) is always abnormal. It is distinct from sepsis, which is the host response to the bacteria. Bacteria can enter the bloodstream as a severe complication of infection (like pneumonia, meningitis, urinary tract infections etc), during surgery, or due to invasive devices such as PVCs, Hickman lines, urinary catheters etc. Transient bacteraemias can result after dental procedures or even brushing of teeth although this poses little or no threat to the person in normal situations.

Bacteraemia can have several important health consequences. The immune response to the bacteria can cause sepsis and septic shock, which has a high mortality rate. Bacteria can also spread via the blood to other parts of the body (haematogenous spread), causing infections away from the original site of infection, such as endocarditis (infection of the heart valves) or osteomyelitis (infection of the bones). Treatment for bacteraemia is with antibiotics for many weeks in some circumstances, however cases such as *Staph aureus* bacteraemia usually 14 days of antibiotic therapy is required.

Cause definitions for *Staph aureus* and device associated bacteraemia

Hospital acquired

- Hospital acquired is defined when a positive blood culture is taken >48 hours after admission i.e. the sepsis is not associated with the cause of admission. An example would a patient with sepsis associated from an infected peripheral vascular catheter.

Healthcare acquired

- Healthcare acquired is defined when a positive blood culture is taken <48 hours after admission but has in the last three month had healthcare intervention such as previous hospital admission, attending Clinics, GP, dentist etc. Note this does not necessarily mean that the sepsis is associated with the previous healthcare intervention.

Nursing home acquired

- Nursing home acquired is defined when a positive blood is taken <48 hours after admission and when symptoms associated with sepsis developed at the nursing home.

Healthcare Associated Infection Reporting Template (HAIRT)

The HAIRT Report is the national mandatory reporting tool and is presented bi-monthly to the NHS Board. This is a requirement by the Scottish Government HAI task Force and informs NHS Forth Valley (NHSFV) of activity and performance against Healthcare Associated Infection Standards and performance measures.

This section of the report focuses on NHSFV Board wide prevention and control activity and actions.

Performance at a glance:

***Staph aureus bacteraemia* - total number this month: 3**

- There were two hospital acquired SABs this month.
- There was one healthcare acquired SAB this month.
- Total SAB case numbers remained within control limits this month.

Device associated bacteraemia – total number this month: 4

- There was one hospital acquired DAB this month.
- There was two healthcare acquired DAB this month.
- There was one nursing home acquired DAB this month
- Total DAB case numbers remained within control limits this month.

***Clostridioides difficile* infection – total number this month: 2**

- There were two hospital acquired CDIs this month.
- There were no healthcare acquired CDI this month.
- Total CDI case numbers remained within control limits this month.

***E coli* bacteraemia – total number this month: 10**

- There was one hospital acquired ECB this month.
- There were 8 healthcare acquired ECBs this month.
- There was one nursing home acquired ECB this month.
- Total ECB case numbers remained within control limits this month.

Surgical site infection surveillance

- There were no reported surgical site infections this month.

HAI Recorded Deaths

- There were no MRSA or *C.difficile* recorded deaths this month.

Outbreaks

- There was one reported influenza outbreak this month.

HAI Surveillance

NHS FV has systems in place to monitor key targets and areas for delivery. Our surveillance and HAI systems and ways of working allow early detection and indication of areas of concern or deteriorating performance. The Infection Prevention & Control Team undertakes over 180 formal ward audits per month in addition to regular weekly ward visits by the Infection Control Nurse; infection investigation is also a significant function within the team as part of our AOP target reporting. This activity provides robust intelligence of how infection prevention is maintained across all areas in Forth Valley and is reported on a monthly basis to all appropriate stakeholders.

Staph aureus bacteraemias (SABs)

All blood cultures that grow bacteria are reported nationally and it was found that *Staph aureus* became the most common bacteria isolated from blood culture. As *Staph aureus* is an organism that is found commonly on skin it was assumed (nationally) the bacteraemias occurred via a device such as a peripheral vascular catheter (PVC) and as such a national reduction strategy was initiated and became part of the then HEAT targets in 2006. Following on from the 2019-2024 AOP targets, new targets are going to be set by the Scottish Government shortly.

Total number of SABs this month; **3** compared to **5** last month.
There was no data exceedance for SABs this month.

Total number of SABs (April 2024 – date) = **47**

- Hospital acquired = **2**
  - Cellulitis (no attributed ward)
  - Umbilical venous catheter (No attributed ward)

  There was no data exceedance for hospital acquired SABs this month.

- Healthcare acquired = **1**
  - CVC

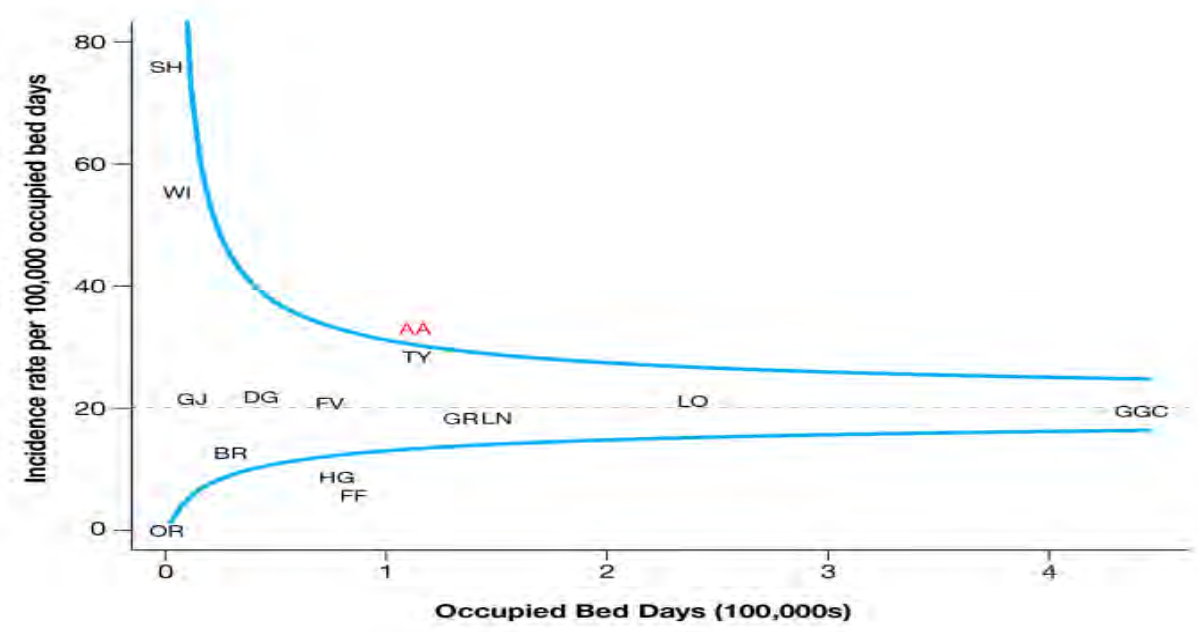
  There was no data exceedance for healthcare acquired SABs this month.

- Nursing Home acquired = **0**
  There was no data exceedance for nursing home acquired SABs this month.

NHS Forth Valley's approach to SAB prevention and reduction
All *Staph aureus* bacteraemia are monitored and reported by the IPCT. Investigations to the cause of infection consist of examining the patients notes, microbiology, biochemistry and haematology reports to identify potential causes of the infection; from this, in most cases, a provisional cause is identified, however this is discussed further with the clinical team responsible for the management of the patient to assist further with the investigation. Any issues identified during the investigations, such as incomplete bundle completion etc is highlighted at this time and where appropriate an IR1 is reported. Once a conclusion has been agreed, the investigations are presented to the Infection Control Doctor/Microbiologist for approval. The investigation is concluded with the IPCT reporting their findings to the clinical team and management.

This data is entered into the IPCT database collated, analysed and reported on a monthly basis. The analysis of the data enables the IPCT to identify trends in particular sources of infections, such as Hickman line infections etc and identifying areas requiring further support. The data also influences the direction of the HAI annual workplan.

National Context
All SABs are reported nationally and reported on a quarterly basis. This provides our board an overview and national context of our national position compared to other boards. Due to the national reporting, unfortunately the data published is 3 months in arrears compared to the local data presented. The funnel plot below contains total case numbers of reported hospital and healthcare attributed infections and provides an indication of FVs position nationally. Below is an extract from the ARHAI Quarter 3 report (July – September 2024) highlighting Forth Valley's position compared to all other boards in Scotland.



Device Associated Bacteraemias (DABs)

In addition to the nationally set targets, infections from an invasive device caused by *Staph aureus* would be investigated fully and reported, any other organism causing the same infection was not mandated to report nationally or to be investigated. As a result of this, in 2014, the IPCT started reporting all bacteraemias attributed to an invasive device regardless of the bacterium causing the infection. Due to the importance and significance of this surveillance, it is now part of our local AOP.

NHS Forth Valley's approach to DAB prevention and reduction
Continual monitoring and analysis of local surveillance data enables the IPCT and managers to identify and work towards ways to reduce infections associated with devices. All DABs are reviewed and investigated fully and highlighted to the patients' clinicians, nursing staff and management. Where appropriate an IR1 is generated to enable infections that require learning is shared and discussed at local clinical governance meetings.

In addition, on a weekly basis the IPCT assess bundle compliance of three invasive devices (PVCs, urinary catheters, CVCs etc) as part of their ward visit programme and this is reported in the monthly Directorate Reports.

Total number of DABs this month; **4** compared to **4** last month.
There was no data exceedance for DABs this month.

Total number of DABs (April 2024 – date) = **63**

- Hospital acquired = **1**
  - Umbilical venous catheter (no attributed ward)

  There was no data exceedance for hospital acquired DABs this month.

- Healthcare acquired = **2**
  - CVC
  - Urinary catheter long term

  There was no data exceedance for healthcare acquired DABs this month.

- Nursing Home acquired = **1**
  - Urinary catheter long term

  There was no data exceedance for nursing home acquired DABs this month.

Escherichia coli Bacteraemia (ECB)

NHS Forth Valley's approach to ECB prevention and reduction
E coli is one of the most predominant organisms of the gut flora and for the last several years the incidence of Ecoli isolated from blood cultures i.e. causing sepsis, has increase so much that it is the most frequently isolated organism in the UK. Following on from the 2019-2024 AOP targets, new targets are still to be set by the Scottish Government. The most common cause of E coli bacteraemia (ECB) is from complications arising from urinary tract infections (UTIs), hepato-biliary infections (gall bladder infections) and urinary catheters infections.

Total number of ECBs this month - **10** compared to **6** last month.
There was no data exceedance for ECBs this month.

Total number of ECBs (April 2023 – date) = **124**

- Hospital acquired = **1**
  - Unknown (No attributed ward)

  There was no data exceedance for hospital acquired ECBs this month.

- Healthcare acquired = **8**
  - UTI x 1
  - Hepatobiliary x 1
  - Unknown x2
  - Urinary catheter long term x1
  - Post procedural x1
  - Gastrointestinal x1
  - Colitis x1

  There was no data exceedance for healthcare acquired ECBs this month.

- Nursing Home acquired = **1**
  - Urinary catheter x 1

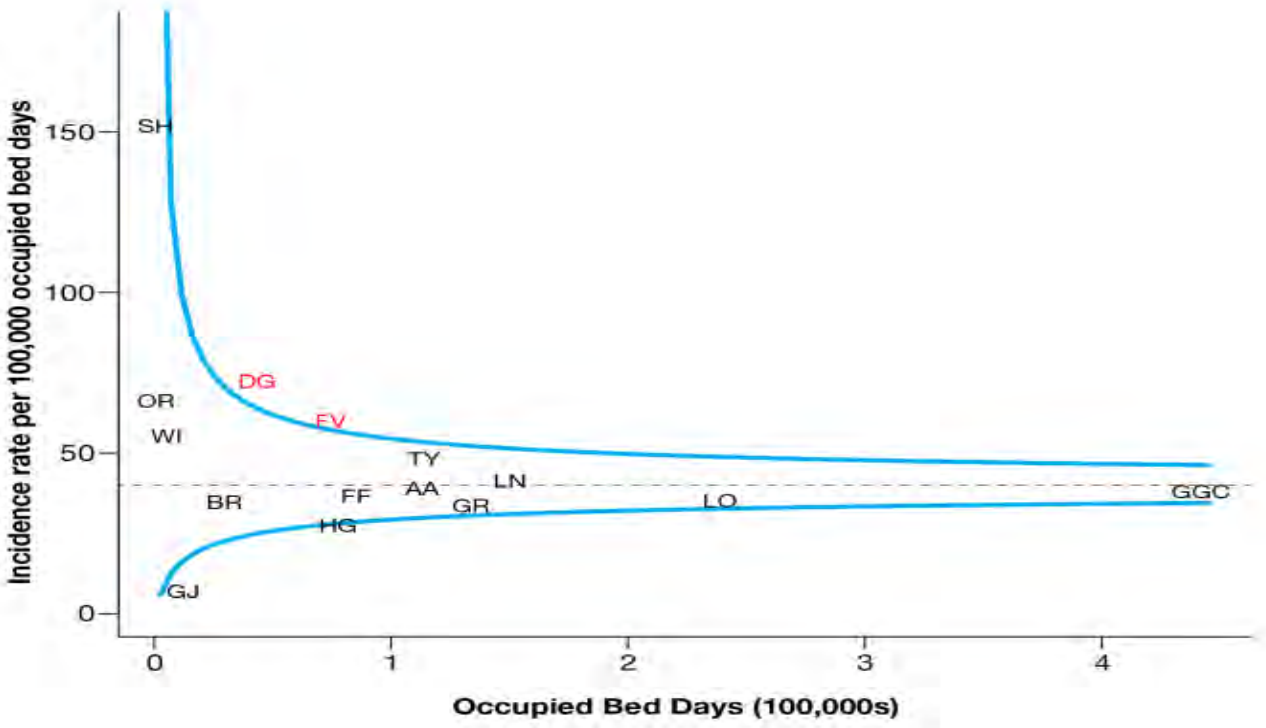
  There was no data exceedance for nursing home acquired ECBs this month.

Local improvement plans through the Safer Together Collaborative are targeting the use of urinary catheters, working on reducing catheter reliance and targeting clinical practice in relation to catheter insertion and maintenance across clinical areas. There is also local work being progressed by the Infection Control clinical lead in relation to the use of PPIs and their link to biliary sepsis. This work has been presented to the surgical community and is being presented to the General Practice community.

National Context

All ECBs are reported nationally and reported on a quarterly basis. This provides our board an overview and national context of our national position compared to other boards. Due to the national reporting, unfortunately the data publish is 3 months in arrears compared to the local data presented. The funnel plot below contains total case numbers of reported hospital and healthcare attributed infections and provides an indication of FVs position nationally. Below is an extract from ARHAIs Quarter 3 report (July – September 2024) highlighting Forth Valley's position compared to all other boards in Scotland. Forth Valley has exceeded control limits for this quarter and work is progressing locally with reduction strategies in place

to reduce infection rates. Provisional local data for October – December 2024 suggests that there will be improvement in our national position returning within control limits in the next published report by ARHAI later this year. In addition, ARHAIs current report also highlights that the year ending rate for this period has shown a reduction in rate compared to the previous years despite the current data exceedance.



Clostridioides difficile infection (CDIs)

Following the Vale of Leven outbreak in 2007 where 131 patients were infected with C. difficile resulting in 34 deaths, it became mandatory for all health boards to monitor, investigate and report all infections associated with C. difficile. NHSFV has met its targets over the years and has maintained a low rate of infection.

C. difficile can be part of the normal gut flora and can occur when patients receive broad spectrum antibiotics which eliminate other gut flora allowing C. difficile to proliferate and cause infection. This is the predominant source of infection in Forth Valley. C. difficile in the environment can form resilient spores which enable the organism to survive in the environment for many months and poor environmental cleaning or poor hand hygiene can lead to the organism transferring to other patients leading to infection (as what happened in the Vale of Leven hospital). Another route of infection is when patient receive treatment to regulate stomach acid which affects the overall pH of the gut allowing the organism to proliferate and cause infection.

Cause definitions for Clostridioides difficile infections

Hospital acquired

- Hospital acquired is defined when symptoms develop and confirmed by the laboratory >48 hours after admission which were not associated with the initial cause of admission.

Healthcare acquired

- Healthcare acquired is defined as having symptoms that develop and confirmed by the laboratory prior to or within 48 hours of admission and has in the last three months had healthcare interventions such as previous hospital admission, attending Clinics, GP, dentist etc.

Nursing home acquired

- Nursing home acquired is defined as having symptoms that develop and confirmed by the laboratory that developed at the nursing home prior to admission.

GP acquired

- GP associated CDI infections are not required to be reported nationally, however, locally it is considered important to monitor and report infections deriving from GP practices. All CDI infections from GPs are reviewed and investigated to the same standard as hospital infections to determine the cause of infection. In addition, data is shared with the Antimicrobial Management Group to allow the group to monitor overall antibiotic prescribing trends for individual GP practices.

NHS Forth Valley's approach to CDI prevention and reduction

Similar to our SABs and DABs investigation, patient history is gathered including any antibiotics prescribed over the last few months. Discussion with the clinical teams and microbiologists assist in the determination and conclusion of the significance of the organism, as sometimes the organism isolated can be an incidental finding and not the cause of infection. Data is shared with the antimicrobial pharmacist and cases are discussed at the Antimicrobial Management Group to identify inappropriate antimicrobial prescribing.

Total number of CDIs this month; **2** compared to **5** last month.
There was no data exceedance for CDIs this month.

Total number of CDIs (April 2024 – date) = **44**

- Hospital acquired = **2**
  - No attributed ward x 2 (associated with antimicrobials/PPIs)

  There was no data exceedance for hospital acquired CDIs this month.

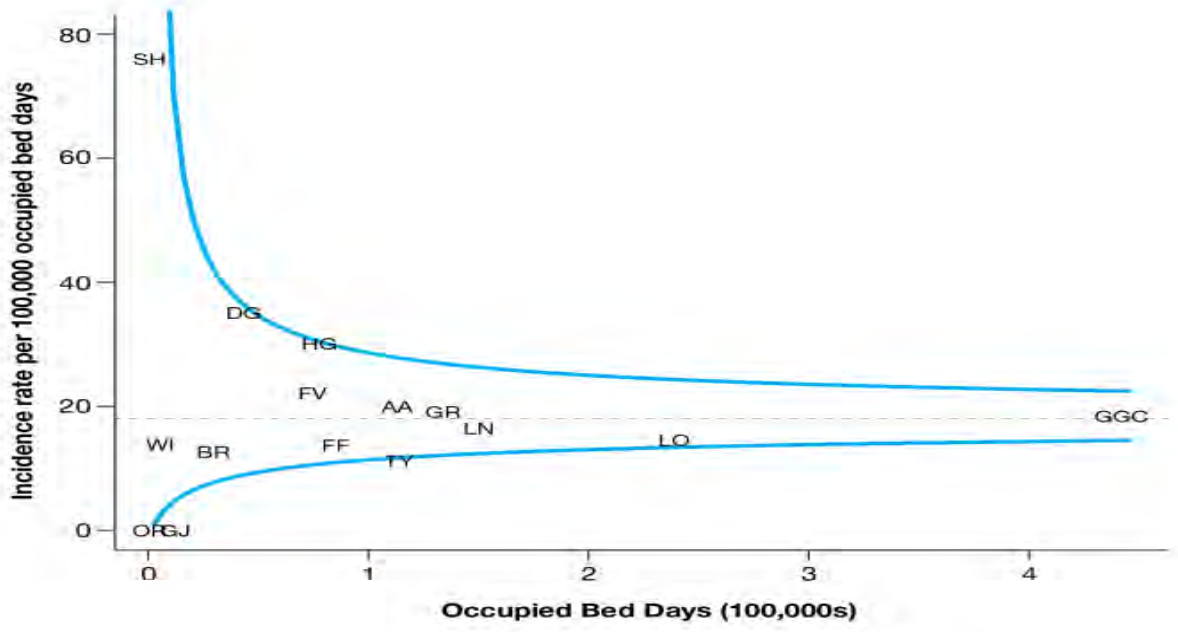
- Healthcare acquired = **0**
  There was no data exceedance for healthcare acquired CDIs this month.

- Nursing Home acquired = **0**
  There was no data exceedance for nursing home acquired CDIs this month.

- GP acquired = **0**
  (GP figures are not included in the total as it is not part of national reporting)

National Context

All CDIs are reported nationally and reported on a quarterly basis. This provides our board an overview and national context of our national position compared to other boards. Due to the national reporting, unfortunately the data published is 3 months in arrears compared to the local data presented. The funnel plot below contains total case numbers of reported hospital and healthcare attributed infections and provides an indication of FVs position nationally. Below is an extract from the ARHAI Quarter 3 report (July – September 2024) highlighting NHS Forth Valley's position compared to all other boards in Scotland.



Surgical Site Infection Surveillance (SSIS)

Surgical site infection surveillance is the monitoring and detection of infections associated with a surgical procedure. In Forth Valley, the procedures include, hip arthroplasty, Caesarean section, abdominal hysterectomy, major vascular surgery, large bowel, knee arthroplasty and breast surgeries. We monitor patients for 30 days post-surgery including any microbiological investigations from the ward/GP for potential infections and also hospital readmissions relating to their surgery. Any infection associated with a surgical procedure is reported nationally to enable board to board comparison. NHS Forth Valley infection rates are comparable to national infection rates.

NHS Forth Valley's approach to SSI prevention and reduction

Surgical site infection criteria is determined using the European Centre for Disease Control (ECDC) definitions. Any infection identified is investigated fully and information gathered including the patient's weight, duration of surgery, grade of surgeon, antibiotics given, theatre room, elective or emergency etc can provide additional intelligence in reduction strategies. The IPCT monitor closely infection rates, and any increases of SSIs are reported to management and clinical teams to enable collaborative working to reduce infection rates. The table below also contains local surveillance with an extended surveillance period of 90 days.

Procedure	No of Procedures this month	No. of Confirmed SSIs this month (Mandatory 30 days)	No. of Confirmed SSIs this month (Local 90 days)
Abdominal Hysterectomy	8	0	0
Breast Surgery	21	0	0
Caesarean Section	86	0	0
Hip Arthroplasty	43	0	0
Knee Arthroplasty	58	0	0
Large Bowel Surgery	12	0	0

Meticillin resistant Staphylococcus aureus (MRSA) & Clostridioides difficile recorded deaths

The National Records of Scotland monitor and report on a variety of deaths recorded on the death certificate. Two organisms are monitored and reported, MRSA and *C. difficile*. Please click on the link below for further information:

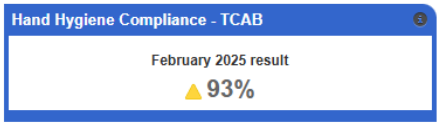
https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths

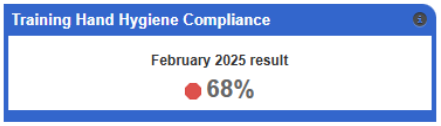
- There were no MRSA or *C. difficile* deaths reported this month.

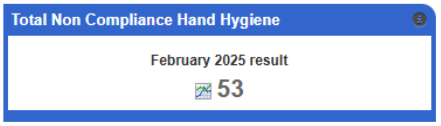
Hand Hygiene Monitoring Compliance (%) Board wide

The data below is an extract from the Pentana dashboard. It includes the total % of compliance that is inputted on TCAB by the nursing staff. It also includes the uptake of staff who have completed the hand hygiene training module in Turas along with the total number of hand hygiene non compliances that are recorded in the Infection Prevention and Control team SICP audits.

The request by Board members to have this data broken down by staff groups is being further explored, it is not readily available for this report, but the feasibility of producing this for future reports is still being worked on.







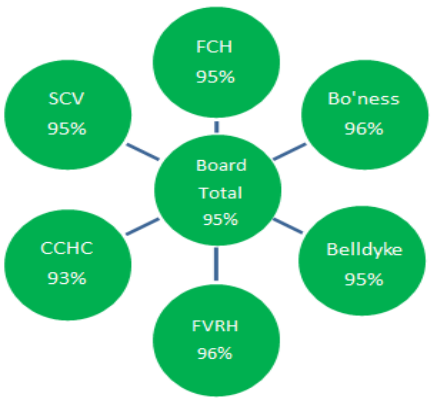
Estate and Cleaning Compliance (per hospital)

The data is collected through audit by the Domestic Services team using the Domestic Monitoring National Tool and areas chosen within each hospital is randomly selected by the audit tool. Any issues such as inadequate cleaning is scored appropriately and if the score is less than 80% then a re-audit is scheduled. Estates compliance is assessed whether the environment can be effectively cleaned; this can be a combination of minor non-compliances such as missing screwcaps, damaged sanitary sealant, scratches to woodwork etc. The results of these findings are shared with Serco/Estates for repair. Similar to the cleaning audit, scores below 80% triggers a re-audit.

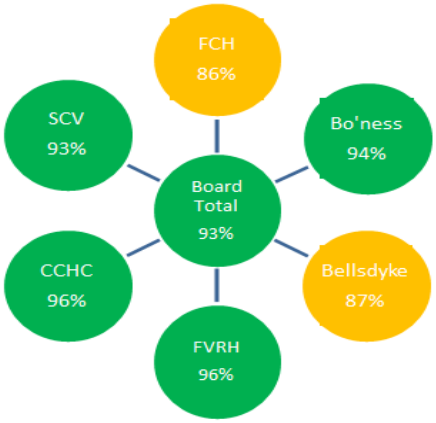
Falkirk Community Hospital and Bellsdyke Hospital Estate Scores

This quarter, the estate scores have remained relatively stable, Falkirk Community Hospital and Bellsdyke Hospital scores have decreased this quarter.

Estates & Domestic Cleaning Scores from Cleaning Dashboard October – December 2024



Cleaning Compliance



Estates Compliance

Colour		Description
●	Green	compliance level 90% and above - Compliant
●	Amber	compliance level between 70% and 90% - Partially compliant
●	Red	compliance level below 70% - Non-compliant

Ward Visit Programme

The purpose of these audits is to assess compliance to standard infection control precautions (SICPs); each aspect or SICP can be contributary factors to infection. All non-compliances are fed back to the nurse in charge immediately following the ward visit. A follow-up email is also sent to the ward and service manager. Details of each non-compliance are reported in the monthly HAI Service Reports and are discussed at the local Infection Control meetings.

The predominant non-compliance categories reported were Managing Patient Care Equipment category; non-compliances included equipment visibly dirty, items stored inappropriately, indicator tape/label missing. Control of the Environment, non-compliances included, area is not well maintained and in good state of repair, all stores are not above floor level and inappropriate items in clinical area. Non-compliances have slightly reduced compared to last month (330 non-compliances).

All non-compliances were highlighted to the nurse in charge at the time of audit and any equipment with cleanliness issues was rectified immediately.

Below is a table detailing the non-compliances identified during the ward visits.

	Patient Placement	Hand Hygiene	PPE	Managing Patient Care Equipment	Control of the Environment	Safe Management of Linen	Safe Disposal of Waste	Totals
Totals	0	53	34	69	115	24	16	311

Please refer to the appendix for a further breakdown of non-compliances.

Incidence / Outbreaks

All outbreaks are notified to Health Protection Scotland and Scottish Government (see below for further details).

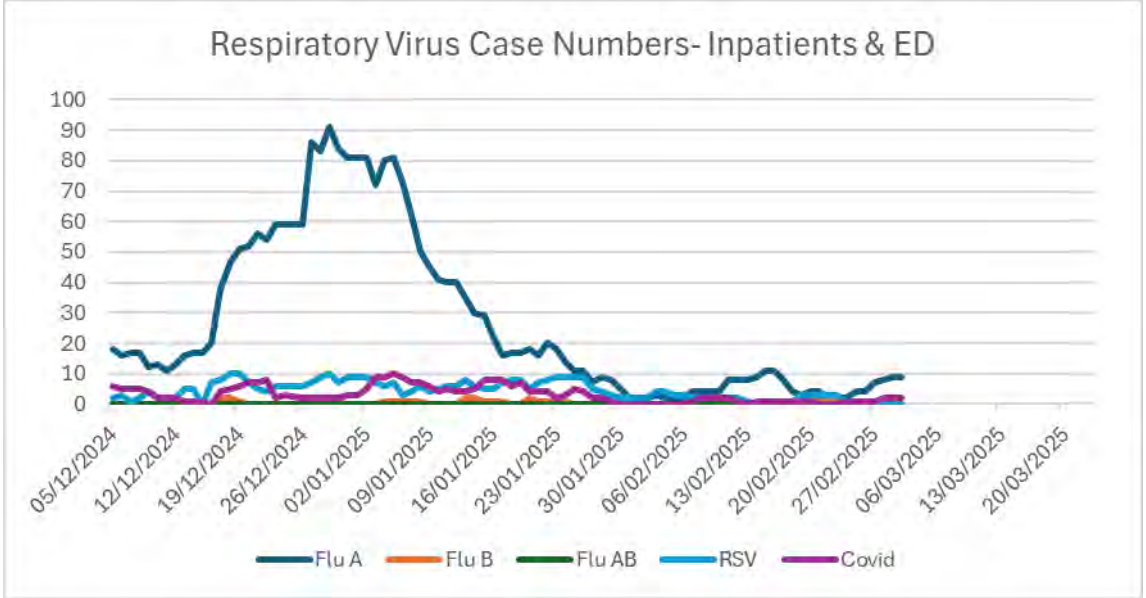
Healthcare Acquired Infection Incident Template (HAIIT)
The HAIIT is a tool used by boards to assess the impact of an incident or outbreak. The tool is a risk assessment and allows boards to rate the incident/outbreak as a red, amber, or green. The tool also directs boards whether to inform ARHAI Scotland/SG of the incident (if amber or red), release a media statement etc.

There was one outbreak reported for this period:

- Ward A12, 5 cases of influenza.

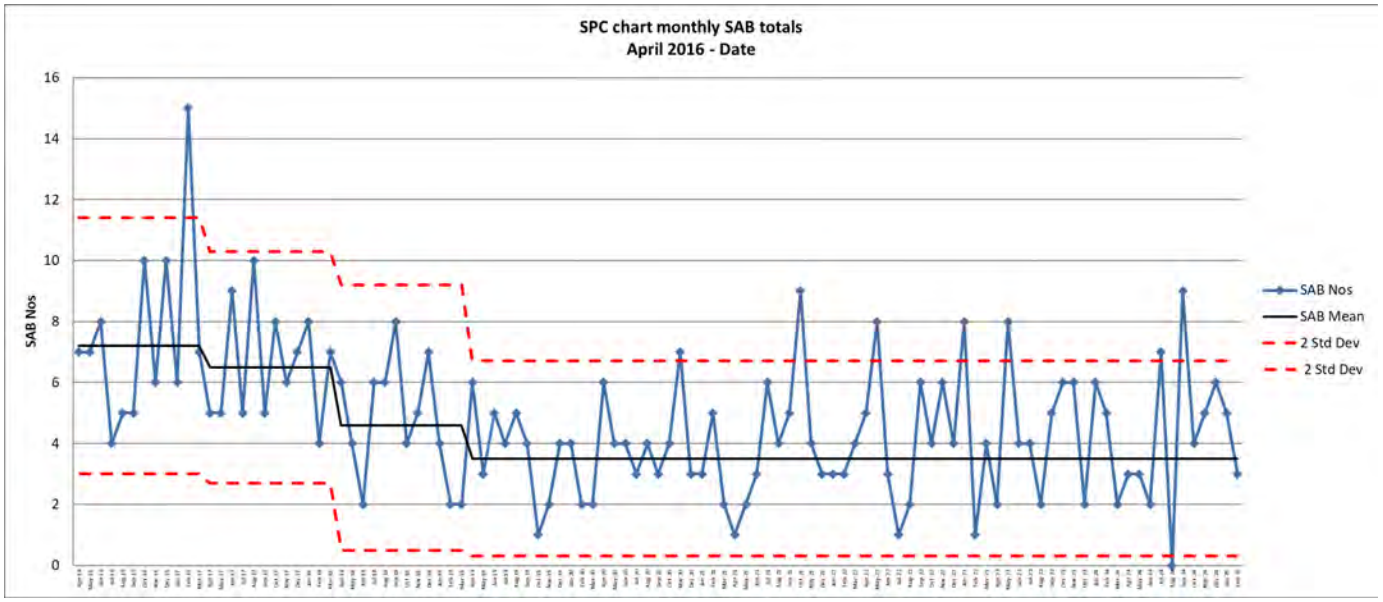
Viral Respiratory illnesses

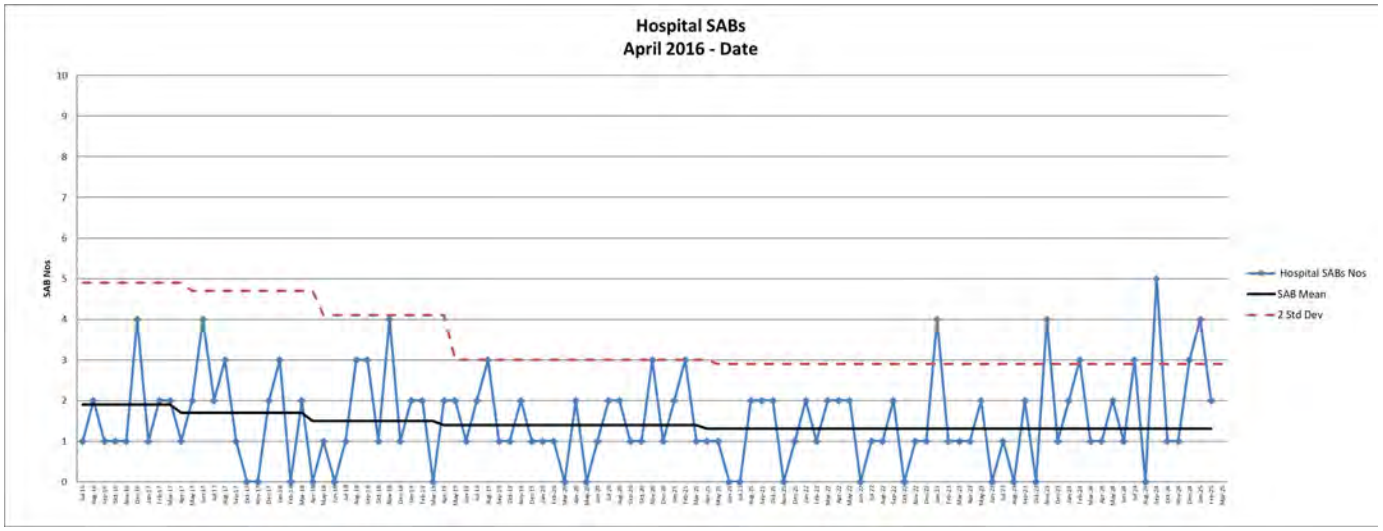
This month respiratory cases continued to remain low over the course of the month.

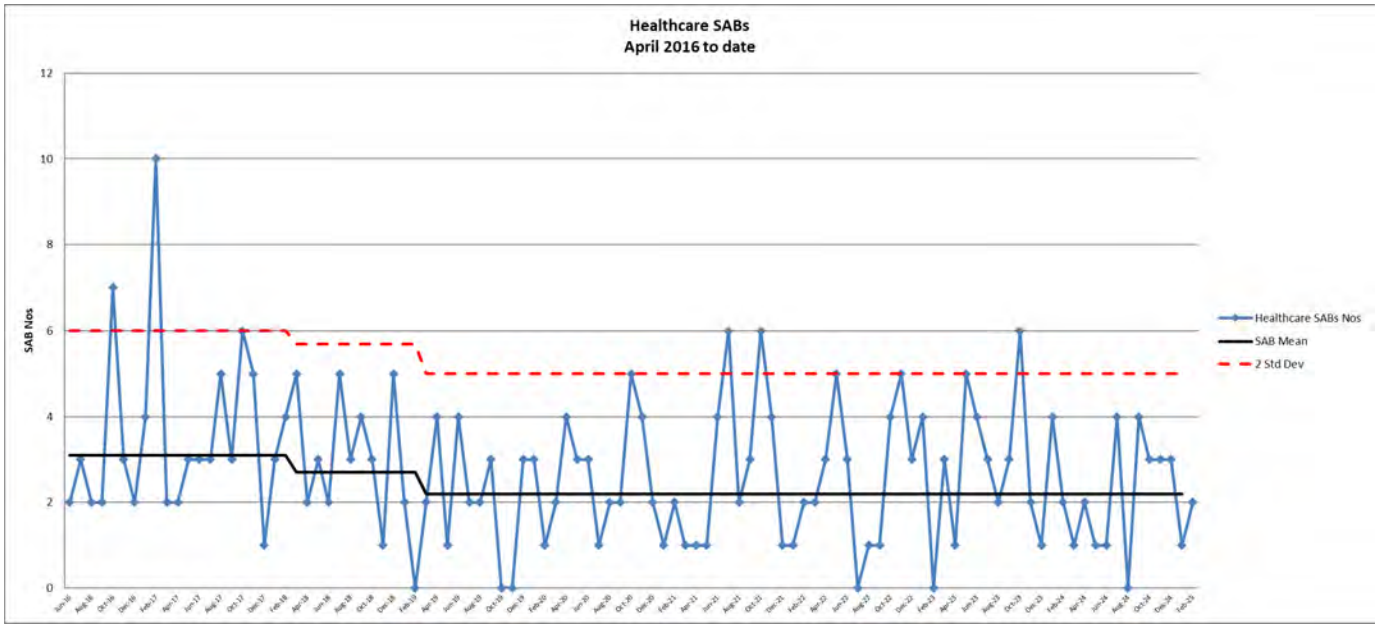


HAI Surveillance Statistical Processing Charts

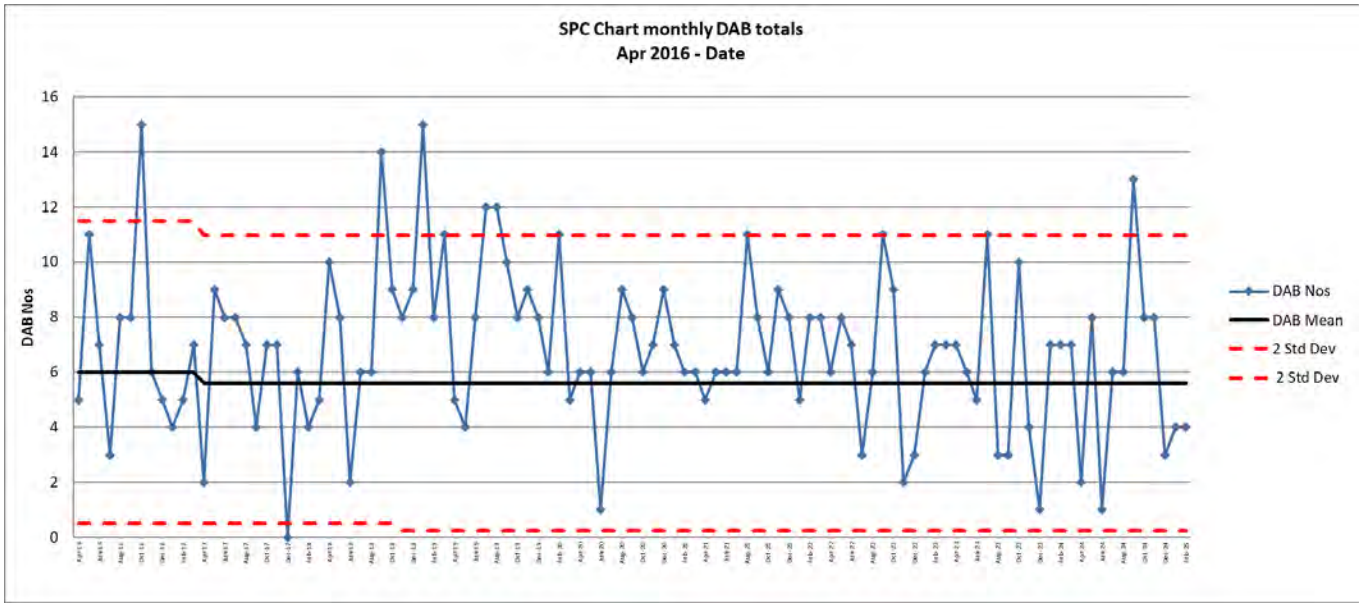
Staphylococcus aureus Bacteraemias (SABs)

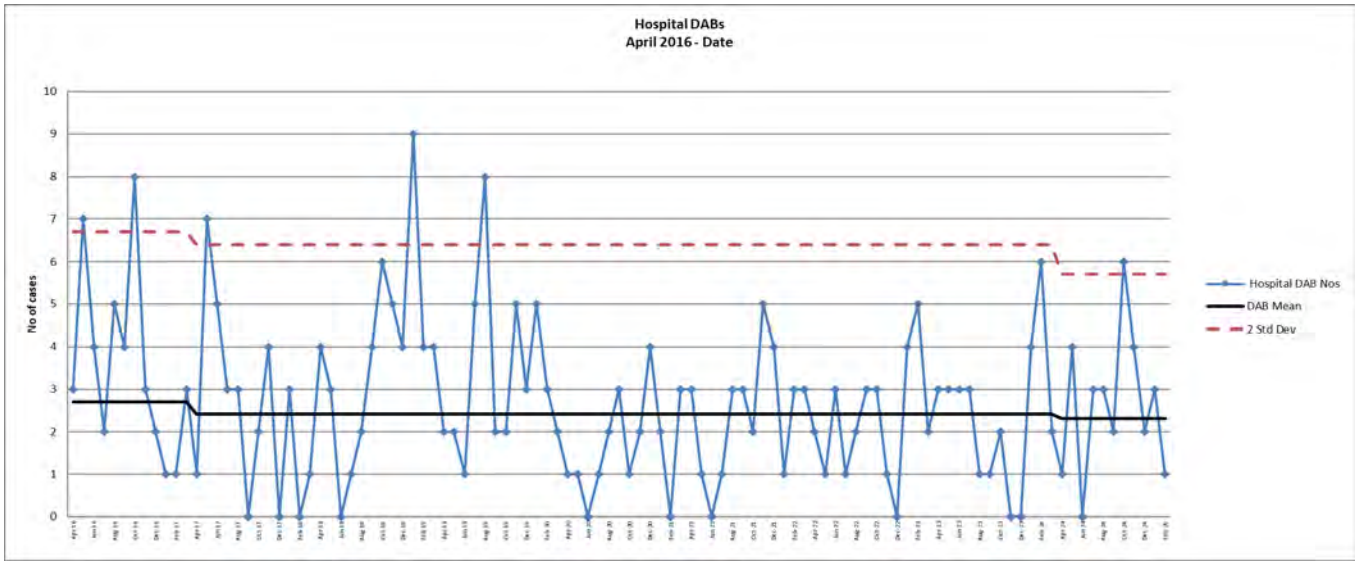


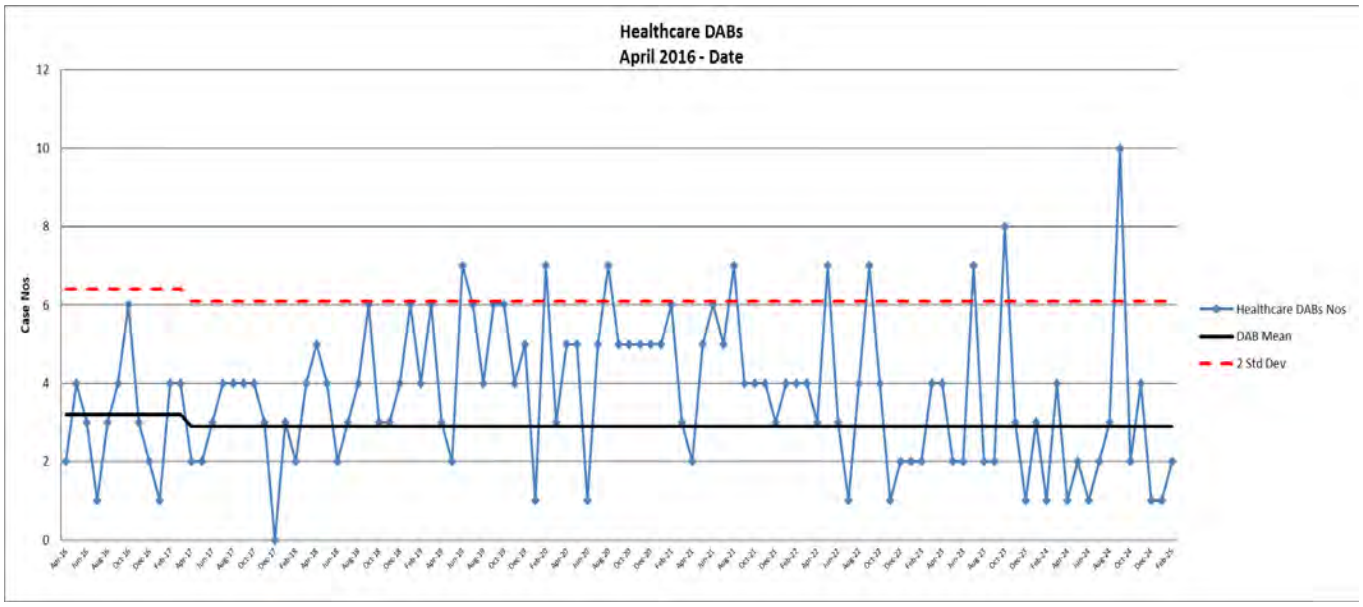




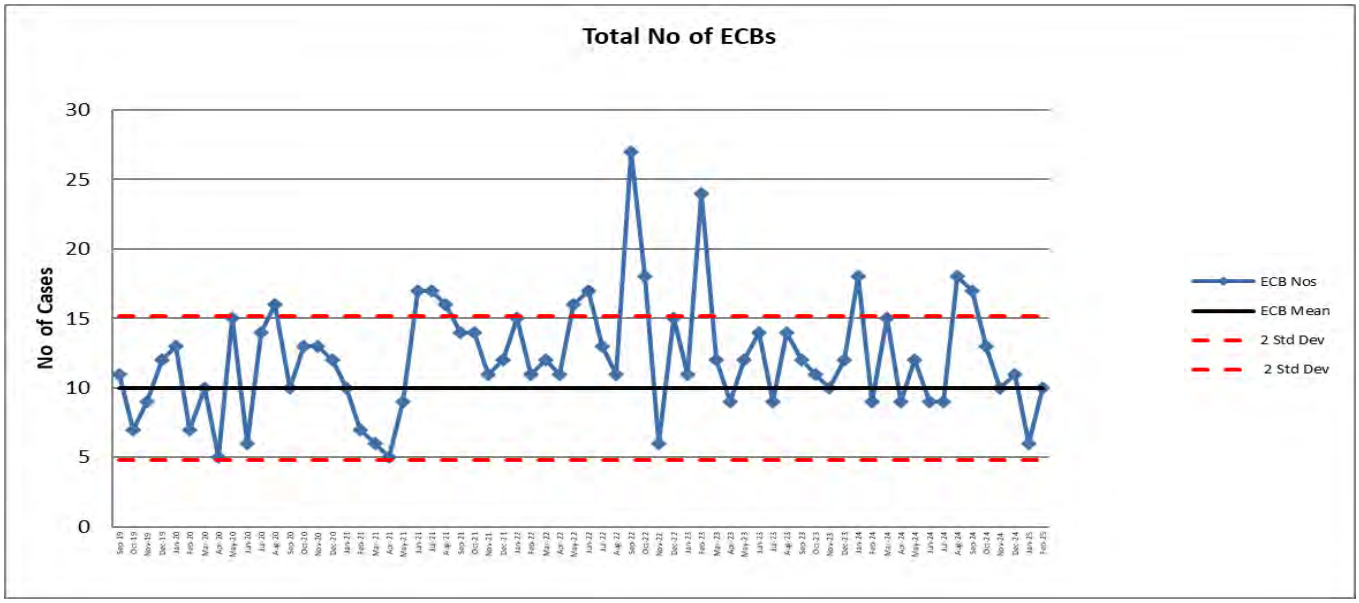
Device Associated Bacteraemias (DABs)

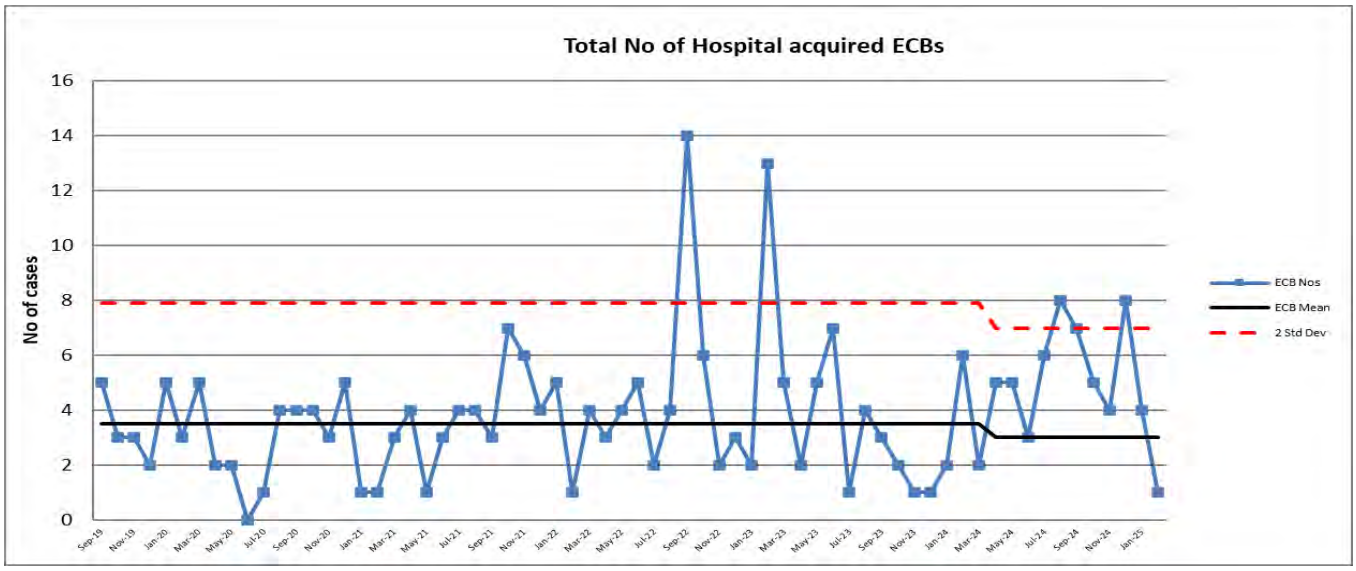


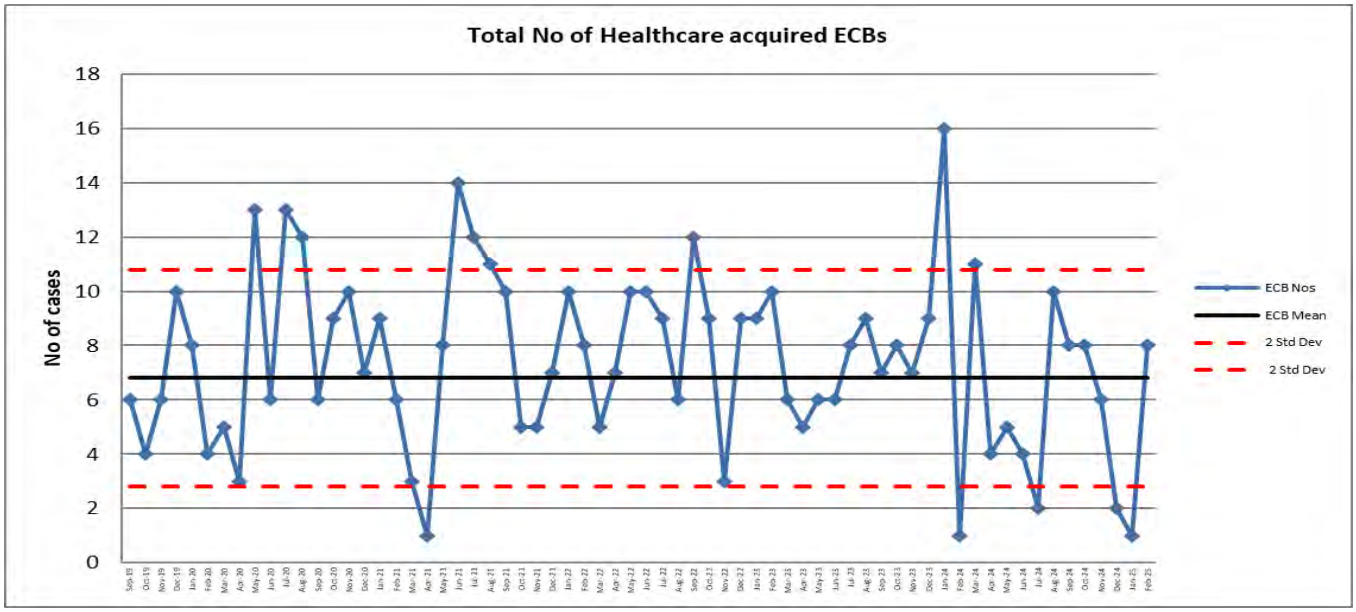




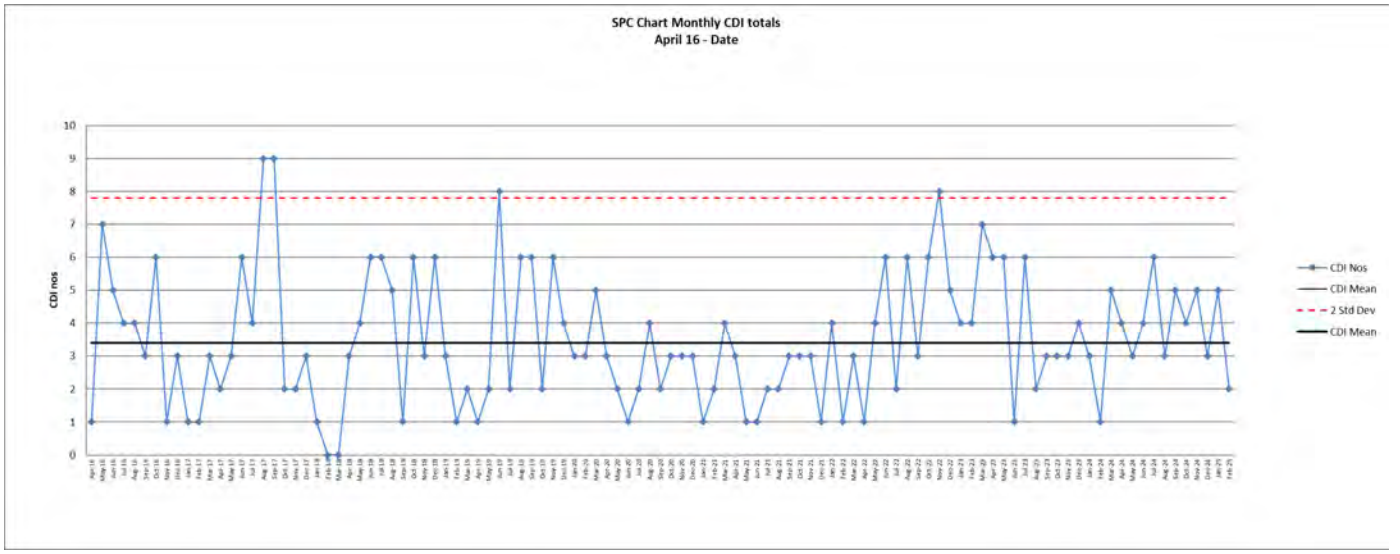
Escherichia coli Bacteraemias (ECBs)

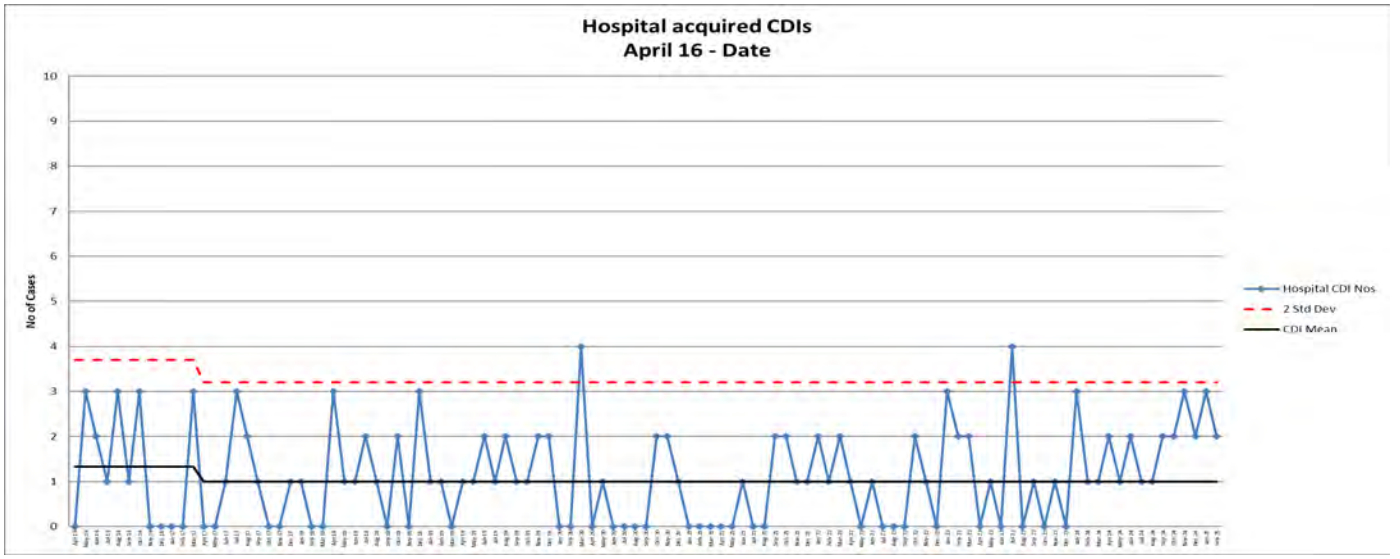

Total No of ECBs
No of Cases
30
25
20
15
10
5
0
ECB Nos
ECB Mean
2 Std Dev
2 Std Dev

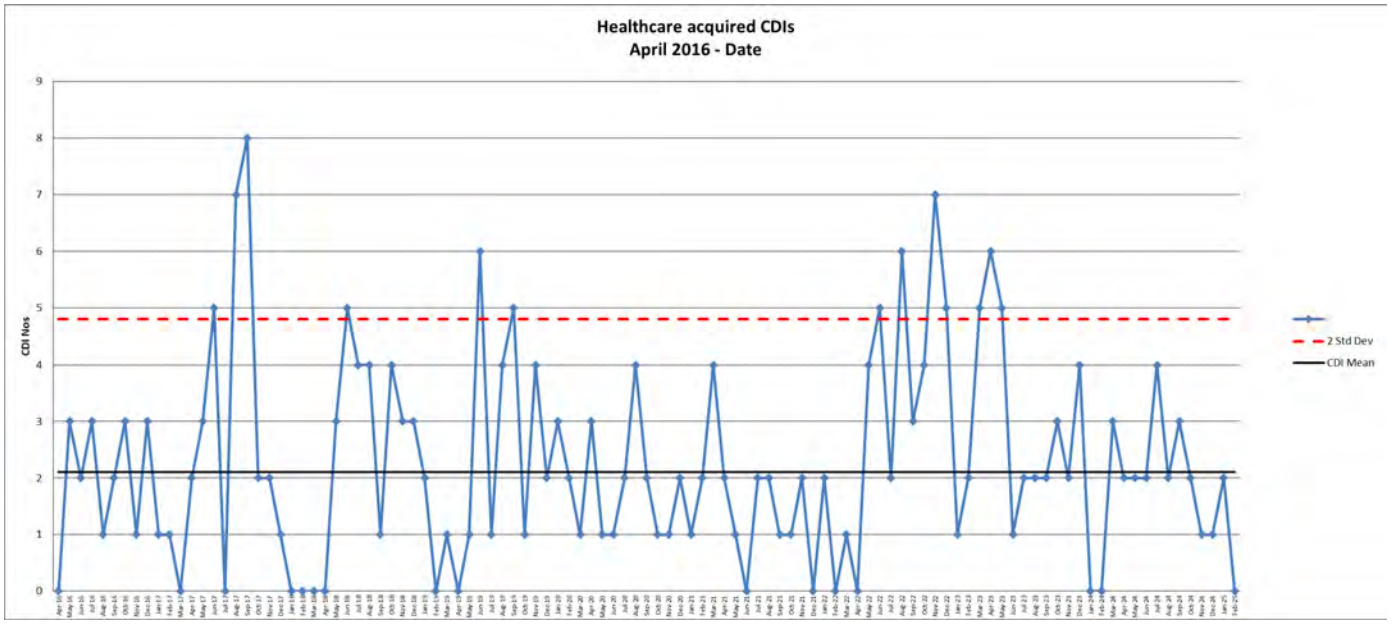

Total No of Hospital acquired ECBs
No of cases
16
14
12
10
8
6
4
2
0
ECB Nos
ECB Mean
2 Std Dev


Total No of Healthcare acquired ECBs
No of cases
18
16
14
12
10
8
6
4
2
0
ECB Nos
ECB Mean
2 Std Dev
2 Std Dev

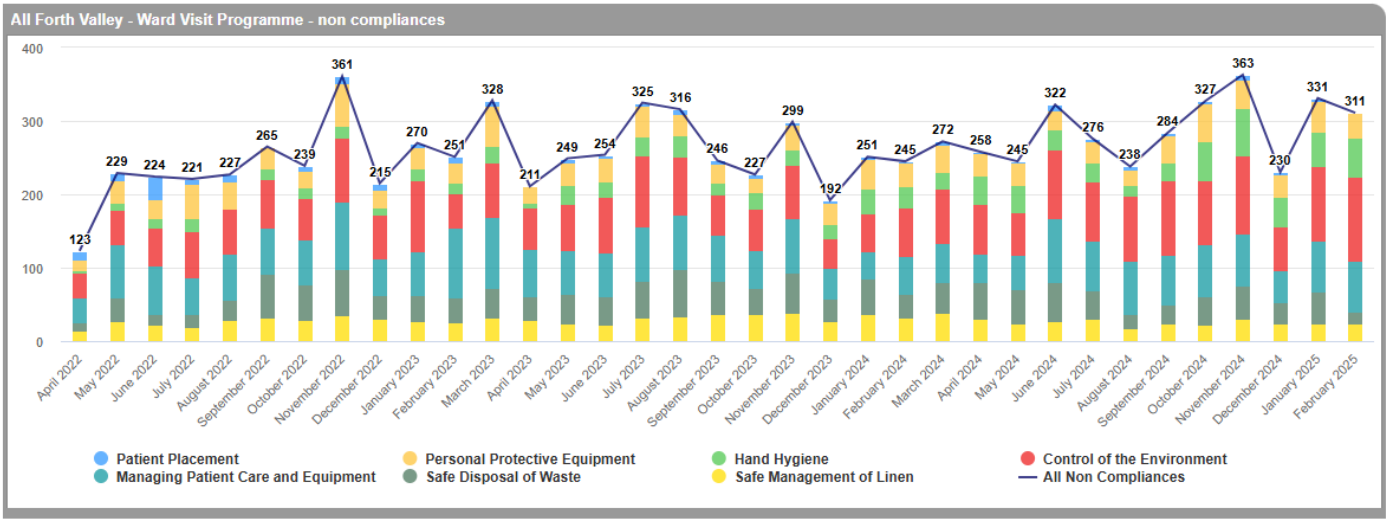
Clostridioides difficile Infections (CDIs)

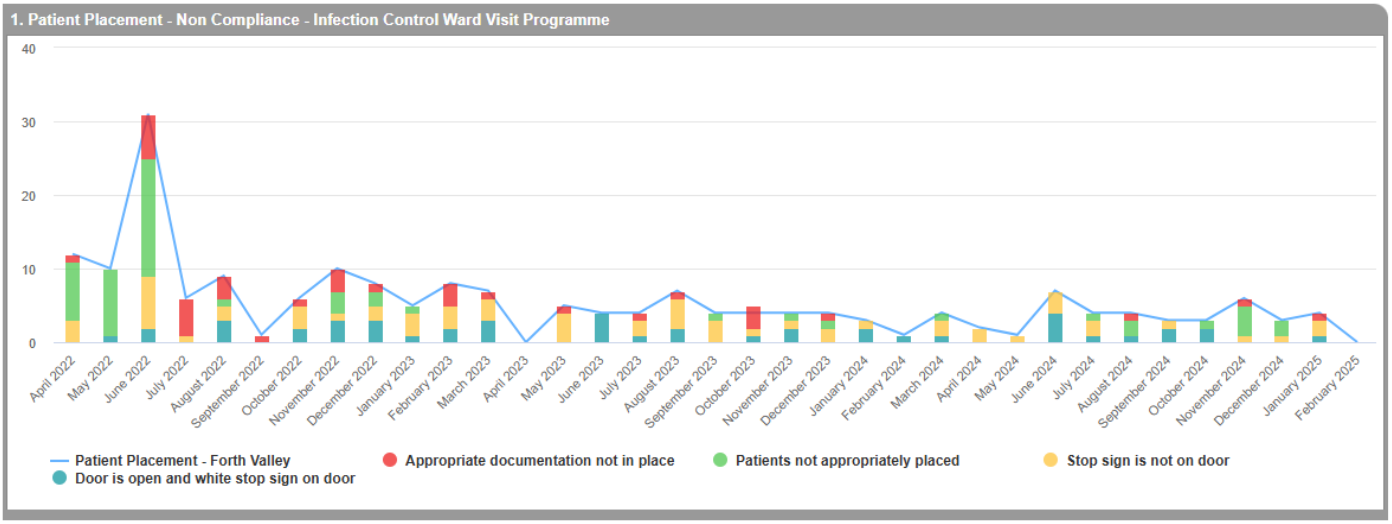


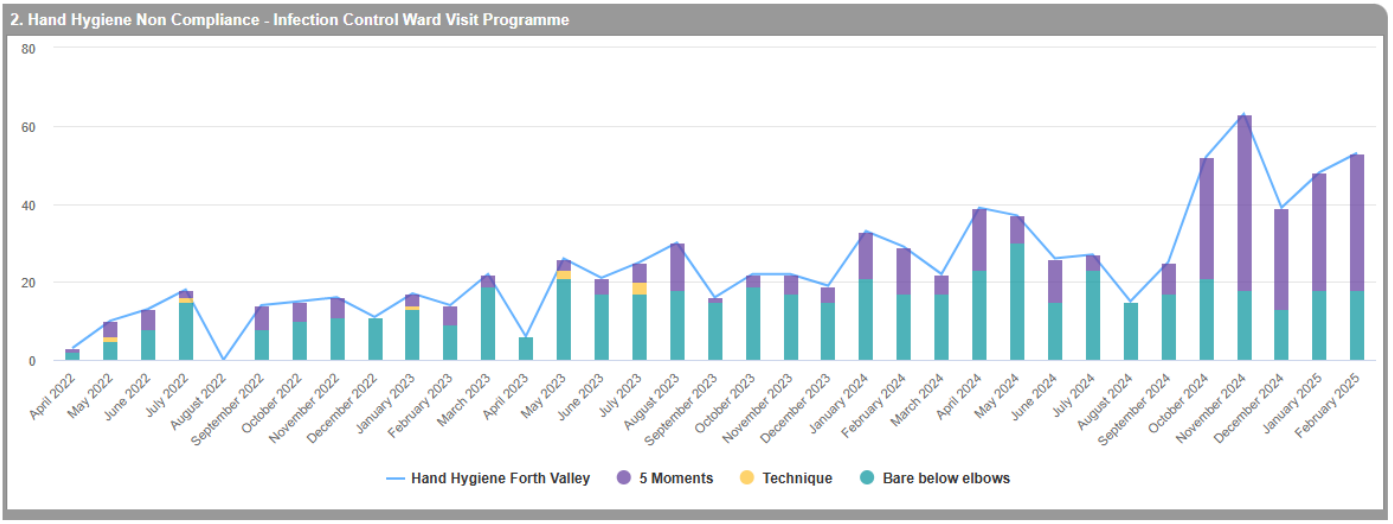


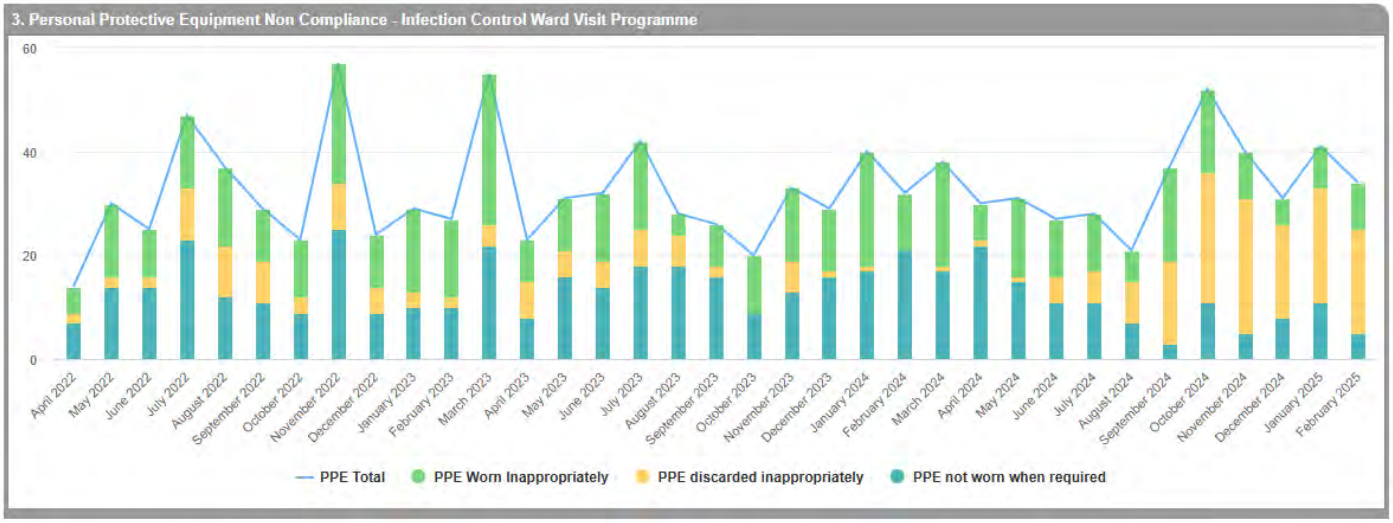

Healthcare acquired CDIs
April 2016 - Date
CDI Nos
2 Std Dev
CDI Mean

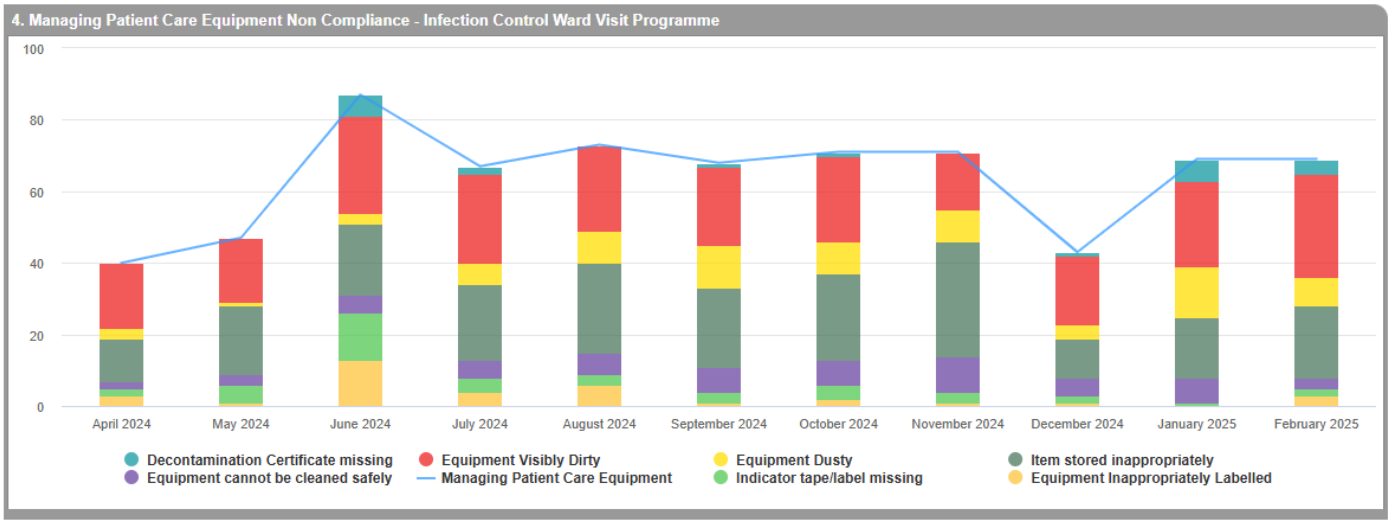
Ward Visit Non Compliances by SICP

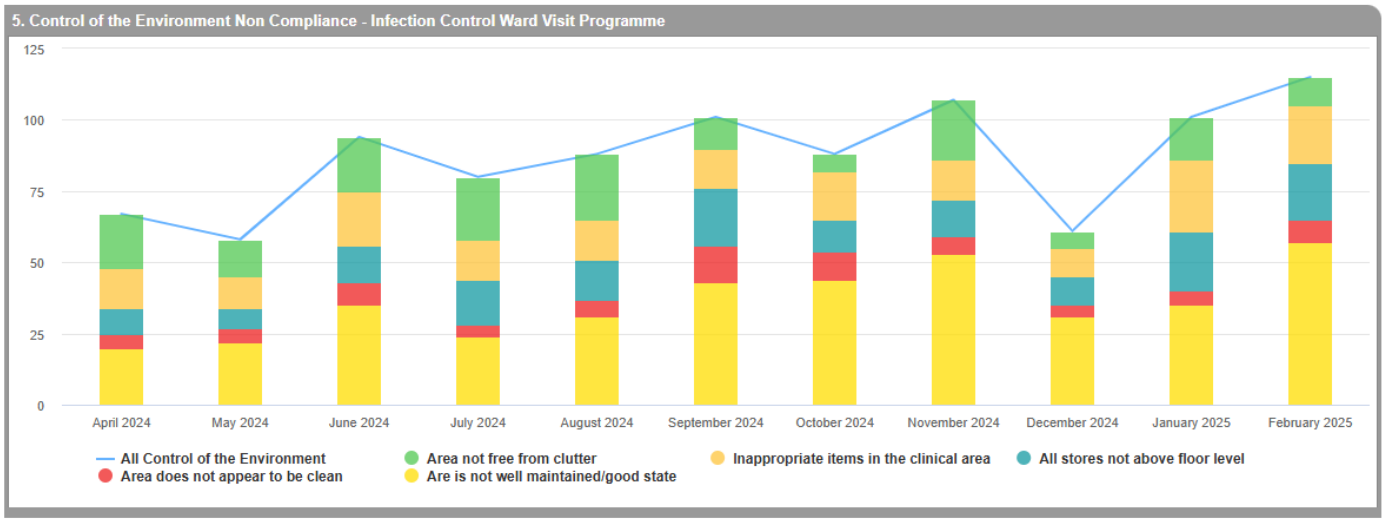


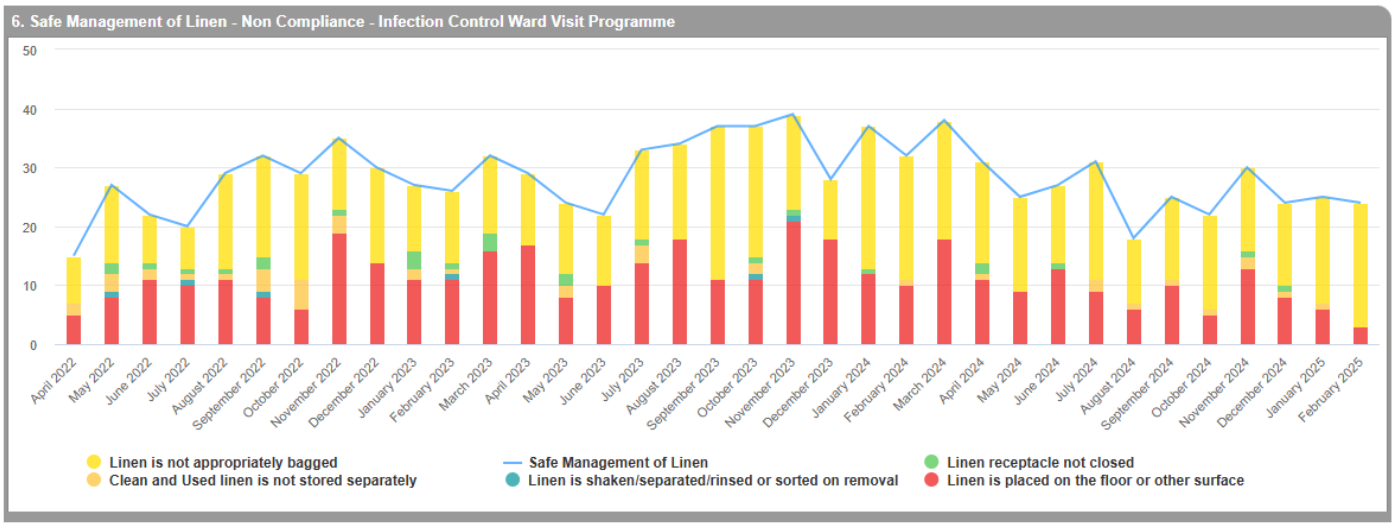


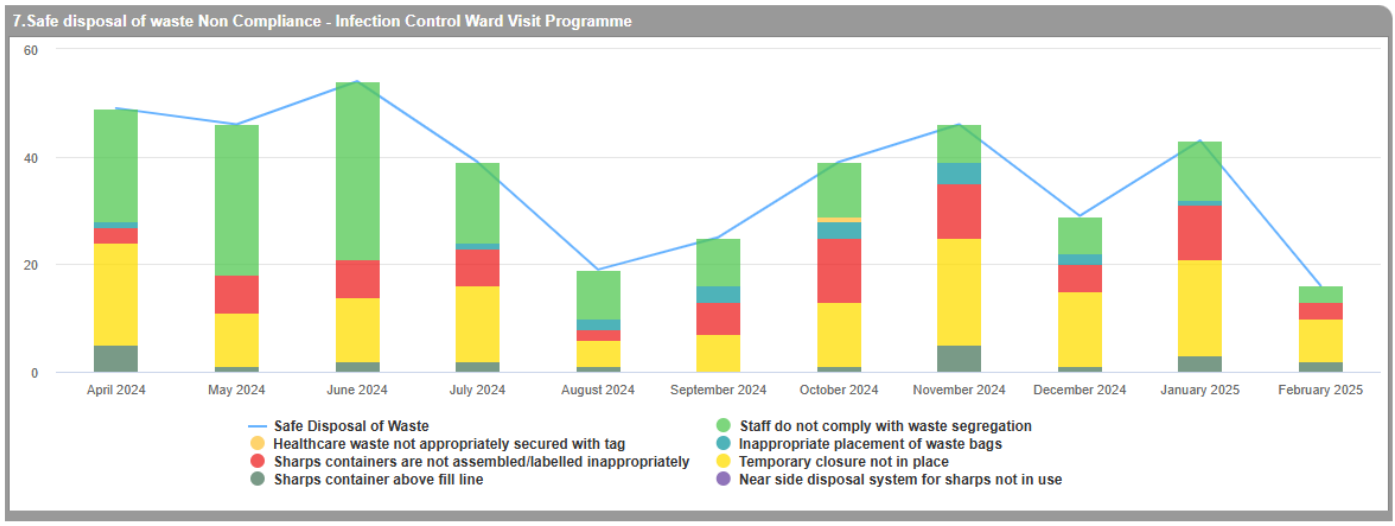



3. Personal Protective Equipment Non Compliance - Infection Control Ward Visit Programme
60
40
20
0
April 2022
May 2022
June 2022
July 2022
August 2022
September 2022
October 2022
November 2022
December 2022
January 2023
February 2023
March 2023
April 2023
May 2023
June 2023
July 2023
August 2023
September 2023
October 2023
November 2023
December 2023
January 2024
February 2024
March 2024
April 2024
May 2024
June 2024
July 2024
August 2024
September 2024
October 2024
November 2024
December 2024
January 2025
February 2025
PPE Total
PPE Worn Inappropriately
PPE discarded inappropriately
PPE not worn when required


4. Managing Patient Care Equipment Non Compliance - Infection Control Ward Visit Programme
100
80
60
40
20
0
April 2024
May 2024
June 2024
July 2024
August 2024
September 2024
October 2024
November 2024
December 2024
January 2025
February 2025
Decontamination Certificate missing
Equipment cannot be cleaned safely
Equipment Visibly Dirty
Managing Patient Care Equipment
Equipment Dusty
Indicator tape/label missing
Item stored inappropriately
Equipment Inappropriately Labelled


5. Control of the Environment Non Compliance - Infection Control Ward Visit Programme
125
100
75
50
25
0
April 2024
May 2024
June 2024
July 2024
August 2024
September 2024
October 2024
November 2024
December 2024
January 2025
February 2025
All Control of the Environment
Area does not appear to be clean
Area not free from clutter
Are is not well maintained/good state
Inappropriate items in the clinical area
All stores not above floor level


6. Safe Management of Linen - Non Compliance - Infection Control Ward Visit Programme
50
40
30
20
10
0
April 2022
May 2022
June 2022
July 2022
August 2022
September 2022
October 2022
November 2022
December 2022
January 2023
February 2023
March 2023
April 2023
May 2023
June 2023
July 2023
August 2023
September 2023
October 2023
November 2023
December 2023
January 2024
February 2024
March 2024
April 2024
May 2024
June 2024
July 2024
August 2024
September 2024
October 2024
November 2024
December 2024
January 2025
February 2025
Linen is not appropriately bagged
Clean and Used linen is not stored separately
Safe Management of Linen
Linen is shaken/separated/rinsed or sorted on removal
Linen receptacle not closed
Linen is placed on the floor or other surface


7.Safe disposal of waste Non Compliance - Infection Control Ward Visit Programme
60
40
20
0
April 2024
May 2024
June 2024
July 2024
August 2024
September 2024
October 2024
November 2024
December 2024
January 2025
February 2025
Safe Disposal of Waste
Healthcare waste not appropriately secured with tag
Sharps containers are not assembled/labelled inappropriately
Sharps container above fill line
Staff do not comply with waste segregation
Inappropriate placement of waste bags
Temporary closure not in place
Near side disposal system for sharps not in use

FORTH VALLEY NHS BOARD
Tuesday 25 March 2025

22. Performance Report
For: Assurance

Executive Sponsor: Professor Ross McGuffie, Chief Executive
Author: Ms Kerry Mackenzie, Acting Director of Strategic Planning & Performance; Ms Claire Giddings, Corporate Performance Manager

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Executive Summary
The overall approach to performance within NHS Forth Valley underlines the principle that performance management is integral to the delivery of quality improvement and core to sound management, governance, and accountability.

The Performance Report is presented to provide the NHS Board with key performance information to support effective monitoring of system-wide performance.

Recommendation
The NHS Board is asked to:

- **consider** the current key performance issues.
- **consider** the detail within the Performance Report.
- **consider** the proposed level of Assurance.

Key Issues to be considered
The Performance Report considers key metrics in relation to system-wide performance and provides a month-on-month progress overview. Included within the metrics are the eight key standards of: 12-week outpatient target, diagnostics, 12-week treatment time guarantee, cancer targets, access to Psychological Therapies, access to Child & Adolescent Mental Health Services and Accident & Emergency 4-hour waits.

Areas of performance cited in NHS Forth Valley's escalation to Stage 4 of the NHS Scotland Performance Escalation Framework (now Support and Intervention Framework) are included within the report and continue to be monitored following a move to Stage 3.

The scorecard provides a comprehensive 'at a glance' view of measures with work on-going to ensure accuracy of data, and that all the definitions and reporting periods remain appropriate and meaningful.

The Performance Report is routinely presented to the scheduled meetings of the Strategic Planning, Performance & Resources Committee ahead of the NHS Board.

1. Key Performance Issues

- ***Unscheduled Care***

Overall compliance with the 4-hour emergency access standard (EAS) in January 2025 was 53.6%; Minor Injuries Unit 99.7%, Emergency Department 46.4%. A total of 2,539 patients waited longer than the 4-hour target across both the ED and Minor Injuries Unit (MIU); with 1,286 waits longer than eight hours, 720 waits longer than 12 hours and 145 waits longer than 23 hours. The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 1,307 patients, noting this was 1,364 in January 2024. Wait for a bed accounted for 751 patients waiting beyond 4 hours with Clinical reasons accounting for 176 breaches.

In January 2025 there were 535 new attendances to Rapid Assessment and Care Unit (RACU), 128 of which were via ED.

- ***Delayed Discharges***

The January 2024 census position in relation to standard delays (excluding Code 9 and guardianship) is 84 delays; this is compared with 67 in January 2024. There was a total of 44 code 9 and guardianship delays and no infection codes. The total number of delayed discharges was noted as 128.

The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the January 2025 census was 2,097, this is a reduction or improvement from 2,897 in January 2024.

- ***Scheduled Care***

At the end of January 2025, the number of patients on the waiting list for a first outpatient appointment was 12,661 compared with 15,332 in January 2024 with the number waiting beyond 12 weeks 3,738 compared to 6,588 in January 2024. Activity against the 2024/25 annual delivery plan highlights we have completed 104% of the predicted activity in quarter 3.

The number of inpatients/daycases waiting increased to 6,616 with an increase in those waiting beyond 12 weeks against the previous year. Activity against the 2024/25 annual delivery plan highlights we have completed 93% of the predicted activity for quarter 3.

At the end of January 2025, 2,975 patients were waiting beyond the 6-week standard for imaging with 339 patients were waiting beyond 6 weeks for endoscopy. Activity against the 2024/25 annual delivery plan highlights we have completed 135% and 118% respectively of the predicted activity for quarter 3.

Cancer target compliance in December 2024:

- 62-day target – 78.8% of patients waited less than 62 days from urgent suspicion of cancer referral to first cancer treatment. This is compared with the December 2023 position of 76.8%.
- 31-day target – 97.8%

The position for the October to December 2024 quarter is that 79.2% of patients were treated within 62 days of referral with a suspicion of cancer. This is a reduction from 84.0% the previous quarter. During the same period, 98.0% of patients were treated within 31 days of the decision to treat.

- ***DNA***

The new outpatient DNA rate across acute services in January 2025 is noted as 5.0% which is an improvement from the position in January 2024 of 5.8%. The return outpatient DNA rate across acute services in January 2025 was 5.6%.

- ***Psychological Therapies***

In January 2025, the draft data indicates that 68.3% of patients started treatment within 18 weeks of referral.

- ***Child & Adolescent Mental Health Services (CAMHS)***

In January 2025, 98.6% of patients started treatment within 18 weeks of referral.

- ***Workforce***

The sickness absence target is 4.0%. Absence remains above the target at 8.46% in December 2024 noting an increase from 7.67% in December 2023.

2. Report format

- The report details Key Performance Issues, Key Performance Measures, and Key Performance Graphs.
- Notes have been included within the Key Performance Measures and provide additional information including definitions and detail in relation to the indicators and targets.
- Measures, Graphs and Key Performance Issues narrative are linked and should be viewed collectively.
- The Scotland comparison has been included where possible in the Key Performance Measures and Key Performance Graphs sections. Note that the Scotland figures are typically a month or quarter behind.
- Where a Forth Valley wide measure is reported any areas of challenging or poor performance within a specialty will be highlighted in the narrative.
- Performance data and graphs continue to be developed within the Pentana Performance & Risk Management System with graph detail from Pentana included in the report.

2.1. Performance Scorecard

BETTER CARE													
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	RUN CHART	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	NOTES
HOSPITAL STANDARDISED MORTALITY RATE													
MR1	SG	Rolling 12 mth	Hospital Standardised Mortality Ratio (HSMR)	30-Sep-24	</= 1.00	0.98	0.96	0.89	-	▼	1.00	30-Sep-24	Hospital Standardised Mortality Ratio (HSMR) is a measure of mortality adjusted to take account of some of the factors known to affect the underlying risk of death. The data is calculated on a rolling 12 months and published quarterly.
UNSCHEDULED CARE													
	FV	Monthly	Total Number of ED Attendances	31-Jan-25	Reduction	4,966	5,115	4,999	-	▲	-	-	
US1	SG	Monthly	Number of ED Attendances (4 hour access target)	31-Jan-25	Reduction	4,731	4,914	4,742	-	▲	-	-	Number of ED attandances and a target of 'Reduction' is relevant in relation to capacity and flow.
US2	SG	Monthly	Emergency Department % compliance against 4 hour access target	31-Jan-25	95%	46.4%	41.2%	42.5%	✓	▲	58.5%	31-Dec-24	National standard for A&E waiting times is that unplanned attendances at an A&E service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care such as EDs, assessment units, minor injury units, community hospitals, anywhere where emergency care type activity takes place.
US3	S5	Monthly	Number that waited >4 hours in ED	31-Jan-25	Reduction	2,537	2,890	2,727	-	▲	-	-	
US4	SG	Monthly	Number that waited >8 hours in ED	31-Jan-25	Reduction	1,286	1,526	1,489	-	▲	-	-	
US5	SG	Monthly	Number that waited >12 hours in ED	31-Jan-25	Reduction	720	714	920	-	▲	-	-	
US6	SG	Monthly	Number that waited >23 hours in ED	31-Jan-25	Reduction	145	153	277		▲	-	-	
	FV	Monthly	Total Number of MIU Attendances	31-Jan-25	Reduction	1,475	1,430	1,522	-	▼	-	-	The measure is the proportion of all attendances that are admitted, transferred or discharged within four hours of arrival. 95% of patients should wait no longer than four hours from arrival to admission, discharge or transfer for A&E treatment.
US7	SG	Monthly	Number of MIU Attendances (4 hour access target)	31-Jan-25	Reduction	736	716	820	-	▼	-	-	
US8	SG	Monthly	Minor Injuries Unit % compliance against 4 hour target	31-Jan-25	95%	99.7%	99.7%	100.0%	-	▲	-	-	
US9	SG	Monthly	NHS Forth Valley Overall % compliance against 4 hour target	31-Jan-25	95%	53.6%	48.6%	51.0%	✓	▲	62.3%	31-Dec-24	
US12	FV	Monthly	Number of Rapid Assessment and Care Unit New Attendances	31-Jan-25	-	535	503	598	-	-	-	-	
US13	FV	Monthly	Number of Rapid Assessment and Care Unit Scheduled Return Attendances	31-Jan-25	-	132	102	138	-	-	-	-	
US14	FV	Monthly	Number of Re-directions from ED	31-Jan-25	-	493	481	559	-	-	-	-	Redirections from ED to a more suitable setting enabling receipt of the right care, in the right place at the right time
US15	FV	Monthly	Re-directions from ED %	31-Jan-25	-	9.9%	9.4%	11.2%	-	-	-	-	
US16	FV	Monthly	Number of Emergency Admissions	31-Jan-25	Reduction	3,163	3,320	3,183	-	▲	-	-	Admission to a hospital bed following an attendance at an A&E service.
OUT OF HOURS													
OH1	FV	Monthly	Number of Out of Hours Presentations	31-Jan-25	Reduction	5,000	5,650	5,518	-	▲	-	-	
	FV	Monthly	Advice	31-Jan-25	-	3,424	3,902	3,776	-	-	-	-	
	FV	Monthly	Attend OOH Appointment	31-Jan-25	-	1,255	1,432	1,427	-	-	-	-	
	FV	Monthly	Home Visit	31-Jan-25	-	208	189	202	-	-	-	-	
	FV	Monthly	Mental Health	31-Jan-25	-	39	28	32	-	-	-	-	
	FV	Monthly	SAS In Attendance	31-Jan-25	-	70	93	80	-	-	-	-	
	FV	Monthly	Remote Consultation	31-Jan-25	-	4	6	1	-	-	-	-	
OH2	FV	Monthly	Out of Hours % Rota Fill	31-Jan-25	-	98%	93%	93%	-	▲	-	-	

SCHEDULED CARE													
OUTPATIENTS													
SC1	SG	Monthly	Total Number of New Outpatients Waiting	31-Jan-25	Reduction	12,661	12,736	15,332	✓	▲	-	-	An outpatient is categorised as a new outpatient at his first meeting with a consultant or his representative following an outpatient referral. Outpatients whose first clinical interaction follows an inpatient episode are excluded. Scotland position quarterly
			Forth Valley	31-Jan-25	Reduction	12,387	12,686						
			Mutual Aid	31-Jan-25	Reduction	274	50						
SC2	SG	Monthly	Number of New Outpatients waiting over 12 weeks	31-Jan-25	Reduction	3,738	3,442	6,588	✓	▲	-	-	
			Forth Valley	31-Jan-25	Reduction	3,508	3,423						
			Mutual Aid	31-Jan-25	Reduction	230	19						
SC3	SG	Monthly	New Outpatients waiting under 12 weeks %	31-Jan-25	95%	70.5%	73.0%	57.0%		▲	39.0%	30-Sep-24	
			Forth Valley	31-Jan-25	95%	71.7%	73.0%						
			Mutual Aid	31-Jan-25	95%	16.1%	62.0%						
SC6	Audit	Monthly	Outpatient Unavailability	31-Jan-25	Monitor	0.6%	1.1%	0.8%	✓	▲	0.8%	30-Sep-24	Unavailability, for patients without a date for treatment, is a period of time when the patient is unavailable for treatment. Unavailability can be for medical or social reasons. Scotland position quarterly
SC7	FV	Monthly	New Acute Services Outpatient % DNA	31-Jan-25	5%	5.0%	5.4%	5.8%	-	▲	6.4%	30-Sep-24	A patient may be categorised as did not attend (DNA) when the hospital is not notified in advance of the patient's unavailability to attend on the offered admission date, or for any appointment. Scotland position quarterly
SC8	FV	Monthly	Return Acute Services Outpatient % DNA	31-Jan-25	5%	5.6%	5.7%	6.9%	-	▲	-	-	
DIAGNOSTICS - Imaging													
SC10	SG	Monthly	Total number waiting - Imaging	31-Jan-25	Reduction	5,978	6,297	9,396		▲	-	-	Waiting times standard is that patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations - Xray, Ultrasound, CT, MRI, Colonoscopy, Upper Endoscopy, Lower Endoscopy, Cystoscopy Scotland position monthly, available quarterly
SC11	SG	Monthly	Number waiting beyond 42 days - Imaging	31-Jan-25	0	2,975	3,405	5,906	-	▲	-	-	
SC12	SG	Monthly	Percentage waiting less than 42 days - Imaging	31-Jan-25	100%	50.2%	45.9%	37.1%	✓	▲	57.4%	30-Sep-24	
DIAGNOSTICS - Endoscopy													
SC15	SG	Monthly	Total number waiting - Endoscopy	31-Jan-25	Reduction	914	862	906		▼	-	-	
SC16	SG	Monthly	Number waiting beyond 42 days - Endoscopy	31-Jan-25	0	339	311	378	-	▲	-	-	
SC17	SG	Monthly	Percentage waiting less than 42 days - Endoscopy	31-Jan-25	100%	62.9%	63.9%	58.3%	✓	▲	41.3%	30-Sep-24	
CANCER													
SC20	SG	Monthly	62 Day Cancer Target - Percentage compliance against target	31-Dec-24	95%	78.8%	80.8%	76.8%	✓	▲	72.6%	31-Dec-24	Cancer services remain a priority for scheduled care. All Urgent Suspicion of Cancer referrals are tracked to support achievement of the 62 and 31 day access targets. In areas where this is not reached priority measures are taken to address this. A robust monitoring system has been established to identify reasons for breaches and ensure a plan is in place to prevent further non-compliance.
SC21	SG	Monthly	62 Day Cancer - Number seen within target against total	31-Dec-24	-	52/66	63/78	63/82	-	-	-	-	
SC22	SG	Monthly	31 Day Cancer Target - Percentage compliance against target	31-Dec-24	95%	97.8%	97.7%	97.9%	✓	▼	94.1%	31-Dec-24	
SC23	SG	Monthly	31 Day Cancer Target - Number seen within target against total	31-Dec-24	-	87/89	86/88	93/95	-	-	-	-	
SC24	SG	Quarterly	62 Day Cancer Target - Percentage compliance against target	31-Dec-24	95%	79.2%	84.0%	76.0%	✓	▲	72.0%	31-Dec-24	
SC25	SG	Quarterly	31 Day Cancer Target - Percentage compliance against target	31-Dec-24	95%	98.0%	99.3%	98.7%	✓	▼	94.4%	31-Dec-24	

BETTER CARE													
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	RUN CHART	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	NOTES
INPATIENTS & DAYCASES													
SC26	SG	Quarterly	Number of patients that waited >12 weeks - Completed Wait	31-Dec-24	0	1386	1490	1167	-	-	-	-	
SC27	SG	Quarterly	% Compliance with 12 week TTG Standard	31-Dec-24	100%	44.6%	44.1%	53.6%	-	▼	57.7%	30-Sep-24	
SC28	SG	Monthly	Total Number of Inpatients/Day cases Waiting	31-Jan-25	Reduction	6,616	6,306	5,474	✓	▼	-	-	
			Forth Valley	31-Jan-25	Reduction	6,511	6,272						
			Mutual Aid	31-Jan-25	Reduction	10	25						
			NTC	31-Jan-25	Reduction	95	9						Treatment Time Guarantee (TTG) - There is a 12 week maximum waiting time for the treatment of all eligible patients who are due to receive planned treatment delivered on an inpatient or day case basis. Scotland position quarterly
SC29	SG	Monthly	Number of Inpatients/Day cases waiting over 12 weeks	31-Jan-25	Reduction	4,189	3,787	3,076	✓	▼	-	-	
			Forth Valley	31-Jan-25	Reduction	4,095	3,771						
			Mutual Aid	31-Jan-25	Reduction	10	25						
			NTC	31-Jan-25	Reduction	95	9						
SC30	SG	Monthly	Percentage of Inpatients/Day cases waiting under 12 weeks	31-Jan-25	100%	36.7%	39.9%	43.8%	✓	▼	32.2%	30-Sep-24	
			Forth Valley	31-Jan-25	100%	37.1%	39.9%						
			Mutual Aid	31-Jan-25	100%	80.0%	72.0%						
			NTC	31-Jan-25	100%	3.2%	0.0%						
SC33	Audit	Monthly	Inpatient/Day case Unavailability	31-Jan-25	Monitor	2.2%	3.5%	3.9%	✓	▲	3.6%	30-Sep-24	Unavailability, for patients without a date for treatment, is a period of time when the patient is unavailable for treatment. Unavailability can be for medical or social reasons. Scotland position quarterly
READMISSIONS													
R1	FV	Monthly	Readmissions - Surgical 7 day	31-Jan-25	Reduction	2.9%	3.4%	4.3%	-	▲	-	-	This is the measure of patients readmitted as an emergency to a medical/surgical specialty within 7 days or 28 days of the index admission. Emergency readmissions as a percentage of all admissions.
R2	FV	Monthly	Readmissions - Surgical 28 day	31-Jan-25	Reduction	6.2%	5.8%	7.2%	-	▲	-	-	
R3	FV	Monthly	Readmissions - Medical 7 day	31-Jan-25	Reduction	1.1%	1.5%	0.8%	-	▼	-	-	
R4	FV	Monthly	Readmissions - Medical 28 day	31-Jan-25	Reduction	4.0%	3.7%	3.3%	-	▼	-	-	
MENTAL HEALTH													
PSYCHOLOGICAL THERAPIES													
MH1	SG	Monthly	Psychological Therapies - 18 week RTT compliance	31-Jan-25	90%	68.3%	75.2%	64.3%	✓	▲	81.5%	30-Sep-24	
MH2	FV	Monthly	Total Number Waiting for Pyschological Therapies Initial Assessment	31-Jan-25	Reduction	986	893	696	-	▼	-	-	
MH3	SG	Quarterly	Psychological Therapies - 18 week RTT compliance	31-Dec-24	90%	74.8%	73.2%	68.9%	✓	▲	80.0%	30-Sep-24	The 18 Weeks RTT is a whole journey waiting time standard from initial referral to the start of treatment. The standard has been determined by the Scottish Government and states that 90.0% of patients should have a completed pathway within 18 weeks.
CHILD & ADOLESCENT MENTAL HEALTH SERVICES													
MH4	SG	Monthly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Jan-25	90%	98.6%	96.1%	86.1%	✓	▲	91.3%	30-Sep-24	
MH5	FV	Monthly	Total Number Waiting for CAMHS Initial Assessment	31-Jan-25	Reduction	53	58	169	-	▲	-	-	
MH6	SG	Quarterly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Dec-24	90%	96.8%	99.2%	66.4%	✓	▲	89.0%	30-Sep-24	
SUBSTANCE USE													
SM1	SG	Quaterly	% Compliance with the 3 Week target - ADP (excluding Prisons)	30-Sep-24	90%	99.5%	94.0%	87.2%	✓	▲	93.6%	30-Sep-24	The Scottish Government set a Standard that 90% of people referred for help with problematic drug or alcohol use will wait no longer than three weeks for specialist treatment that supports their recovery.
SM2	SG	Quaterly	% Compliance with the 3 Week target - Prisons	30-Sep-24	90%	93.5%	98.9%	92.2%	✓	▲	95.8%	30-Sep-24	
COMPLAINTS													
C1		Monthly	% Compliance Forth Valley (inc. prisons)	31-Dec-24	100%	67.9%	68.4%	64.5%	✓	▲	-	-	Complaints monitoring and feedback is a standing item on the Clinical Governance Committee agenda
C2		Monthly	% Compliance Stage 1 (inc. prisons)	31-Dec-24	100%	77.8%	55.8%	70.1%	✓	▲	-	-	
C3		Monthly	% Compliance Stage 2 (inc. prisons)	31-Dec-24	100%	16.7%	19.0%	19.7%	✓	▼	-	-	

REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	PREVIOUS YEAR	RUN CHART	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	
BETTER WORKFORCE													
WF3	SG	Monthly	Overall Absence	31-Dec-24	4.0%	8.46%	7.37%	7.67%	✓	▼	7.07%	31-Dec-24	From 1st April 2024 all coronavirus absences are included within the sickness absence totals.
WF4	FV	Monthly	Short Term Absence	31-Dec-24	-	3.48%	2.62%	2.85%	-	▼	-	-	Hours lost due to sickness absence / total hours available (%).
WF5	FV	Monthly	Long Term Absence	31-Dec-24	-	5.19%	4.75%	4.82%	-	▼	-	-	Short Term Absence - a period of sickness absence of 28 days or less Long Term Absence - a period of sickenss absence lasting over 28 days
WF6	FV	Rolling 12 mth	Overall Absence	31-Dec-24	-	7.67%	7.58%	7.07%	-	▼	6.49%	31-Dec-24	Absence Management is a standing item on the Staff Governance Committee agenda.
BETTER VALUE													
REF	**Target Type**	**FREQUENCY**	**MEASURE**	**DATE**	**TARGET**	**CURRENT POSITION**	**PREVIOUS POSITION**	**PREVIOUS YEAR**	**RUN CHART**	**DIRECTION OF TRAVEL (YEAR ON YEAR)**	**SCOTLAND POSITION**	**SCOTLAND DATE**	
DELAYED DISCHARGES													
VA1	FV	Monthly	Delayed Discharges - excl. Code 9 & Guardianship (Standard Delays)	31-Jan-25	Reduction	84	87	67	✓	▼	-	-	A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge, and who continues to occupy the bed beyond the ready for discharge date
			Falkirk	31-Jan-25	Reduction	50	61	47	✓	▼	-	-	
			Clackmannanshire	31-Jan-25	Reduction	9	10	4	✓	▼	-	-	
			Stirling	31-Jan-25	Reduction	20	13	13	✓	▼	-	-	
			Outwith Forth Valley	31-Jan-25	Reduction	5	3	3	✓	▼	-	-	
VA2	FV		Code 9 & Guardianship Delays	31-Jan-25	Reduction	44	47	53	✓	▲	-	-	
			Falkirk	31-Jan-25	Reduction	19	20	29	✓	▲	-	-	
			Clackmannanshire	31-Jan-25	Reduction	12	8	4	✓	▼	-	-	
			Stirling	31-Jan-25	Reduction	8	14	16	✓	▲	-	-	
			Outwith Forth Valley	31-Jan-25	Reduction	5	5	4	✓	▼	-	-	
VA3	FV		Total Bed Days Occupied by Delayed Discharges	31-Jan-25	Reduction	2,097	2,742	2,897	✓	▲	-	-	
			Falkirk	31-Jan-25	Reduction	1,385	1,568	1,562	✓	▲	-	-	
			Clackmannanshire	31-Jan-25	Reduction	128	527	182	✓	▲	-	-	
			Stirling	31-Jan-25	Reduction	343	216	514	✓	▲	-	-	
			Outwith Forth Valley	31-Jan-25	Reduction	241	431	639	✓	▲	-	-	
VA4	FV	Daily	Number waiting for a Community Bed	31-Jan-25	Reduction	43	48	58	-	▲	-	-	
AVERAGE LENGTH OF STAY													
VA4	FV	Monthly	FVRH Acute Wards Average Length of Stay (Days)	31-Jan-25	Reduction	7.33	6.77	8.35	-	▲			This is the mean length of stay (in days) experienced by inpatients in FVRH Acute wards, does not include MH or W&C. Scotland position quarterly - All Inpatients
EFFICIENCY													
E1	FV	Monthly	ED Attendances per 100,000 of the population - Forth Valley	31-Jan-25	Reduction	1,563	1,593	1,551	-	▼	-	-	
E2	FV	Rolling 12 mth	Acute Emergency Bed days per 1,000 population - Forth Valley	31-Jan-25	Reduction	791	805	813	-	▲	-	-	
E3	FV	Monthly	% Bed Occupancy - FVRH	31-Jan-25	Reduction	118.0%	108.6%	114.1%	-	▼	-	-	The percentage occupancy is the percentage of average available staffed beds that were occupied by inpatients during the period. 85% is the nationally agreed standard supporting optimum flow
E4	FV	Monthly	% Bed Occupancy - Assessment Units	31-Jan-25	Reduction	111.7%	107.9%	117.2%	-	▲	-	-	
E5	FV	Monthly	% Bed Occupancy - ICU	31-Jan-25	Reduction	93.0%	107.1%	88.5%	-	▼	-	-	
EQUITABLE													
EQ1		Rolling 3 year	Scottish Breast Screening Programme	2020/23	70%	76.4%	74.4%	74.4%	-	▲	75.9%	2020/23	Percentage uptake (three-year rolling periods), females aged 50-70 years
EQ2		Annually	Scottish Cervical Screening Programme	2021/22	-	72.5%	73.2%	73.2%	-	▼	68.7%	2021/22	The percentage of eligible women who are up-to-date with their screening participation
EQ3		Rolling 2 year	Scottish Bowel Screening Programme	2021/23	60%	66.6%	67.3%	67.3%	-	▼	66.1%	2021/23	Overall uptake of screening - percentage of people with a final outright screening test result, out of those invited (2 year reporting period)
EQ4		Annually	Scottish Abdominal Aortic Aneurysm (AAA) sreening programme	2022/23	75%	24.1%	80.8%	80.8%	-	▼	70.7%	2022/23	Percentage of eligible population who are tested before age 66 and 3 months
		Annually	Surveillance AAA scan (quarterly)	2022/23	90%	81.0%	94.2%	94.2%	-	▼	93.2%	2022/23	Due to attend quarterly surveillance and tested within 4 weeks of due date
		Annually	Surveillance AAA scan (annually)	2022/23	90%	84.4%	97.6%	97.6%	-	▼	94.0%	2022/23	Due to attend annual surveillance and tested within 6 weeks of due date
EQ5		Quarterly	NHS stop smoking services: Local Delivery Plan (LDP) - Number of 12-week quits	30-Jun-24	86.75	50	79	51	-	▼	-	-	The LDP Standard for NHS Scotland in 2024/25 is to achieve at least 7,026 self-reported successful twelve-week quits through smoking cessation services in the 40% most deprived areas
EQ6		Quarterly	NHS stop smoking services: 12-week quits as a % of the LDP Quarterly Target	30-Jun-24	100%	57.6%	91.1%	35.9%	-	▲	77.0%	30-Jun-24	
FINANCE													
F1	SG	FYTD	Year to date revenue position	31-Dec-24	Breakeven	-£11.794m	-£18.162m	-£7.7m	-	▼	-	-	

Scorecard Detail	
Target Type	FV - Local target/measure set and agreed by NHS Forth Valley; SG - Target/measure set by Scottish Government
Frequency	Frequency of monitoring in relation to scorecard
Measure	Brief description of the measure
Date	Date measure recorded
Target	Agreed target position
Current Position	As at date
Previous Reporting Period	Previous year, quarter, month, week or day dependent on frequency of monitoring
Previous Year	Same reporting period in previous year
Run Chart	✓ - indicates run chart associated with measure is available
Key to Direction of travel	▲ - Improvement in period or better than target
	▼ - Deterioration in period or below target
	◄► - Position maintained
Scotland Position	Scotland measure
Scotland Frequency	Frequency of Scotland measure
Notes	

3. Performance Exceptions Report

3.1 Unscheduled Care

Percentage of patients waiting less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment - 95% standard.

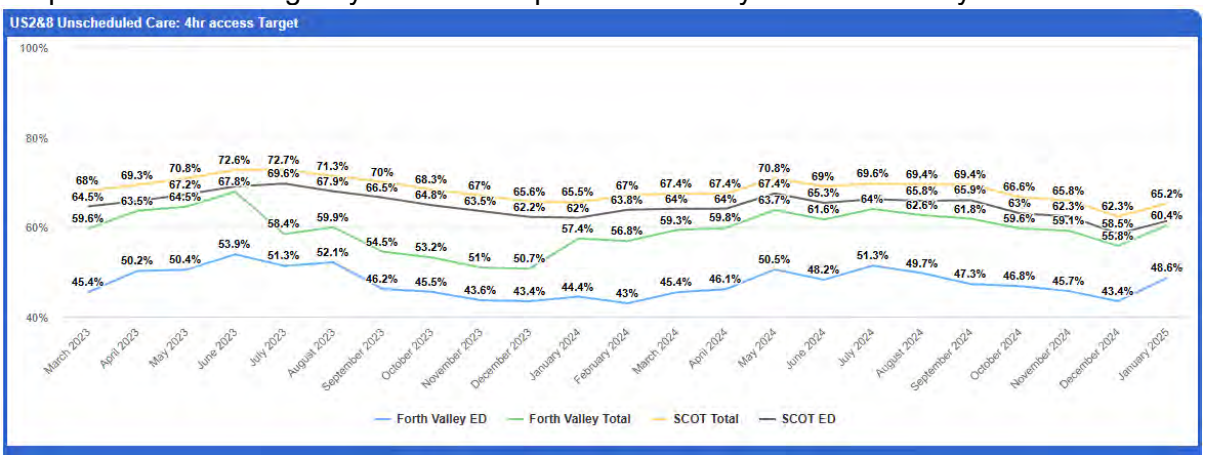
Current Performance

- January 2025 ED Compliance 53.6% - Forth Valley Total.
- January 2025 ED Compliance 46.4% - ED Only.

Scotland Performance

- December 2024 ED Compliance 62.3% - Scotland Total.
- December 2024 ED Compliance 58.5% - Scotland ED Only.

Graph 1: 4-hour Emergency Access Compliance February 2023 to January 2025



Overall compliance with the 4-hour emergency access standard (EAS) in January 2025 was 53.6%; Minor Injuries Unit 99.7%, Emergency Department 46.4%. A total of 2,539 patients waited longer than the 4-hour target across both the ED and Minor Injuries Unit (MIU); with 1,286 waits longer than eight hours, 720 waits longer than 12 hours and 145 waits longer than 23 hours. The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 1,307 patients, noting this was 1,364 in January 2024. Wait for a bed accounted for 751 patients waiting beyond 4 hours with Clinical reasons accounting for 176 breaches.

Following presentation of the Urgent and Unscheduled Care and Delayed Discharge action plan paper to the NHS Board in November, work has continued to support delivery of actions aligned to the various workstreams and projects underway system wide to support ongoing improvements in performance. In addition, NHS Forth Valley has joined the Discharge without Delay Collaborative which will influence the structure of how we align the ongoing actions in, and reporting through, one consolidated Urgent and Unscheduled Care/Delayed Discharge plan.

The Discharge without Delay programme underpins the work already underway in Forth Valley and focusses on four integrated delivery workstreams. Namely:

- Planned Date of Discharge and Integrated Discharge Hubs
- Discharge to assess / Home First
- Frailty at the Front Door
- Community Hospital and Step-Down Rehabilitation Units

The aim is to improve the patient and staff experience, building towards better performance and flow through the hospital. This in turn will reduce patient length of stay and support a reduction in the financial burden.

In January 2025 there were 535 new attendances to Rapid Assessment and Care Unit (RACU), 128 of which were via ED. This is compared to 599 new attendances in January 2024, 185 of which presented via ED. There were 132 scheduled returns in January 2024 compared with 139 in January 2024. 493 patients were redirected from ED to a more suitable setting enabling receipt of the right care, in the right place at the right time. This number equates to 9.9% of all ED attendances in January.

NHS Forth Valley is working to improve the delivery of Out of Hours services supported by a comprehensive action plan.

3.2 Delayed Discharge

- Number of patients waiting more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete.
- Number of Bed Days Occupied by delayed discharges.
- Number of Guardianship, Code 9 and Code 100.

Current Performance

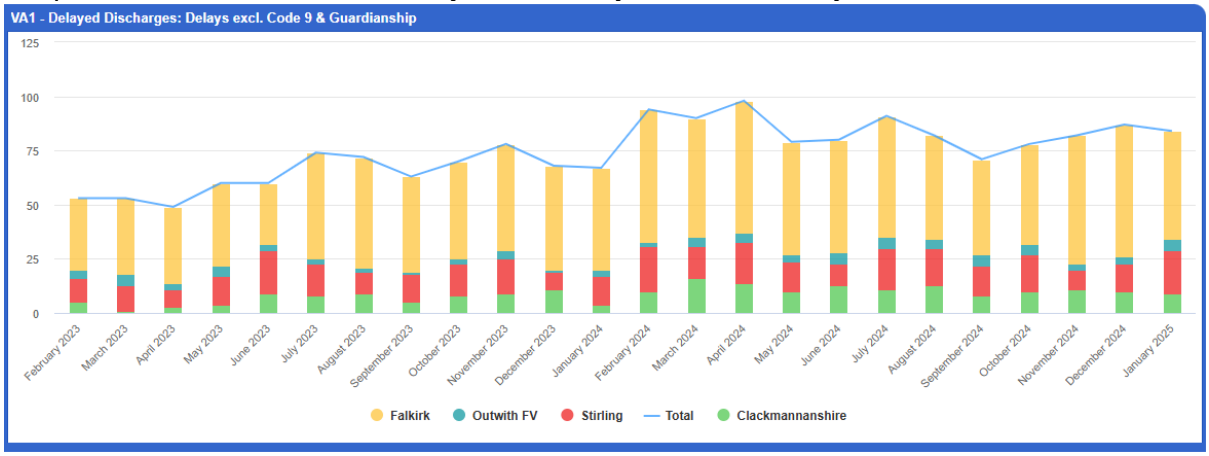
At the January 2025 census:

- 45 patients were delayed in their discharge for more than 14 days.
- 39 patients delayed less than 14 days.
- 30 guardianship delays.
- 14 code 9 delays.
- 128 delays in total.
- 2 code 100 delays.
- 2,097 bed days were lost due to delays in discharge.

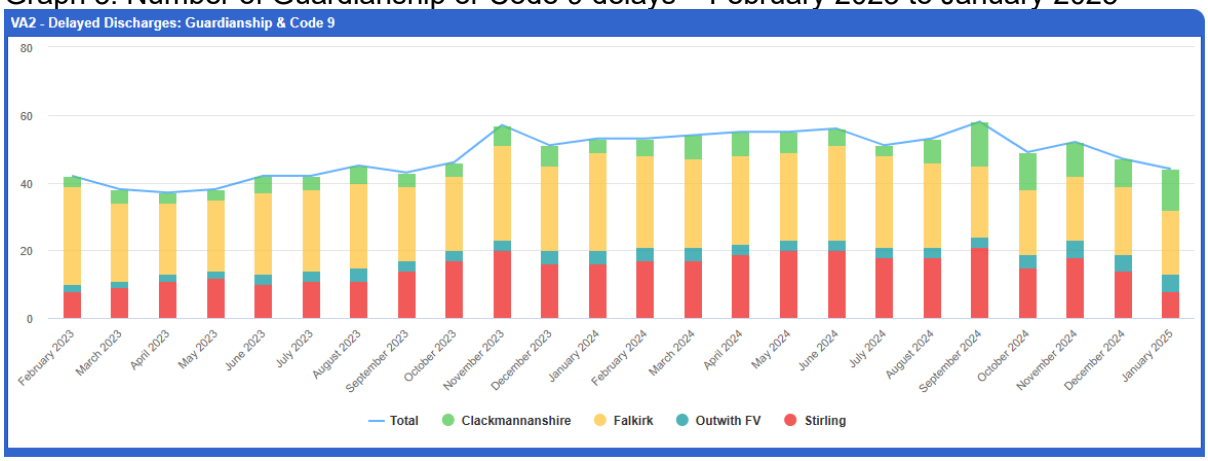
Scotland Performance

- There is no direct Scotland comparison.

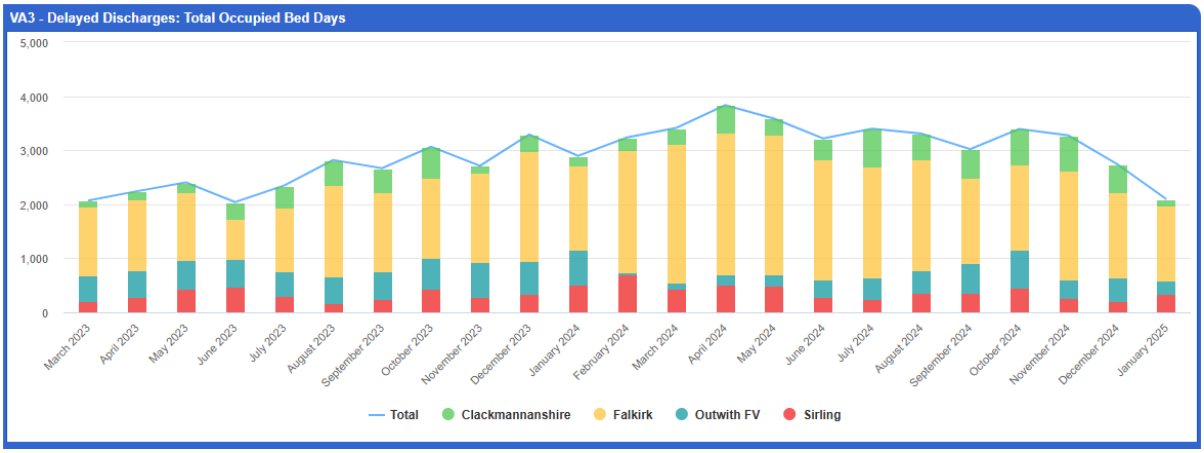
Graph 2: Number of standard delays – February 2023 to January 2025



Graph 3: Number of Guardianship or Code 9 delays – February 2023 to January 2025



Graph 4: Delayed Discharge occupied bed days – February 2023 to January 2025



The January 2025 census position in relation to standard delays (excluding Code 9 and guardianship) is 84 delays; this is compared to 67 in January 2024. There was a total of 44 code 9 and guardianship delays and no infection codes, with the total number of delayed discharges noted as 128.

In addition, there were 2 code 100 patients. (These patients are undergoing a change in care setting and should not be classified as delayed discharges however are monitored).

The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the January 2025 census was 2,097, this is a reduction from 2,897 in January 2024. Local authority breakdown is noted as Clackmannanshire 128, Falkirk 1,385, and Stirling 343. There were a further 241 bed days occupied by delayed discharges for local authorities' out with Forth Valley.

Delayed Discharge is a particular focus of attention at Scottish Government and COSLA with weekly meetings attended by all 31 Chief Officers focussing on this issue.

In addition, delayed discharge is receiving considerable daily focus and attention by the respective HSCP Chief Officers and their teams, jointly with the Acute hospital site. There is a continued focus on refining processes across our whole system discharge and flow activity. This includes process improvements around assessment and for adults with incapacity. Colleagues are visiting other board areas to learn from what is working well elsewhere and developing tests of change locally.

Scheduled Care

3.3 Outpatients

The percentage of patients waiting less than 12 weeks from referral to a first outpatient appointment – 95% Target.

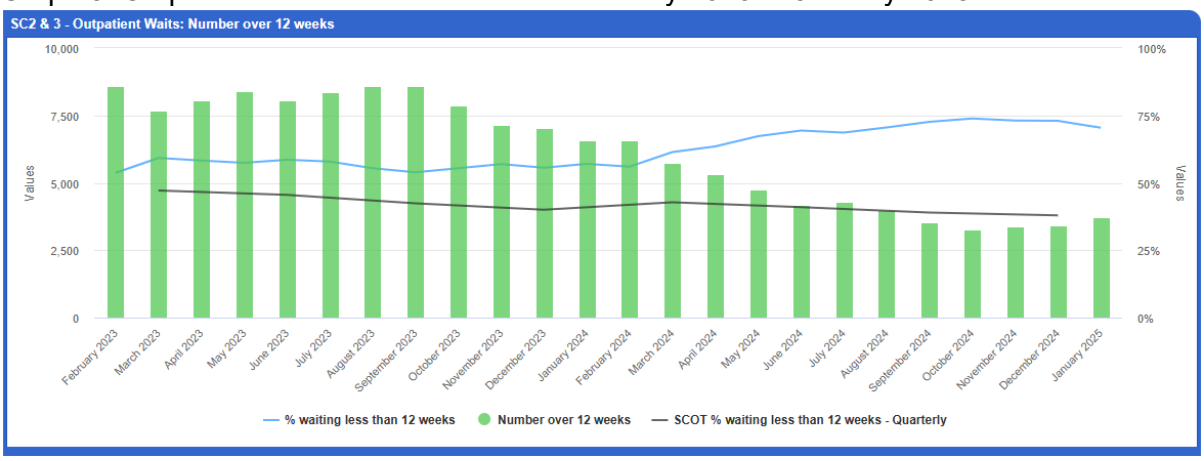
Current Performance

- January 2025 8,923 patients waiting within 12 weeks for new outpatient appointment – 70.5% compliance.
- In quarter 2, 73.0% of new outpatients were waiting less than 12 weeks.

Scotland Performance

- In quarter 2, 39.0% of new outpatients were waiting less than 12 weeks.

Graph 5: Outpatient waits over 12 weeks – February 2023 to January 2025



NHS Forth Valley concurrently treat patients that require urgent clinical care as well as those waiting for long periods, in line with associated Scottish Government guidance and targets.

At the end of January 2025, the number of patients on the waiting list for a first outpatient appointment was 12,661 (12,387 excluding mutual aid) compared with 15,332 in January 2024 with the number waiting beyond 12 weeks 3,738 (3,508 excluding mutual aid) compared to 6,588 in January 2024. Note 70.5% (71.7% excluding mutual aid) of patients were waiting less than 12 weeks for a first appointment; an improvement in performance from 57.0% the same period the previous year. Activity against the 2024/25 annual delivery plan highlights we have completed 104% of the predicted activity for quarter 3.

3.4 Inpatients

Treatment Time Guarantee (TTG) - Eligible patients who start to receive their day case or inpatient treatment within 12 weeks of the agreement to treat – 100% Target.

Current Performance

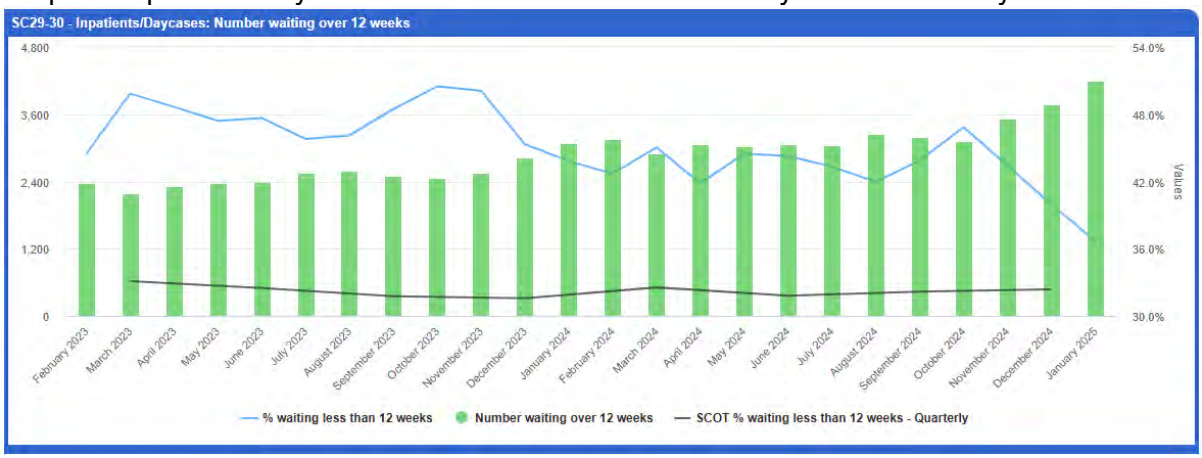
- Inpatient/Daycase treatment time guarantee Quarter 3 – 44.6%
- January 2025 – 6,616 patients waiting on an inpatient/daycase treatment – 44.1% waiting under 12 weeks.
- In quarter 3, 39.9% of inpatients and daycases had an ongoing wait under 12 weeks.

Scotland Performance

- Inpatient/Daycase treatment time guarantee Quarter 2 – 57.7%.
- In quarter 2, 32.2% of inpatients and daycases had an ongoing wait under 12 weeks.

Graph 6: 12 Week Treatment Time Guarantee

Graph 7: Inpatients/Daycase waits over 12 weeks – February 2023 to January 2025



In January 2025, the number of inpatients/daycases waiting increased to 6,616 (6,511 excluding mutual aid and NTC) from 6,306 (6,272 excluding mutual aid and NTC) the previous month and from 5,474 in January 2025. An increase from the previous year in those waiting beyond 12 weeks was also noted. Activity against the 2024/25 annual delivery plan highlights we have completed 93% of the predicted activity for quarter 3.

3.5 Unavailability

Monitoring of patient unavailability is an Audit Scotland recommendation and refers to the percentage of outpatient or inpatient/daycase unavailability as a proportion of the total waiting list size.

- Outpatient unavailability in January 2025 was 0.6% of the total waiting list.
- Inpatient/daycase unavailability in January 2025 was 2.2% a reduction from 3.9% in January 2024. The unavailability rate is less than 8% for all specialties except for Cardiology at 11.1% (1 patient). The highest in terms of numbers is Orthopaedics with 74 patients unavailable (3.3%). This position is monitored on an ongoing basis.

3.6 Did Not Attend (DNA)

The new outpatient DNA rate across acute services in January 2025 is noted as 5.0% which is an improvement from the position in January 2024 of 5.8%. Variation across specialties continues with rates ranging from 18.5% to 0.1%. The biggest impact in terms of the number of DNAs can be seen in Ophthalmology 6.9% (66 patients) and Orthopaedics 3.7% (36 patients).

The return outpatient DNA rate across acute services in January 2025 was 5.6%. There continues to be a high number of DNAs in Ophthalmology with 288 patients (4.5%), Diabetes 181 patients (13.5%), Orthopaedics 137 patients (5.7%) and Orthodontics (7.5%).

A number of actions are ongoing to support a reduction in the number of DNAs including the roll out of patient focus booking. Application of the Access Policy is actively endorsed and there is ongoing benchmarking against national DNAs and removal rates. Patient information provides detail on the process to cancel or change an appointment with the relevant contact information.

3.7 Diagnostics

Waiting times standard is that patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations.

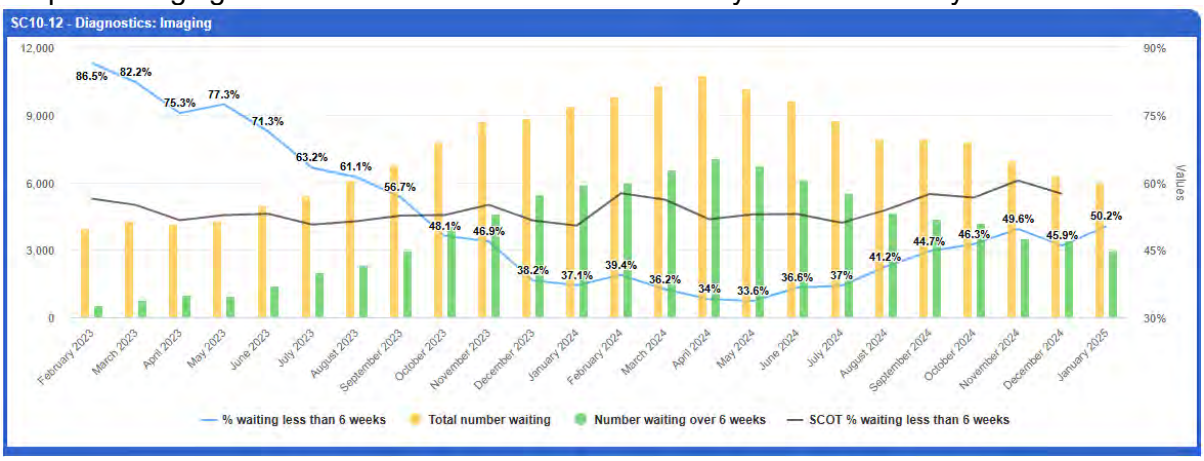
Current Performance

- January 2025 - Imaging – 2,975 patients waiting beyond 6 weeks; 50.2% were waiting less than 6 weeks.
- January 2025 - Endoscopy - 339 patients waiting beyond 6 weeks; 62.9% were waiting less than 6 weeks.

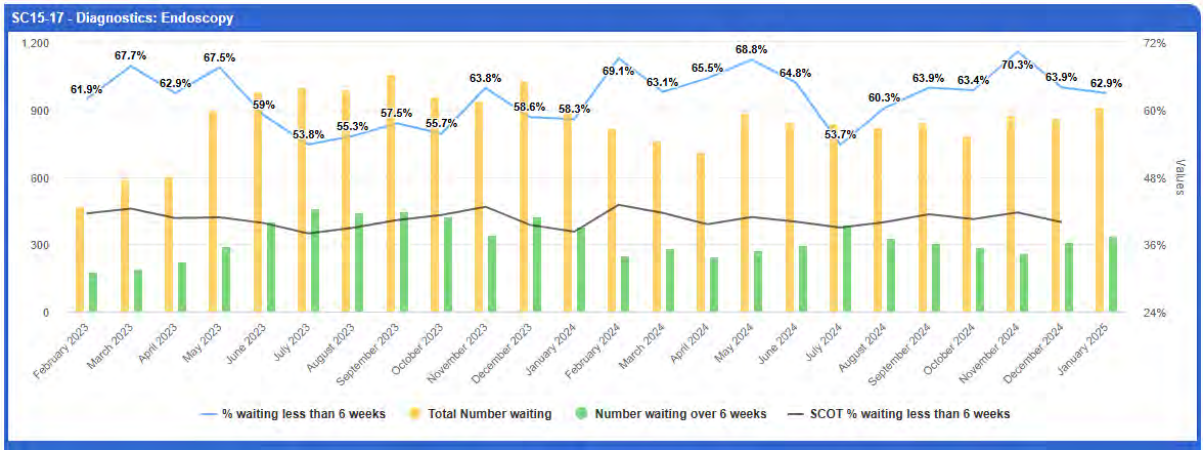
Scotland Performance

- Imaging – 57.4% of patients were waiting less than 6 weeks in September 2024.
- Endoscopy – 41.3% of patients were waiting less than 6 weeks in September 2024.

Graph 8: Imaging waits over 6 weeks and total - February 2023 to January 2025



Graph 9: Endoscopy waits over 6 weeks and total - February 2023 to January 2025



3.7.1 Imaging

At the end of January 2025, 2,975 patients were waiting beyond the 6-week standard for imaging, a reduction from 5,906 in January 2024. 50.2% of patients were waiting less than the standard noting sustained improvement since April 2024. Activity against the 2024/25 annual delivery plan highlights we have completed 135% of the predicted activity at quarter 3.

Patients continue to be seen on a priority basis with waiting lists actively monitored and managed on an ongoing basis. The total number of patients waiting for imaging in January 2025 was 5,978; compared with 9,396 in January 2024 with a continuing reduction been seen since April 2024. Note that scan requests for urgent suspicion of cancer are prioritised.

A CT van is on-site, funded by Scottish Government, to support bring our longest waiting patients in line with the 6-week target. Activity is shared 50:50 with NHS Lanarkshire.

MRI has been impacted this year due to the National Treatment Centre allocations being applied. The performance in MRI continues to be consistent however as the scanners run 13hrs/day, 7-days/week there is no scope for increased capacity at present. The Forth Valley NTC allocation for 2024/2025 has been increased by 20%.

In a further effort to meet rising demand, NHS Forth Valley will soon introduce a third CT scanner with work progressing in this regard. It is anticipated that capacity will be increased by 6,500 scans per year and reduce the need for patients to travel to other sites for imaging services.

It should be noted that over the last 10 months NHS Forth Valley has successfully reduced waiting lists for CT and Ultrasound scans by 6,000 patients. In addition, over the past two years, the Breast team and the National Treatment Centre MRI scanner have supported nearly every territorial Health Board in Scotland, helping to reduce scan waits across the country.

3.7.2 Endoscopy

At the end of January 2025, 339 patients were waiting beyond 6 weeks for endoscopy compared to 378 in January 2024. 62.9% of patients waiting less than the 6-week standard. Activity against the 2024/25 annual delivery plan highlights we have completed 118% of the predicted activity in quarter 3 which is 94% of the full financial year's predicted activity. Despite this level of activity, the total number of patients waiting for endoscopy is 914 patients in January 2025 comparable with 906 in January 2024.

The Endoscopy team is working closely with the Quality improvement team to move forward improvement work at pace. Modernising ways of working will ensure compliance with the national strategy and guidelines and will maximise current resource and ensure all endoscopy pathways are as efficient as possible.

3.8 Cancer

The 62-day standard states that 95% of eligible patients should wait no longer than 62 days from urgent suspicion of cancer referral to first cancer treatment.

Current Performance

- In December 2024, 78.8% of patients were seen within the 62-day standard.
- In the quarter ending December 2024, 79.2% of patients were seen within the 62-day standard.

Scotland performance

- In the quarter ending December 2024, 72.0% of patients were seen within the 62-day standard.

The 31-day standard states that 95% of all patients should wait no more than 31 days from decision to treat to first cancer treatment.

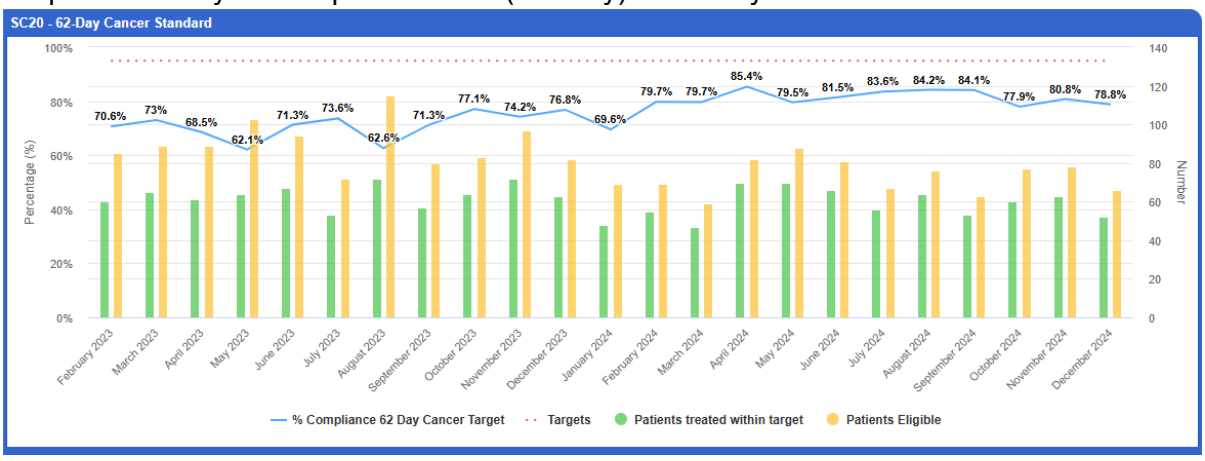
Current Performance

- In December 2024, 97.8% of patients were seen within the 31-day standard.
- In the quarter ending December 2024, 98.0% of patients were seen within the 31-day standard.

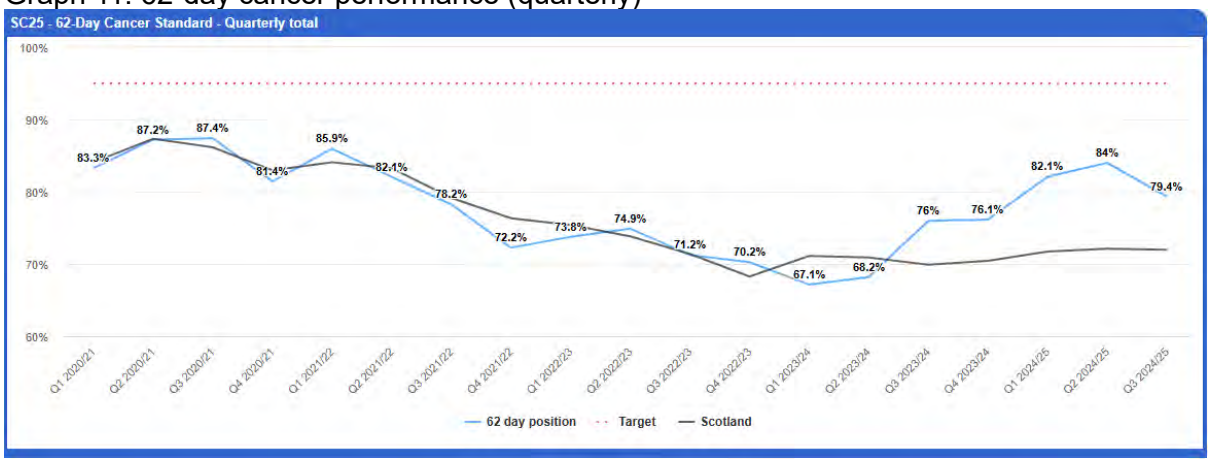
Scotland Performance

- In the quarter ending December 2024, 94.4% of patients were seen within the 31-day standard.

Graph 10: 62-day cancer performance (monthly) – January 2023 to December 2024



Graph 11: 62-day cancer performance (quarterly)



Cancer services remain a priority for scheduled care. All Urgent Suspicion of Cancer referrals are tracked to support achievement of the 31-day and 62-day access targets. In areas where this is not reached priority measures are taken to address this. A robust monitoring system has been established to identify reasons for breaches and ensure a plan is in place to prevent further non-compliance.

The number of patients being tracked on the 62-day cancer pathway is currently approximately 1063 of which 13% are confirmed cancer patients.

Four of the 10 cancer pathways achieved 100% with upper GI 83.3% (5/6), lung 76.9% (10/13), colorectal 75.0% (3/4), lymphoma 66.7% (2/3), urology 63.2% (12/19) and head & neck 50% (1/2). The highest number of breaches are within the urology pathway with 7 out of 19 patients not meeting the standard.

3.9 Psychological Therapies

The standard has been determined by the Scottish Government and states that 90.0% of patients should have a completed pathway within 18 weeks.

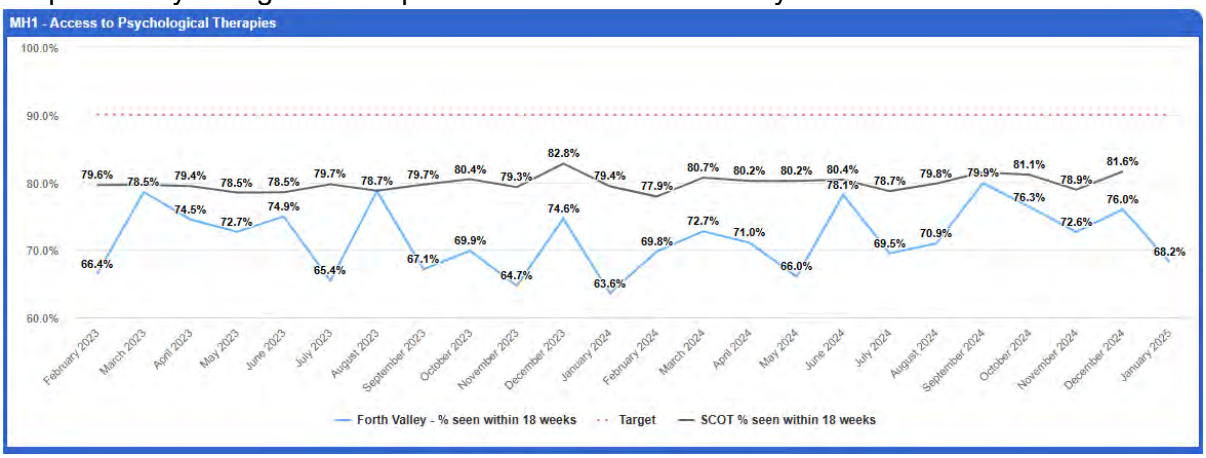
Current Performance

- In January 2025, draft numbers indicate 68.3% of patients were treated within 18 weeks.
- In quarter 3, 74.8% of patients were treated within 18 weeks.

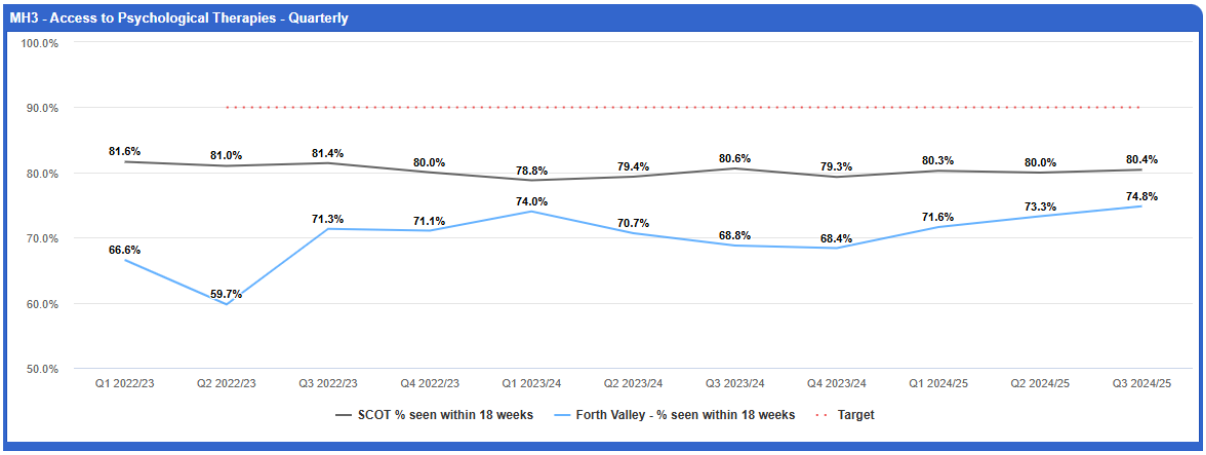
Scotland Performance

- In September 2024, 81.5% of patients were treated within 18 weeks.
- In quarter 2 Compliance, 80.0% of patients were treated within 18 weeks.

Graph 12: Psychological Therapies 18-week RTT – February 2023 to December 2024



Graph 13: Psychological Therapies 18-week RTT – Quarterly



In January 2025, 68.2% of patients started treatment within 18 weeks of referral. This is a reduction in performance from the previous month position of 75.2% however an improvement from 64.3% in January 2024. Variance in the RTT can be explained by: seasonal trends; a plateau in terms of IESO (online therapy) uptake by those with short waits as it became business as usual; new clinicians taking up caseloads comprised of patients who had been

waiting for a very long time; and group therapy starting for some cohorts of patients who had been waiting a long time.

The number of people awaiting assessment has generally been increasing since Q1 of 2023/2024 with 893 people awaiting assessment in December 2024. This is largely explained by the increase in referrals to the service over the same time period, with these now impacting the numbers waiting over 18 weeks for assessment. While there is a genuine trend towards increasing numbers of people waiting, the December 2024 data is inflated because it includes people who may not opt-in or will fail to respond to contact the department letters and will be discharged over the coming weeks.

3.10 Workforce

To reduce sickness absence to 4%

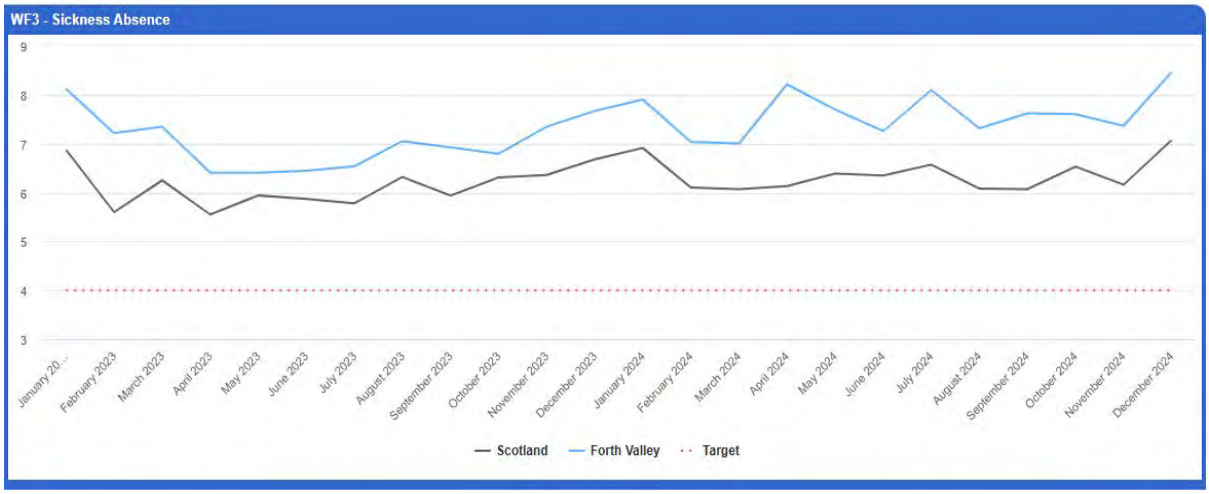
Current Performance

- 8.46% absence rate in December 2024

Scotland Performance

- 7.07% absence rate in December 2024

Graph 14: Sickness Absence – January 2024 to December 2024



The sickness absence target is 4.0%. Absence remains above the target at 8.46% in December 2024 noting an increase from 7.67% in December 2023. The 12-month rolling average January 2024 to December 2024 is noted as, NHS Forth Valley 7.67%; Scotland 6.49%.

The management of absence and the improvement of staff wellbeing remain key priorities for NHS Forth Valley noting a 2% reduction in absence has been agreed as part of the escalation response and has been included in the Executive Leadership Team objectives. This issue is being addressed through Directorate reviews with the expectation that targeted trajectories will be agreed for 2025/2026.

Work to improve attendance is focussed on the 3 key areas of Attendance Management, Occupational Health and Staff Wellbeing. An Attendance Management Plan has been developed in partnership with staff side colleagues and an audit of the implementation of the NHS Once for Scotland Attendance Policy had been undertaken to review adherence and to understand any barriers.

A range of Occupational Health support services are undertaken with a recent review and redesign of core clinical work to align with Once for Scotland Policies. A review of managerial and self-referral pathways has been undertaken along with the development of a proactive Occupational Health consultation advice line and educational training package for accessing Occupational Health services.

With research evidence highlighting the link between the health and wellbeing of the workforce, and the ability to deliver high-quality patient care, work to support employee wellbeing continues supported by the Staff Support and Wellbeing Programme Group.

Issues in relation to sickness absence and workforce continue to be examined and discussed at the bi-monthly Staff Governance Committee.

4. Implications

Financial Implications
Financial implications and sustainability are being considered on an ongoing basis working closely with Scottish Government colleagues and Health & Social Care Partnership Chief Finance Officers. The Finance Report is a standing item on the Performance & Resources Committee and Forth Valley NHS Board meeting agendas.

Financial Breakeven is detailed on the Strategic Risk Register as a Very High risk for NHS Forth Valley. As such it is reviewed and managed as a risk assigned to the Performance & Resources Committee.

- SRR.005: Financial Breakeven

If our recurring budget is not sufficient to meet the recurring cost base there is a risk there will be an increasing recurring gap in our finances, resulting in an inability to achieve and maintain financial sustainability, and a detrimental impact on current/future service provision.

Workforce Implications
Specific workforce issues aligned to areas of performance are highlighted within the report.
The NHS Forth Valley Workforce Plan 2022 – 2025 has been developed and is aligned to the Five Pillars of Workforce Planning outlined within the National Workforce Strategy - Plan, Attract, Train, Employ, Nurture.

Infrastructure Implications including Digital
There are no specific infrastructure implications in respect of this paper.

Sustainability Implications
There are no specific sustainability implications in respect of this paper.

Sustainability Declaration
Further to consideration the author can confirm that due regard has been given to compliance with the key aims of the NHS Scotland Climate Emergency & Sustainable Development Policy (DL (2021) 38) as part of the decision-making process A policy for NHS Scotland on the climate emergency and sustainable development*. (please tick relevant box)*
□ *Yes*
✓ *N/A*

Where applicable, the climate change, environmental and sustainability impacts, and any mitigating measures are noted above/contained in the supporting papers.

Quality / Patient Care Implications
There are no specific quality or patient care implications in respect of this paper.

Information Governance Implications
There are no specific information governance implications in respect of this paper.

Risk Assessment / Management
Adequate monitoring, scrutiny and management of performance supports the organisation to manage its risk with performance reporting linked to Strategic Risks:

- SRR.002 Urgent & Unscheduled Care

If NHS Forth Valley does not have enough whole system capacity and flow to address key areas of improvement there is a risk that we will be unable to deliver safe, effective, and person-centred unscheduled care resulting in a potential for patient harm, increases in length of stay, placement of patients in unsuitable places, and a negative impact on patients and staff experience.

- SRR.004 Scheduled Care

If NHS FV does not consider and plan for current and future changes to population and associated demand/case-mix, there is a risk that the model for delivery of planned care will not meet demand or prioritise effectively, resulting in poorer patient outcomes, avoidable harm and failure to meet targets.

- SRR.016 Out of Hours

If NHS Forth Valley is unable to provide a fully staffed OOHS taking an integrated, multidisciplinary approach, there is a risk that the service will not have the resilience and capacity to flex to meet demand, negatively impacting on the patient experience and journey, and ability to deliver care at the right time, right place by the right person.

In addition, there is linkage to Organisational Risks in respect of Waiting Times, Delayed Discharge, Mental Health Services – Psychological Therapies and CAMHS and the 62-day cancer target.

These risks are updated accordingly by responsible risk owners with Strategic Risk Register update presented on a quarterly basis to NHS Board Assurance Committees and the NHS Board.

Relevance to Strategic Priorities
The NHS Board is accountable for the scrutiny and performance of NHS Forth Valley as a whole and to ensure that best value principles are adhered to in delivery and commissioning of services.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity

Communication, involvement, engagement and consultation
Cognisance has been taken of feedback and comments from Non-Executive and Executive Director colleagues.

Minute of the **Clackmannanshire & Stirling Integration Joint Board meeting** held on **Wednesday 20 November 2024, The Boardroom, Carseview House, Stirling**

PRESENT

Voting Members

Councillor David Wilson (Chair), Stirling Council
Allan Rennie (Vice Chair), Non-Executive Board Member, NHS Forth Valley
Councillor Martha Benny, Clackmannanshire Council
Councillor Wendy Hamilton, Clackmannanshire Council
Councillor Janine Rennie, Clackmannanshire Council
Councillor Martin Earl, Stirling Council
Councillor Rosemary Fraser, Stirling Council
Gordon Johnston, Non-Executive Board Member, NHS Forth Valley
Martin Fairbairn, Non-Executive Board Member, NHS Forth Valley
Stephen McAllister, Non-Executive Board Members, NHS Forth Valley

Non-Voting Members
David Williams, Interim Chief Officer
Ewan Murray, Chief Finance Officer, IJB and HSCP
Alan Clevett, Third Sector Representative, Stirling
Helen McGuire, Service User Representative, Clackmannanshire
Eileen Wallace, Service User Representative, Stirling
Dr Kathleen Brennan, GP Clinical Lead, HSCP
Robert Clark, Employee Director, NHS Forth Valley
Michael Grassom, Interim Chief Social Work Officer, Stirling Council
Kevin McIntyre, Union Representative, Clackmannanshire

Standards Officer
Lesley Fulford, Senior Planning Manager

In Attendance
Sandra Comrie, PA (minutes)

1. APOLOGIES FOR ABSENCE

Councillor Wilson explained any questions/queries raised by IJB members prior to the meeting had been responded to or would be covered within the presentation of papers.

Apologies for absence were noted on behalf of:

Julie Morrison, Union Representative, Stirling
John Stuart, Non-Executive Board Member, NHS Forth Valley
Andrew Murray, Medical Director, NHS Forth Valley
Sharon Robertson, Chief Social Work Officer, Clackmannanshire Council
Lorraine Robertson, Chief Nurse HSCP

Narek Bido Third Sector Representative, Clackmannanshire
Mike Evans, Localities representative
Paul Morris, Carers Representative, Clackmannanshire
Helen Duncan, Third Sector Representative, Stirling
Wendy Forrest, Head of Strategic Planning and Health Improvement

2. NOTIFICATION OF SUBSTITUTES

None

3. DECLARATIONS OF INTEREST

Councillor David Wilson (Chair) noted a declaration of interest in relation to agenda item 7, it was agreed that Mr Rennie (Vice Chair) would Chair this item.

4. DRAFT MINUTE OF MEETING HELD ON 02 October 2024

The draft minute of the meeting held on 02 October 2024, was approved, with the following amendments:

Item 4. The draft Minute of Meeting held on 7th August 2024 omitted a decision, suggested by Mr Fairbairn, to delete the sentence at the end of 15.2 of the Standing Orders "if said member does not leave the meeting the meeting must be suspended by the Chair".

Item 18. Clinical and Professional Care Governance Update, amend sentence to read "Mr Fairbairn suggested "light touch" be reworded and he proposed that paragraph 3.1 in the papers be specifically noted in the minute as an expectation of the Board of the IJB"

5. ACTION LOG

The action log was approved.

6. CHIEF OFFICER UPDATE

Mr Williams provided a verbal update to the IJB.

Mr Williams introduced the newly appointed Interim Chief Officer, Joanna MacDonald, who commences her role on 16th December 2024. Mr Williams will be working with Ms MacDonald to produce a detailed handover.

The joint inspection of Adult Health and Social care Integration is now complete, and the final report will be published on Tuesday 26th November 2024. A link to view the report will be available. Mr Williams confirmed the improvement plan is

required to be completed and submitted by 28th January 2025 and that the steering group will continue to meet and oversee the production of this. The report and improvement plan will be considered at the Budget Seminar on 18th December 2024. The Chief Executives of Forth Valley Health Board, Clackmannanshire Council and Stirling Council will meet with Ms MacDonald in early January to consider the draft improvement plan and discuss their views and consideration and make amendments prior to submission. Arrangements are being put in place to arrange a suitable date next year for everyone to receive the full report with the finalised improvement plan, thereafter the focus will be on delivering this, and it will be brought to the IJB on 29th January 2025.

Mr Williams acknowledged the briefing note which was sent out regarding The Whins Learning Disability Day Centre in Alloa. As this is an operational issue, he advised that work is progressing, collaboratively with Clackmannanshire Council, to address the requirements identified by the Care Inspectorate.

In relation to the National Care Service, Scottish Government announced last week that stage 2 of the bill will be deferred into the new year.

Mr Williams explained that there were four papers on the agenda for Decision with Direction, which need to be addressed separately but they are all intrinsically linked due to the IJB's statutory responsibility to deliver the nine national health and wellbeing outcomes which are set out in the legislation. He highlighted the importance of ensuring that the IJB is making best use of resources available and have an engaged workforce to ensure the delivery of better performance and outcomes for people with health and social care needs. The papers align to the 10-year Strategic Commissioning Plan which seek to ensure services are needs led and resource bound.

7. COMMISSIONING A CHANGE TO THE MODEL OF LONG TERM CARE FOR OLDER ADULTS

The IJB considered the paper presented by David Williams, Interim Chief Officer

Due to a conflict-of-interest Councillor David Wilson (Chair) left the meeting and Mr Rennie (Vice Chair) took over as Chair.

Mr Rennie was advised of two deputations:

- Ms Bridle, Chief Executive, Clackmannanshire Council
- Mr McIntyre, Union Representative, Clackmannanshire.

Mr Williams explained the direction of travel for provision of health and social care to older people across Scotland with assessed care needs, has been to support people in their own homes for as long as possible through the provision of primarily care at home support. It is, therefore, recognised that individuals who may previously have been placed in long term mainstream residential care facilities would no longer require this form of care. However, there is also recognition that not everyone is able to maintain living within their own homes even with significant levels of support made available. This is because of the complexity of their needs

and in recognition of those needs care can normally only be provided for within a long-term nursing care environment.

Mr Williams explained that this approach has been fully in place in Stirling Council for several years, but in Clackmannanshire this direction of travel was being diluted by the ongoing provision of long-term care for a small number of individuals within Menstrie Care Home, a mainstream residential care home. As a result, the IJB is unable to progress a 'once for Clackmannanshire and Stirling' approach for the population which it has a statutory duty to strategically plan for and commission the provision of services from the respective Councils.

The paper recommended that the IJB no longer commission the delivery of mainstream residential care services from Clackmannanshire Council to ensure a once for Clackmannanshire and Stirling approach. Mr Williams explained that the national trend of supporting people in their own homes has moved ahead but there hasn't been a specific Direction brought to the IJB to this effect. Mr Williams explained that the consequence of this was that Clackmannanshire Council, through the HSCP, has continued to manage the care home at Menstrie House and in order to address this discrepancy, there is now a need for Direction to confirm the policy direction. He highlighted the importance of IJB members being aware of the impact of the recommendation and the impact of the decision if taken, namely that from the 1st April 2025 funding to provide mainstream residential care provision would no longer be available. The paper also set out some of the consequences and responsibilities which operationally would be required to be followed through on, not least of which would be the expectations that Trade Unions, Clackmannanshire Council and staff would have in relation to addressing their rights and also those of the 14 residents in terms of the need to review all of their individual care requirements and making suitable continuing nursing care arrangements for them.

Mr Williams confirmed he met with trade union colleagues, staff and family members on 15th November 2024 and an accurate summary of the responses was appended to the paper. Concerns were raised by those he met about a lack of consultation and engagement. Mr Williams explained that it was a briefing only as no decision had been made by the IJB. Suggestions were made as to whether Menstrie House could be a nursing home facility, Mr Williams advised that in his opinion, the Care Inspectorate would not simply reregister the existing service without considerable infrastructure and capital expenditure. He confirmed that central to this change, if the IJB agrees the recommendations, there will be the need for individual reviews for all the current residents and the provision of alternative and continuing care arrangements that will fully meet ongoing care needs. Moreover, engagement and consultation with staff and their respective Trade Unions will be required to be undertaken to ensure that the employer's responsibilities are able to be fully met in such circumstances.

Mr Williams wanted to note that he had expected the residents to be invited to attend the meeting on 15th November 2024 as three of them were reported to have capacity to make decisions for themselves. Due to an oversight, they had not been invited. At the meeting concerned family members took the decision not to update any of the residents until a decision was made.

Mr Rennie invited Nikki Bridle to present her deputation on behalf of Clackmannanshire Council.

Ms Bridle explained that Clackmannanshire Council fully supported integration and delegated both budgets and operations early in the HSCP's development, and that integration if implemented effectively has considerable potential to deliver better integrated services designed around the needs of users. The IJB and HSCP had experienced challenges in the past, and Clackmannanshire Council, as a partner, remained committed to delivering on the potential of integration for the residents and service users in Clackmannanshire, supporting new models and approaches to secure improvements.

Menstrie House and the implementation of integration have been in consideration for several years. Ms Bridle has been clear of the need to manage any proposals and transitions sensitively and supportively for both service users and staff. A paper to review arrangements was considered two years ago which she viewed as the start of a process but indicated that this work was not progressed.

Ms Bridle stated that the council's expectation is that any decision including the Direction are clear and transparent on the impact to service users. Future costs and the impact on the workforce need to be clearly understood. In terms of good governance, it was her view that alternative models needed to be understood prior to any decisions being made otherwise partners do not feel that they are part of the consultation. She did not believe this has been the approach to date.

Ms Bridle advised that earlier this year Mr Williams raised the intention to bring forward proposals for Menstrie House. Advice was provided on the due diligence requirement to secure a Council decision, consequently there were two significant political engagements with senior elected members, both of which she felt were constructive and recognised the need for the review and the options to be progressed. As a partner, Clackmannanshire Council believed they were engaged in a process and as no proposals, impacts, risks models or options were discussed at this time they believed that these would be brought forward and developed as the process continued. Ms Bridle felt this belief was curtailed by the paper being presented, and the lack of clear proposals and consultation had provided uncertainty for residents and staff. She explained that the Council may have views on how Menstrie House could be used, one option being the potential for a nursing home facility.

Ms Bridle concluded that the Council do not believe that the implementation date of 31st March 2025 is realistic as there were no options under discussion. She was concerned about the timing due to the appointment of the new Interim Chief Officer, winter pressures and budget planning. There was also a need to consider the availability of key officers to progress this work over the festive period.

Ms Bridle thanked the Board for their time and attention and summarised the Councils deputation as follows:

- Clackmannanshire Council remains committed to integration and the pursuit of new models of care and service delivery.
- Clackmannanshire Council is fully aware of the challenging context the Board is operating within and the very difficult decisions it's facing.
- Clackmannanshire Council remains open to looking at the future model of long-term care and Menstrie House, they believe good governance is better discharged by ensuring that the Board is aware of the impacts and implications for service users, families and staff as well as the financial impacts.
- Clackmannanshire Council is keen that a proper business case is developed setting out the options available and this is consulted on with key stakeholders in line with the proper protocols and policies.
- Senior elected members of Clackmannanshire Council have asked Ms Bridle to request that the Board defers the recommendation to issue the Direction today to allow for further work to be completed in line with the timescale agreed by the new Interim Chief Officer before bringing the proposal back to a future IJB for Direction.

Mr Rennie invited Mr McIntyre, Union Representative, Clackmannanshire to present his deputation on behalf of trade unions involved.

Mr McIntyre accepted that the direction of travel was to provide more care to people in their own home, but he had some concerns about the proposal which needed more consideration, and therefore asked that IJB members vote against implementing the decision.

He explained there was a lack of detail of what the closure of Menstrie House would look like for all parties involved. There was no solid proposal on what would be replacing the service or what this would mean for current residents, future service users or staff members. He accepted that service users will want care at home but there needs to be consideration for those who will still require residential care. Clackmannanshire has an aging population with an increased need for care services and Mr McIntyre was concerned that if the Direction was agreed a local service may be closed rather than looking at ways to improve it to meet the needs for the future, or with a nursing element to it.

Without Menstrie House the service would need to be provided by other care providers and if residents are moved to new locations, it could make visitation hard for families. Mr McIntyre highlighted that that care providers were struggling with rising costs, including increasing employers National Insurance contributions, and there were questions over the viability of the sector. In addition, staff were not clear of the intent to ensure they still have jobs as these currently do not exist elsewhere and would require agreement by Clackmannanshire Council. Domestic staff would need to be redeployed, and some fixed term domestic staff employed by Clackmannanshire Council may face losing their jobs.

Mr McIntyre felt that the proposal lacked detail, with unrealistic timescales. He asked the IJB to consider potential options for delivering this service before making the decision to close the facility. It was important to allow time for employers and Trade Unions to consult on detailed proposals to find a way forward rather than

forcing the issue with a hasty decision which is likely to be unpopular. The process felt rushed, and the timing of the paper being made available did not allow Trade Unions to discuss implications. All parties had concerns about the timing from the proposal to the decision for the change to take effect. Mr McIntyre asked to see future communications for staff and asked the IJB to take this information into consideration.

Councillor Rennie asked the following questions:

- Does the Board now ignore the consultation process.
- As no business case had taken place and Mr Williams mentioned that other IJB areas didn't have this process in place due to Directions, how many of these decisions were made by local authorities rather than IJB.
- When did the Board make the decision that there was no funding available.
- What business case/independent assessment was done to conclude that the care home was not ready to be used as a different facility.

Finally, she questioned whether it was the right time to move forward with this, as it was close to the festive period and with a new interim Chief Officer starting at a difficult time.

Mr Williams stated that the IJB was not being asked to make a decision to close Menstrie House, its closure would be the consequence of a strategic decision by the IJB and managing the closure would be an operational matter.

There was a clear expectation to come back to the IJB with a clear proposal about new models of care followed up with engagement and consultation. Mr Williams explained that the model of care is known, which is to support people at home and for the smaller number who can't be supported at home they will go into residential nursing care

In response to Councillor Rennie's question Mr Williams confirmed that the IJB does not ignore consultation. In relation to item 8, there was a clear expectation to come back to the IJB with a clear proposal about new models of care followed up with engagement and consultation. In relation to item 9 there had been months of engagement across Forth Valley to get an understanding of the improvement people want to see in relation to the provision, which will also come back to the IJB to enable a plan to be developed. He explained that the model of care in item 7 is known, which is to support people at home and for the smaller number who can't be supported at home they will go into nursing care.

Mr Williams explained that, over the last few years, several care homes have been closed as a result of commissioning decisions made by IJBs across Scotland.

The development of a business case to replace or convert Menstrie House would require engagement and consultation with a range of stakeholders, Mr Williams explained it was important to consider how much would be required before an IJB decision is made. He stated Menstrie House currently utilises almost 10% of Clackmannanshire Council's allocation to the IJB to provide the care for 14 people. He confirmed there is funding available but there is no specific Direction determining how the funding should be used.

Councillor Hamilton requested a motion to amend recommendation 2 & 3 in the paper, she asked that they are deleted and replaced with her amended wording the text of which was:

"Complete a thorough process which sets out viable options for future of Menstrie which are fully costed and have realistic timelines which takes into account the need for full consultation and engagement with all key stakeholders and service users/families/staff/trade unions and constituent partners in the Health and Social Care Partnership.

Once completed this work is presented to the meeting of the Board on 29th January 2025 for Decision."

Contributions were made by many of the members of the IJB which echoed the concerns noted by Ms Bridle, Mr McIntyre and Councillors Rennie and Hamiliton about lack of consultation with residents, families, employees and other stakeholders, an unrealistic timetable, lack of financial detail and lack of clarity on alternatives.

Although difficult, Mr Fairbairn recognised the need for the paper to be brought to the IJB and thanked Mr Williams for commencing the work. He acknowledged that the key strategic drivers were about a shift of choice and maximising the steps to enable people to remain in their homes for as long as possible and agreed that the principle of the paper was accurate. He would like to see the policy dimension being clearly referenced in the paper and recognised that the consultation process was the role of the local authority, which should be properly conducted and managed. He suggested that it would be useful to calculate the broad indicative impact of expenditure for 2025/26 and for future years, so the Board are aware of what the main movement of expenditure is going to be so that they can try and avoid any unintended consequences financially or manage this in some way. He appreciated the risks were listed in the paper but suggested it would be useful to see a fuller description of how the main risks are mitigated. The policy needs to be well founded, understood and referenced. It should have more substantial assurance about appropriate consultation, financial impact and risk management. He confirmed he would be comfortable to agree to the proposed Direction with Councillor Hamilton's amendments if a specific meeting date was added.

Mr Williams wanted to be clear that there has not been any suggestion about people losing jobs, and that he understands the concerns about the impact on the community. He explained that residents could not be reassessed in the meantime without good reason or without them requesting a review as it would set an expectation that something would happen as a consequence of it. Finally, he confirmed that there needs to be a clear understanding of strategic and operational responsibilities and that these need to be managed separately. He set out that operational responsibility is about dealing with the decisions that a strategic body makes.

In summing up, Mr Rennie said there was a clear consensus from IJB Board members that there were fundamental issues over lack of consultation and

understanding the costs and alternative models, and as such there was not currently support to approve the direction as laid out in the paper.

He summarised the position as follows:

- That the IJB accepts categorically the need for change to the model of long-term care for elderly adults, however, there is further detail required as set out in Councillor Hamilton's amendment.
- That the IJB is concerned about the lack of consultation, particularly with residents.
- That the IJB requires further detail on alternative provisions
- Further detail on estimated costs, and an initial assessment of the impact on staff and the community is required.
- Noted concerns over the short timetable for implementation.
- While the IJB do not reject the strategy they are looking for more detail, more information and more consultation to make an informed choice and a paper brought back on 29th January.

Councillor Hamilton asked if 29th January 2025 will give the new interim Chief Officer enough time to work on the paper. Mr Williams explained that there was a team of people who can lead the work in the two-week crossover period. Mr Fairbairn expressed the importance of the paper coming back to the meeting on 29th January 2025.

Mr Rennie wanted to ensure that there is ongoing engagement with residents of Menstrie House in the interim. He clarified that the timetable of 31st March 2025 will no longer exist.

The Integration Joint Board:

1) **Declined to approve the direction as laid out in the paper.**
2) **Fully accepted the need for implementation of the model of long-term care for elderly adults**
3) **Instructed the completion of a thorough process which sets out viable options for future of Menstrie which are fully costed and have realistic timelines which takes into account the need for full consultation and engagement with all key stakeholders and service users/families/staff/trade unions and constituent partners in the Health and Social Care Partnership.**
4) **Agreed that this work is presented to the meeting of the Board on 29th January 2025 for Decision with Direction.**

8. IMPLEMENTING THE CLACKMANNANSHIRE AND STIRLING SELF DIRECTED SUPPORT POLICY FOR ADULTS WITH LEARNING DISABILITIES

The IJB considered the paper presented by David Williams, Interim Chief Officer

Mr Williams explained there are several provisions which are operationally managed within the HSCP, commissioned historically by the IJB in the annual

generalised Directions at the start of each financial year and where there is a need for reflection and probable change regarding the continuing nature of this provision in their respective current forms. This is because they are resources that were in existence prior to the commencement of the Integration Authority and have been in place for decades in their current form, and as such should be subject to review to ensure delivery of value-based care/best value and to afford the best opportunities to people to live their best lives.

Most if not all the individuals who receive a service in the respective services will not have been afforded any level of choice and control in the terms of the Self-directed Support legislation or they may now be impacted as a consequence of the national Coming Home agenda which relates to ensuring appropriate living arrangements closer to home.

Mr Williams confirmed HSCP staff are required to progress the development of options and proposals around future models of care that are better suited to meet needs and enable people to live their best lives. It will not be a quick process and consultation, and engagement will need to take place which has been set out in the Direction.

The Integration Joint Board:

1) **Noted the contents of the paper and the scale and scope of the issues currently facing services providing care in a range of settings for people with learning disabilities.**
2) **Considered the current action being taken to address these issues as set out in section 3.**
3) **Approved the development of proposals that will result in change to the historical commissioning from both Councils for delivery of two Day Centres across the Integration Authority.**
4) **Issued the Direction at Appendix 1.**

9. PALLIATIVE AND END OF LIFE CARE

The IJB considered the paper presented by David Williams, Interim Chief Officer

It was agreed at the IJB on 25 March 2024 that the Clackmannanshire and Stirling and Falkirk IJB work together to develop a strategic commissioning plan for palliative and end of life care across Forth Valley. Mr Williams confirmed that engagement took place across Stirling, Clackmannanshire and Falkirk between April and May 2024. Engagement was sought from those who had views on palliative and end of life care. In Stirling and Clackmannanshire six engagement events took place, which included a session hosted in Stirling that specifically sought the views of people who had experience of palliative and end of life care because of a loved one using drugs and/ or alcohol. As this is often an area where care and support can differ from that received by those who are dying of other conditions.

In August and September, a follow up initial consultation took place on the six themes that emerged from the earlier engagement, and in Stirling and Clackmannanshire two engagement events were held, as well as an online survey. Clear themes have been extracted from initial engagement activities, these were topics raised multiple times in both Health and Social Care Partnership (HSCP) areas. The themes explain what is considered by many to be a fundamental or important component to accessing high quality palliative and end of life care for all those involved. They will be at the core of commissioning activity going forward all with an emphasis on shifting the balance of care to support delivery of the vision. The themes are:

- Good communication
- Good, coordinated care
- Staff Learning and Education
- Good holistic Future Care Planning
- Education/ Awareness for families and carers
- Bereavement Support

Mr Williams highlighted the need to endeavour to do a lot more for care at home for people and including people in care homes. The plan sets out that the HSCP would strive to achieve 90.6% of people able to receive care at home. This activity is in the set aside space as its about urgent and unscheduled care so there is a potential challenge with this, which is demonstrated in the charts in the paper.

Mr Williams wanted it noted that he had received correspondence from the Chief Executive of Strathcarron Hospice who felt that the figures reported grossly misrepresented the figures for Strathcarron Hospice and that there was a view that the paper is about NHS Forth Valley funding. Mr Williams explained it was about the totality of the spend, and all the care home and care at home provision is funded by Clackmannanshire, Stirling and Falkirk Councils. The Chief Executive of Strathcarron Hospice would prefer that the paper reflected the bed cost based on the allocation from NHS Forth Valley through the two IJBs, this would equate to £233. Mr Williams agreed to reflect her views to the Board, but did not agree with their position as it would be misleading. The Board noted the important contribution of the role of Strathcarron Hospice.

Mr Rennie asked whether the Scottish Ambulance Service was involved in the consultation and whether they would be part of the Commissioning Consortium as they have a key role. Councillor Earl highlighted the importance of providing services to people who reside in rural areas and asked about the role of the patient transport service as people have had to previously rely on third sector or volunteer organisations to bridge this gap. Both himself and Mr Fairbairn would like to see how the work will be monitored, how it will evolve and when an updated report will be brought back to the IJB.

Mr Williams explained that the Scottish Ambulance Service and patient transport service would need to be consulted as part of the Commissioning Consortium approach. He hoped a report would be brought back to the IJB in March 2025.

The Integration Joint Board:

1) **Noted the contents of the report**
2) **Approved the Palliative and End of Life Care Strategic Commissioning Plan**
3) **Issued the Direction as set out in Appendix 3**

10. FINANCIAL RECOVERY

The IJB considered the paper presented by Ewan Murray, Chief Finance Officer.

Mr Murray presented items 10 and 11 together as they were interlinked.

11. Financial Report

The financial report illustrated a further worsening of projections on the integrated budget of just over £0.409m despite a material improvement in the Primary Care Prescribing projection. Adverse movements related to:

- Increases in long term care numbers in Stirling in late September and early October although these have reduced slightly again by late October
- Corrections to Stirling projections from Month 5 where some costs had not been accurately reflected in projections – this particularly impacts the Bellfield Centre projection
- Increased costs in relation to Learning Disability Residential Care
- These increases were partially offset by a reduction in the projected prescribing overspend of £0.475m

Mr Murray explained that overall, the IJB continued to face increased demand, and associated costs well in excess of long-term trends which was more noticeable across adult social care, particularly prescribing, combined with an overlap of a lack of traction reflected in the report in delivering the planned savings and efficiencies which drives the projected overspend. It was requested at the IJB meeting on 2 October 2024 that there was more explanatory detail of where planned savings were not being delivered to date. Additionally, there was significant complexity regarding primary care prescribing efficiencies. He confirmed that jointly, Clackmannanshire and Stirling HSCP, Falkirk HSCP and colleagues in Forth Valley Health Board were in the process of producing a short briefing on this. The paper detailed cost pressures and cost drivers in relation to the set aside budget of large hospital services including compliance of unfunded contingency beds and associated workforce costs.

Mr Fairbairn questioned whether recommendation 4 may cause the Board to be challenged in the future and suggested that the wording in the Direction referred to relevant sections in paper to make it clearer. This was accepted. Councillor Earl was uncomfortable taking assurance that key controls are in place and wished further evidence to base this on, possibly to be brought to the combined Finance, Audit and Performance Committee.

The Integration Joint Board:

1) **Noted the projected outturn based on financial performance to Month 6, specifically the high likelihood of significant overspend in the current financial year.**
2) **Noted the Integrated Finance Report including narrative on areas of significant variance and update in respect of the Set Aside Budget for Large Hospital Services. (Sections 3 and 4)**
3) **Noted the Transformation and Savings Programme progress (Section 5 and Appendix 1)**
4) **Noted and drew assurance from the key control actions in place. (Section 6)**

10. Financial Recovery

Mr Murray, Chief Finance Officer, colleagues and Chief Executives across all constituent authorities were uncomfortable with the position across the whole system.

Collaborative and constructive discussions have continued to be held since the last IJB on 2 October 2024 and the report illustrated that there have been considerations of all areas to materially recover the position and noted the challenges in progressing for the reasons set out in the paper. Mr Murray explained that it was essential that the IJB are sighted on the considerations. Work needed to be carried out as a whole system and the report set out proposals including where Directions can be used.

The report included feedback from the engagement Mr Murray and Mr Williams had with Scottish Government, which the IJB directed them to undertake given the scale of the challenges faced and the associated risk.

Mr Murray explained the long-term care savings plan was informed by observing the numbers in long term care and looking at comparative information from the annual care home census which showed that people are being placed into long term care earlier than other systems. This was a matter of continual discussion about what can be done to deliver against the direction of the IJB.

The learning disability target was informed by the overspend last year and the requirement to address this. There was still a lot of work to be done looking at out of area packages and whether it is possible to provide care for some of the service users locally. Work is ongoing around the review of the care and support framework for care at home and a specific paper would be brought to the IJB in January 2025 on this.

Councillor Earl was not concerned that the IJB agreed to set a savings target, which at the time was close to being achievable, and questioned whether harder decisions should have been made at the start of the year. Mr Murray acknowledged this and explained the paper set out further detail on where the

difficulties in terms of delivery of transformation and associated savings are in response to discussion at the last meeting. Mr Murray stated the infrastructure needs to support the activity and there are still some technical issues with the implementation of Self-directed Support within Clackmannanshire Council in particular.

Ms Bridle asked Mr Murray, given the timing of the budget announcement for the constituent partners, what capacity does it give him when preparing the IJB budget to do due diligence on the savings proposals. Is there something in the process which needs to be changed. Mr Murray responded to say 2025/26 budget planning was already underway but significant further progress was required to prepare the budget options and conduct due diligence.

Mr Clevett raised concerns about the non-residential overspends, and wanted to look at how this could be used better, he highlighted the importance of looking at the smaller savings in the communities. Mr Murray agreed that this can be linked to work being done around the Right Care Right Time programme and how we support the workforce to deliver services.

Councillor Fraser asked how the Board should decide to divide the 10 million overspend. Mr Williams confirmed that it was a priority for the constituent authorities given a balanced budget position was not going to be delivered, and discussions were in place with the Chief Executives, Directors of Finance, the incoming Interim Chief Officer and Mr Murray.

Mr Williams reiterated Mr Murray's update on the meeting which took place with Scottish Government colleagues and informed the Board that Glen Deakin from the Health and Social Care Directorate of Scottish Government was in attendance to observe the meeting and note the outcome of the meeting, particularly the financial recovery paper. Mr Williams has suggested that himself and the Chief Executives meet with Scottish Government as soon as possible to highlight and reinforce how significant the position is. He confirmed the position requires to be clearer by the next meeting on 29 January 2025.

The Board agreed that this year's budget wasn't achievable. Mr Murray agreed that there needed to be new ways of thinking differently regarding sustainable service delivery and there is a requirement to demonstrate the IJB have taken every action possible to achieve a balanced budget. This will be part of the conversation with Scottish Government.

Mr Fairbairn wanted it noted that at the beginning of the year Mr Williams recognised some major areas where there needed to be progress in terms of how the IJB delivered Health and Social Care, this didn't deliver this year but requires to be included in the budget for next year. The challenges faced trying to achieve deliverables this year means that next year the IJB have a much better understanding of what needs to be achieved and what the challenges are.

The Integration Joint Board:

1) **Noted and considered the contents of the paper.**
2) **Noted and approved the further actions set out in Section 4**
3) **Issued the Directions as set out in Appendix 1. A Board member suggested the wording was clearer and CFO agreed to expand the text.**

12. QUARTER 2 PERFORMANCE REPORT

The IJB considered the paper presented by Ewan Murray, Chief Finance Officer.

The Board approved the paper.

The Integration Joint Board:

1) **Reviewed and considered the content of the Report.**
2) **Agreed the content of Quarter Two (July to September 2024) Executive Summary (Appendix 1) & Report (Appendix 2).**

13. REVISED STANDING ORDERS

The IJB considered the paper presented by Lesley Fulford, Senior Planning Manager.

The Board approved the paper subject to the following amendment:

Deletion of the sentence at the end of 15.2 of the Standing Orders “if said member does not leave the meeting the meeting must be suspended by the Chair”.

The Integration Joint Board:

1) Approved the amended Standing Orders set out at appendix 1.

14. INTEGRATED CLINICAL AND PROFESSIONAL CARE GOVERNANCE ASSURANCE

The IJB considered the paper presented by David Williams, Interim Chief Officer.

The Board approved the paper.

The Integration Joint Board:

1) Noted the content of the report.

15. FOR NOTING

Minutes

a. Strategic Planning Group – 21.08.2024

21. ANY OTHER COMPETENT BUSINESS (AOCB)

The Board acknowledged it was David Williams last IJB meeting, they thanked him for his contribution over the last year and wished him well for the future.

22. DATE OF NEXT MEETING

29 January 2025

Minute of hybrid meeting of the Integration Joint Board held within **Grangemouth Community Education Unit, 69-71 Abbots Road, Grangemouth, FK3 8JB** and **remotely** on **Friday 29 November 2024** at **9.30 a.m.**

Voting Members:	Councillor Fiona Collie Councillor Jim Flynn Councillor Anne Hannah Gordon Johnston Stephen McAllister Michele McClung
Non –voting Members:	Margo Biggs, Service User Representative Ian Dickson, Third Sector Representative Carol Ann Harrower, Carer Representative Marie Keirs, Chief Finance Officer (Items IJB40 and IJB41) Sara Lacey, Chief Social Work Officer Victoria McRae, Third Sector Interface Roger Ridley, Staff Representative, Falkirk Council Gail Woodcock, Chief Officer (Item IJB39)
Also Attending:	Michelle Campbell, Personal Assistant Tom Cowan, Interim Head of Primary Care Caroline Doherty, Interim Head of Integration Jack Frawley, NHS Board Secretary (Item IJB44) Nickola Jones, Transformational Programme Manager (Item IJB44) Calum MacDonald, Performance & Quality Assurance Manager (Item IJB45) Jim Millar, Team Leader - Committee Services (Item IJB44) Paul Surgenor, Communications Officer (Item IJB46) Margaret Thom, Community Mental Health Support Services Team Manager (Item IJB43) Martin Thom, Head of Integration Carly Toland, Democratic Services Graduate Nicola Wood, Falkirk HSCP Chief Nurse (Item IJB42)

IJB35. Apologies

Apologies were submitted on behalf of Kenneth Lawrie, Ross McGuffie and Andrew Murray.

IJB36. Declarations of Interest

There were no declarations of interest.

IJB37. Transparency Statements

Ian Dickson made a Transparency Statement in relation to Items IJB41 and IJB42. He stated that he had a connection to the item by reason of his position as the Chief Officer of Falkirk's Mental Health Association, who receives partnership funding. Having applied the objective test, he considered that he did not have an interest to declare.

Victoria McRae made a Transparency Statement in relation to Items IJB41 and IJB42. She stated that she had a connection to the item by reason of her position as the Chief Executive Officer of CVS Falkirk, who receives partnership funding. Having applied the objective test, she considered that she did not have an interest to declare.

IJB38. Minute

Decision

The Integration Joint Board approved the minute of the meeting held on 27 September 2024.

IJB39. Action Log

An action log detailing ongoing and closed actions following the previous meeting on 27 September 2024 was provided.

Decision

The Integration Joint Board noted the Action Log.

IJB40. Chief Officer Report

The Board considered a report by the Chief Officer and Senior Service Manager which highlighted current developments locally, regionally and nationally which were likely to be of interest to IJB members:

Local Updates:

- Senior Leadership Structure Progression;
- IJB Workshop and Budget & Governance;
- IJB Annual Accounts;

- Delayed Discharges, and
- Scottish Careers Week.

Regional Updates

- NHS Forth Valley Change in Escalation Level;
- Winter Plan;
- NHS Forth Valley Annual Review Meeting;
- Developing Forth Valley's Mental Health & Wellbeing Strategic Commissioning Plan – Progress Update;
- Health and Care Staffing Scotland Act 2019, and
- Prison Population Early Release.

National Updates

- Equality and Human Rights Commission (EHRC) correspondence, and
- National Care Service.

The Board asked about the impact of the IJB's financial position on delayed discharge from hospitals. The Chief Officer advised that this was an area of focus nationally, and significant improvements had been made in Falkirk. She noted that this time of year saw a higher frequency of hospital admissions and therefore a higher frequency of delayed discharges. She noted that 16 interim beds had been purchased in a provider care home to mitigate any detrimental impacts. The Interim Head of Integration added that the Rapid Assessment at Home model was expected to reduce the number of patients remaining in hospital for longer than necessary.

Decision

The Integration Joint Board noted the report.

IJB41. 2024/25 Budget Monitoring Report – Quarter 2

The Board considered a report by the Chief Finance Officer which provided a high-level summary of the 2024/25 projected financial position including consideration of new and emerging risks. It should be noted that projections were based on Month 6 forecasts provided.

The forecast position was a projected overspend of £8.559m on the integrated budgets and an overspend of £7.069m was anticipated in relation to the set aside budgets for large hospital services delegated to the IJB.

Services in relation to Social Care were expected to overspend by £8.769m following the allocation of £0.925m of service pressure reserves agreed at

Quarter 1 to offset spend within care at home and long-term care placements.

Services provided by NHS Forth Valley were expected to underspend by £0.210m.

In line with integration scheme requirements, a budget recovery plan was agreed at the September meeting of the IJB to address the projected overspend of £5.982m at that time. For the purposes of the report the increased overspend was assumed to be funded from non-recurring reserves, and it was assumed that the budget recovery plan would be fully delivered. The impact of the budget recovery plan was minimal at this stage due to timing of reporting. IJB agreed the plan on 27 September and the Quarter 2 report showed the position to the end of September.

The Board requested further information on the decision to pause Partnership Funding. The Chief Finance Officer advised that, given the current financial position, this decision would allow for any uncommitted non-recurring reserves for partnership funding to be protected. The Board noted its concern about the impact this would have on third sector organisations.

Following a question regarding the 2-for-1 approach taken in long-term care in order to control costs, the Interim Head of Integration advised that this was monitored on a weekly basis, and urgent admissions were facilitated where necessary to reduce the risk of harm.

The Board asked about matters relating to prescribing costs. The Head of Primary Care stressed the complexity of this issue, noting that addressing the overspend in prescribing would require work across Primary, Secondary and Acute Care with a hybrid approach. He advised that work was being undertaken to identify savings, but the volatility of prescribing costs made this challenging. As a follow-up question, the Board requested further information on social prescribing. The Head of Primary Care advised that work was being undertaken to support practitioners to link patients with support services rather than prescribing medication may help control these costs.

Decision

The Integration Joint Board:-

(1) noted the current projected position for integrated budgets and set aside services;

(2) noted the pause on decisions in relation to Partnership funds, and

(3) authorised the Chief Officer to issue revised directions to Falkirk Council and NHS Forth Valley as per the Directions summary provided at Appendix 6 of the report.

Councillor Flynn left the meeting during consideration of the following item.

IJB42. 2025/26 IJB Draft Business Case and Medium-Term Financial Plan (MTFP) Update

The Board considered a report by the Chief Finance Officer which provided an update on the 2025/26 Revenue Budget process and medium-term financial plan setting process in respect of the current assumed position.

The IJB agreed the proposed Budget Strategy at its meeting of 27 September 2024. Since that time, the Budget Working Group had been considering any additional pressures and had begun the process of considering areas of efficiency to move towards setting a balanced budget for 2025/26 and to address the medium-term financial gap.

The current timeline for the IJB budget was set out at 5.3 of the report, where the key budget announcement would be the Scottish Government funding settlement. The Scottish Government commitment to the Scottish Living Wage for adult social care workers, and any associated uplift was expected to be funded and passported via the Council. The position noted in the report took account of this assumption. Council employed care staff were paid at least £12.70 per hour, which was higher than the current Scottish Living Wage level. There was an ongoing job evaluation process for care workers which was discussed further in the risk section of the report.

The Senior Management Team were working to identify potential savings and transformational change proposals to bridge the projected medium term funding gap. This would continue to be developed over the coming weeks through the Budget Working Group, with a series of development sessions for IJB members planned. Per the Integration Scheme a budget update paper was required to be brought to IJB and remitted to partners thereafter.

The Board requested further information on the implications of the increased National Insurance contributions for employers on the National Care Home contract, third party and independent providers and GPs. The Chief Finance Officer advised that the budget settlement for the UK Government made assumptions about levels of staffing and pay, but these tended to be higher in Scotland. Assumptions made by the UK Government regarding employer National Insurance contributions therefore did not usually represent the actual contributions made in Scotland. It was estimated that the Partnership's contribution would be £400k, but there was a lack of clarity on whether this would be fully funded. She noted that it was

likely that this would have implications for providers and GPs, but this would not become clear until the settlement was announced. An update would be provided at the IJB in January with the latest position on this.

The Board requested further information on the impact of the limits being implemented to restrict the number of hours which could be increased within care at home. The Chief Finance Officer advised that this had an impact on care, but measures were in place to mitigate this impact, such as the establishment of Resource Allocation Panels, taking a risk-based approach, and spreading the cost across all teams. The Interim Head of Integration added that this was being monitored closely, and development sessions were ongoing to ensure that team managers felt supported in this process. As a follow-up question, the Board requested further information on engagement with service-users. The Interim Head of Integration advised that ensuring services were person-centred was a priority. She added that a review of the eligibility criteria was being undertaken currently and a consultation period would take place in January, where service-user and carer representatives would be invited to share their views.

Decision

The Integration Joint Board:-

(1) noted the most recent position with the 2025/26 revenue budget and medium-term financial plan;

(2) noted the indicative savings identified to date at 5.1 of the report,

(3) approved the proposed approach in relation to planning expenditure against Partnership Funds set out in Appendix 1 of the report, and

(4) noted the additional funding pressures identified at Section 4 of the report, and that the Budget Working Group (BWG) would continue to develop savings and transformational change proposals to close the budget gap which would be brought to the March meeting of the IJB for approval.

IJB43. Forth Valley Palliative and End of Life Care Strategic Commissioning Plan

The Board considered a report by the Falkirk HSCP Chief Nurse which presented the draft Forth Valley Strategic Commissioning Plan for Palliative and End of Life Care (PEOLC) to the Board for consideration and approval. This was approved by Clackmannanshire and Stirling IJB on 20 November 2024. This report outlined the joint approach taken across both Health and Social Care Partnerships (HSCPs) to develop the plan, including the consultation and engagement activity.

The Strategic Commissioning Plan, if approved, would form the basis of any review of current spend or proposals for future spend in relation to PEOLC across Forth Valley.

The Chief Nurse advised that correspondence had been received from the Chief Executive of Strathcarron Hospice following the submission of the report. The Chief Nurse stated that the Chief Executive felt that the figures reported in the Plan grossly misrepresented the costs for the Hospice, as there was a view that the paper was solely about NHS Forth Valley funding of the Hospice. She confirmed that the figures quoted for the bed day spend for the Hospice were intended to represent the totality of spend and not just that funded by NHS Forth Valley. She also noted that all figures related to care home and care at home provision were those funded by Clackmannanshire, Stirling and Falkirk IJBs. She stated that the Chief Executive of Strathcarron would have preferred that the paper reflected the bed costs solely based on allocations from NHS Forth Valley, and it was subsequently agreed that these views would be reflected in the minute of the meeting of the IJB, but the costs included in the Plan would not be amended.

The Board requested further information on the correspondence received by the Chief Executive of Strathcarron Hospice. The Chief Nurse advised that the costs stated in the report were in relation to the total funding that Strathcarron Hospice received. The Hospice received £5.9m in funding in total, which was comprised of funding from NHS Forth Valley and NHS Lanarkshire. The cost per bed day was calculated based on the number of bed days reported by Public Health Scotland alongside the total funding received by the Hospice. The Chief Executive of Strathcarron Hospice wanted to highlight that if the NHS Lanarkshire funding was not included, it was predicted that the cost per bed day would be lower than that stated in the report. The Chief Officer added that the Hospice also participated in various fundraising projects, which generated significant additional funding, and this was included in the £5.9m figure.

Decision

The Integration Joint Board:-

(1) approved the Forth Valley PEOLC Strategic Commissioning Plan;

(2) noted the next steps proposed based on agreement of the Plan, and

(3) authorised the Chief Officer to issue the Directions at Appendices 2 and 3 of the report to the Chief Executives of Falkirk Council and NHS Forth Valley.

IJB44. Redesign of Day Services for Adults with Disabilities

The Board considered a report by the Community Mental Health Support Services Team Manager which outlined the consultation undertaken and the recommendations to establish the Day Care needs for individuals with a disability within Falkirk Health and Social Care Partnership (HSCP). The focus of this consultation was to consider the location and service provision of day care services for Adults with Disabilities and identify resources required.

The aims and objectives of the consultation were to:

- engage and gather the views of service users, families, staff, and carers;
- establish a model of service to meet the day care needs for Adults with Disabilities within Falkirk;
- consider the buildings resource for Adults with Disabilities operated by the Falkirk HSCP, and
- identify the resources required to provide services.

The Board noted that 32 service-users attended eight meetings over the consultation period. It asked what this was as a proportion of the overall number of service-users. The Community Mental Health Support Services Team Manager advised that this number represented approximately 65-70% of service-users who had interacted with the service. The Board commended staff on their extensive consultation process.

Decision

The Integration Joint Board:-

(1) approved the model of service which had been identified through the engagement process; namely operate one building based service based in Dundas Resource Centre and one community-based service;

(2) noted the proposed building adaptations at Dundas Resource Centre to create an environment that enables adults with disabilities within Falkirk to achieve their desired outcomes, with full funding coming from the Council's allocated capital budget for Day Services;

(3) agreed the closure of Oswald Avenue as a Day Centre resource;

(4) noted that a scoping exercise would be undertaken to consider potential future use of the Oswald Avenue resource, and

(5) instructed the Chief Officer to issue the Direction attached as Appendix 5 to the report to the Chief Executive of Falkirk Council.

The Committee adjourned at 11:00am for a comfort break and reconvened at 11:15am.

IJB45. IJB Governance

The Board considered a report by the NHS Board Secretary, Transformational Programme Manager, Team Leader, Committee Services and Senior Service Manager which presented proposals to:

- increase the frequency of IJB meetings from four to six per year and the proposed meeting dates for 2025;
- stand down the Audit Committee and Clinical and Care Governance Committee and establish a Performance, Audit, and Assurance Committee that would meet six times a year;
- ask the IJB to nominate members of the proposed Performance, Audit, and Assurance Committee, and
- agree the level of information required from the Joint Staff Forum.

An initial refresh of the IJB Standing Orders had been done in line with the proposals set out in the report. These were attached to the report for consideration and approval. It was proposed that a more detailed review of the Standing Orders was completed and reported to the IJB in June 2025.

The report also noted the recruitment for carer and service user representation membership on the Board. It also noted that the requirements for the Board to submit an annual Climate Change report are being progressed.

The Board noted the merits of increasing the number of IJB meetings but acknowledged the time this would require of members of the Board.

The Board asked about the remit of the new Performance, Audit and Assurance Committee. The Transformational Programme Manager advised that this Committee would combine the functions of the Audit and Clinical Care and Governance Committees with the added function of performance review.

Following a discussion regarding the non-voting membership of the Performance, Audit and Assurance Committee, the Board agreed to adjust recommendation 2.4 of the report to note that the non-voting membership of the Performance, Audit and Assurance Committee would be discussed at the first meeting of the Committee, with all non-voting members invited to this

meeting. Non-voting membership arrangements would subsequently be presented to the next meeting of the IJB.

The Board then turned to the nomination of voting members to the Performance, Audit and Assurance Committee from each constituent party.

Councillor Collie nominated Councillors Hannah and Flynn as Falkirk Council representative members.

Michele McClung nominated Gordon Johnston and Stephen McAllister as NHS Forth Valley Board representative members.

There being no further nominations, the Board agreed to appoint these voting members to the Performance, Audit and Assurance Committee.

The Chief Officer agreed, following a request, that members would be informed when a Joint Staff Forum meeting had occurred.

Decision

The Integration Joint Board:-

(1) approved the proposal to increase the number of IJB meetings from four to six per year;

(2) established a new Performance, Audit and Assurance Committee;

(3) agreed to stand down the Audit Committee and Clinical and Care Governance Committee effective from the first meeting of the new Committee;

(4) agreed that the membership of the Performance, Audit and Assurance Committee would include two voting members from each constituent party, and that arrangements for non-voting membership would be discussed at the first meeting of the Performance, Audit and Assurance Committee, with all non-voting members invited to the first meeting. Non-voting membership arrangements would be presented to the next meeting of the IJB;

(5) appointed Councillors Flynn and Hannah as Falkirk Council representative members to the Performance, Audit and Assurance Committee;

(6) appointed Gordon Johnston and Stephen McAllister as NHS Forth Valley Board representative members to the Performance Audit and Assurance Committee;

(7) agreed that whichever constituent party holds the Chair of the IJB shall not hold the Chair of the Performance, Audit and Assurance Committee;

(8) agreed the programme of meetings for 2025;

(9) approved the changes to the IJB Standing Orders and agreed that a detailed review of the Standing Orders would be completed and reported to the IJB in June 2025;

(10) approved the proposal to discontinue the sharing of Joint Staff Forum (JSF) minutes, with the JSF Chair providing updates when necessary;

(11) noted that work was undergoing to identify carer representatives on the Board;

(12) agreed the process for the recruitment of service user vacancies on the Board as they arise set out in section 4 of the report, and

(13) noted that the Energy and Climate Change Coordinator from Falkirk Council would submit the Integration Joint Board's annual Climate Change report on behalf of the Board.

IJB46. Performance Monitoring Report

The Board considered a report by the Performance & Quality Assurance Manager, Corporate Performance Team, NHS Forth Valley and Performance Review Officer, Falkirk HSCP which presented the Performance Monitoring Report September 2023 – September 2024 to fulfil its ongoing responsibility to ensure effective monitoring and reporting of service delivery.

The report provided a summary of key performance issues and drew on a basic balanced scorecard approach with a focus on exception reporting.

The Board requested further information on sickness absence across the Partnership. The Chief Officer advised that levels of sickness absence remained stubbornly high across both NHS Forth Valley and Falkirk Council, and this was also a national problem. She noted, however, that there were measures in place to address this and HR support was available. The Head of Primary Care added that challenges associated with the growing prison population may have contributed to the level of sickness absence. The Board noted issues surrounding absence management in cases of self-diagnosis, and the Chief Officer advised that these comments would be relayed to colleagues in HR.

The Board noted the dissatisfaction of many carers as a result of the government decision to withdraw Carers Allowance for individuals who received a State Pension above a particular threshold. Many carers had also

expressed that there was a lack of future planning for disabled young people. The Chief Officer advised that a collaborative approach was being taken to ensure that people remained well and independent for as long as possible. The Interim Head of Integration advised that support for children and young people transitioning from school to adult services this was being reviewed. She highlighted that this review was still in its early stages, and there was a view to involve carers in developing this further.

The Board questioned the low performance of the Emergency Department in meeting the 4-hour emergency access standard. The Chief Officer advised that this standard was just one indicator in a whole system of performance measures. She noted that there had been some improvements, but due to the nature of this department, performance fluctuated significantly on a day-to-day basis. She added that there was work underway to support the improvement of performance levels and this remained an area of focus for the Partnership.

The Board asked about response times for complaints made in relation to HSCP services. The Chief Officer advised that this was an area of focus for the Partnership and received the attention of management. She noted that the Clinical Care & Governance Committee received a regular report which provided updates on complaints performance for members to consider and comment on. She added that additional capacity was being brought in to support the management of complaints.

Decision

The Integration Joint Board:-

(1) noted the report, and

(2) noted that appropriate management actions continued to be taken to address the issues identified through Performance Monitoring Reports.

IJB47. Communication and Engagement Update

The Board considered a report by the Communications Officer and the Participation and Engagement Policy Officer which provided a summary of communications and engagement activity undertaken during July September 2024.

The Partnership’s communications activity had covered key service developments, media issues, and ongoing updates to the website and digital channels.

The Partnership’s participation and engagement activity had supported the development of new policies, strategies, and co-design of services.

The Board asked for more information on wider communication to the public around support for future planning, and the national campaign regarding Power of Attorney. The Communications Officer advised that the Power of Attorney campaign would launch in February, and he would bring the Board's comments to discussions about local activity surrounding this. The Head of Primary Care added that there were several helpful resources available online regarding Power of Attorney, and advertising this information could reduce costs for members of the public. The Board suggested that publishing this information on the HSCP website could help promote this information. The Communications Officer advised that the Falkirk Council website was in the process of being refreshed and published information regarding Adult and Child Protection was under review.

Decision

The Integration Joint Board noted the report.

IJB48. Approved Minutes of Meetings

The Board considered the following minutes of the committees and groups:-

- Audit Committee – 17 September 2024
- Clinical and Care Governance Committee – 17 September 2024
- Strategic Planning Group – 29 August 2024
- Falkirk Joint Staff Forum – 24 September 2024

Decision

The Integration Joint Board noted the minutes of Committees and Groups.