NHS
Forth Valley

A meeting of the **Forth Valley NHS Board** will be held on **Tuesday 27 January 2026** 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 25 November 2025**	For Ratification **Pages 6 to 23**	
4.	**Matters Arising from the Minute / Action Log**	For Approval **Pages 24 to 26**	
5.	**Chair's Report** Verbal Update by Ms Neena Mahal, Board Chair	For Assurance	**9.40**
6.	**Board Executive Team Report** (Paper presented by Professor Ross McGuffie, Chief Executive)	For Discussion **Pages 27 to 31**	**9.50**
	7. COMMITTEE MINUTES AND AN OPPORTUNITY FOR COMMITTEE CHAIRS TO HIGHLIGHT MATERIAL ISSUES TO THE BOARD		**10.05**
	Governance Committee Minutes		
7.1	**Audit & Risk Committee – Minute of Meeting of 31 October 2025 and Verbal Update from the Meeting of 23 January 2026** (Presented by Cllr Fiona Collie, Committee Chair)	For Assurance **Pages 32 to 40**	
7.2	**Clinical Governance Committee – Minute of Meeting of 11 November 2025 and Verbal Update from the Meeting of 13 January 2026** (Presented by Mr John Stuart, Committee Chair)	For Assurance **Pages 41 to 54**	
7.3	**Staff Governance Committee – Minute of Meeting of 18 November 2025 and Verbal Update from the Meeting of 20 January 2026** (Presented by Mr Martin Fairbairn, Committee Chair)	For Assurance **Pages 55 to 65**	
7.4	**Strategic Planning, Performance & Resources Committee – Minute of Meeting of 16 December 2025** (Presented by Ms Neena Mahal, Committee Chair)	For Assurance **Pages 66 to 79**	
	Advisory Committee Minutes		
7.5	**Area Clinical Forum – Minute of Meeting of 13 November 2025 and Verbal Update from the Meeting of 15 January 2026** (Presented by Mrs Kirstin Cassells, ACF Chair)	For Noting **Pages 80 to 84**	

7.6	**Area Partnership Forum – Verbal Update from Meeting of 16 December 2025** (Presented by Mr Robert Clark, APF Co-Chair)	For Noting	
	INTEGRATION JOINT BOARDS		
7.7	**Minute of Clackmannanshire & Stirling Integration Joint Board – 24 September 2025 and Directions**	For Assurance **Pages 85 to 96**	
7.8	**Minute of Falkirk Integration Joint Board – 31 October 2025 and Directions**	For Assurance **Pages 97 to 103**	
	FOR APPROVAL		
8.	**Strategic Risk Register Update – December 2025 to January 2026** (Paper presented by Ms Vicky Webb, Head of Risk Management)	For Decision **Pages 104 to 130**	**10.35**
	FOR DISCUSSION & ASSURANCE		
	Quality & Safety		
9.	**Update on Safety:** **(a)** **Quality and Assurance Report** (Paper presented by Mr Andrew Murray, Medical Director and Professor Karen Goudie, Executive Nursing Director) **(b)** **Healthcare Associated Infection (HAI) Report December 2025** (Paper presented by Mr Jonathan Horwood, Infection Control Manager & Clinical Lead)	For Assurance **Pages 131 to 158** **Pages 159 to 184**	**10.50**
	BREAK 11.20 to 11.35		
10.	**HIS Unannounced Maternity Inspection-NHS Forth Valley** (Paper presented by Professor Karen Goudie, Executive Nursing Director)	For Assurance **Pages 185 to 244**	**11.35**
11.	**Spotlight on Services - Specialist Rehabilitation Unit** (Paper presented by Professor Karen Goudie, Executive Nurse Director)	For Assurance **Pages 245 to 254**	**11.55**
12.	**Whistleblowing Standards & Activity Report** (Paper presented by Professor Karen Goudie, Executive Nurse Director)	For Assurance **Pages 255 to 267**	**12.20**
	Finance & Performance		
13.	**Finance Report** (Paper presented by Mr Scott Urquhart, Director of Finance)	For Assurance **Pages 268 to 279**	**12.35**
14.	**Performance Report** (Paper presented by Ms Kerry Mackenzie, Acting Director of Strategic Planning & Performance)	For Assurance **Pages 280 to 341**	**12.55**
15.	**Schedule of Business**	For Information **Pages 342 to 343**	
	16. ANY OTHER COMPETENT BUSINESS		

17. RISKS AND REFLECTIONS			
18.	**Date and Time of Next Meeting** Tuesday 24 February, 9.30am	For Noting	
19.	**Matter to be Considered in Private Session**		
20.	**Pharmacy Model Hours Variation Application** (Paper presented by Ms Gail Woodcock, Chief Officer Falkirk IJB)	For Decision **Pages 344 to 358**	**1.15**
21.	**Minute of Private Session of Forth Valley NHS Board meeting held on 30 September 2025**	For Ratification **Pages 359 to 362**	

Forth Valley NHS Board
Record of Attendance: 1 April 2025 to 31 March 2026

MEMBERS	29 April (special)	27 May	17 June (private)	29 July	30 Sept	25 November	27 January	24 February
Neena Mahal (Chair)	✓	✓	✓	✓	✓	✓		
Kirstin Cassells	✓	✓	✓	✓	✓	✓		
Jennifer Champion (from 10.09.25)					✓	✓		
Robert Clark	✓	✓	✓	✓	✓	✓		
Fiona Collie	✓	X	✓	✓	✓	✓		
Frances Dodd (demitted office 15 July 2025)	✓	✓	X					
Martin Fairbairn	✓	✓	✓	✓	✓	✓		
Karen Goudie (from 16 July 2025)				✓	X	✓		
Alison Jaap				✓	✓	✓		
Gordon Johnston	✓	✓	✓	✓	✓	✓		
Fiona Law	✓	✓	✓	✓	✓	✓		
Stephen McAllister	✓	✓	✓	✓	✓	✓		
Ross McGuffie	✓	✓	✓	✓	✓	✓		
Clare McKenzie				✓	✓	✓		
Andrew Murray	✓	✓	✓	✓	✓	✓		

Allan Rennie	✓	✓	X	✓	✓	✓		
Finlay Scott				X	✓	✓		
John Stuart	✓	✓	✓	✓	✓	✓		
Scott Urquhart	✓	✓	✓	✓	✓	✓		
David Wilson (until 30 November)	✓	✓	X	✓	✓	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 25 November 2025
For: Ratification

Minute of the Forth Valley NHS Board Meeting held on Tuesday 25 November 2025 at 9.30am in the Boardroom, Carseview House.

Present:
Ms Neena Mahal (Board Chair)
Ms Kirstin Cassells (Non-Executive Director)
Dr Jennifer Champion (Director of Public Health)
Mr Robert Clark (Non-Executive Director)
Mr Martin Fairbairn (Non-Executive Director)
Professor Karen Goudie (Executive Nurse Director)
Ms Alison Jaap (Non-Executive Director)
Mr Gordon Johnston (Non-Executive Director)
Cllr Fiona Law (Non-Executive Director)
Mr Stephen McAllister (Non-Executive Director)
Professor Ross McGuffie (Chief Executive)
Professor Clare McKenzie (Non-Executive Director)
Mr Andrew Murray (Medical Director)
Mr Allan Rennie (Vice Chair)
Mr Finlay Scott (Non-Executive Director)
Mr John Stuart (Non-Executive Director)
Mr Scott Urquhart (Director of Finance)

In Attendance:
Ms Laura Byrne (Director of Pharmacy)
Ms Elsbeth Campbell (Head of Communications)
Mr Tom Cowan (Head of Strategic Planning & Transformation, Falkirk IJB)
Mrs Morag Farquhar (Director of Facilities)
Mr Jack Frawley (Board Secretary)
Mr Jonathan Horwood (Infection Control Manager & Clinical Lead) item 11(b)
Ms Marie Kiers (Chief Finance Officer, Falkirk IJB) item 17(b)
Ms Joanna MacDonald (Interim Chief Officer Clackmannanshire & Stirling IJB)
Kerry Mackenzie (Acting Director of Strategic Planning, Performance & Resources)
Ms Jackie McEwan (Corporate Business Manager)
Mr David Munro (Senior Planning Manager) item 9
Mr Stephen Nelson (Head of Digital Infrastructure)
Mr Kevin Reith (Director of People)
Dr Jillian Taylor (Child Health Commissioner & Chief Nurse)
Miss Vicky Webb (Head of Risk Management)
Ms Gail Woodcock (Chief Officer, Falkirk HSCP)

---

1. Welcome, Apologies for Absence and Confirmation of Quorum

The Chair welcomed all present to the meeting.

There was an apology from Cllr Fiona Collie (Non-Executive Director) and Cllr David Wilson (Non-Executive Director). The Board meeting was quorate.

Garry Fraser and Scott Jaffray were not in attendance.

2. Declarations of Interest

There were no declarations of interest.

3. Minute of Meeting

The minute of the meeting held on 30 September 2025, subject to previous electronic circulation and Board member approval, was **confirmed** as a correct record.

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 that actions 099, 100, 101, 102, 103, 104, 105 and 106 were marked as complete and would be removed from the Action Log.

Board members noted that actions 090, 096 and 097 would be added to the SPPRC forward planner and closed.

The Forth Valley NHS Board approved the Action Log.

Stephen McAllister joined the meeting during consideration of the previous item. Cllr Law joined the meeting during consideration of the following item.

5. Chair's Report

(a) De-escalation to Stage 2 of NHS Scotland's Support and Intervention Framework

The Forth Valley NHS Board considered a report, presented by Ms Mahal, which provided an update on NHS Forth Valley's escalation status having been moved to Stage 2 effective 9 October 2025.

Key messages in the report included:

(i) De-escalation to Stage 2 meant that direct formal support would no longer be required. However, it remained essential that the improvements achieved were sustained, and that the Board continued to prioritise delivery of the agreed actions.

(ii) Culture work had also transitioned to business as usual and the Scottish Government would, through the Chief People Officer, continue to work with NHS Forth Valley in this area.

(iii) NHS Forth Valley would continue to focus on making progress in the areas of Culture, Leadership and Governance with the intention being to submit further evidence to NPPOG in spring 2026.

The following points were made in discussion:

(i) The Board Chair thanked all staff for their contribution to achieving the de-escalation to stage 2 of the support and intervention framework. A note of thanks from the Board had been issued when the letter had been received from Scottish Government.

The Forth Valley NHS Board:

(1) noted the decision of NPPOG to move NHS Forth Valley to Stage 2 of the NHS Scotland Support and Intervention Framework for Governance, Leadership and Culture, effective 9 October 2025, and

(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(b) Verbal Update by Ms Neena Mahal

The Board Chair highlighted the following:

(a) The Chair led the Board in thanking Cllr David Wilson for his contribution to the Board during his period as the Stirling Council representative.

(b) The Chair had undertaken a number of visits/events since the previous meeting including:
- Balfron Health Centre which had given a great understanding of rural general practice, and
- Radiology which had given an understanding of how the increase in referrals were being dealt with.

(c) The Chair, and other Non-Executives, had attended the AHP Showcase Event and the Safer Together Celebration Event which had been excellent forums for showcasing innovative practice and high-quality care by staff.

(d) The Annual Review had been a great opportunity to engage with communities. Meetings had been held with the Area Partnership Forum, Area Clinical Forum and the Public Patient Forum. Items had been raised to take forward in the engagement and participation strategy.

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

(c) Highlight Report: Board Seminars Update

The Forth Valley NHS Board **noted** for information the Board Seminars Update report on the Development session in October on Risk Management and Digital & Innovation. The Chair also highlighted the value of the deep dive session on Urgent and Unscheduled Care held on 19 November.

6. Chief Executive Update

(a) 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.

Key messages in the report included:

(i) NHS Forth Vally staff and teams won four national awards at this year's Scotland's Health Awards.

(ii) Forth Valley Royal Hospital Neonatal Unit has been awarded Gold accreditation by the national baby charity Bliss.

(iii) An inspection took place at HMP Glenochil, with the Healthcare standards being rated as Good, the highest rating possible. This made HMP Glenochil the first Prison Healthcare Team in Scotland to be awarded a rating of 'Good' since the inspection processes commenced. Within the overall inspection report, 35 areas of good practice were highlighted, 20 of which were in relation to the delivery of healthcare.

(iv) The Director of Finance was leading a national group supporting a shift towards increased investment in prevention aligned to Scottish Government policy and strategy.

(v) The Executive Nurse Director had taken over as chair of the Excellence in Care National Programme Board.

(vi) The Maternity Inspection report was due to be issued on 27 November and actions would be monitored by the Clinical Governance Committee

The following points were made in discussion:

(i) In relation to the new 24hr Staff Helpline run by NHS Lanarkshire which was now available to Forth Valley staff, it was suggested that a staff helpline could support addressing absence rates.

The Forth Valley NHS Board noted the report.

(b) DL(2025)25 Implementation of Sub National Planning: Co-operation and Planning Directions 2025

The Forth Valley NHS Board considered a report, presented by Professor McGuffie, which provided an update on the implementation of the sub-national planning directions.

Key messages in the report included:

(i) The Directions required Health Boards to:
- meet a specific objective (relating to the MyCare.scot service), and
- develop and submit plans detailing how certain other objectives (relating to the Treatment Time Guarantee for orthopaedic elective services; emergency healthcare services; Once for Scotland approach to Business Systems and the MyCare.scot service) would be achieved.

(ii) The Sub-national Planning and Delivery Committees (SPDCs) for the West and East are chaired by the Chair of NHS Greater Glasgow and Clyde and Chair of NHS Lothian respectively. The Chief Executives of NHS Lothian and NHS Greater Glasgow and Clyde had been asked to play a lead role in establishing and co-ordinating the SPDCs and supporting them in their work.

The following points were made in discussion:

(i) NHS Forth Valley was part of the West of Scotland structure.

(ii) It was highlighted by the Employee Director that there was concern at a national level from trade unions on the lack of consultation before the Director's Letter had been issued.

(iii) Members considered how progress would be monitored locally on joint plans and whether joint plans would be subject to local approval processes. It was recognised that the practicalities were still being worked through. SPPRC and Board would have opportunities to input into and influence plans.

The Forth Valley NHS Board noted the report.

7. Committee Minutes

7.1 Audit & Risk Committee – Verbal Update from meeting of 31 October 2025

In the absence of the Chair, Scott Urquhart provided a verbal update on the meeting of 31 October 2025 noting that the Fraud Action Plan had been approved. There had been a verbal update on the External Audit Plan.

The Forth Valley NHS Board noted the verbal update on the meeting of the Audit & Risk Committee of 31 October 2025.

7.2 Clinical Governance Committee – 9 September 2025

Key items had previously been highlighted at the September Board meeting. The minute was commended to the Board for noting. A verbal update was also provided on the meeting of 11 November 2025.

Mr Johnston, who had chaired the November meeting, noted that significant improvement in complaints had been reported. There had been some

improvement with SAERs with discussion of temporary additional resource to help clear the backlog.

The Forth Valley NHS Board noted the minute of the Clinical Governance Committee meeting of 9 September 2025 and the key issues from the verbal update on the meeting of 11 November 2025.

7.3 Staff Governance Committee – 16 September 2025

Key items had previously been highlighted at the September Board meeting. The minute was commended to the Board for noting. A verbal update was also provided on the meeting of 18 November 2025.

The Chair of the Committee, Mr Fairbairn, noted that the Committee and Board needed sight of the Culture Change & Compassionate Leadership Programme measures as soon as possible and that the Committee would consider this at its next meeting. There was an action plan for PDP compliance. Absence management required focus to deliver improvements. There was also some concern at Committee that the progress made with Violence and Aggression training had stalled with a request for practical steps which could make a difference. Mr Reith assured the Board that the areas of concern were being reviewed for further actions.

The Forth Valley NHS Board noted the minute of the Staff Governance Committee meeting of 16 September 2025 and the key issues from the verbal update on the meeting of 18 November 2025.

Karen Goudie left the meeting during consideration of the following item.

7.4 Strategic Planning, Performance & Resources Committee (SPPRC) – 28 October 2025

The Forth Valley NHS Board received the Strategic Planning, Performance & Resources Committee Minute of the meeting held on 28 October 2025. The minute was commended to the Board for noting.

The Chair of the Committee, Ms Mahal, highlighted that the Committee had considered the financial recovery plan and had early sight of the Seasonal Surge Plan for discussion and comment to inform the finalising of the plan.

The Forth Valley NHS Board noted the minute and key issues highlighted from the Strategic Planning, Performance & Resources Committee meeting of 28 October 2025.

Advisory Committee Minutes:

7.5 Area Clinical Forum (ACF) - 25 September 2025

Key items had previously been highlighted at the September Board meeting. The minute was commended to the Board for noting. A verbal update was also provided on the meeting of 13 November 2025.

Ms Cassells, ACF Chair, highlighted that the Forum meeting had been part of the Annual Review engagement. Good practice had been shared from area committees. Flash reports would be used to share good news with the Board Chair and Chief Executive. There was a plan to deal with concerns relating to the Area Medical Committee. The ACF felt it was being involved in consultations at the right time and was able to influence.

Following a question on concerns regarding acute site engagement with the Area Medical Committee, feeding into the Area Clinical Forum, it was noted that there had been some challenges with engagement but that there was a plan to address this and that this would be kept under review.

The Forth Valley NHS Board noted the minute of the Area Clinical Forum meeting of 25 September 2025 and the key issues from the verbal update on the meeting of 13 November 2025.

7.6 Area Partnership Forum - 26 August 2025
Key items had previously been highlighted at the September Board meeting. The minute was commended to the Board for noting. A verbal update was also provided on the meeting of 28 October 2025.

Mr Clark, APF Chair, highlighted that the meeting on 28 October had been part of the Annual Review engagement.

Clarity was sought on whether there were any issues about the Reduced Working Week that required raising. Mr Clark advised that the guidance had been clarified nationally. How RWW was adopted would be considered service by service. Solutions would be found for all areas.

The Forth Valley NHS Board noted the minute of the Area Partnership Forum meeting of 26 August 2025 and the key issues from the verbal update on the meeting of 28 October 2025.

7.7 The Minute of Clackmannanshire & Stirling Integration Joint Board – 13 August 2025 and Directions were noted for information.

7.8 The Minute of the Falkirk Integration Joint Board – 5 September 2025 was noted for information.

8. Strategic Risk Register Update: October – November 2025
The Forth Valley NHS Board considered a report for approval, presented by Miss Webb which provided an update on the Strategic Risk Register for the period of October to November 2025.

Key messages in the report included:
(i) During the reporting period, all the current strategic risks had been reviewed, and all remained static.
(ii) There was no change to the appetite profile of the Board for the reporting period. There were 0% of risks within the Board's appetite, 25% within the Board's tolerance and 75% outwith appetite and tolerance.

The following points were made in discussion:
(i) A breakdown of milestones for SRR004 – Scheduled Care was asked for in the period between March 2026 and March 2027. It was noted that the theatre efficiency programme was a large piece of work connected to this risk.
(ii) There was also a question on SRR004 to clarify whether there was any additional risk by the new sub-national planning structure arrangements. This was already considered in relation to the mutual aid arrangements provided. There could be an impact on planned care performance but actions were being taken to ensure that reporting showed total figures and those with Forth Valley only patients.

(iii) For SRR005 – Financial Sustainability it was noted positively that the strategic initiatives were reflected in this risk. There were three key themes: the financial sustainability action plan, Value Based Health Care and improved financial stewardship.
(iv) A view was sought on when each risk will return to tolerance. Although this would be discussed with the risk owners however, there were many variables to try and understand. Updates would be provided as the position of a risk moved. Further work would also be undertaken by the Short Life Working Group on appetite and tolerance.
(v) Clarity was sought on the actions relating to the establishment of the Primary Care Programme Board as set out in SRR018 – Primary Care Sustainability. The first meeting would be held on 18 December 2025 and allow actions to progress. The risk would continue to be aligned with SPPRC.

The Forth Valley NHS Board:
(1) approved the changes to the Strategic Risk Register for the period October – November 2025;
(2) noted the progression of the mitigating actions identified;
(3) noted the update on the focused reviews conducted within the period, and
(4) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action
(i) The SLWG on Risk to consider expanding its scope to include updating risk timelines and the review of risk appetites and tolerances. Vicky Webb

9. Seasonal Surge Preparedness Plan
The Forth Valley NHS Board considered a report, presented by Mr Munro, which provided the Forth Valley Health & Social Care Whole System Seasonal Surge Preparedness Plan 2025/26. The Plan set out a high-level, system-wide approach to managing periods of increased demand across health and social care services, with a particular focus on winter and other peak times.

Key messages in the report included:
(i) The Plan built on year-round arrangements for urgent and unscheduled care, planned care, business continuity, adverse weather, respiratory illness, vaccination, norovirus, and communications.
(ii) The Plan was developed collaboratively by NHS Forth Valley, Clackmannanshire & Stirling Health & Social Care Partnership, and Falkirk Health and Social Care Partnership.
(iii) An initial draft of the Seasonal Surge Preparedness Plan was submitted to the Scottish Government on 16 October 2025. The Plan was dynamic, regularly updated to reflect changing pressures and new ways of working. It was underpinned by strong governance, regular review, and a commitment to learning and improvement.
(iv) Comments from consideration of an earlier draft of the plan by SPPRC had been taken account of with an additional section on Primary Care.

The following points were made in discussion:
(i) Members noted the flu was already resulting in absences and asked about immunisation rates. Data from Public Health Scotland was 29.9% for Forth

Valley, with the national average at 28.2%. The social care workforce uptake was approx. 13% and above the national average for this cohort. Uptake was being widely encouraged.

(ii) There was discussion on minimising the use of contingency beds. Contingency beds were an area of concern for staff causing additional pressures. Ward A11 had been closed as part of Shifting the Balance of Care and could be used for improvement programmes such as bathroom remediation works allowing ward decants. There were 50 contingency beds open, where the week previous this had been in the 20s. Work would be undertaken to clear these as much as possible ahead of the peak period.

(iii) How would data be used to inform future planning and in-build resilience. Colleagues in Information Services were working on this and getting better data earlier to start planning for future years. There would however always be surges to deal with.

(iv) What changes would there be to senior on-call arrangements and availability of medical decision makers out of hours and at weekends. There would be increased capacity of the key group. Additional Senior Decision Makers would cover twilight shifts during core winter months which would result in reduced backshift queue and support rapid review and enhanced triage. Should elective work be stood down then there would be further contribution from the medical cohort to flow. Options had been looked at to support the 'golden hour' in relation to discharge.

(v) Members asked why there was no EQIA. There was a national EQIA in relation to the seasonal surge plan. Senior Leadership Team would consider the best approach to be taken in instances where national EQIAs were available.

(vi) Board sought information on the communications plan and assurance that departments knew what was being committed to. The one-page high level information document would be circulated.

The Forth Valley NHS Board:

(1) approved the Forth Valley Whole System Seasonal Surge Preparedness Plan 2025/26;

(2) noted that the Forth Valley Whole System Seasonal Surge Preparedness Plan 2025/26 was dynamic and would continue to evolve throughout the year, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions had been identified.

Action

(i) Circulate the one-page high level information document. Elsbeth Campbell

(ii) SLT to consider how national EQIAs would be pulled through for local strategies and plans in future. Kevin Reith

10. Governance Report: Meeting Dates

The Forth Valley NHS Board considered a report, presented by Mr Frawley, which provided a schedule of meetings for approval.

Key messages in the report included:

(i) The Board and Strategic Planning, Performance & Resources Committee met on the last Tuesday of alternate months. To date the Board met in January, March, May etc. including a July meeting. In response to feedback received and from both Non-Executive Members and Executives an

alternative schedule had been produced to remove the Board meeting from July to support operational issues during the peak summer holiday period. In order to effect the change for 2026 it was proposed that Board meetings were held back-to-back in January and February.

(ii) Both the Clinical Governance and Staff Governance Committees had scheduled meetings for July. It was suggested that the Executive Leads and Chairs of these Committees consider the matter for 2026 and whether they wish to revisit their schedules to avoid a July meeting.

(iii) It was proposed that going forward Board Seminars were held in diaries for full day sessions to assist with diary planning, the volume of business and Board Development opportunities.

(iv) Board Seminars would take place on:

- 10 February
- 3 March (new date)
- 21 April
- 9 June
- 11 August
- 6 October

The following points were made in discussion:

(i) Seminars should be used efficiently and effectively with the right balance between providing information and facilitating engagement in the topic while keeping in mind Members' governance roles. Going forward the Board Chair had discussed the involvement of the Head of Organisational Development in supporting the Seminars process.

(ii) Additional meetings could be held beyond those in the schedule of meetings if required.

The Forth Valley NHS Board:

(1) approved the timetable of Board and Strategic Planning, Performance & Resources Committee meetings set out in appendix 1 to the report;

(2) approved the Committee and Seminar dates for 2026 including the additional March Seminar;

(3) noted that the Executive Leads and Chairs of the Clinical Governance Committee and Staff Governance Committee would be asked to consider the scheduling of their July meetings in 2026 and future years;

(4) noted the intention to increase Board Seminars to be scheduled for a full day, and

(5) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Actions

(i) Circulate the dates of meetings including IJB dates and Seminars to Board Members and administrative leads of all committees and remind colleagues of the use of the Corporate Calendar. — Jack Frawley

The Board adjourned at 11.05am and reconvened at 11.20am with all members present as per the attendance list with the exception of Professor Goudie.

11. Update on Safety

(a) Quality Assurance and Improvement Report

The Forth Valley NHS Board considered a report for assurance, presented by Mr Murray which provided an overview of the current position in relation to quality assurance and progress across key priorities in quality and safety.

The key messages in the report included:

(i) Assurance and progress with SAERs, HSMR, FOI and Complaints Management.

(ii) The Safer Together Collaborative had concluded after driving improvements in key harm areas, including falls with harm, cardiac arrests, pressure ulcers, enhanced observations, and catheter care. A New Quality and Safety Steering Group is being established to oversee whole system safety and ongoing work aligned to the Scottish Patient Safety Programmes for Mental Health and Adults in Hospital.

(iii) Healthcare Improvement Scotland undertook an unannounced inspection of NHS Forth Valley on 25 and 26 August, focusing on Mental Health Services and Women and Children's Services. The factual accuracy report for Women and Children's Services had been received and was undergoing review for factual accuracy.

(iv) SPSP Process Improvement with a new protocol was implemented to ensure that all data submissions underwent rigorous internal review prior to dissemination beyond the Board.

The following points were made in discussion:

(i) Members discussed the possibility of industrial action by Resident Doctors. If there was industrial action the Board would be kept apprised of this.

(ii) Members acknowledged the progress being made with SAERs and Complaints but still had concerns about pace of progress. Discussion included whether the Board was sighted on learning from issues where they arise and what actions were taken. Broad themes were reported to the Clinical Governance Committee with reporting to the Clinical Governance Working Group which focussed on organisational learning. Actions were put in place immediately when incidents occurred. It was suggested that visibility of themes and learning could be considered further at the Board Seminar

(iii) A question was asked on how to bring the information on quality safety together into an overarching assessment going forward. It was suggested that this could be further considered at the upcoming Board Seminar on Quality & Safety in 2026.

(iv) Clarity was sought on the timeline and impact of putting temporary additional resource into the SAER team. The Clinical Governance Committee had endorsed the staffing plan which was being worked up on the basis of a fixed term resource.

(v) In relation to complaints there was discussion on the improved flow through the system and a question on the issues raised, root causes behind these and severity of the matters considered. Complaints numbers continued to rise which was being seen across Boards and there was a focus on learning to ensure that issues did not repeat.

(vi) A question was asked as to whether all SAERs were clinical. There were distinct processes in relation to health & safety matters. Occasionally SAERs had been used to consider matters such as infrastructure failures by way of a thematic review. The Medical and Executive Nurse Directors could commission a SAER if they felt there was value in doing so. The Adverse Events Policy and health & safety information would be circulated after the meeting.

The Forth Valley NHS Board:

(1) reviewed the key areas of Quality and Safety contained within the report, noting the areas of progress and risk, and

(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Actions

(i)	**Provide updates on developments relating to potential industrial action by Resident Doctors.**	Andrew Murray
(ii)	**Circulate the Adverse Events Policy and health & safety information to Board members.**	Kevin Reith

(b) Healthcare Associated Infection (HAI) Report October 2025

The Forth Valley NHS Board considered a report for assurance, presented by Mr Horwood, which was a mandatory reporting tool for oversight of HAI targets and other activities.

Key messages in the report included:

(i) Total SABS exceeded control limits. There were four hospital acquired SABs in October.
(ii) Total DABs remained within control limits. There were two hospital acquired DABs in October.
(iii) Total CDIs remained within control limits. There were no hospital acquired CDIs in October.
(iv) Total ECBs remained within control limits. There were five hospital acquired ECBs in October.
(v) There was one mandatory surgical site infection in October.
(vi) There were no outbreaks reported in October.

The following points were made in discussion:

(i) Influenza numbers had been increasing, with this taking place around a month earlier than usual. There were 23 cases on the acute site. This would be monitored on a daily basis.
(ii) In relation to the LDP Targets a question was asked on what would happen beyond March 2026. The Board was advised that Scottish Government set the targets based on ARHAI recommendations which target a 10% decrease from baseline.
(iii) Clarity was sought on whether sepsis related to urinary catheters was reported through this report. It was confirmed that when there were sepsis episodes they would be reported and that this extended to Care Homes.
(iv) Members discussed the increase in non-compliances recorded as part of the ward visit programme. All non-compliances were fed back to the nurse in charge immediately following the ward visit. A follow-up email was also sent to the ward and service manager. Details of each non-compliance were reported in the monthly HAI Service Reports and discussed at the local Infection Control meetings.

The Forth Valley NHS Board:

(1) noted the HAIRT report;

(2) noted the performance in respect for SABs, DABs, CDIs & ECBs, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

12. Spotlight on Services – Community Pharmacy Sunday Winter Opening Pilot

The Forth Valley NHS Board considered a report, presented by Ms Byrne, which provided an update following the success of the phase one pilot. The Board also viewed a video story on the Service.

Key messages in the report included:

(i) The phase 2 of the initiative would extend Sunday opening up to 7 community pharmacy sites covering a 3 week rota across Forth Valley for 9 weeks from 14 December 2025 to 8 February 2026.

(ii) The aim of the pilot was to increase access to Community Pharmacy services over the weekend (with a specific focus on Sundays) in order to increase access for patients and to support Out of Hours (OOH) as part of the NHS Forth Valley Winter Plan.

(iii) Evaluation of the phase one pilot in 2024/25 revealed that 222 patients had used the community pharmacy service. There was a small decrease in OOH presentations compared to the previous year, despite higher flu and respiratory virus (RSV) levels and the pilot may have contributed to this reduction. 78% of patients required treatment under Pharmacy First Plus, suggesting that without the service an additional 173 OOH presentations might have occurred.

(iv) As part of the pilot, patient satisfaction data was also gathered, whereby 99 patients responded stating 100% satisfaction with the service, with their condition being fully managed by the pharmacist. Furthermore, when asked what action they would have taken if the pharmacy had not been open:

- 48 (48%) would have contacted NHS 111
- 8 (8%) would have gone to A&E

The following points were made in discussion:

(i) Members commented that it was heartening to see patients get the service they needed when they needed it. There was discussion on whether opening on Christmas and New Year's days could be considered over the festive period.

(ii) A question was asked on whether the geographic coverage provided was sufficient as the participation of pharmacies was voluntary. More pharmacies would be interested in taking part as the service expanded and generated positive outcomes for people. There was good geographic coverage but in the future there was a desire to expand further.

(iii) There were questions in relation to how well the pilot contributed to the organisation’s overall aims, was the service effective and cost efficient and did it reach patients in areas of deprivation. There would be an evaluation of the impact of all pilots and that further investment would be made where a difference had been evidenced. The deadline to submit GP Walk-In Centre proposals to Scottish Government was 28 November and ensuring the right cohort of patients could access this was part of the development of the proposal. The Board asked that when evaluation of the pilot was done that it reported through the relevant committee and included not just cost but patient experience as well.

(iv) The Pharmacy First message was intended to support the whole system allowing people to see the right professional at the right time with triage

through pharmacy. There were links to the OOH team to get advice where needed to treat confidently there and then.

(v) Clarity was sought on the communications plan. The Board asked that the information on communications, locations and openings was shared after the meeting.

The Forth Valley NHS Board:

(1) noted the implementation of Phase 2 of the Community Pharmacy Sunday Opening Pilot and the use of non-recurring Community Pharmacy Development Budget funding to support the initiative;

(2) supported strong communications for the public and all NHS Forth Valley staff and services, in particular OOH and urgent and unscheduled care, to ensure successful delivery, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action

(i) Circulate the communications plan and information on locations and openings to Board members. Laura Byrne

13. Corporate Parenting

The Forth Valley NHS Board considered a report, presented by Dr Taylor, which provided an overview of the duties NHS Boards had to advocate for the best interests of care experienced children and young people.

Key messages in the report included:

(i) An overview of the corporate parenting duties and responsibilities of the Board in order to raise awareness.

(ii) The Care Inspectorate had announced that their strategic plan of joint inspections in 2025 onwards would focus on the experiences and outcomes of CYP subject to a compulsory supervision order (CSO) and living at home with parents. As part of this scrutiny process, the Care Inspectorate plan to examine the leadership and direction of corporate parents throughout Scotland.

(iii) During early preparations, involving self-assessment, it emerged that the Board would benefit from coming together for a Board seminar/workshop to increase its understanding of their statutory duties as a corporate parent and to consider the strategic direction of the Board in keeping The Promise.

(iv) An early draft of the NHS Forth Valley Corporate Parenting Plan for 2026-2030 was provided for comment.

The following points were made in discussion:

(i) There was a question on the current statistics in relation to training. The level of completion was now at 83% which was an increase from 67% previously. It was important to highlight the value of the training even for staff who did not work directly with children and young people.

(ii) Members asked how it was ensured that staff and services, including independent contractors, understood their responsibilities. Training was available to all staff through the TURAS module which GPs and pharmacies could also access. There had been very clear messaging on responsibilities through increased activity to encourage uptake.

(iii) The Board asked that in the updated strategy and plan that there was a focus on setting targets which were specific and measurable.
(iv) There was discussion on collaboration with partners, particularly in terms of transition. The next Falkirk IJB development session would include Corporate Parenting responsibilities with a particular focus given the inclusion of Children's Social Work Services to the IJB. Transition was a holistic priority with the local Councils.

The Forth Valley NHS Board:
(1) agreed to hold a learning and development Board Seminar on Corporate Parenting in February 2026;
(2) agreed to undertake the pre-requisite TURAS learn module prior to February 2026;
(3) considered and commented on the draft Corporate Parenting Plan for 2026-30;
(4) noted the assurance responsibility the Board had for ensuring the effectiveness of services in meeting the needs of care experienced CYP;
(5) supported ongoing collaboration with partner organisations to enhance service delivery and outcomes;
(6) agreed to champion the voice and participation of care experienced CYP in all relevant decision-making processes;
(7) agreed to monitor and promote continuous improvement in the quality and responsiveness of services provided to care experienced CYP, and
(8) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Actions
(i) Ensure TURAS was available to all contractors. Jilly Taylor
(ii) Send initial comments on the plan to Jillian Taylor. Board Members

14. Finance Report
The Forth Valley NHS Board considered a report for approval, presented by Mr Urquhart, which provided an overview of the month 7 financial position and an updated forecast outturn for the year.

Key messages in the report included:
(i) An overspend of £4.6m was recorded for the 7-month period ending 31 October 2025, reflecting a range of ongoing financial pressures, primarily within the Acute Services Directorate.
(ii) Following detailed review and analysis at the end of Quarter 2 including the anticipated impact of recovery plan actions, the updated projection showed an improved position, with an overspend of £5m forecast by 31st March 2026.
(iii) Work continued to further reduce the projected year-end deficit as far as possible and to maximise the pace of savings delivery, whilst recognising risks associated with seasonal service and staffing pressures during the winter months.
(iv) The Scottish Budget announcement would be made on 13 January and the Board seminar in February would consider the Financial Plan which needed to be submitted to Scottish Government.

The following points were made in discussion:
(i) Members highlighted two of the key risks to delivery of a balanced position: seasonal surge and pace of savings delivery asking how significant these risks were. It depended on the severity of the flu season. Seasonal surge impact was

built into the forecasts but this could be exceeded. There was significant cost pressure brought using contingency beds. There was low risk around the area of assumed funding which was yet to be received. If there was a worse than planned for outturn for the IJBs this would negatively impact the financial position but provision had been made on the expected risk share amount. There was no single issue likely to cause a deficit position but there was risk that collectively issues could result in an overspend.

The Forth Valley NHS Board:

(1) noted a £4.6m overspend after 7 months of the 2025/26 financial year;

(2) noted the improved forecast overspend for the year estimated at £5m, subject to risk in relation to the potential impact of winter and pace of savings delivery in the latter half of the financial year;

(3) noted the ongoing work in relation to financial planning and improved financial stewardship, and

(4) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

15. Performance Report

The Forth Valley NHS Board considered a report for assurance, presented by Ms Mackenzie which provided an update on performance against a range of national and local measures.

Key messages in the report included:

(i) Performance Summary.
(ii) Area of Focus – Planned Care.
(iii) Performance Report: Priority Areas and Other Areas.
(iv) Performance Scorecard.

The following points were made in discussion:

(i) Members reiterated that it was important that the impact evaluation of the frailty model expansion and Hospital at Home approach was robust. The evaluation of the frailty model would be reported to the SPPRC initially.

(ii) Further information was sought in relation to Code 9 and Guardianship in relation to delayed discharges. There had been significant improvement in the standard delays position in Falkirk, although the number of Code 9 cases had increased and compared poorly nationally. Improvement work was being undertaken with Scottish Government and HIS which was making an impact with early signs being promising. Adults With Incapacity was a national issue with the complexity of many cases also being understood at a national level.

(iii) A question was asked on medicine targets not being met. Rehabilitation medicines was a small service which had been carrying a consultant vacancy. With recent recruitment to fill this position it was expected that the delays would be brought down rapidly with no over 52 weeks at that stage.

(iv) There was a comment on ensuring that the key performance metrics aligned with and supported Value Based Health and Care.

(v) Members reiterated the need to follow through on the agreed plan and actions on urgent and unscheduled care as discussed at the Board deep dive on performance.

The Forth Valley NHS Board:

(1) noted the latest performance data and the Area of Focus – Planned Care and Priority Areas of Performance;

(2) noted the progress made in reducing the number of patients waiting over 52 weeks for a new inpatient appointment and for an inpatient/daycase procedure, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

16. Value Based Health & Care

The Forth Valley NHS Board considered a report for assurance, presented by Dr Champion, which set out the leadership that was required to shift from performance driven operations to value-based, person-centred care.

The key messages in the report included:

(i) The deliverables for VBHC going forward were:
- Redesign the reporting framework towards learning from new data, including
- outcome data.
- Reframe leadership and governance approaches to allow focus on new data and ensure rigorous learning from it.
- Create and sustain convening spaces for learning and decision making.
- Systematise and coordinate learning activities – including pre-existing research and insights.

(ii) Work was ongoing to develop Patient Reported Outcome measures (PROMS) and Workforce Reported Outcome measures (WREMS).

(iii) VBHC steering group and cardiology staff were working with Scottish Government and HIS to test a PROM in cardiac rehabilitation.

(iv) A draft WREM was being developed with senior leaders in the organisation.

(v) 'Collaborate' would be developed as part of the patient Hub. Collaborate was an app that assessed joint decision making from the patient's perspective. This was an important aspect of personal value.

The following points were made in discussion:

(i) Board Members would be invited to the Value Based Health and Care Collaborative launch event in January 2026.

(ii) The framework would need to change to go beyond VBHC data to obtain fresh insights and align with population health outcome measures. National measures would be used but there may be a desire to augment those locally to support the Forth Valley Strategy. Members highlighted the value of partnership working, for example with Active Stirling and monitoring societal benefits.

(iii) Partnership was key and the Health & Social Care Partnerships were involved in the transition to VBHC.

(iv) There was discussion on procuring locally and how to deliver the resource Forth Valley had. There would be community mapping work to better understand communities, look at services and understand access and inequalities. When the population was understood resource could be matched to need and increase the value of interventions.

(v) In terms of data and automated decision making it was stated that having too many measures could lead to data blindness so it was important to retire those indicators which were of little value. By looking at outliers it was possible to identify where risk sat within the system. However, members recognised that for colleagues unused to using data there should be appropriate support made available.

The Forth Valley NHS Board:

(1) agreed continued commitment to the VBHC Programme;
(2) endorsed the Guide for launch and dissemination, and
(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

17. Health & Social Care Partnerships' Annual Performance Reports:

(a) Clackmannanshire & Stirling

The Forth Valley NHS Board considered a report for noting, presented by Ms MacDonald, which provided the Annual Performance Report for the Clackmannanshire & Stirling HSCP.

The key messages in the report included:

(i) The Annual Performance Report was provided as an appendix to the report.
(ii) The five strategic themes were:
- Prevention, early intervention & harm reduction
- Independent living through choice and control
- Care Closer to Home
- Supporting empowered people & communities
- Loneliness & isolation

(iii) The key actions for 2025/26 were:
- Develop tools that mean asset based and good conversations can be evidenced on systems, after assessments, support plans or reviews take place.
- Continue to inform and educate both staff and communities about SDS and their right, and how these can be implemented in a way that meets an individual's outcomes.
- Work related to dementia commissioning will focus on developing the Hub and Spoke Model and determining what commissioning activities are required going forward to ensure sustainable service delivery that can meet increasing demand.

The Forth Valley NHS Board:

(1) noted Clackmannanshire & Stirling's Annual Performance Report;
(2) was assured of performance related to NHS services, and
(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(b) Falkirk

The Forth Valley NHS Board considered a report for noting, presented by Ms Woodcock, which provided a summary of the performance of the Falkirk HSCP along with the most recent update of the Business Case and Medium-Term Financial Plan.

The key messages in the report included:

(i) The Annual Performance Report was provided as an appendix to the report. The APR described the numerous service developments and redesign work being taken forward.
(ii) Information was provided on the four priority areas:
Priority 1 – Support and Strengthen Community-based Services
Priority 2 – Ensure People Can Access the Right Care at the Right Time, In the Right Place
Priority 3 – Focus on Prevention, Early Intervention and Minimising Harm
Priority 4 – Ensure Carers are Supported in their Caring Role

(iii) In 2025/26 focus would be to progress the transformation plan including delivering the service changes and reviews, agreed by the IJB in March 2024.

The Forth Valley NHS Board:

(1) noted the report and progress by the HSCP in meeting its priorities in the Strategic Plan;

(2) discussed and commented on the Draft Business Case and Medium-Term Financial Plan, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

18. Schedule of Business

The Forth Valley NHS Board **noted** for information the Schedule of Business which would be updated to align with the programme of meetings agreed earlier in the meeting.

19. Any Other Competent Business

Valedictory

The Board Chair led a vote of thanks to Ms Joanna MacDonald, Interim Chief Officer – Clackmannanshire & Stirling IJB for her exemplary service and wished her well in her new national role.

20. Risks and Reflections

The Forth Valley NHS Board resolved that there were no matters to recommend that the Senior Leadership Team consider to be included in the Strategic Risk Register.

21. Date and Time of Next Meeting: Tuesday 27 January 2026 at 9.30am.

4. Action Log
Forth Valley NHS Board – 27 January 2026

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
070	28.01.25	Integration Schemes	An update on any Ministerial feedback received.	Jillian Thomson / Ross McGuffie	28.04.26	The Falkirk Integration Scheme was approved by Board on 28 January and subsequently by Falkirk Council at its meeting on 30 January 2025. Comments were received from Scottish Government and further drafting work is progressing. The C&S Integration Scheme was approved by Board on 28 January and subsequently Stirling Council at its meeting on 6 February 2025. The dispute resolution process regarding the C&S Scheme is ongoing and making positive progress.	In progress

107	25.11.25	Strategic Risk Register Update: October – November 2025	The SLWG on Risk to consider expanding its scope to include updating risk timelines and the review of risk appetites and tolerances.	Vicky Webb	27.01.26	Risk appetite work will likely complete by end of January and the SLWG will consider the additional requests after that. Follow up reporting on this ask will be tracked through SPPRC reporting.	Complete
108	25.11.25	Seasonal Surge Preparedness Plan	Circulate the one-page high level information document.	Elsbeth Campbell	27.01.26	The winter communications plan was circulated to Board Members.	Complete
109	25.11.25	Seasonal Surge Preparedness Plan	SLT to consider how national EQIAs would be pulled through for local strategies and plans in future.	Ross McGuffie	27.01.26	National EQIAs, or relevant information from these, will be provided to Board/Committee as appropriate when considering items for which these are available.	Complete
110	25.11.25	Governance Report: Meeting Dates	Circulate the dates of meetings including IJB dates and Seminars to Board Members and administrative leads of all committees and remind colleagues of the use of the Corporate Calendar.	Jack Frawley	27.01.26	Information circulated to Members and Administrative Leads.	Complete
111	25.11.25	Quality Assurance and Improvement Report	Provide updates on developments relating to potential industrial action by Resident Doctors.	Andrew Murray	27.01.26	Information was provided in relation to the potential and then cancellation of industrial action.	Complete
112	25.11.25	Quality Assurance and Improvement Report	Circulate the Adverse Events Policy and health & safety information to Board members.	Andrew Murray/Kevin Reith	27.01.26	The documents were circulated to Board Members on 27.11.25.	Complete
113	25.11.25	Spotlight on Services –	Circulate the communications plan and information on	Laura Byrne	27.01.26	The information was provided to Members.	Complete

		Community Pharmacy Sunday Winter Opening Pilot	locations and openings to Board members.				
114	25.11.25	Corporate Parenting	Ensure all independent contractors are aware of their responsibilities in relation to corporate parenting.	Jilly Taylor	10.02.26	Assurance on the arrangements in place will be provided in due course.	In progress
115	25.11.25	Corporate Parenting	Send initial comments on the plan to Jillian Taylor.	Board	27.01.26	The opportunity to comment was provided.	Complete

STATUS:
Overdue
In progress
Complete

NHS Forth Valley

Forth Valley NHS Board

6. Board Executive Team Report
Purpose: This report is for Discussion

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Ross McGuffie, Chief Executive

Executive Summary

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

Action Required

The Forth Valley NHS Board is asked to note the contents of the report.

Governance Route to the Meeting and Previous Board Consideration

This Board Executive Report is a standing item at Board meetings, providing an opportunity to update the Board on key issues.

Risk Assessment and Mitigation

No risk assessment has been undertaken on this update report.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications

There are no financial implications within this update report.

Workforce Implications

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

Quality / Patient Care Implications

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

Population Health & Care Strategy

This report will include regular updates on key successes and developments around the population health strategy implementation.

Climate Change / Sustainability Implications

There are no sustainability implications within this update report. .

Engagement and Communications

Was statutory engagement with stakeholders required? Yes ☐ No ☒

Appendices

Appendix 1 – Main Report

Appendix 1

1. Celebrating Success

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.

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

- Nicola Watt, Head of Emergency Planning and Resilience has commenced training to become a **Resilience Academy Associate**, a subject matter expert or practitioner who facilitates high-quality training, workshops, and exercises for the UK Resilience Authority, helping organisations and communities build skills in emergency planning, crisis management, and societal preparedness for diverse risks.

  The Academy strategic goals are to:
  - Strengthen professionalism
  - Foster collaboration in resilience
  - Provide access to learning, training, exercising and development

  This will further strengthen NHS Forth Valley's resilience planning and preparedness going forwards.

- **Burnbrae Care Home** in Falkirk Council has been awarded grades of six and five, which is one of the most impressive inspection reports within the area. The collaboration across the system was well recognised with the report, with inspectors noting:
  - Quality improvement work around safer mobility (the Care home was one of the Safer Together test teams)
  - Environment and setting (Dementia and Delirium Nurse consultant Yvonne Cairns has undertaken environmental audit work with the team)
  - Polypharmacy review work (funded as a test of change through the Care Home budget and steered through the Care Home Steering Group)

- A new **Workforce Wellbeing Framework (2025 – 2029)** was launched at the beginning for January 2026 to help improve staff health and wellbeing. The Framework is the result of extensive engagement carried out over the last year where staff from all roles and backgrounds shared their experiences, insights and ideas on what matters most to them at work. The launch is being supported by a range of events including winter wellness events and pop-up sessions as well as information and resources.

- NHS Forth Valley recently celebrated **20 years of our local Newborn Hearing Screening Programme**, marking two decades of early detection and treatment for babies experiencing hearing loss.

Since the programme was launched in 2005, around 58,000 babies born across NHS Forth Valley have been screened. The service has supported thousands of families by identifying hearing challenges within weeks of birth, enabling timely treatment, support and significantly improved outcomes.

- Emma Wakefield, Unscheduled Care Improvement Advisor received the Project Advocate Award at the **2025 Consultant Connect awards**, for her work to implement the new Consultant Connect system in NHS Forth Valley. Emma has played a pivotal role in implementing over 30 new pathways onto Consultant Connect for clinicians across Forth Valley including key pathways such as the Scottish Ambulance Service to Mental Health, the Minor Injuries Unit to the Emergency Department, and the Scottish Ambulance Service to Hospital at Home.

- Four staff from NHS Forth Valley have received **honorary appointments** by the University of Stirling. Dr Catherine Labinjoh, Clinical Cardiologist; Marissa Parker, Chief Nurse, NMAHP Practice Development Unit; Dr Lyndsay Cardwell, Strathcarron Hospice Community Lead Nurse; and Dr Karen Adamson, Deputy Medical Director have been appointed as Honorary Clinical Associate Professors.

- More than 50 members of staff were recognised for **supporting nursing students** at an awards ceremony held at Forth Valley Royal Hospital on Friday, 28 November. The Inspirational Practice Supervisor/Assessor Celebration event, which is based on nominations from local nursing students, recognises the vital role supervisors and assessors play to students during their clinical placements.

- NHS Forth Valley's Person Centred Care Team coordinated the purchasing, wrapping and donating of 620 gifts for patients who were in Forth Valley Royal Hospital on Christmas Day. Last year, our Acute Assessment Unit (AAU) invited local children to create Christmas cards for patients and received 36 beautiful hand-drawn cards. This year, they put out a wider appeal and thanks to our incredible local communities, they received enough cards for every patient spending Christmas in our acute wards at Forth Valley Royal Hospital. On Christmas morning, each patient received a hand-drawn card alongside their gift. The Person Centred Care and AAU teams would like to thank all the schools, organisations, families and individuals who took the time to support them in spreading some Christmas cheer.

2. General Updates

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

- As previously noted to the Board, the Scottish Information Commissioner raised a level 3 intervention around compliance with the **Freedom of Information Act**. A full action plan has been developed and a group has been established to meet twice weekly to coordinate the reduction of the backlog and improved compliance with the 20 day standard. The intervention set a target for the Board to be at 90% compliance by December, with performance being at 93%, continuing the month on month performance above target. The backlog of enquiries has reduced from a high of over 200 cases to zero.

- The Board's **Value Based Health and Care Collaborative** launched at an event held in FVRH on Thursday 22nd January. The approach aims to take learning from the Safer Together Collaborative to create a real momentum in the roll out of value based health and care across the whole system.

3. Inspection Activity

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

- The Board received the **Healthcare Improvement Scotland Unannounced Maternity Inspection Report** on 27th November. The report recognised the compassionate and responsive care provided, strong multidisciplinary team work, visible senior leadership and staff health and wellbeing, whilst noting delays in induction of labour, governance of adverse events and the need for better oversight of real-time staffing risks as areas requiring improvement. Overall, the report outlined nine areas of good practice, two recommendations and eleven requirements, with an action plan developed to ensure all improvements identified are implemented in a timely manner.
- The inspection report around **Mental Health Services** is expected to be finalised before the end of January.

4. Visible Leadership

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.

4.2 Visits include:

- Bellfield visit with Tom Arthur, Minister for Social Care and Mental Wellbeing
- Meadows service visit
- Met with FVRH surgeons
- Sim Safety Club
- VBHC Collaborative Launch Event
- Frailty unit visit with Caroline Lamb
- SAER Lead Reviewers event
- Quality and Corporate services working together options appraisal
- Corporate CG and Directorate CG managers full day session
- Acute site walkrounds on Christmas Eve and Hogmanay
- Minor Injuries Unit in SCH

5. National Developments

5.1 The Board Executive Team have a number of lead national roles, with updates as follows:

- The Chief Executive is leading work nationally around Diagnostics, with a Strategic Needs Assessment underway that is focusing on imaging, clinical physiology, labs and endoscopy.
- The Chief Executive and Falkirk Chief Officer are leading work around the Prisoner Healthcare Ministerial Assurance Group, feeding in some of the key developments and priorities from the NHSFV service.

6. Horizon Scanning

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

- The Cabinet Secretary announced a new Director's Letter (DL) on 13th November, setting out arrangements for new sub-national planning structures, with NHS Forth Valley sitting within the West of Scotland Sub-National Planning Committee. Further updates will be prepared for Board members.

7.1 Minute of the Audit & Risk Committee Meeting
For: Ratification

Minute of the Audit & Risk Committee held remotely on 31 October 2025

Present: Robert Clark, Non-Executive Director
Fiona Collie, Chair
Martin Fairbairn, Non-Executive Director
Finlay Scott, Non-Executive Director

In Attendance: Jack Frawley, Board Secretary
Ian Howse, Public Sector Industry Lead Partner, Deloitte
Jocelyn Lyall, Chief Internal Auditor
Ross McGuffie, Chief Executive
Kerry Mackenzie, Acting Director of Strategic Planning and Performance
Anne Marie Machan, Regional Audit Manager
Neena Mahal, Board Chair
Scott Urquhart, Director of Finance
Vicky Webb, Head of Risk Management

---

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

Apologies had been received from Stephen McAllister and David Wilson.

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

3. Minute of the Audit & Risk Committee Meeting held on 17 June 2025
The minute of the meeting held on 17 June 2025 was **approved** as a correct record.

4. Matters Arising from the Minute / Action Log
The Action Log was **reviewed** by the Chair and an update was provided around all actions.

In terms of Action 22b, Martin Fairbairn sought clarity around the requirements for Committee Chairs. A verbal update was provided within the meeting and it was confirmed no additional action was required.

Members noted all actions were now complete and would be removed from the action log.

For future meetings, it was also agreed that the action log would be updated in advance of the meeting. **Action: Jack Frawley**

The Audit & Risk Committee noted the Action Log.

5. Audit Planning Update
A verbal update was provided by Ian Howse. Key messages in the update included:
(i) A Debrief Session had been undertaken, facilitate by Audit Scotland. This was noted as a practical and productive discussion.

(ii) A key agreement from the session was the bringing forward planning and interim work.
(iii) Initial planning for December 2025, with staff booked in January and February 2026 for completion of planning and interim work. Wider scope had also been scheduled in advance of year end.
(iv) Delays in obtaining Pension information was recognised as a National issue and vigilance was required.
(v) Stirling Council 2024/25 accounts remained outstanding with consideration required around impact.

The following points were made in discussion: -
(i) A Planning meeting had been arranged between NHSFV and Deloitte to confirm deadlines.
(ii) Audit Planning document would be brought to January Audit & Risk Committee.
(iii) Ross McGuffie confirmed ongoing discussions with the Chief Executives of Clackmannanshire and Stirling Councils regarding the Integration Scheme and the finalisation of the accounts.
(iv) The Chief Finance Officer post for Clackmannanshire & Stirling was vacant and associated risk was recognised. Temporary arrangements were detailed.

The Audit & Risk Committee noted the verbal update.

Action:

1.	**Issues around pensions would be taken through the Director of Finance Group to discuss potential mitigation work with SPPA.**	Scott Urquhart
2.	**Audit Planning document to be brought to January 2026 meeting.**	Ian Howse

6. Internal audit Progress Report – October 2025

The Committee considered a paper presented by Anne Marie Machan.

Key messages in the report included:
(i) Report provided a summary around 2 periods of progress due to the June 2025 meeting being focussed on Annual Accounts.
(ii) The 25/26 Internal Audit Plan was electronically approved by the Committee in August 2025 along with consideration of the Internal Audit External Quality Assessment Report and the Internal Audit Improvement Action Plan.
(iii) Finalised audit work was summarised within the paper.
(iv) The overall Audit Plan was outlined, with current position for each of the areas. No concerns were highlighted to the Committee around 2024/25 delivery.
(v) Summary of Audit Findings provided a summary outcome against each of the audit areas from the plans across both years.
(vi) Discussion with the Director of Finance confirmed recent stand alone audits (Adverse Events, Supplementary Staffing; Property Transactions) were considered by the Senior Leadership Team on 27 October 2025.

The following points were made in discussion:
(i) Members noted that the report did not clearly indicate whether any findings raised material concerns. This was attributed to the inclusion of year-end summaries. It was agreed that future reports should more clearly highlight areas where processes were not operating effectively.
(ii) Members confirmed that all relevant reports had been shared and that systems would be reviewed to ensure this remained appropriate.
(iii) Improved compliance with actions was welcomed as strengthening overall assurance. However, it was agreed that a further review would be undertaken to

confirm that actions continued to be appropriate and were delivering the intended outcomes.

(iv) Members agreed that actions should be considered in the context of the assurance sought by Non-Executive Members.

(v) Regarding supplementary staffing, assurance was provided that the initial focus remained on Nursing, reflecting the early stage of the newly established governance process.

The Audit & Risk Committee:

(1) Noted the progress made in delivering the Internal Audit Plans and ongoing Internal Audit activity.

(2) Agreed several actions around risk areas and items within reports.

(3) Confirmed the report provided sufficient assurance that appropriate controls were in place to manage identified risks, organisational objective were being supported, and where improvements were needed, clear actions had been identified.

Action:

1.	**Adverse Event Management to be circulated to members.**	Jack Frawley
2.	**Check of Internal Audit Systems to ensure full reports were being issued to Committee members.**	Jocelyn Lyall
3.	**Consider scope of audit from Non-Executive perspective and ensure high-risk areas were made clear.**	Jocelyn Lyall

7. Improvement Action Plan

The Audit and Risk Committee considered the Improvement Action Plan presented by Jocelyn Lyall.

Key messages in the report included:

i) The 2025/26 Internal Audit Improvement Action Plan was shared with the Audit & Risk Committee on **8 August 2025**

ii) No significant risks to completion had been identified to date.

iii) Full improvement action plan would continue to be monitored by the FTF Partnership Board, Chaired by Scott Urquhart.

iv) The report provided a high-level update outlining the key points.

v) Progress over the last two months was outlined, noting as of 17 October 2025:

- 21 actions were **Complete**
- 16 were **In Progress**
- 2 were **Delayed** with revised completion dates and assurance was provided around position.
- 11 are in the **Planning** stage

(50 total)

(vi) Completed, in-progress and planned actions (Appendix 1) directly contribute to delivering the 50 improvement actions.

vi) Significant focus to date had been improving planning and reporting methodologies.

vii) Substantial training work and improvement on working practices also noted.

viii) Focus areas for the next quarter would be revision of internal audit manual and revision of internal control evaluation report. Detail around requirements and aims was noted.

ix) Progress was satisfactory to date, recognising significant additional work required.

The following point was made in discussion:

(i) The Committee praised the proposal for a shorter, more concise ICE report

The Audit & Risk Committee:

(1) noted the implementation status of the improvement action plan and the FTF Partnership Board's conclusion.

(2) Confirmed the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions were identified.

8. Audit Follow Up Report – October 2025

The Audit and Risk Committee received the Audit Follow Up Report for October 2025, presented by Anne Marie Machan.

Key messages in the report included:

(i) The report outlines Audit Follow-Up activity from **1 March to 30 September 2025**

(ii) Information was drawn from Pentana system updates, management evidence, and committee reports, and Internal Audit independently reviewed, validated and reported on the status of actions to provide assurance on progress, risks, and control effectiveness.

(iii) Of the 54 actions reviewed, 42 (78%) were fully completed and validated, with only 3 extended and none overdue, demonstrating strong overall progress and no significant risks.

(iv) Detail was provided around the action relating to Consultants Job Plans, noting routine reporting of position to the Staff Governance Committee and an improved position. Resultantly it had been agreed the action would be closed off within the Audit follow up system.

(v) No significant risks have been identified that would affect Internal Audit's ability to provide assurance for 2025/26.

The following points were made in discussion:

(i) The Committee noted the improvement in action position, praising the reduction around the number of extended actions.

(ii) Concern was again highlighted around lack of clarity around management responses

(iii) Members asked whether the action relating to sustainable transport had become unnecessarily complex. A follow-up review will be undertaken to ensure the requirement is fully understood and appropriately scoped.

(iv) Regarding the action on Supply Chain Management, assurance was given that the substantive work had been completed, although the associated governance reporting is still to be finalised.

(v) Assurance was provided that the Penanta system provided a comprehensive overview of each action.

(vi) The follow up around related risks following action closure was also discussed with further discussion to take place outwith the meeting.

The Audit & Risk Committee:

1. Noted the implementation status of all management actions reviewed during the Audit Follow-Up period.

2. Noted the Internal Audit assessment of actions with extended completion dates.

3. Confirmed overall progress and any remaining residual risk is acceptable.

4. Confirmed the report provided sufficient assurance that appropriate controls are in place, risks are being effectively managed, and improvements are supported by clear actions.

Action:

(i)	**Follow up with Derek Jarvie around sustainable transport action to ensure delivery around specific actions**	Scott Urquhart
(ii)	**SLT to consider streamlining ongoing reporting and agree a prioritisation process for audit actions while continuing wider programme delivery.**	Ross McGuffie Jocelyn Lyall
(iii)	**Follow up around related risks following action closure to be considered as part of overall work.**	

9. Audit Follow Up Protocol

The Audit and Risk Committee considered the Audit Follow Up Protocol report presented by Jocelyn Lyall.

Key messages in the report included:

(i) The Protocol was updated annually and described the process to ensure appropriate action was taken to address internal audit findings.
(ii) Protocol provided clear guidance drawing on GIAS requirements, the External Quality Assessment findings, and NHS Scotland Good Governance expectations. This provided a risk-based, efficient, and accountable process for tracking, reviewing, and validating audit actions.
(iii) A flow chart had not been included, but this could be added if the Committee this would be of assistance.
(iv) The audit follow up position on Internal Audit findings would be presented to every Audit and Risk Committee
(v) Internal Audit managed the follow up system and reviewed evidence to ensure completion of actions and confirm effectiveness
(vi) The protocol would be by introducing a strengthened risk-based follow-up approach with full validation of fundamental and significant findings. This would include escalating non-responses to the Director of Finance, and shifting the focus from recommendations to findings, ensuring alignment with GIAS, EQA expectations, and management-action terminology.

The following points were made in discussion:

(i) Reference to follow up system and review of evidence noting as aligning with earlier points raised around action following up on completion.
(ii) Process to escalate non-responses was praised as providing additional assurance.
(iii) Clarity was provided that there was no retest element to the follow up process, with focus on assessment of evidence. However, review of previous reports was also undertaken as appropriate.
(iv) Clarity was sought around the robustness of the process of issuing email alerts from Pentana. Assurance was provided that alerts included a link to the specific audit follow up actions, with recipients being those who authorised the responses. Additionally, man marking work was also being undertaken. It was confirmed this process worked well and Internal Audit also provided an offer to meet with officers individually if required.
(v) A generic Pentana mailbox was now available and the document would be updated accordingly.

The Audit & Risk Committee:

1. Approved the revised audit protocol, subject to the below action being completed.

Action:

(i) Contact for Pentana queries and support to be amended to generic Pentana mailbox. Jocelyn Lyall

10. Counter Fraud Update Report in October 2025

The Audit and Risk Committee considered the Counter Fraud Update Report presented by Anne Marie Machan.

Key messages in the report included:

(i) The purpose of the paper was to provide assurance through an update on national and local Counter Fraud Services activity and outline NHS Forth Valley's current counter-fraud position.

(ii) Detail was provided around roles and processes.

(iii) A summary was provided around Operation Orwell, noting this related solely to NHS Forth Valley. Investigation was conducted and reported, however the Crown Office and Procurator Fiscal confirmed no proceedings. A report had also been submitted to the General Medical Council for their consideration.

(iv) NHS Forth Valley's 2024/25 assessment showed strong performance against the Counter Fraud Standards, with ten of twelve standards fully met, two partially met and clear actions in place to achieve full compliance, reflecting continued improvement and a well-established counter-fraud framework. Consistency with other Health Boards was noted.

(v) Fraud awareness training remained a key prevention measure, with NHS Forth Valley continuing to achieve the highest completion rates across Scottish Boards. Counter-fraud learning had now becoming mandatory through the Scottish Government's Protected Learning Time initiative, with anticipation this would further strengthen uptake.

(vi) The Economic Crime and Corporate Transparency Act 2023 introduced a new corporate offence of failing to prevent fraud which came into effect on 1 September 2025. To support compliance, CFS had provided NHS Boards with a standardised risk assessment template, now being implemented within NHS Forth Valley. This was also noted as an action within the Fraud Annual Action Plan with work ongoing in this area.

(vii) International Fraud Awareness Week 2025 will run from 16 November, with NHS Forth Valley planning stands within Procurement, Estates and IT. Focus would be on the Nolan Principles which set the ethical standards expected of anyone working in public service.

The following points were made in discussion: -

(i) In terms of the Economic Crime and Corporate Transparency Act, challenge was noted around the delay in issuing the risk assessment template. Assurance was provided that many of the requirements should already be in place, but completion of the template was required to ensure no material gaps.

(ii) Members requested clarity around trends noting the National Report detailed the number of referrals into Counter Fraud Services for each Board. A small increase was noted for NHS Forth Valley. Potential linkage with communication and training in discovering fraud was noted.

(iii) Local intelligence within the report highlighted that a number of referrals were found to have no issue identified following fact-finding process. Potential around vexatiousness was recognised, with assurance provided that much of the fact-finding work would be undertaken prior to the staff member being made aware.

(iv) The recent Board Seminar highlighted the emergent risk around Cyber Security and the increasing risk of staff being offered bribes to provide login details. Proactive work around emerging risks was noted. Linkage to the Fraud Awareness Week and focus on Nolan Principles was noted.

(v) Assurance was provided that any issues Counter Fraud wished to highlight were automatically fed into the NHSFV Intranet page.
(vi) In terms of Operational Orwell, assurance was provided that the Medical Director was fully aware of the position and all necessary mitigations were in place.

The Audit & Risk Committee:
1. **Noted the updates from Counter Fraud Services and note NHS Forth Valley's position in relation to this activity.**
2. **Confirmed the report provided sufficient assurance that controls are in place to manage fraud risks and that clear improvement actions have been identified where needed.**

11. Fraud Annual Action Plan (FAAP) 2024/25 and 2025/26

The Audit and Risk Committee considered the Fraud Annual Action Plan presented by Anne Marie Machan.

A key message from the report included:
(i) The Action Plan was a key element of the Fraud Standards previously referenced in the meeting and focussed on a partnership approach with Boards.

The Audit & Risk Committee:
1. **Noted the outcome of the 2024/25 Fraud Annual Action Plan.**
2. **Approved the 2025/26 Fraud Annual Action Plan.**
3. **Confirmed the report provided adequate assurance that controls are in place to manage fraud risks and support delivery of objectives, and that clear improvement actions have been identified where needed.**

12. Strategic Risk Register Update – Quarters 1 & 2

The Audit and Risk Committee received the Strategic Risk Register update, presented by Vicky Webb,

Key messages in the report included:
(i) The report summarised movements across **12 strategic risks**, highlighting **one increase** (Scheduled Care SR04 rising from 15→20 due to anaesthetic shortages), **one decrease** (Estates & Infrastructure SR10 falling from 16→12 following Scottish Government funding),
(ii) Due to extended timeframe, an overview position was provided against each Strategic Risk.
(iii) **six focused reviews** had been undertaken providing assurance levels from *limited* to *reasonable*. Presentation had been made to appropriate standing assurance Committees.
(iv) Detail was provided around the general work undertaken by the Risk Team. Areas of focus had included a strengthening of training provision as well as commencement of the review of review of Risk Framework and Risk Appetite Statements had commenced with a SWLG established.
(v) Refreshment of report would be undertaken to understand and clarify the type of assurance given to the Committee.

The following points were made in discussion:
(i) In response to a request for clarity around key controls, it was confirmed work was ongoing to strengthen linkages between Audit and Risk to ensure consistency in language.
(ii) An assessment of all strategic risks was undertaken within focussed reviews with assessment around criticality of controls. This was detailed within Section 5 of the report.

(iii) The recommendations within the paper were discussed, with agreement the reference to assurance around appropriate controls was not reflective of this specific paper.

The Audit & Risk Committee:

(1) Noted the changes to the Strategic Risk Register for Quarter 1 and Quarter 2 (2025/26).

(2) Noted the six focused reviews carried out during the reporting period.

(3) Note the work progressed by the Corporate Risk Management Team in the first half of 2025/26.

(4) Confirmed their assurance that the Risk Management System was working well.

Action:

(i) Recommendation around appropriate controls would be reworded to reflect the Committee's assurance that the Risk Management System was working well. Vicky Webb

13. Property Transaction Monitoring

The Audit and Risk Committee received the Property Transaction Monitoring presented by Anne Marie Machan.

Key messages in the report included:

(i) The report advised the Committee of the outcome of the Audit of Property Transaction Monitoring concluded in 2024/25.

(ii) The assessment criteria for transactions and Committee oversight was mandated by Scottish Government as specified within Property Management Handbook.

(iii) A review of three property transactions completed in 2024/25 found two rated A (properly conducted) and one rated B, with Internal Audit confirming overall compliance with Handbook requirements.

(iv) The Carseview House lease was rated B because, although management provided verbal updates due to financial urgency, the decision did not follow the formal governance route required by the Code of Corporate Governance—specifically, it should have been reviewed and approved by the Performance & Resources Committee before proceeding. This was recognised as a technical breach.

The following points were made in discussion: -

(i) Clarity was sought around sample size, confirming 60%, with choice of purchase, sale and lease ensuring variance around nature of transaction.

(ii) Context was provided around Carseview House Lease noting utilisation of existing break clause. Due to focus on arrangements, the code of corporate governance requirement had been overlooked. Assurance was provided around approval process meeting all requirements, with this being a technical governance omission only.

(iii) An addition had been made within SLT to discuss any implications for Committees. It was agreed the breach would be discussed within this forum.

The Audit & Risk Committee:

(1) Approved submission of the Post-Transaction Monitoring report to the Scottish Government by 31 October 2025

(2) Confirmed the findings and required actions provide sufficient assurance over governance and control arrangements

Action:

1. **Technical breach to be discussed within SLT to ensure appropriate coverage and consideration in future.** Ross McGuffie

14. Internal Audit Annual Report 2024/25

The Audit and Risk Committee considered the Internal Audit Annual Report 2024/25 presented by Jack Frawley.

Key messages in the report included:

(i) Following completion of the Internal Audit Annual Report process, the Acting Director of Strategic Planning, Board Chair and Board Secretary.
(ii) The review had identified a number of points within the main narrative that had been incorporated and set out in the appendix of the report.
(iii) These further findings will be monitored through the relevant Governance Committees, ensuring appropriate oversight and follow-up.
(iv) Following discussion with Internal Audit, it had been agreed that findings and comments would be clearly separated within the document.

The following points were made in discussion: -

(i) Challenge was recognised around ensuring balance between findings and areas detailed previously or that were currently ongoing. Resultantly, an additional section within the 2025/26 Internal Control Evaluation report template had been added around 'Items for Consideration.' This should ensure clarity around disparate areas.
(ii) The addition of this section was welcomed by members.
(iii) Assurance was provided that additional actions would be added to the Pentana system and reported through regular Assurance / Governance Committee Internal Audit Action Follow Up Report.

The Audit & Risk Committee:

(1) Noted the additional internal audit findings identified since publication of the 2024/25 Annual Report, with oversight assigned to the relevant Governance Committees.
(2) Agreed the report provided sufficient assurance that appropriate controls were in place to manage associated risks, achieve organisational objectives, and ensure improvements are clearly identified where required.

15. Schedule of Business

The Schedule of Business was presented to the Committee for information.

The timing of the 2026/27 Internal Audit Annual Plan—scheduled for June due to year-end processes—was discussed, with agreement that it will be considered during the meeting rather than circulated electronically.

16. Any Other Competent Business

There were no items raised.

17. Matters to raise at Board

There were no matters to be raised at the Board.

18. Date and time of next meeting: Friday 23 January 2026 at 9 am

FORTH VALLEY NHS BOARD
Tuesday 27 January 2026

7.2 Minute of the Clinical Governance Committee Meeting held on Tuesday 11 November 2025

For: Assurance

Minute of the Clinical Governance Committee Meeting held on Tuesday 11 November 2025 at 9.00am in the Boardroom, Carseview House.

Present:
Mrs Kirstin Cassells (Non-Executive Director)
Mr Gordon Johnston (Committee Chair)
Cllr Fiona Law (Non-Executive Director)
Mr Stephen McAllister (Non-Executive Director)
Professor Clare McKenzie (Non-Executive Director)

Mrs Neena Mahal (Board Chair)

In Attendance:
Dr Karen Adamson (Deputy Medical Director) Item 8a
Miss Jennifer Brisbane (Corporate Services Assistant) Minute
Ms Laura Byrne (Director of Pharmacy)
Mr Ashley Calvert (Head of Clinical Governance)
Mr Jack Frawley (Board Secretary)
Mrs Lesley Fulford (Patient Relations Operations Manager) Item 13
Ms Marie Gardiner (Head of Acute Services) Item 12b
Professor Karen Goudie (Executive Nurse Director) From 10am
Mr Jonathan Horwood (Infection Control Manager) Item 9
Mr Andrew Murray (Medical Director)
Mrs Wendy Nimmo (Interim Head of Efficiency, Improvement & Innovation)
Dr Kate Patrick (Director of Medical Education) Item 16
Dr Jennifer Rodgers (Dental Public Health Consultant) Item 11
Miss Vicky Webb (Corporate Risk Manager)

---

1. Welcome, Apologies for Absence and Confirmation of Quorum
There was an apology from Mr John Stuart. The meeting was quorate.

Dr Jennifer Champion and Professor Ross McGuffie were not in attendance.

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

3. Minute of Clinical Governance Committee held on 9 September 2025
The minute of the meeting held on 9 September 2025, subject to previous electronic circulation and committee member approval, was **confirmed** as an accurate record.

4. Matters Arising from the Minute/ Action Log
The Clinical Governance Committee reviewed the action log and noted the complete actions, and below updates:
(i) Actions 75 & 76: Work was ongoing to update the Public Protection Report and assurance was provided that, despite the action being overdue, public protection

reporting was captured within other reports presented to the Committee. Timescale **extended.**

(ii) Action 93: It was agreed that the timescale would be **extended** due to the thematic analysis of complaints remaining in progress.

(iii) Action 96: Timeline **extended**.

(iv) Action 99: It was agreed that detail on East Region Health Protection Service governance processes would be included in the next Public Health Report.

(v) Actions 95 and 97 were noted as **complete**.

The Clinical Governance Committee noted the Action Log

Items 5a & 5b were taken in conjunction.

5.

(a) Clinical Governance Committee Planner

(b) Draft Committee Planner with Proposed Changes

The Clinical Governance Committee received the Committee Planner and Draft Committee Planner with Proposed Changes presented by Mr Andrew Murray, where an overview of proposed changes and rationale was provided.

Key messages in the paper included:

(i) A review of the Committee Planner had been undertaken by the Medical Director and Head of Clinical Governance following a request to create capacity for the Committee to refocus on specific areas of concern, with an aim to reduce duplication of items discussed at other meetings.

(ii) The proposed removal of the below items was due to sufficient oversight provided by the Clinical Governance Working Group (CGWG) or Quality Programme Board:

- Scottish Patient Safety Programmes (SPSP) Workstreams
- Scottish National Audit Programme (SNAP) Audits
- Cancer Updates
- Prison Updates
- Quality Strategy Annual Update
- Innovation Plan Annual Update
- Standards and Reviews
- Annual Reports presented to CGWG

The following points were made in discussion:

(i) It was agreed that further consideration of proposed amendments would be undertaken at the 13 January 2026 committee meeting due to apologies noted on behalf of Mr John Stuart, Committee Chair.

(ii) Concern was raised regarding the oversight of the Quality Programme Board, where assurance was provided that work was ongoing to strengthen the group's governance, such as progress reporting to the Senior Leadership Team on a biannual basis.

(iii) The Medical Appraisal & Revalidation Annual Report would be considered by the Staff Governance Committee. The Clinical Governance Committee would maintain oversight of the Medical Education Annual Report. Committee members were informed of the potential patient safety implications associated with medical staff issues therefore the Clinical Governance Committee was considered as the most appropriate governance route.

(iv) In reference to the CGWG meeting minutes, concern was raised over the relevance of receiving minutes that were not reflective of the most recent meeting. It was advised that the most up to date approved minutes were provided to the Committee and assurance was provided that detail from more recent meetings was included within the CGWG Updates.

The Clinical Governance Committee:
(1) Noted the Committee Planner.
(2) Reviewed the proposed Committee Planner changes.

Action:
(1) Schedule Draft Committee Planner Proposed Changes to 13 January 2026 meeting agenda for further consideration. Jennifer Brisbane

7. In Our Services, Is Care Safe Today?

(a) Emerging Clinical Issues

The Clinical Governance Committee received the 'Emerging Clinical Issues' paper presented by Mr Andrew Murray, which provided an overview of an unannounced Healthcare Improvement Scotland (HIS) visit to Forth Valley Royal Hospital's (FVRH) Mental Health and Women & Children's Maternity services on 25 and 26 of August 2025.

Key messages in the report included:
(i) The embargoed report for the Maternity Service had been received and was being reviewed for factual accuracy. At time of reporting, it was noted that there were:
- 2 recommendations.
- 11 requirements which were high level, however assurance was provided that there had not been any areas of significant concern identified.
- 9 areas of good practice.

(i) Dialogue with HIS regarding evidence requested to allow completion of the Mental Health services report was ongoing, where a formal letter determining next steps was sent by NHS Forth Valley to HIS on 10 November to provide further assurance.

The following points were made in discussion:
(i) A query was raised on whether a Standard Operating Procedure (SOP) was in place for when HIS reports were received to ensure sight of the appropriate members of staff. Committee members were advised that work was ongoing to develop a SOP following benchmarking against other Health Boards.
(ii) Committee members were advised that the HIS improvement plans would be presented to the Committee.

The Clinical Governance Committee:
(1) Noted the current timelines and outstanding issues, prior to the Board receiving final reports.
(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

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

(a) Acute Directorate Safety & Assurance Report

The Clinical Governance Committee received the 'Acute Directorate Safety & Assurance Report' presented by Dr Karen Adamson, providing assurance of robust clinical governance within the Acute Services Department (ASD), and appropriate scrutiny at the CGWG for the Committee.

Key messages in the report included:
(i) Hospital Standardised Mortality Rate (HSMR) remained below the threshold of 1 at 0.94.
(ii) Adult Cardiac Arrest rate was 1.85 per 1,000 admissions which saw a small reduction from the previous reporting period. Cascade cardiopulmonary

resuscitation (CPR) trainer courses were delivered in October and November, where data was being centralised for monitoring.

(iii) Overall Stoke Bundle compliance remained unchanged at 55.3% in August 2025, however strong performance was noted within the thrombolysis times and aspirin administration, with completion of implementation of the CT scanner and development of a new standard operating procedure for stroke admission. Improvement work was required with timely access to the stroke unit and recording of swallow assessments.

(iv) Pressure Area Damage rate for Grades 2-4 had reduced from 0.83 per 1,000 occupied bed days to 0.6 per 1,000 occupied bed days following improved risk assessments and documentation. A target of reducing falls and falls with harm by 30% in November 2025 was noted.

(v) Falls with Harm rate within the Acute Directorate was at 0.2 per 1000 occupied bed days, with all inpatient falls rate at 10 per 1,000 occupied bed days.

(vi) NHS Forth Valley was above average for the Scottish Hip Fracture Big 6 Standard.

(vii) The implementation of the Electronic Observation System (eObs) was successfully implemented within the cardiology unit and data continued to be reviewed on a regular basis.

The following points were made in discussion:

(i) A query was raised on a lack of cover of clot busting, where it was advised that onsite cover was only provided Monday to Friday however it was noted that there were protocols, SOPs and access to a stroke physician in place for out of hour cover. Assurance was provided that the Associate Medical Director for Unscheduled Care was aware of the need to improve the out of hours thrombolysis time. National work was being undertaken by stroke physicians to explore regional cover arrangements to build a resilient rota.

(ii) Assurance was sought on whether there was collaboration with Health & Social Care Partnership colleagues to mitigate pressure ulcers acquired within the community. Committee members were advised that a whole system collaborative approach was adopted by NHS Forth Valley to implement mitigations.

(iii) Concern was raised over the recommendations regarding cardiac arrests, specifically highlighting that it noted the plans to increase training however did not reference the need to focus on the appropriateness of CPR attempts. Reassurance was provided that it was considered as a priority within improvements and was included within the deteriorating patients and eObs work.

The Clinical Governance Committee:

(1) Noted the position, challenges, and quality improvements being made in relation to the specific SPSP measures and compliance with national targets.

(2) Considered that the reported provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(b) Whole System Assurance Report

The Clinical Governance Committee received the 'Whole System Assurance Report' presented by Mr Ashley Calvert, providing assurance that the clinical governance processes within each directorate were working as intended.

Key messages in the report included:

(i) An overview of the continued improved format of the report was provided, where it was advised that work was ongoing to shift to a dashboard approach in order to incorporate Key Performance Indicator (KPI) measures and metrics, and ensuring consistency across directorates.

(ii) An engagement workshop was scheduled for January 2026 to collaborate with directorates to discuss key areas to capture within future reports in order to gain consistency and cohesion across the system.
(iii) Complexity was noted in the reporting of HSCPs due to Integration Joint Boards holding their own Clinical Care Governance Committees, where it was noted that direct reporting to the NHS Forth Valley Clinical Governance Committee was required therefore a whole system approach had been undertaken.

The following points were made in discussion:
(i) Concern was raised regarding the risks highlighted within the report and a lack of evidence of the actions undertaken to mitigate such risks. Therefore, further consideration of the ask of the Committee to directorates was sought in future reports, to encourage accountability within directorates.
(ii) A committee member proposed the focus on a distillation of the clinical governance work for each directorate for the Committee to provide oversight and scrutiny as opposed to operational level. Following discussion regarding a paper outlining the clinical governance structure of the Board to gain a better insight into the position of each directorate's governance processes, assurance was provided that work would be undertaken to produce a template to capture such detail in future reports, and Corporate Clinical Governance Managers were being aligned to directorates to provide support and guidance. It was agreed that directorates would be asked to provide a draft report to be reviewed by the Committee.
(iii) Further assurance was provided that the Corporate Director of Nursing and Corporate Clinical Governance Manager would be attending all clinical governance meetings across the system to gain oversight of function, provide recommendations and facilitate standardisation of processes and reporting.

The Clinical Governance Committee:
(1) Noted the agenda items discussed and presented at the Directorate Clinical Governance meetings, and data sources.
(2) Considered that the reported provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:
(1) Seek draft reports from directorates for review and consideration at Committee, in relation to an improved whole system assurance report. Ashley Calvert

9. Healthcare Associated Infection (HAI) Report

The Clinical Governance Committee received the 'Healthcare Associated Infection (HAI) Quarterly Report July- September 2025' presented by Mr Jonathan Horwood. Which provided an oversight of the HAI targets, Staph aureus bacteraemias (SABs), Clostridioides difficile infections (CDIs), Device associated bacteraemias (DABs), Escherichia coli bacteraemias (ECBs) incidents, outbreaks and all other HAI activities across NHS Forth Valley.

Key messages in the report included:
(i) Total SABs, DABs, CDIs and ECBs reported cases remained within controlled limits.
(ii) Within the reporting period of July to September 2025, there were:
- 5 hospital acquired SABs.
- 7 hospital acquired DABs.
- 3 hospital acquired CDIs. Assurance was provided that following concern raised at the previous meeting regarding CDI infections contributed to poor bundle

compliance, as a result of improvement work undertaken with wards, there had been a reduction from 9 wards to 1 attributed infection due to poor compliance.
- 9 hospital acquired ECBs.
- No deaths with *C.difficile* or MRSA recorded on the death certificate.
- 3 surgical site infections reported.
- 4 outbreaks reported (1 Norovirus and 3 Covid-19)

(iii) Influenza cases had risen with 10 reported within Forth Valley Royal Hospital, 5 of which were attributed to an outbreak within the hospital. Surveillance of Australian influenza trends within the winter periods, indicated an anticipated to rise earlier than previous years, with a lower infection rate over a more extended period of time.

(iv) No significant areas of concern were raised, and assurance was provided that there was continued monitoring.

The Clinical Governance Committee:

(1) Noted the report.

(2) Noted the performance in respect for SABs, DABs, ECBs & CDIs.

(3) Noted the detailed activity in support of the prevention and control of Health Associated Infections.

(4) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

10. Draft Quality & Safety Report

The Clinical Governance Committee received the 'Draft Quality & Assurance Report' presented by Mrs Wendy Nimmo, providing an overview of NHS Forth Valley's position in relation to quality planning, improvement, assurance and control.

Key messages in the report included:

(i) The report was an iterative document within its development stage, with its purpose being to provide Board-level assurance on clinical quality and safety through reporting the below areas:
- Significant Adverse Events
- Hospital Standardised Mortality Rate
- Complaints Management
- Safer Together Collaborative
- Freedom of Information Compliance
- Healthcare Improvement Scotland Unannounced Inspections
- Scottish Patient Safety Programme
- Clinical Policies and Guidelines

(ii) Committee members were asked to consider the desired purpose of the report and its governance route, whilst taking into account reducing duplication across reports.

The following points were made in discussion:

(i) A committee member proposed incorporation of the organisation's position with Stroke Bundle Compliance and suggested future discussions regarding the report were undertaken at the end of the meeting, once all agenda items had been discussed to support identification of key issues.

(ii) A shift in the purpose of the paper was suggested, where it was advised that highlighting priority areas to the Board as opposed to operational in-depth detail on such areas was preferred.

(iii) Following discussion on the topics to be referenced within the report and the level of detail required at Forth Valley NHS Board. it was noted that when considering potential public domain implications and the detail outlined, further refinement was required to clarify the content, level of detail, and governance routes prior to submission to the

Forth Valley NHS Board. Therefore, the report would be deferred until appropriately amended.

The Clinical Governance Committee:

(1) Considered the clinical and quality-related content and governance route of the report.

(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

(1) Amend report and consider discussions undertaken prior to presentation to the Committee and submission to the Forth Valley NHS Board. Wendy Nimmo

In Our Services, Will Care Be Safe In the Future?

11. Public Health Update

The Clinical Governance Committee received the 'Public Health Update' paper presented by Dr Jennifer Rodgers, where an overview of the governance arrangements and structure of the Sexual Health/ Blood Bourne (SHBBV) Managed Clinical Network (MCN).

Key messages in the report included:

(i) Committee members were made aware of the emerging issue of the governance arrangements and structure of the SHBBV MCN, where it was advised that a restructure of arrangements was proposed to the Director of Public Health.

(ii) A routine visit from the Scottish Government had been arranged in early December 2025 to discuss the SHBBV MCN, which would include the proposed governance arrangements.

The following points were made in discussion:

(i) It was agreed that an update on the outputs of the visit would be provided to the Committee, in conjunction with the proposed SHBBV MCN governance structure.

The Clinical Governance Committee:

(1) Noted the contents of the report.

(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

(1) Provide an update on the Scottish Government meeting and proposed SHBBV MCN governance structure. Jennifer Rodgers

12. Risk Management

(a) Strategic Risk Register

The Clinical Governance Committee received the 'Strategic Risk Register' paper presented by Miss Vicky Webb, which provided an update on the Strategic Risk Register, with a focus on the risks aligned to the Committee.

Key messages in the report included:

(i) The below strategic risks aligned to the committee were reviewed, where it was noted that there were no changes to the risk profiles:
- SRR002: Urgent & Unscheduled Care
- SRR004: Schedule Care

(ii) There were 20 controls mitigating the strategic risks aligned to the Committee with no overdue actions and 3 actions due to be completed within the next quarter.

The Clinical Governance Committee:

(1) Endorsed the Clinical Governance Strategic Risks for the period September to November 2025 for onward reporting the Forth Valley NHS Board.

(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(b) Focused Review of SRR004: Scheduled Care

The Clinical Governance Committee received the 'Scheduled Care Focused Review' paper presented by Miss Vicky Webb and Ms Marie Gardiner, which provided the Committee with an objective assessment of SRR004: Scheduled Care controls to ensure they were designed and operating effectively.

Key messages in the report included:

(i) Following a bow-tie analysis on the risk description and assessment on controls aligned to key performance indicators, there was no change to the risk of 20 which was considered as averse to the Board's appetite.

(ii) Mitigations were reviewed, where the below updates were noted:
- Action SRR004.20 Implementation theatre efficiencies programme to improve efficiency and to address impacts of repatriated patients, was added to the risk.
- Action SRR004.15 Implementation of a 24-month plan to improve efficiency and to address impacts of the National Treatment Centre (NTC), was noted as complete.

(iii) The main challenge experienced within the Schedule Care directorate was maintaining theatre efficiency and reduce inpatient day cases waiting times. Outpatient waiting times were performing well against the 52-week target. However, vulnerability was noted within Orthopaedic and NTC ward due to the potential of repurposing of beds during the winter period, risking failure to meet the 52-week target and NTC responsibilities. Assurance was provided that monitoring of activity was ongoing to plan and mitigate such risks.

The following points were made in discussion:

(i) Committee members were advised of the work ongoing to refresh the Scheduled Care Programme Board, chaired by the Director of Acute Services.

The Clinical Governance Committee:

(1) Endorsed the evaluation of assurance provided for SRR004: Scheduled Care.

(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

The Committee held a minute of silence in honour of Remembrance Day. Thereafter, adjourned at 11am and reconvened at 11:10am with all members present as per the attendance list.

Is Our Care Person Centred?

13. Person Centred Care Report

The Clinical Governance Committee received the 'Person Centred Care Report' presented by Professor Karen Goudie and Mrs Lesley Fulford, providing an overview of complaints performance in line with national key indicators.

Key messages in the report included:

(i) Significant improvements in addressing open complaints were noted with a shift from 526 open complaints in August to 231, as a result of escalation and focused work with

internal teams, specifically with Stage 2 complaints and those overlapping with significant adverse events.

(ii) The importance of aligning complaints and significant adverse events was emphasised where it was noted that improved measurement and oversight was implemented.

(iii) The Complaints Handling Procedure was under review, and an internal improvement plan had been developed for the team.

(iv) Annual feedback and complaints performance for 2024/25 against national Key Performance Indicators (KPIs) highlighted that:
- Overall Stage 1 compliance was at 75%, and 62.4% excluding prison complaints. Stage 2 compliance, including prison complaints was 31.6%.
- The key complaint themes identified were related to Clinical Care & Treatment, Medication Issues, Poor Nursing Care, Staff Attitude and Behaviour.
- An outstanding complaint from 2024, regarding the Mental Health and Learning Disabilities directorate, remained open due to an ongoing significant adverse event review. Assurance was provided that closure of the complaint was anticipated in the near future.

(v) Improvement work focused on the patient experience by enhancing systems to capture thematics aiming for richer insights and better linkage with the quality management system. In addition to prioritisation of staff wellbeing within the Patient Relation Team (PRT) due to resource pressures experienced.

The following points were made in discussion:

(i) A committee member sought further consideration of a large piece of work which considered complaint themes and potential whole system mitigations outwith PRT, using complaints data to drive system-wide improvements.

(ii) Clarity was provided on the timeframe of the additional resource provided to PRT, where it was noted that the extra capacity would be in place until June 2026.

(iii) A query was raised on whether focus could be placed on supporting staff to undertake early resolution to mitigate issues transpiring into a complaint. Reassurance was provided that despite a difficulty in measuring early resolution, plans were in place to provide quality improvement support, coaching and better use of Care Opinion Feedback to facilitate reduction in complaints received.

(iv) Concern was raised over the increase of complaints received in comparison to previous years, where it was advised that a similar increase had been experienced nationally.

(v) The importance of normalising feedback was identified, where it was noted that further work to improve feedback mechanisms more visible to staff and public would be of benefit to the organisation. Committee members were advised of a recent initiative, 15 Steps, which had been undertaken within the Maternity Unit and allow previous patients to provide feedback directly to senior staff. An evaluation piece was anticipated in 2026 where potential expansion was noted.

(vi) Detail on next steps and mitigations were sought in future reports to support understanding of the team's position.

(vii) Concern was raised over the high proportion of prison-related complaints received, where assurance was provided that despite the significant volume received, effective turnaround was noted, and further thematic analysis was planned to address recurring issues.

The Clinical Governance Committee:

(1) Noted the organisational risk attached to the current position.

(2) Noted the challenges in demand and capacity within the service and steps taken to improve performance within budget.

(3) Noted the action and mitigation plans.

(4) Noted recent changes to child-friendly complaints.
(5) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

14. Patient Safety Conversation Visit Supportive Documents

The Clinical Governance Committee received the Patient Safety Conversation Visit supporting documents presented by Mr Ashley Calvert. Committee members were reminded of the previous ask to provide oversight of the documents following discussion on the Patient Safety Conversation Visit Bi-annual Report at the 9 September 2025 meeting.

The Clinical Governance Committee noted the:
(a) General Questions for Visiting Team
(b) Report & Action Plan Template
(c) Facilitation Aide Memoire

15. Are We Learning and Improving?

(a) Significant Adverse Event Report

The Clinical Governance Committee received the 'Significant Adverse Event Report' presented by Mr Ashley Calvert, which provided detail on Significant Adverse Events (SAEs) in relation to the requirements specified by the Scottish Government.

Key messages in the report included:

(i) At time of presenting there were 31 open SAERs, of which:
- 1 was commissioned in 2023 and in draft report stage.
- 8 were commissioned in 2024, with 1 report submitted for approval.
- 22 were commissioned in 2025.
- 16 SAERs with lead reviewers but no assigned panel.

(ii) Following thematic analysis, the most common SAER categories were Diagnosis Failure, Diagnosis Delay, Stillbirth and Failure to Recognise Patient Deterioration.

(iii) Challenge was noted that the team was operating at maximum capacity with facilitators supporting more SAERs than desired therefore raising concerns regarding sustainability. Context was provided on the high quality of the SAER process undertaken by the team with strong family involvement, and generation of learning summaries completed for each SAER and shared internally. It was proposed that additional resource was required to address SAER backlog and maintain review quality.

The following points were made in discussion:

(i) Assurance was provided that the overall position of SAERs was stable, however it was noted that gaps in addressing backlog and timeliness of reviews remained a risk until additional capacity within the team was considered. Following discussion on potential expansion of facilitator capacity and administration support, committee members recognised the urgency of developing a business case for additional resource. It was agreed that a paper would be developed and presented to the Senior Leadership Team for consideration.

(ii) A query was raised on whether lead reviewers could support capacity by undertaking facilitator roles, where it was advised that it would not be viable due to the expertise required by facilitators.

The Clinical Governance Committee:

(1) Noted NHS Forth Valley's position on the commissioning completion, acceptance of SAERs and development of an improvement plan, with the timescales of the national framework.

(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

(1) Develop a business case for additional resource to support SAERs, for consideration of the Senior Leadership Team and presentation at the January Committee meeting. Ashley Calvert

(b) Safer Together Collaborative Update

The Clinical Governance Committee received the 'Safer Together Collaborative Update' paper presented by Professor Karen Goudie, providing an update on the progress of the Safer Together Collaborative (STC), highlighting measurable improvements across all workstreams, increased by Quality Improvement capability, and plans for transition into a new governance framework. Outlining the sustainability strategy, learning system insights, and alignment with national safety programme.

Key messages in the report included:

(i) Closure of the collaborative into a business-as-usual arrangement had begun, with a celebration event scheduled for 13 November 2025 to present the whole system working across partnerships, aligned to national Scottish Patient Safety Programme initiatives.

(ii) An update was provided on the below high-level measurements of aims, developed during the establishment of the collaborative:

- Reduce catheter care usage by 30%: had been achieved due to successful trails without catheters across multiple clinical areas, contributing to a reduction in unnecessary catheterisation and supporting safer patient care.
- Reduce cardiac arrest rate by 40%: significant improvements were noted against the aim with a reduction from 4.4 cardiac arrests per 1,000 discharges to 2.76, with a shift from the top 10th centile within the National Cardiac Arrest Audit to the 75th centile.
- Reduce enhanced observations by 50%: following a collaborative approach with the Mental Health and Older Adult team liaisons, a 87% reduction was noted.
- Reduce organisationally acquired pressure ulcers by 30%: verification of all pressure ulcer cases continued to be undertaken, aligned with the implementation of electronic system enhancements in November 2024 that strengthened the accuracy and reliability of data reporting. Grade 2 pressure data evidenced a 5-point trend in reduction.
- Reduce falls with harm 'moderate and severe' by 30%: the aim was achieved and recognised by Healthcare Improvement Scotland.

(iii) Assurance was provided that reporting and oversight of workstreams would be integrated into Quality Programme Board to ensure accountability and safety reporting.

The Clinical Governance Committee:

(1) Noted the improvements against high-level improvement aims.

(2) Noted the progress with development of the infrastructure and systems to support the quality planning and assurance.

(3) Noted the transition plans after November 2025.

(4) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.
(5) Commended colleagues for their work with the STC.

Are Our Systems Reliable?

16. Medical Education Annual Report

The Clinical Governance Committee received the 'Medical Education Annual Report' presented by Dr Kate Patrick, providing reassurance that NHS Forth Valley met the standards required by the General Medical Council in relation to Educational Governance.

Key messages in the report included:

(i) Paediatrics were recognised as an area of excellence for medical trainees, and good practice letters were received in both secondary and primary care departments.
(ii) Concerns were highlighted around survey data following an NHS Education for Scotland (NES) Quality Engagement meeting within Trauma and Orthopaedics, where it was advised that a summary report was pending.
(iii) Challenges remained within medicine, where work was ongoing to address staffing challenges and rota gaps. It was anticipated that the development of a programme of Band 3 Clinical Support Workers would help to alleviate such challenges.
(iv) A Foundation Year 1 Whole Hospital at Night rota was trialled in 2024, and subsequently discontinued following feedback on challenges around the new format which did not work as anticipated.
(v) As a result of £0.5m in ACT Funding obtained, refurbishment of the Falkirk Community Hospital medical student's accommodation block had commenced.
(vi) NHS Forth Valley were in partnership with St Andrew's University to support the new Medical MBChB course.
(vii) Concern was raised over a lack of a rest accommodation for nightshift staff, assurance was provided that the risk was on the Organisational Risk Register, and a 4-bedded bungalow and emergency taxi service was available to staff.

The following points were made in discussion:

(i) Clarity was provided that the Falkirk Community Hospital accommodation block was available to all staff, and that NHS Forth Valley was not considered as an outlier as most Private Finance Initiative hospitals did not have arrangements for nightshift facilities.
(ii) Concern was raised over discrimination around a specific ward area, where assurance was provided that a discrimination reporting process was undertaken and the team were commended by NES for handling of the process.
(iii) Detail was sought on the escalation route for recurring issues, where it was advised that risks considered were captured on the Risk Register where mitigation actions were developed.
(iv) A committee member sought further detail on improvements of key issues from previous years within future reports in order to evidence developments and provide further assurance.
(v) Committee members sought identification of a key issue to be raised at the Forth Valley NHS Board, where a lack of rest space for nightshift staff was recognised as the issue of most concern for staff wellbeing.

The Clinical Governance Committee:

(1) Noted the contents of the Postgraduate Part 1 & 2 Reports, and the Undergraduate Report.
(2) Noted that there was discussion undertaken regarding the best means of overseeing Medical Educational Governance within the corporate structure in

NHS Forth Valley and that given the impact on patient safety, the Clinical Governance Committee was the optimal group.

(3) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

17. Clinical Governance

(a) Internal Audit Follow Up Actions

The Clinical Governance Committee received the 'Internal Audit Report 'presented by Mr Ashley Calvert, which provided oversight of the audit actions aligned to the remit of the Clinical Governance Committee.

Key messages in the report included:

(i) Of the actions aligned to the Committee, A10/26 Action Points 9 and 10 were noted as outstanding with timescales of 31 March 2026 and 31 December 2025.

(ii) Appendix 1 outlined the findings from the Audit of A15/25, where updates were provided on the below 6 findings aligned to the Committee:

- Finding 1: Duty of Candour
- Finding 2: Improvement Plan- Milestones
- Finding 3: Sharing of Learning
- Finding 4: Actions resulting from SAER Recommendations
- Finding 5: Local Management Team Reviews Progress Monitoring
- Finding 6: Improvement Monitoring

The Clinical Governance Committee:

(1) Noted that the management response to findings would be reviewed by the committee through the Internal Audit Follow Up Actions Report.

(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(b) Clinical Governance Working Group Update

The Clinical Governance Committee received the 'Clinical Governance Working Group Update' presented by Mr Ashley Calvert, which provided an update from the Clinical Governance Working Group in relation to key items discussed, noted and approved.

Key messages in the report included:

(i) The items considered at the CGWG were:

- Medical Education Annual Report
- Clinical Governance Strategic Implementation Plan
- Blood Transfusion Annual Report
- Acute Services Directorate Safety & Assurance Report
- Whole System Assurance Report
- Healthcare Associated Infection Report
- Risk Management Update
- Person Centred Care Report
- Significant Adverse Event Review Report
- NHS Safety Collaborative
- Fatal Accident Inquiry re Labs
- Cabinet Secretary Letter re SAERs

(ii) Assurance was provided that detail on discussion undertaken at the working group had been incorporated into the report, following request by the Committee.

The Clinical Governance Committee:

(1) Noted the paper and key issues that arose from the Clinical Governance Working Group.
(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

For Noting

18. The Clinical Governance Committee noted the Organ & Tissue Donation Committee Terms of Reference.

19. The Clinical Governance Committee noted the minutes from the below associated Clinical Governance Groups:
(a) Clinical Governance Working Group Minute 14.08.25
(b) NHS Forth Valley Infection Control Committee Minute 10.09.25

20. The Clinical Governance Committee noted the below Standards and Reviews Reports:
(a) July 2025
(b) August 2025

21. The Clinical Governance Committee noted the below Scottish Patient National Audit Programmes:
(a) Scottish Stroke Care Audit
(b) Scottish Multiple Sclerosis Register

22. Any Other Competent Business
There was no other competent business.

23. Matters to Raise at Board
The Chair highlighted that key matters discussed would be raised at the 25 November 2025 Forth Valley NHS Board meeting.

24. Date and Time of Next Meeting
Tuesday 13 January 2026 at 9:00am, in the Boardroom, Carseview House.
The Chair closed the meeting at 12:55pm.

FORTH VALLEY NHS BOARD

Item 7.3 Minute of the Staff Governance Committee Meeting held on Tuesday 18 November 2025

For: Assurance

Minute of the Staff Governance Committee Meeting held on Tuesday 18 November 2025 at 9.00am in the Boardroom, Carseview House and via MS Teams.

Present:
Mr Robert Clark (Non-Executive Director)
Mr Martin Fairbiarn (Committee Chair)
Mr Nicholas Hill (GMB Representative)
Ms Alison Jaap (Non-Executive Director)
Mr Gordon Johnston (Committee Chair)
Mrs Karen Morrison (Unison Representative)

In Attendance:
Mr Michael Brown (Head of Workforce Resourcing)
Mr Ross Cheape (Head of Service, Mental Health & Learning Disabilities)
Mrs Morag Farquhar (Director of Facilities)
Mr Jack Frawley (Board Secretary)
Prof Karen Goudie (Executive Nurse Director)
Mrs Aileen Love (Head of Occupational Health)
Mrs Neena Mahal (Chair)
Mrs Jenny McCusker (Head of Organisational Development)
Mrs Elaine McDonald (Interim Head of Employee Relations)
Prof Ross McGuffie (Chief Executive)
Mrs Julie McIlwaine (Interim HR Service Manager)
Mr Cameron Raeburn (Head of Health and Safety) Item 16
Miss Becky Reid (Corporate Services Assistant/PA) Minute
Mr Kevin Reith (Director of People)
Mr Allan Rennie (Vice Chair)
Mrs Linda Robertson (HR Service Manager – Staff Governance)
Ms Rachel Tardito (Equality, Diversity and Wellbeing Lead)
Mr Scott Urquhart (Director of Finance)
Miss Vicky Webb (Corporate Risk Manager)

---

1. Welcome, Apologies for Absence and Confirmation of Quorum
The Chair welcomed all present to the meeting. Apologies were received from Mr John Stuart.

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

3. Draft Minute of Staff Governance Committee Meeting held on Tuesday 15 July 2025.
The note of the meeting held on Tuesday 16 September 2025 was approved as an accurate record.

4. Matters Arising from the Minute / Action Log
The action log was reviewed, and the completed actions were acknowledged. The following updates were provided:

- Action 22: Mrs Jenny McCusker confirmed that the management training information was included in the OD update in September, but the figures would be updated in the next report shared with the committee.

- Action 38 – was complete but an update would be provided at the next meeting of the committee.
- Action 45- target date was amended to the next meeting of the committee.
- Action 55 –This was to be marked as complete as this was reflective of the considerations that were not classified as recommendations and were reported within the paper presented today.
- Action 63 – target date amended to January.

Regarding the work noted within the update for action 64 it was recognised that the full detail of the impact of work implemented through the Culture Change & Compassionate Leadership Program was to be reflected within the update provided to the committee in January which should include further detail on the measurement framework. It was imperative that all the workstreams from phases 1 & 2 were pulled together and shared with committee to allow for clarity on the controls in place to ensure this work continued to progress in a positive manner.

5. Staff Governance Committee Workplan

The Staff Governance Committee considered the 'Staff Governance Committee Workplan 2025/26' presented by Mrs Linda Robertson noting any adjustments made from the previous version approved at the July 2025 meeting of the Committee.

Key messages in the report included: -

(i) The Anti-Racism plan would be discussed within the Equality and Diversity workplan agenda item.

(ii) Highlighted was the Health & Safety Quarterly report was noted as being presented at the July meet of the Committee in error.

The Following point was raised in discussion: -

(i) Confirmation was provided that the 'People Strategy' would be incorporated within the committee workplan for 2026/27. The draft 2026/27 workplan would be shared at the January meeting and would outline the anticipated dates that the people strategy would be presented.

The Staff Governance Committee: -

- **Approved the updates to the Committee Work Plan for 2025/26.**

6. Staff Governance Report – Including Workforce Performance Reporting

The Staff Governance Committee received the 'Staff Governance Report – Including Workforce Performance Reporting' presented by Mr Kevin Reith to provide an update on a range of Staff Governance and Partnership priorities, related workforce reporting metrics and associated improvement activity being undertaken to support enhanced performance and to mitigate present risks.

Key messages in the report included: -

(i) There had been an increase in absence to 8.10% with increases in all areas except for Corporate. The primary cause continued to be 'anxiety, stress, depression and other psychiatric illnesses' but there had been increase in 'respiratory illnesses'. Pressures of winter illness were impacting the organisation earlier than anticipated.

(ii) Through service performance reviews discussions were taking place to consider the absence rates and an ask was put to Executive Directors and Senior teams to consider appropriate trajectories and realistic timelines to ensure absence rates were reduced.

(iii) Noted that it would be beneficial for the committee to have sight of a high-level action plan outlining the activity to provide assurance on the work being undertaken to reduce high absence rates

(iv) Employee Relations cases continued to broadly track downward although the number of grievance cases had slightly increase and despite Bullying & Harassment cases having decreased slightly the number of cases remained relatively high. Focus work was being carried out to complete cases that had been in the system for a long period of time.

(v) Personal Development Review (PDR) compliance remained below the 80% national target, achieving 40%. Mrs Jenny McCusker was working alongside all Executive Directors to outline the anticipated trajectories for each service area to ensure the national target was achieved within the upcoming year.

(vi) Due to compliance and approval processes the Time to Hire KPI was out with the national benchmarking at 19 weeks. Focus work was being carried out in this area to significantly reduce the lengthy timescales.

The following points were raised in discussion: -

(i) Concerns were raised over the lack of effectiveness of the current systems in place to improve absence management and PDR compliance and further clarity was requested to understand the improvement journey necessary to ensure all areas were successful in improving these targets.

(ii) Noted the requirement to monitor the downward trend of employee relation cases, specifically Bullying & Harassment cases as in previous years improvements seemed to plateau, but the conclusion of these cases were vital to reduce the lasting effects on staff members.

(iii) Following a question on the spike seen within the report of staff leaving within a year of their start date it was noted that the rationale of this was understood and the committee was advised that there are a number of factors including contracts ending. Confirmation was provided that there was no clear correlation between these leavers and the increased use in supplementary staffing.

(iv) Clarity was provided that reference to the workforce metrics within the report referred to the work to continuously improve the quality of the data being presented to the committee. Feedback from the committee was welcomed noting this was an iterative document and the data could be further refined dependant on the committees ask.

(v) Extensive work had been carried out within recruitment and going forward thought would be given to how the activity levels were reflected within the report. Reflecting upon the benchmark figure for Time to Hire it was confirmed that NHS Forth Valley was not an outlier in not achieving this standard and confirmed that the current position was positive. Through work that had been carried out to streamline the recruitment process continued improvement was being recognised.

(vi) Following a question regarding the reduced working week it was noted that all areas are reviewing the requirements to implement the 37-hour working week when anticipated reflecting the national guidance which ash been provided. Local partnership discussions are ongoing to address technical issues.

(vii) Mr Scott Urqhaurt confirmed that conversations were taking place to understand the interventions that could be put in place to assist with reducing the significant financial loss due to high absence rates. A request was put forward for the outcomes of these discussions and the expected impact of the measures being put in place be shared with the committee.

The Staff Governance Committee: -

- **Recognised the wide range of areas discussed within the report and confirmed they were assured on the process in place for the majority of areas.**

- **Were not satisfied with the current measures in place to manage absence levels and PDR compliance.**
- **Requested that clear definitive detail be provided at the next committee meeting outlining the measures being put in place to improve performance in these areas.**

7. Internal Audit Action Update

The Staff Governance Committee received the 'Internal Audit Action Updates' presented by Mrs Linda Robertson to provide detail of the best practice approach to audit action tracking and previous discussions at the Staff Governance Committee regarding visibility of all audit activity under its' responsibility.

Key messages in the report included: -

(i) To provide assurance that action was being taken to address identified control weaknesses regular progress reports were provided to the Audit and Risk Committee.

(ii) Committee members were made aware of the revised target dates to 30 November 2025 for the following recommendations:
   a. Annual Internal Audit Report 2025/25 Ref 11 – Staff Governance Committee Annual Report
   b. Annual Internal Audit Report 2024/25 Ref 12 – Development of the People Strategy

(iii) Supplementary Staffing was an additional recommendation that would be discussed under item 13 on the agenda.

The following messages were raised in discussion: -

(i) Mr Kevin Reith noted that the outstanding action for Audit Ref 11 was in relation to the Terms of Reference (ToR) for the Strategic Workforce Programme Board. There was an ask to the committee to agree the closure of this action due to the ToR being discussed on this agenda.

(ii) There was a proposal to close Audit Ref 12 as the People Strategy would be incorporated within the committees workplan for 2026/27 with the anticipated target of final approval being September 2026.

The Staff Governance Committee: -

- **Were content with the update provided.**
- **Agreed to close Audit Ref 11 as the Terms of Reference was on this agenda for the committee to have sight of.**
- **Accepted the proposal to close Audit Ref 12 due to the People Strategy being incorporated within the 2026/27 committee workplan and a timeline of the work being presented at the January meeting of the committee.**

8. Employability Framework

The Staff Governance Committee received the 'Employability Framework' presented by Mrs Jenny McCusker to provide an update on the programme of work to be delivered under the Employability remit and linked to needs identified in the NHS Forth Valley Workforce Strategy and Local and National Anchor objectives.

Key messages in the report included: -

(i) This work would allow for NHS Forth Valley to employ individuals through education pathways and encourage flexible working arrangements that would enable a more diverse workforce.

(ii) There was an increased focus on enabling apprenticeships through the recruitment process to identify eligible posts for an apprentice and assist with meeting targets of 15 new entrants per year.
(iii) To further encourage the uptake of work experience within NHS Forth Valley thought would be given to introducing a guaranteed interview approach to improve the likelihood of permanent employment.
(iv) Due to the success of the work already undertaken and the strong connections built with partners through ongoing anchor work there had been an increase in demand for involvement. To increase capacity and build this workstream further, spend to save options would be considered.

The following points were made in discussion: -
(i) Clarity was provided that this item was discussed due to historic representation but would be incorporated within the workforce planning initiatives going forward.

The Staff Governance Committee: -

- **Endorsed the work detailed in the report and approved the approach being taken.**

9. Equality and Diversity Workplan

The Staff Governance Committee received the 'Equality and Diversity Workplan' provided by Miss Rachel Tardito to provide assurance on the progress being made and outlining the highlights of delivery of the Equality Objectives and key pieces of work.

Key messages in the report included: -
(i) As an organisation there was a legislative and ethical duty to develop and deliver upon an Equality and Diversity Workplan. An Equality and Inclusion Strategic Framework for 2025 to 2029 was published in April of 2025 in line with the legal obligations set out within the Public Sector Equality Duty.
(ii) Context was provided that the report presented was narrative heavy as it outlined the progress made during the initial six-month period of development. As work progresses and engagement increases the report would provide measurable outputs and the finer detail of the work being implemented.
(iii) A yearly update detailing the progress to date was scheduled to be released in April 2026.
(iv) A Pentana dashboard was being finalised so the evidence gathered would be available to demonstrate the progress being made as well as illustrate key improvement needs.
(v) Included within the papers shared with the committee was the initial draft of the Anti-Racism plan.

The following points were raised in discussion: -
(i) Clarity was provided that the Anti-Racism Plan would be presented to the Strategic Planning, Performance & Resources in December for final reviewing before being submitted to NHS Board in January 2026 for approval.
(ii) Committee members agreed to share any comments or feedback to Rachel Tardito offline.
(iii) Noted the need for concise reporting and a clear line of sight within the framework detailing the work being undertaken including highlighting the anticipated timelines allocated to action plans.
(iv) The Ethnic Diversity Network Executive Committee meeting taking place in December would discuss how best to celebrate diversity and the invite could be shared wider to include Board members.

The Staff Governance Committee: -

- **Were content that the report provided assurance to deliver the equality objectives.**
- **Endorsed the draft Anti-Racism plan.**

Action:

- **Any comments or feedback to be shared with Rachel Tardito on the content of the draft Anti-Racism plan.**
- **Future reports to clearly link the information within the framework and the work being implemented and timelines.**

10. Workforce Wellbeing

The Staff Governance Committee received the 'Workforce Wellbeing' report provided by Miss Rachel Tardio seeking approval for the Workforce Wellbeing Framework (2025 to 2029).

Key messages in the report included: -

(i) The Workforce Wellbeing Framework included a high level 4-year action plan and a detailed annual delivery tool that is responsive to ongoing engagement, collaboration and data to ensure strategic alignment, best use of resources and responsive to evolving workforce needs.

(ii) This framework would be published on the external NHS website in the aim to decrease and reduce accessibility barriers.

(iii) The new programme board structure was noted to be the appropriate governance route for updates and assurances to be provided where necessary. Going forward the Staff Governance Committee would receive a high-level detail report which could be tailored to reflect key areas or specific feedback at the committee's request.

The following points were raised in discussion: -

(i) A communications plan was in development to ensure the information being shared with staff was direct and related to specific areas.

(ii) Following a question, it was confirmed that this framework was produced to be an overarching high-level document produced using feedback provided by staff that would be used to develop the appropriate action plans.

(iii) Committee members raised concerns over the lack of clarity on the interdependencies of the framework and the key priorities being taken forward in relation to the corporate objectives for the upcoming year. Clarity was requested on how progress would be monitored going forward and for this detail to be incorporated within the report going forward.

(iv) A steering group was being formed to drive and monitor the work being carried out and providing feedback to the Strategic Workforce Programme board on the progress of work for onward reporting to the appropriate committees.

The Staff Governance Committee: -

- **Endorsed the Workforce Wellbeing Framework.**
- **Requested an update be provided to the committee outlining the key dependencies, the metrics and provide an understanding of how progress would be measured prior to the anticipated annual update.**
- **Thought to be given to how the detail of the framework would be communicated to staff advising on specific areas in a meaningful way to highlight the work being undertaken.**

Items 11 and 14 were taken in conjunction due to their relative matters.

11. Worforce Planning Update
The Staff Governance Committee received the 'Workforce Planning Update' presented by Mr Michael Brown which provided an update on the development of the NHS Forth Valley Workforce Planning governance and infrastructure.

Key messages in the report included: -
(i) The Strategic Workforce Programme Board which would be supporting the work of the Workforce Plan had their first meeting where the Terms of Reference was discussed and had been included within this report for committees' oversight.
(ii) A Workforce Planning Manager had been appointed, and the aim was that through this role the individual would assist with pulling the interdependencies of the various workforce initiatives together to assist with creating the workforce plan.
(iii) National and regional discussions remained ongoing regarding the national requirements of the future workforce plans. Focus work was being carried out to produce a 2026/27 workforce plan update which would be shared with the committee by 31st March 2026.
(iv) The one-year workforce planning update for 2026/27 would be underpinned by the five pillars of workforce to provide an updated whole system view of the workforce.

In discussion it was confirmed that the plan would include numerical analyses of the current and projected requirements; and comparison of actual staff levels against these requirements.

14. Workforce Focused Review
The Staff Governance Committee received an update on the 'Workforce Focussed Review' presented by Miss Vicky Webb to provide assurance on the effective management of the strategic risk SRR009 Workforce Plans which is aligned to the Staff Governance Committee.

Key messages in the report included: -
(i) An overview of current controls was reflected within the report shared with the committee and noted was an improvement within the control environment.
(ii) Two controls had a red RAG status, but robust actions were in place to address this.

The following points were raised in discussion: -
(i) Recognition was given to the gaps identified within the risk analysis in reference to lack of organisational expertise but as the plan developed and implementation took place it was expected that the risk would come into tolerance.
(ii) Following a comment from a committee member clarity was provided to confirm that it would not be the full Workforce Plan that would be shared with the committee by March 31st 2026, rather an update to provide the committee with assurance of the position prior to the full plan being produced.
(iii) Comments were raised on the importance of developing this plan collaboratively with both Health and Social Care partnerships to accurately reflect the direction of travel for service delivery and the staffing requirements.
(iv) When questioned if there was support nationally to ensure all NHS Health Boards worked to a similar perspective it was confirmed that this was not the case at present, but work would continue with Scottish Government colleagues to ensure a collective approach was being taken.

The Staff Governance Committee:
- **Were supportive of the work outlined within the report provided.**
- **Were content with the risk analysis detailed caveat to the details within the plan reducing the current status of the red risks.**

12. Staff Governance Monitoring Exercise

The Staff Governance Committee received an update on the 'Staff Governance Monitoring Exercise' paper by Mrs Linda Robertson to provide assurance on the information being shared to Scottish Government by the anticipated deadline of 17 December 2025.

Key messages in the report included: -

(i) The Staff Governance Monitoring Exercise is required to be submitted to the Scottish Government annually.

(ii) There had been a streamlined standardised assurance template used on this occasion which was intended to be less onerous on Health Boards whilst still supplying sufficient information on the requested areas: Bullying & Harassment, Whistleblowing, EQIA, Retire and Return and highlighting any challenges and successes.

(iii) The challenges and success were yet to be built into the report, and an ask would be shared with the APF committee for suggestions to be included.

(iv) Prior to the submission deadline of 17 December 2025, a finalised version of the template would be shared with the committee for awareness.

The Staff Governance Committee: -

- **Approved the draft template but requested that the finalised version be circulated to the committee prior to submission.**
- **Agreed that final sign off would be done by Robert Clark and Ross McGuffie.**

13. Supplementary Staffing Audit Report

The Staff Governance Committee received the 'Supplementary Staffing Audit Report' presented by Mrs Linda Robertson highlighting the outcomes following the anticipated audit of supplementary staffing included within the 2024/25 Internal Audit Plan.

Key messages in the report included: -

(i) As a result of the audit on supplementary staffing from the Internal Audit Plan 2024/25 there had been 5 recommendations for action which related to:
   a. Suspension of Control Procedures
   b. Allocate Optima Bank System – System Warnings
   c. Training – SafeCare
   d. Workforce Governance Groups' Action Logs
   e. Medical Workforce Governance Group (Medical WGG)

(ii) Action owners had been identified for each action and these would be built into the pre-existing work identified to facilitate reductions in supplementary staffing costs across all service workforces.

(iii) Updates on the progress of these actions would be shared with committee through the regular Internal Audit Action Update report and the Staff Governance Reports.

The following points were made in discussion: -

(i) Mr Micheal Brown confirmed that because of this audit, focus work was being carried out to reduce the use of supplementary staffing within medical in the hope to replicate the successfulness that was seen within the nursing department.

(ii) Clarity was provided on the ask to internal audit for this area to be audited was to allow for assurances to be provided on the sustainability of the improvements already made with the reduction in spend of supplementary staffing and the robustness of systems in place.

The Staff Governance Committee: -

- **Endorsed the actions identified within the report and the work being implemented to progress.**

15. Strategic Risk Register

The Staff Governance Committee received an update on the 'Strategic Risk Register' presented by Miss Vicky Webb to provide an update of the position as of November 2025, focusing on the risks aligned to the Staff Governance Committee

Key messages in the report included: -

(i) As risk SRR009: Workforce was subject of a deep dive and covered previously on this agenda the report presented referred to risk SRR019: Culture & Leadership.

(ii) At the time of reporting there were no overdue actions and the detail of the actions completed through the focused review period were included within the report.

The Staff Governance Committee: -

- **Endorsed the assessment of the risk presented for onward reporting to the NHS Forth Valley Board.**
- **Were content with the assurance provided that appropriate controls are in place.**

16. Health & Safety Quarterly Report

The Staff Governance Committee received the 'Health & Safety Quarterly Report' presented by Mr Cameron Raeburn detailing the Health and Safety issues for NHS Forth Valley and those being worked upon by the Health and Safety department.

Key messages in the report: -

(i) The summary table reflecting compliance against Key Performance Indicators (KPI) for each Directorate/HSCP was highlighted for awareness, recognising a high number of areas that were non-compliant. Those areas would be of particular focus in the upcoming Quarters for Health and Safety.

(ii) There had been an amendment so that incomplete adverse events which had been 'saved for later' were not included as they were not events that had been reported. These would be reported separately going forward. These figures had also been removed from the reporting of Q1 to allow for an accurate baseline when reporting on 2025/26.

(iii) Reports which had been 'saved for later' were discussed at a recent Health and Safety committee meeting and the proposal had been put forward that after 4 weeks if reports remain unfinished this would be removed from the system as managers would have received multiple reminders this was outstanding.

(iv) Reporting an adverse event within 3-days achieved 88% compliance, whilst the reviewing of adverse events within 9-days was 75% compliant, both of which had decreased from the previous quarter. As at 12 October 2025 there had been an increase from 318 to 359 of overall adverse events. Noted was that 84% of these adverse events were within Acute Services. Noted was that there had been lack of representation from the Acute services in attendance of the Health and Safety Committee meetings.

(v) Excellence reporting allows for employees to report something that had gone well based on 5 key themes. There had been an increase in Q2 with 315 events being reported and it was thought this was a result of the further development of advertisement of the reporting method.

(vi) Compliance targets for the self-reporting aspect of the control book was 80% with the organisation achieving beyond this with 86%. Of the 116 control books audited, 50 had been completed in terms of the actions identified and an over 69% of actions had been completed.

(vii) The report detailed 4 outstanding actions that had been identified within the Q1 Health and Safety report. Responses to these actions should be picked up within directorate performance review highlight report. All actions identified within Q2 were included within table 15 of the report.

(viii) As of 4 November 2025, the overall position of training compliance had stalled following what was thought to be a positive start to improvements. Manual Handling (MH) had decreased to 63%, Management of Violence & Aggression (V&A) within high level areas remined 82%, moderate level areas decreased to 72% and low-level areas remained 60%.

(ix) Concerns were raised on the little progress that had been made to achieve compliance targets as well as staff attendance at training courses decreasing. From June to October 64% of non-attendance reasoning was seen to be due to capacity issues which was anticipated to worsen due to winter pressures.

(x) A V&A moderate level course was due to take place within the Learning Centre of Forth Valley hospital, and there was hope that this location would have a positive impact on attendance.

The following points were raised in discussion: -

(i) Mr Scott Urquhart shared that a series of Short Life Working Group (SWLG) meetings had taken place regarding MH and V&A training compliance. These meetings were to ensure all leads from service areas that attended understood the expectation to drive steady improvement against compliance. It also allowed an opportunity for individuals to highlight the barriers within their area preventing them from being compliant. Initial improvement following this meet had stalled so conversations would continue at the SLWG's to understand what more can be done to further enhance improvement and support attendance.

(ii) Concerns were raised over the lack of representation and engagement from Acute services with the Health and Safety Committee.

(iii) Committee members raised concern over the lack of attendance at training courses by staff and questioned what efforts could be made to improve attendance rates. Discussion took place around the potential barriers noting that managers had a responsibility to ensure sufficient staffing levels were in place to allow staff to be released. There was hope that attendance rates would improve with training sessions now being scheduled to take place within the Learning Centre reducing the potential barrier of traveling offsite.

(iv) Requested that a full assessment be carried out to understand the extent of the issues against compliance and what could be done to address these barriers and have this information incorporated within the Health and Safety Quarterly report at the next Staff Governance Meeting.

(v) The table on page 336 of the report required further detail to be included highlighting the work being done to resolve the issues highlighted.

The Staff Governance Committee:

- **Were assured on the system in place to monitor Health and Safety within areas.**
- **Requested for the detail of what's being done to mitigate issues be further developed to provide further assurance.**
- **Were not satisfied with the training compliance against Manual Handling and Violence & Aggression, especially within high-risk areas and requested feedback be incorporated within the next report reflecting the work highlighted by Mr Scott Urquhart.**

Action:

- **Feedback from the work outlined by Mr Scott Urqhart to be presented within the next report to the Staff Governance Committee.**

17a. Area Partnership Forum Minute 24.06.2025
The Staff Governance Committee **noted** the Area Partnership Forum Minute.

17b. Health & Safety Committee Minute 12.08.2025
The Staff Governance Committee **noted** the Health & Safety Committee Minute.

17c. NHS Scotland Workforce Policies
Mr Kevin Reith shared that national conversations were ongoing regarding alterations to timelines, but no further feedback had been received from Scottish Government therefore we were continuing to progress the work in line with current timescales.

18. Any Other Competent Business
There was no other competent business.

19. Matters to Raise at Board and Reflections
Mr Fairbairn confirmed that the below matters would be raised at Board:

- Assurance was not provided for the processes in place to improve absence management and PDR compliance.
- Were not satisfied with the training compliance figures and there was a requirement for significant improvement to be made.
- The committee would want to receive further information on the impact of the work being implemented through the Workforce wellbeing work.
- Endorsement of the work being undertaken through the Workforce plan and understand successful implementation would reduce the risks associated with workforce.

Discussions took place to reflect on the meeting and members noted their positivity on the clarity of focus and the direction of travel of the committee. Reflection of the meeting would be a standing item going forward to allow members the opportunity to provide any feedback or suggestions for improvement and to note what was going well for the committee.

20. Date of Next Meeting
Tuesday 20 January 2026 at 9:00am, Boardroom Carseview House, Stirling

The Chair closed the meeting at 12:10pm

FORTH VALLEY NHS BOARD
Tuesday 27 January 2026

7.4 Minute of the Strategic Planning, Performance & Resources Committee Meeting held on Tuesday 16 December 2025

For: Assurance

Minute of the Strategic Planning, Performance & Resources Committee Meeting held on Tuesday 16 December 2025 at 9.30am in the Boardroom, Carseview House.

Present:
Ms Neena Mahal (Chair)
Mrs Kirstin Cassells (Non-Executive Director)
Mr Robert Clark (Non-Executive Director)
Cllr Fiona Collie (Non-Executive Director)
Mr Martin Fairbairn (Non-Executive Director)
Ms Alison Jaap (Non-Executive Director)
Mr Gordon Johnston (Non-Executive Director)
Professor Clare McKenzie (Non-Executive Director)
Mr Allan Rennie (Non-Executive Director)
Mr Finlay Scott (Non-Executive Director)
Mr John Stuart (Non-Executive Director)

In Attendance:
Mrs Claire Alexander (Corporate Performance Manager)
Miss Jennifer Brisbane (Corporate Services Assistant) Minute
Mrs Elsbeth Campbell (Head of Communications)
Ms Caroline Doherty (Head of Community Services) Item 10
Cllr Scott Farmer (Stirling Council)
Mrs Morag Farquhar (Director of Facilities)
Mr Garry Fraser (Director of Acute Services)
Mr Jack Frawley (Board Secretary)
Mrs Laura Henderson (Performance & Assurance Programme Manager)
Mrs Sarah Hughes-Jones (Head of Information Governance) Items 5 & 14
Mr Scott Jaffray (Director of Digital)
Mr Sam McCartney (Corporate Risk Advisor)
Ms Jackie McEwan (Corporate Business Manager)
Professor Ross McGuffie (Chief Executive)
Ms Kerry Mackenzie (Acting Director of Strategic Planning and Performance)
Mr Andrew Murray (Medical Director)
Mr Kevin Reith (Director of People)
Mrs Jillian Thomson (Deputy Director of Finance) Item 6
Mr Scott Urquhart (Director of Finance)
Mrs Gail Woodcock (Director of Falkirk Health and Social Care Partnership)

---

1. Welcome, Apologies for Absence and Confirmation of Quorum

Apologies were intimated for Cllr Fiona Law and Stephen McAllister. The meeting was quorate.

Jennifer Borthwick, Jennifer Champion, Karen Goudie and Vicky Webb were not in attendance.

2. Declarations of Interest

There were no declarations of interest.

3. Minute of Strategic Planning, Performance & Resources Committee on 28 October 2025

A committee member requested that Item 7, discussion point ii, be amended to indicate that assurance was given after a question was raised about the evidence for the forecast net balance shown in Table 7.

The minute of the meeting held on 28 October 2025, subject to previous electronic circulation and committee member approval, was **confirmed** as an accurate record subject to the above amendment.

4. Matters Arising from the Minute / Action Log

The Action Log was reviewed by the Chair and consideration was given to the actions still in progress.

Actions 135, 136, 143, 146, 154, 155, 156, 157, 158, 159, 160, 161, 162 and 163 were marked as complete and would be removed from the Action Log.

The Chair advised committee members that a Short Life Working Group, composed of Governance Committee Chairs, had been established to review the operations of the Board and its Governance Committees with the intention of holding a Board seminar on Governance on 21 April 2026.

The Strategic Planning, Performance & Resources Committee approved the Action Log.

5. Chief Executive Update

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

(i) **GP Walk-in Centres**: The Scottish Government had requested that territorial Health Boards submit GP Walk-in Centre business cases by 12 December 2025, with the aim to have services operational by April 2026. Professor McGuffie outlined the proposed model for the NHS Forth Valley Board submission and the rationale for the potential location. The Forth Valley business case proposed a triage at the front door model to create a different pathway for patients. The location proposed for the service was selected having considered the areas of highest out of hours service demand and greatest deprivation. If the pilot was successful, it was hoped there could be more sites across the geography of Forth Valley. Members raised a number of points including expected outcomes; the clinical governance arrangements; positive out of hours feedback from Sir Lewis Ritchie, and whether there would be Scottish Government evaluation across all sites. Following discussion, it was agreed that as part of the process, the Chief Executive would raise the issue of ensuring there is a national evaluation in order to obtain learning across this initiative.

(ii) **Over 104 Week Waits**: Professor McGuffie outlined the national imperative to clear waits for all patients across Scotland of over 104 weeks by March 2026, using a collaborative national approach with Health Boards providing mutual aid. The Chief Executive outlined the potential implications for NHS Forth Valley to support Waiting Times in other Health Board area and provided an update on the mutual aid already being provided by NHS Forth Valley. Members raised a number of points including: the capacity of the team to provide the operational support around mutual aid requests; how performance

would be included in Forth Valley's figures; how wasted capacity was measured and practice in improvements is shared; assurance on specific clinical governance arrangements for mutual aid patients and the need to ensure that there was coordination across mutual aid requests and that Value Based Health Care principles are maintained.

(iii) **Scotland West Sub-national Committee**: The East and West sub-national committees had been established with a national oversight group to be established. Each sub-national delivery group would be led by the Board Chief Executive for NHS Lothian in the East and the Chief Executive for NHS Greater Glasgow and Clyde in the West. As outlined in the DL issues to Boards, the work would focus on Elective Orthopaedic Plans, Finance Plans, Business Systems, Urgent & Unscheduled Care Plans and Digital Front Door Plans. Members raised a number of points including: the role of clinical engagement; the involvement of Chief Officers in the Committees; concerns around the capacity of Executives, and that Authority, Responsibility and Accountability should be themes in the Committees. Members agreed that cooperation and collaboration should provide additionality and opportunities. Mr Clark, Employee Director, noted that Trade Union involvement was being discussed nationally.

(iv) **Supreme Court Ruling:** An update on the action being taken to comply with the supreme court ruling on the definition of sex was provided with assurance that the approach was aligned with that of other Boards.

(v) **Synnovis Cyber Attack**: An update was provided on this issue and the implications for the NHS in Scotland and NHS Forth Valley. There would be a further update provided to the meeting on 31 March 2026. It was agreed that a risk assessment would be undertaken to consider if escalation to the Forth Valley NHS Board was required.

(vi) **Mental Health Inspection**: An update was provided on the publication timelines for The Health Improvement Scotland inspection of Mental Health Services. Assurance was provided that action was being taken where findings had been raised. It is intended that the published report would be considered at the 24 February 2026 meeting of the Forth Valley NHS Board.

The Strategic Planning, Performance & Resources Committee noted the verbal update.

Action:

(1) The Chief Executive to raise the issue of having a national evaluation process across the proposal for Walk in Centres. Ross McGuffie

6. Finance

(a) Finance Report

The Strategic Planning, Performance & Resources Committee received the Finance Report presented by Scott Urquhart, which provided an updated overview on the 2025/26 financial position and 3-year Financial Plan from 2026/27.

Key messages in the report included:

(i) The projected year-end deficit of £5m against a £970m budget remained unchanged, with emerging risks and offsetting opportunities identified, focusing on financial recovery with the aim to achieve a break-even position by year end.

(ii) Emphasis was placed on the focus on the Financial Recovery Plan and the requirement to contain spend over the remaining months of the financial year.

(iii) Scottish Government had published new guidance for the 3-year Financial Plan, which sought a draft plan by February 2026. An overview of

requirements, key dates and priorities were provided where it was noted that key themes would be explored at the 10 February 2026 Forth Valley NHS Board Seminar, and a further update would be presented at the 31 March 2026 committee meeting.

The following points were made in discussion:

(i) A query was raised on the potential financial implications associated with the introduction of the NHS Sub-National arrangements, where concern was noted on the impact of financially challenged boards. Committee members were advised that there would be an expectation to support the most challenged Boards however details were to be clarified.

(ii) Confirmation was provided on the timescale of the Financial and Workforce Stewardship Toolkit where a draft was expected in January 2026, aligned with the Value-Based Health & Care Collaborative.

(iii) A committee member queried the use of mutual aid as an opportunity to generate additional funds for NHS Forth Valley, where it was advised that the principle expected from the Scottish Government was to recover additional costs as opposed to generating profits un the spirit of cooperation and collaboration.

(iv) Committee members queried the Integration Joint Board (IJB) risk share and overspend. Clarity was provided on current provisions, the risk share arrangement, and uncertainty regarding the final overspend figure which was being monitored. Committee members were assured that close collaboration with IJB Chief Finance Officers was being undertaken to integrate planning and risk-share arrangements.

(v) Points were raised over the timing of the submission of the draft Financial Plan to the Scottish Government prior to Board review. Assurance was provided that consideration would be given at the Board seminar in February and the Chair intimated that another opportunity would be sought to enable consideration of the Financial Plan before formal sign off.

(vi) A committee member queried financial exposure from safe staffing legislation where assurance was provided that assessment was ongoing with funding assumptions being tested where further clarity was anticipated by the year-end.

The Strategic Planning, Performance & Resources Committee:

(1) noted that the year-end projected deficit remained at c£5m, and a further in-depth review would be carried out to reassess the forecast following receipt of the December financial results.

(2) noted the potential risks to the forecast linked to winter capacity, Resident Doctor rota compliance and IJB risk sharing arrangements.

(3) noted that the financial planning process was underway for the 3-year period 2026/27 to 2028/29 and that a Board Seminar on Finance was scheduled for 10 February 2026.

(4) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

(1) Consider building in an opportunity for further discussion of the Plan between the Board Seminar and Final Plan Submission. Jack Frawley/ Scott Urquhart

(b) Financial Sustainability Oversight

The Strategic Planning, Performance & Resources Committee received the Financial Sustainability Report presented by Scott Urquhart, providing an overview of the refreshed Financial Sustainability Action Plan for 2025/26 and the work of the Financial Stewardship Group.

Key messages in the report included:

(i) Detail on savings delivery, projections and risk ratings against each area in addition to progress in achieving actions.

The following points were made in discussion:

(i) The cost of absence was noted at over £6m, assurance was provided that a deep dive into staff absence would be presented at the 20 January 2026 Staff Governance Committee. A variety of measures were being developed to address absence such as a focus on nursing leadership, enhanced occupation support for stress and anxiety, and Human Resource support for attendance management.

(ii) A committee member suggested a benefits assessment within 2026/27 may be helpful to identify savings that were not being delivered, despite activities being noted as complete.

The Strategic Planning, Performance & Resources Committee:

(1) noted the contents of the report.

(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

(1) Undertake a financial sustainability benefits assessment in 2026/27. Scott Urquhart

(c) Financial Sustainability Strategic Risk Review

The Strategic Planning, Performance & Resources Committee received the Financial Sustainability Strategic Risk Review report presented by Scott Urquhart, providing an assurance assessment on SRR005: Financial Sustainability.

Key messages in the report included:

(i) Financial sustainability remained one of the highest corporate risks, with significant ongoing financial and operational pressures expected to persist. The risk was separated into External Financial Environment with limited assurance, and Internal Controls where moderate assurance was provided.

(ii) There was no change to the risk score, remaining ‘very high’ due to ongoing uncertainties and the scale of the challenge, despite previous experience of achieving financial balance.

The following points were made in discussion:

(i) Committee members sought further review and refinement of the financial sustainability risk and controls, aligned to the financial plan development. It was proposed that such activity could be undertaken by the short life working group on Risk as an extension to its remit.

(ii) A focus on supply-side measures in reference to risk controls was noted, where it was suggested that an emphasis on demand management, aligned to the Value Based Health Care Strategy and prevention work should be considered.

The Strategic Planning, Performance & Resources Committee:

(1) endorsed the evaluation of assurance provided for SRR005: Financial Sustainability.
(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:
(1) Consider how the short life working group on Risk could review the Financial Sustainability risk definition, controls and impact. Scott Urquhart

7. Robotic Business Case

The Strategic Planning, Performance & Resources Committee received the Robotic Business Case report presented by Mr Andrew Murray which provided an overview of the proposed procurement of a Da Vinci XI dual console robotic system. Mr Murray emphasised that he was keen to give Members early sight of the proposed Business Case so that comments and views could be taken into consideration for bringing the Business Case to the Board when appropriate for formal approval. Funding from Scottish Government was being sought to take this forward.

Key messages in the report included:
(i) Evidence of improved clinical outcomes suggested that procurement of the robotic system would result in improved functional outcomes, minimal blood loss, reduced length of stay, decreased post-operative pain and quicker return to normal activities.
(ii) The business case sought capital funding from the Scottish Government, with recurring costs expected to be covered by reallocating existing resources used for surgical procedures and consumables.
(iii) Consultant access to the robot would be limited to ensure sufficient experience and maintain improved outcomes.
(iv) NHS Forth Valley is an outlier in relation to having this facility and the benefits would support patients and the recruitment and retention of staff.

The following points were made in discussion:
(i) Committee members expressed support of the proposal in principle, recognising the clinical benefits to patients and staff. Further clarity was sought on the cost of decontamination, any risks to the Board; whether Robotics formed part of a national or regional strategy; more information on running costs and a clear link to NHS Forth Valley's strategic priorities. Mr Murray agreed that the comments would be helpful in finalising the Business Case and that any additional comments should be sent by email for.

The Strategic Planning, Performance & Resources Committee:
(1) supported the options and associated cost to proceed with the purchase of a Robotic System in principle, recognising that Board approval was required and the Business Case would be updated to address the discussion.
(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:
(1) Members to provide any additional feedback on the Business Case to Jack Frawley. All

8. National Treatment Centre Update

The Strategic Planning, Performance & Resources Committee received the National Treatment Centre (NTC) Update report presented by Mr Scott Urquhart which provided an update on the NTC facility.

Key messages in the report included:

(i) Delays continued in relation to outstanding fire safety compliance issues. Information submitted by NHS Forth Valley had been re-assessed by Building Control in November 2025. A letter was subsequently issued from the Building Standards Surveyor to Portakabin, outlining further items to be addressed before approval could be granted.

The following points were made in discussion:

(i) Following discussion on reputational and operational risks for the organisation associated with delays, Committee members were advised of the different solutions. Officers would continue to advance the current option until a final determination on this approach was made. Members expressed their concern on the delay in reaching a solution and sought assurance that all actions within the Board's gift were being taken to expedite a solution and that Scottish Government were fully apprised of the situation.

(ii) It was advised that the NTC had been designed to facilitate 28 beds however interim arrangements provided 8 to 14 beds for NTC activity, Members considered the suitability of such arrangements if delays persisted. Reassurance was provided that the Scottish Government classified the NTC as 'partially open'.

(iii) In reference to the paediatric Ear, Nose & Throat mutual aid that would be provided to support NHS Greater Glasgow & Clyde, it was highlighted that specialist paediatric nurses would be required to meet paediatric requirements.

(iv) It was agreed that further consideration of the risk and potential escalation from an operational to a strategic risk would be undertaken by the Senior Leadership Team given the concerns and discussion by Members.

The Strategic Planning Performance & Resources Committee:

(1) noted the status of the National Treatment Centre programme.

(2) noted that the timeline for ward completion and associated Key Stage Assurance Review processes is not confirmed and will require resolution of outstanding compliance issues as advised by NHS Scotland Assure.

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks as far as the role of the Board was concerned, to support the delivery of objectives and where improvements were needed, clear actions had been identified However, concerns were expressed by Members that complete assurance on the timelines and progress to resolution were not available.

Action:

(1) Consider potential escalation of the NTC risk at the Senior Leadership Team to the Strategic Risk Register. Ross McGuffie

9. Capital & Infrastructure Projects, Property Transactions, Medical Equipment & eHealth Update

The Strategic Planning, Performance & Resources Committee considered a report presented by Mrs Morag Farquhar, which provided an update in relation to the

2025/26 Capital Plan and the various strands therein, including property transactions and the timing of capital receipts.

Key messages in report included:

(i) Slippage was identified within the Decontamination Unit in the Capital Business Continuity Plan. However, assurance was provided that mitigating actions were being explored in relation to adjustments to the design and installs process, and regular meetings with the Scottish Government were ongoing to manage business continuity and confirmed slippage. The tender process for the decontamination unit extension had been delayed to February where cost estimates were higher than anticipated.

(ii) An interim submission of the Capital Business Continuity Plan had been provided to the Scottish Government in November 2025, where confirmation of funding was awaited. Committee members were advised that the only changes made to the Plan from previous submissions, was an increase in the funding requirement for Anti Ligature work from £1m to £1.5m. In addition, to the cost of £300k to address the current risk associated with staff electronic lockers due to key parts requiring replacement was included.

(iii) An update was provided on a community asset transfer request.

(iv) Committee members were advised that the medical physics and digital infrastructure was on track with capital spending, however, national projects were delayed, with the Order Communications systems being the most challenging due to its complexity and impact on diagnostics.

The following points were made in discussion:

(i) Following a query on obtaining assurance on system changes around digital and a digital maturity assessment, it was advised that clinical engagement and continuity planning were central to implementation, with digital being a key theme in the Workforce Plan.

(ii) A committee member sought a strategic overview of the transition from manual to digital record keeping, including local and national context to ensure system alignment. It was noted that such changes would require a national Once for Scotland initiative, however, an update would be brought to a future meeting.

(iii) A question was raised on the implications of delays in ultrasound and fluoroscopy equipment replacement, where it was noted that an update would be provided at a future meeting following liaison with the Head of Medical Physics.

The Strategic Planning, Performance & Resources Committee:

(1) noted the various project, procurement and property transaction updates as presented in the paper.

(2) noted the continued submissions under the auspices of the Business Continuity Plan process.

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

(1) Provide detail on the implications of delays in replacement ultrasound and fluoroscopy equipment. Scott Jaffray

(2) Provide an update on the strategy to transition from manual to digital record keeping at a future meeting. Scott Jaffray

10. Performance

(a) Shifting the Balance of Care - Evaluation

The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Gail Woodcock and Ms Caroline Doherty which provided an overview of the Shifting Balance of Care (SBoC) test of change model which aimed to shift assessment and care planning from hospital to community settings, enabling timely discharge and improving patient outcomes.

Key messages in the report included:

(i) The SBoC model was supported by a non-recurring £2.021m resource transfer with the target of discharging 32 additional patients and reprovisioning a 32-bed acute ward.

(ii) Evaluation of the first 3 months of the project evidenced the below positive patient impacts:
- Delayed discharges reduced from 80 to 63.
- The average hospital stay reduced from 79 days to 36 days.
- Patient experience highlighted high satisfaction.
- There was no significant increase in readmissions.
- Ward A11 was successfully reprovisioned and acute occupancy temporarily declined.

(iii) System level benefits were noted with improved resource utilisation, reduced acute occupancy and enhanced patient flow with effective team collaboration.

(iv) Challenges were noted with information systems, work and capacity issues, and operational and planning gaps.

(v) The development of a 24-hour discharge to assess model and opportunities to embed the SBoC approach into frailty pathway for earlier intervention and integrated care support would be explored.

A short video was shared featuring a patient who had benefited from the model, reinforcing the positive impact on patient experience.

The following points were made in discussion:

(i) Committee members were advised of the significant work undertaken regarding the Criteria to Reside which would regularly assess if patients should be cared for with the Acute site. This was in addition to the new ways of working introduced such as Discharge to Assess, reducing contingency beds usage and driving flow within the system.

(ii) Members asked about how these successes were being communicated more widely and whether further evaluation could be directly linked to impact on the 4hr front door target.

(iii) Colleagues were congratulated for their work, and it was noted that this was an excellent example of whole system collaboration and integration.

The Strategic Planning, Performance & Resources Committee:

(1) noted the data and progress made.

(2) noted the largely positive impact for patients and their carers supported through Shifting Balance of Care.

(3) noted the evaluation report.

(4) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(b) Performance Report

The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Kerry Mackenzie which provided an update on performance against national and local measures with information to support effective monitoring and management of system-wide performance. Ms MacKenzie noted that the report required review going forward and she would welcome any thoughts on this from Members.

Key messages in the report included:

(i) Areas of good performance were acknowledged within Planned Care following discussion on the Shifting the Balance of Care model.

(ii) Committee members were advised that it was the first report that incorporated both Falkirk and Clackmannanshire & Stirling Health & Social Care Partnership Performance Reviews. Work was ongoing to standardise the performance review agenda, and to provide the committee with assurance on discussions undertaken.

(iii) A review of the Performance Report was proposed for 2026 in order to realign focus and data reviewed within future reports. It was agreed that a discussion would be undertaken, and committee members would be asked for comment at a later date.

The following points were made in discussion:

(i) Members reiterated the need to measure urgent and unscheduled care performance against the agreed Rapid Improvement Plan.

(ii) A question was raised on the impact of Planned Care initiatives, such as the reprovisioning of Ward A11, on Urgent & Unscheduled Care. It was advised that despite there being no improvements evidenced within the 4-hour target, performance had been maintained within the Emergency Department despite pressures associated with significant flu cases.

(iii) A member raised whether it was feasible to have a Value Based Health & Care related additional measure control across the population in relation to Hospital Standardised Mortality Rates as the strategic approach focused on Shifting the Balance of Care and Population Health. It was agreed that consideration of Population Health would be incorporated in the review of the performance reports and therefore would be addressed outwith the meeting.

(iv) Concern was raised over the long wait within the Paediatric Neurodevelopmental service, where it was queried when a whole system response would be provided to the Committee. Committee members were advised that NHS Forth Valley had a lower length of waits in comparison to other Scottish Health Boards. However, it was noted that further work was required to address waits. Assurance was provided that work was ongoing to explore a test of change similar to the Paediatric Speech & Language Service which would focus on early identification of children and provide support within schools, shifting emphasis from diagnosis.

The Strategic Planning, Performance & Resources Committee:

(1) considered the latest performance data within the Performance Report noting the Area of Focus – Urgent & Unscheduled Care, and Priority Areas of Performance.

(2) considered the progress made in respect of the number of patients waiting over 52 weeks for a new inpatient appointment and for an inpatient/daycase procedure.

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Actions:

(1) Consider how best to undertake the review of the Performance Report. Kerry Mackenzie

(2) Consider whether it would be feasible to have a population health control measure in relation to hospital standardised mortality rates. Jennifer Champion / Ross McGuffie

(3) Provide a paper outlining the test of change model for the Paediatric Neurodevelopmental Service at a future meeting.

11. Draft Anti-Racism Plan

The Strategic Planning, Performance & Resources Committee received the 'Draft Anti-Racism Plan' paper presented by Mr Kevin Reith which provided an overview of the latest iteration of the Draft Anti-Racism Plan which would go to the January Board for approval.

Key messages in the paper included:

(i) Extensive engagement had been undertaken to draft the plan in response to Scottish Government requirements, and the Plan would be reviewed by the Ethnic Diversity Network prior to final submission to the Forth Valley NHS Board.

(ii) It was agreed that further comments would be provided outwith the meeting to be incorporated into the Plan prior to submission to the Board in January, acknowledging that Members had already had the opportunity to provide input through previous discussions and the Staff Governance Committee.

The following points were made in discussion:

(i) A query was raised on the reference to consequences of non-compliance from staff members, where it was agreed that work would be undertaken to consider the wording used within the document to further strengthen the message.

(ii) A committee member sought clarity on whether a guidance document for staff would be developed, with assurance provided that such work would be included within the active bystander work, once the final plan was approved.

The Strategic Planning, Performance & Resources Committee:

(1) noted the Anti-Racism Plan, Equality Impact Assessment and Communications Plan would be presented at the 27 January Forth Valley NHS Board.

(2) noted the proposed content and considered gaps or areas where additional information was required.

(3) noted the content of the draft plan and considered whether it aligned effectively with the Scottish Government ask (appendix 2) and the wider strategic aims and vision as an organisation.

(4) provided feedback to shape the next iteration of the Plan, being mindful that builds from APF, Staff Governance and stakeholder engagement are already being worked on.

(5) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Actions:

(1) Members to provide additional comments to Jack Frawley. All

(2) Consider strengthening wording used within the Anti-Racism Plan to evidence the requirement for staff compliance. Kevin Reith

12. Strategic Risk Register Update

The Strategic Planning, Performance & Resources Committee received the 'Strategic Risk Register Update' report presented by Mr Sam McCartney which provided an update to the Strategic Risk Register as of December 2025, with a focus on the risks aligned to the Committee.

Key messages in the paper included:

(i) The work undertaken by the short life working group to review the risk appetite levels, with significant progress made was noted. Assurance was provided that the document outlining the new risks appetite and levels would be presented to the committee at the 31 March 2026 meeting.

The Strategic Planning, Performance & Resources Committee:

(1) endorsed the risks aligned to the Committee for the period of October to December 2025 for onward reporting to the Forth Valley NHS Board.

(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

13. Internal Audit

(a) Internal Audit Actions Follow Up

The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Kerry Mackenzie, which highlighted the status of Internal Audit follow up actions aligned to the Committee for oversight.

Key messages in the paper included:

(i) At the time of reporting, there were 7 actions aligned to the Committee of which:
- All actions were due for completion throughout 2025/26 and were on track, with monitoring through the Committee and Audit & Risk Committee.
- Actions A13/23 and A25/23 were given revised due dates.

(ii) The additional findings identified following the review of the Internal Audit Annual Report 2024/25 by the Chair, Board Secretary and Acting Director of Strategic Planning & Performance were included in Pentana for monitoring. An action related to Financial Governance was closed on initial reporting to the Committee, and a Corporate Governance action was noted within the Audit Summary Report.

The Strategic Planning, Performance & Resources Committee:

(1) noted the status of the current audit follow up actions aligned to the Committee.

(2) noted the additional finding and associated action aligned to the Committee following a review of the Internal Audit Annual Report, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(b) Property Transaction Monitoring Internal Audit

The Strategic Planning, Performance & Resources Committee considered a report presented by Mr Scott Urquhart, which provided the outcome of the internal audit of the property transactions concluded in 2024/25.

Key messages in the paper included:

(i) Post-transaction monitoring was an integral part of the internal audit programme. To meet this requirement a sample of completed property transactions were measured by Internal Audit with transactions being categorised as one of:
A - Transaction has been properly conducted
B - There are reservations on how the transaction was conducted, or
C - A serious error of judgment has occurred in the handling of the transaction.

(ii) The audit opinion for each transaction reviewed was:
Purchase of Killin Medical Practice - A
Sale of Carronshore Dental Clinic - A
Lease of Carseview House – B.

The following points were made in discussion:

(i) Members noted the audit opinion for the Lease of Carseview House and requested assurance that any learning would be incorporated into future transactions. Professor McGuffie acknowledged that this had been considered by the Senior Leadership Team to avoid any potential issues in the future.

The Strategic Planning, Performance & Resources Committee:

(1) noted the Post Transaction Monitoring report, presented to the Audit & Risk Committee at its meeting of 31 October and submitted to the Scottish Government.

(2) noted the assessment of risk around the approval to enter into the Carseview lease, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

14. Freedom of Information Update

The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Sarah Hughes-Jones, which outlined NHS Forth Valley's progress against the Commissioner's targets and the Improvement Plan.

Key messages in the paper included:

(i) At the time reporting, FOI compliance was trending at appropriate levels with the backlog noted as complete and the Scottish Information Commissioner was satisfied.

(ii) 86% compliance was highlighted with 93% noted within reach by the end of the month. Assurance was provided that enforcement action was unlikely however sustained levels would be required within the monitoring period.

The following points were made in discussion:

(i) A query was raised on the Freedom of Information Manager vacancy and potential implications to compliance. Reassurance was provided that the recruitment process was underway, with action and timescales to address the gap within resource.

(ii) Members discussed the need for a lessons learned document, where assurance was provided that an action to provide a joint learning document about addressing FOIs and SAERs had been discussed and incorporated within the Forth Valley NHS Board action log. It was agreed that a lesson learned paper would be considered by the Senior Leadership Team and provided to the Committee.

The Strategic Planning, Performance & Resources Committee:

(1) noted the current position and progress against the Scottish Information Commissioner's targets, and

(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

(1) Confirm the development of a lessons learned document at the Senior Leadership Team for sharing with the Committee. Ross McGuffie

15. Strategic Planning, Performance & Resources Committee Planner

The Strategic Planning, Performance & Resources Committee received the 'Strategic Planning, Performance & Resources Committee Planner'.

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

16. Emergency Planning & Resilience Group Minute

The Strategic Planning, Performance & Resources Committee received the 'Emergency Planning & Resilience Group Minute'.

The Strategic Planning, Performance & Resources Committee noted the Emergency Planning & Resilience Group Minute.

17. Any Other Competent Business

There was no other competent business.

18. Risks, Reflections & Areas to Highlight to the NHS Forth Valley Board

There were no further comments provided other than that raised under Item 8 of the agenda National Treatment Centre

Consider potential escalation of the NTC risk at the Senior Leadership Team to the Strategic Risk Register.

19. Date and Time of Next Meeting

Tuesday 31 March 2026 at 9:30am, in the Boardroom, Carseview House.
The Chair closed the meeting at 1:15pm.

Item 7.5

Minute of the **Area Clinical Forum** meeting held on 13 November 2025 at 6.15 pm via MS Teams.

Present: Kirstin Cassells (Chair), Elizabeth Kilgour, Fiona Struthers, Gillian Lennox, Lucie Risk, Marissa Parker, Oliver Harding, Rhona King

In attendance: Neena Mahal (Board Chair), Ross McGuffie (Chief Executive)

---

1. Apologies for Absence/Confirmation of Quorum

The Chair welcomed everyone to the meeting, noting no apologies for absence. Introductions were made and the Chief Executive, Ross McGuffie and NHS Board Chair, Neena Mahal, were welcomed.

2. Declaration(s) of Interest(s)

No declarations of interest were made by any members.

3. Draft minute of Area Clinical Forum meeting held 25 September 2025

The note of the meeting was approved as an accurate record.

4. Action Log

1. **Reimbursement for Professional Committees**: Benchmarking data was being collected from other Boards; awaiting response from finance.
2. **Workforce Development**: Sarah to provide update at a future meeting; still pending.
3. **Board Sustainability Group**: Fiona would follow up with
4. **Professional Assurance Framework**: Circulated, no concerns raised. Admin to advise Andrew Murray the ACF were content with document. **Admin**
5. **Finance/Annual Delivery Plan**: Finance colleagues to be invited to January meeting for discussion.
6. **Programme Board Structure**: This was now available on the Intranet. Oliver provided instructions for access and would share the web address.
7. **Annual Review Topics Pre-Meeting:** Complete.

5. Matters Arising

There were no matters arising.

6. FOR DISCUSSION

6.1 Non-Ministerial Annual Review ACF Session (taken first on the Agenda)

6.1.1 Update on Area Medical Committee

The Chair opened the meeting, inviting Oliver Harding to provide an update around the Area Medical Committee, noting the challenges in engagement. Oliver highlighted the successful

GP Sub Committee which met regularly and was well attended. It was therefore being proposed that a Hospital Doctors Sub-Group be established. This was supported by Kirstin as the ACF Chair, along with Neena Mahal and Ross McGuffie. Terms of Reference would be drafted and consultation undertaken with all Secondary Care Doctors. Ross McGuffie offered his assistance in co-ordinating governance with Jack Frawley.

Action: Oliver Harding

The discussion then focused on the requirement for Chairs to update their Terms of Reference for to align with the new Board template. A progress check would be scheduled for January and March with submission to the Board Secretary, Jack Frawley, required by April 2026. Rhona King confirmed submission of the AOC Terms of Reference with a response awaited. Neena Mahal confirmed she would follow up and advise of any further requirements.

6.1.2 ACF as a formal consultation body

The ACF also highlighted the need for their continued involvement in policy and strategy consultations. The importance of including the Area Clinical Forum and its advisory groups in policy and strategy consultations was agreed, highlighting recent improvements and plans to further embed this engagement within Board processes. Note

6.1.3 Spotlight in Leadership Sessions

Marissa Barker provided an overview of leadership development sessions for Nursing and Allied Health staff, detailing the structure, focus areas, and collaborative efforts with other groups, with the positive reception and expansion of these initiatives**.**

Leadership development within the Nursing and Midwifery teams were noted, with an outlining of the expansion of leadership sessions to include all staff bands. Establishment of peer networks was proposed and there had been a positive reception of breakout sessions focused on practical skills such as breaking bad news and handling difficult conversations. Marissa also described the successful rollout of emotional intelligence training, which had been widely adopted, particularly among Allied health professionals. The strategic alignment of these initiatives was emphasized with organizational goals and quality improvement and noted collaboration with other Boards to share best practices.

6.1.4 Sharing good practice and successes

Psychology Advisory Committee - Lucie Risk provided an update around the Psychology Advisory Committee's progress. She highlighted improved cohesion between child and adult psychological services, with clearer team structures and referral criteria to support smooth transitions for service users. Broader representation was noted across specialisms, resulting in more balanced and effective consultation within the Board. The successful launch of Silver Cloud was also outlined, noting this was a computerized CBT program for adults, young people, and parents.

Healthcare Science - Elizabeth Kilgour provided an overview of the challenges and developments within healthcare science, noting most Boards in Scotland lacked a dedicated director-level post for healthcare science, relying instead on voluntary leadership, which limited strategic influence and operational capacity. Reference was made to recent Scottish Government papers which recommended the establishment of director-level posts for healthcare science in every Board. It was anticipated there would be discussions among CEO's around implementation.

The need for improved workforce recognition and governance was also highlighted, particularly in areas such as clinical physiology and audiology, citing ongoing efforts to align accreditation and quality standards. Liz also emphasized the importance of including healthcare scientists in service planning and pathway development, noting that diagnostics were often overlooked in strategic decisions.

Areas of positive local initiatives were also highlighted, such as audiology-led patient pathways and point-of-care service improvements. Resource constraints and additional investment need was acknowledged.

Both Ross McGuffie and Neena Mahal were supportive, recognising the challenges and affirming the value of healthcare science contributions. Liz was encouraged to continue advocating for the profession and offered direct engagement to address specific needs or areas requiring attention.

AHP Clinical Advisory Group - Fiona Struthers provided an update on behalf of the AHPs, which currently represented six professions and was seeking to expand its membership to include orthoptists and radiographers. The groups commitment to supporting organizational strategies and developments was highlighted, encouraging colleagues to engage with them for advice and input. The successful completion of a comprehensive Dietetic Review was outlined, which involved all dietetic teams across the region and resulted in reduced waiting times, improved staff collaboration, and the integration of quality improvement processes. Additionally, it was noted the Children's Speech and Language Therapy Team had received awards for innovation and tackling health inequalities through embedding therapists in nurseries and schools. This had improved access and collaboration with education and families. The ACF were advised of the significant positive impact of these initiatives on patient care and staff morale.

Dentistry - Gillian Lennox delivered an update regarding ongoing recruitment challenges within dentistry, noting that these difficulties were shared across the sector. Forth Valley would hold its first Dental Recruitment Fair, scheduled to take place in January 2026, with the aim of attracting first-year graduate trainees (VDPs) and promoting the region as an appealing place to work. The event would be held on Health Board premises and would offer verifiable CPD to encourage participation from general practitioners. Gillian expressed optimism that, if successful, the initiative could be expanded to recruit other members of the dental team. She also welcomed suggestions for further engagement, such as participating in local careers fairs, to increase recruitment and awareness of opportunities within Forth Valley dentistry.

Area Optical Committee - Rhona King provided an update on the Area Optical Committee, highlighting several ongoing initiatives. She reported an increase in independent prescribing optometrists, with new supplementary fees introduced for managing specific eye conditions in the community, thereby reducing referrals to hospital services. Forthcoming changes were noted that would allow non-prescribing optometrists to refer patients to prescribing colleagues, improving access and convenience for patients, particularly in remote areas. The development of community-based management for low-risk glaucoma patients was also detailed, noting plans to discharge suitable cases from hospital care to qualified optometrists. Additionally, there was discussion around efforts to streamline cataract services by enabling direct referrals for surgery, minimizing unnecessary clinic appointments and reducing waiting times. These initiatives aimed to enhance patient experience and alleviate pressure on hospital ophthalmology services.

Area Pharmaceutical Committee - Kirstin Cassells provided a comprehensive update outlining several significant developments. The Committee had actively engaged with presentations on both the Population Health and Care Strategy and the Mental Health and

Wellbeing Plan. These sessions facilitated discussions regarding the role of pharmacy in trauma-informed care and the support of patients with substance use issues. As a result, targeted training in these areas was planned for the upcoming year.

The Committee also reviewed the Sunday Pilot for community pharmacies, which received positive feedback. There was strong support for extending this pilot to a nine-week period, with the objective of alleviating pressure on out-of-hours and emergency department services. There were forthcoming plans to undertake evaluation and gather patient feedback.

Capturing of comprehensive pharmacy activity data was recognised as an ongoing challenge, particularly for services such as Pharmacy First Plus. Efforts were underway to collect baseline data to more accurately measure the impact of these services and to identify potential missed opportunities for preventive care.

Advisory Group Reporting – The Forum discussed introducing flash reports to provide concise summaries from each advisory group, highlighting both notable achievements and items requiring escalation. It was proposed that these individual reports would feed into an overarching ACF report, ensuring that good work and key issues were clearly communicated to senior leadership. The approach was supported by all present, including both Ross McGuffie and Neena Mahal.

The AHP Clinical Advisory Group volunteered to pilot the template, and the Forum would further refine and integrate the format into future meetings.

7. FOR NOTING

This item was covered during the Annual Review discussion.

7.1 Allied Health Professionals 4 June 2025
7.2 Area Pharmaceutical Committee 6 August 2025
7.3 Area Optical Committee 25 August 2025
7.4 Area Optical Committee 12 May 2025
7.5 Allied Health Professionals Flash Report
7.6 Psychology Advisory Committee
7.7 Area Nursing & Midwifery Advisory Committee

8. AOCB

Neena Mahal thanked everyone for their input, highlighted the value of the feedback and discussions and encouraged direct communication with herself and Ross McGuffie. The Forum were asked to consider what support they required from the Board to strengthen the Area Clinical Forum's role. It was agreed this would be discussed at the next meeting.

8.1 Items for escalation to Chair/Chief Executive
This was covered during earlier discussions.

9. Date of Next Meeting:

The Board meeting dates for 2026 had not been finalized. Once these dates are confirmed by Jack, Sarah would distribute the Area Clinical Forum meeting invitations to ensure alignment with the new Board schedule. **Action: Admin**

Colleagues were advised there would be an adjustment to the meeting sequence, with the July meeting being removed to accommodate peak annual leave periods. As a result, there may be consecutive Board meetings in the early part of the year.

There being no other competent business, the Chair closed the meeting at 7.20 pm.

Minute of the **Clackmannanshire & Stirling Integration Joint Board meeting** held on **Wednesday 24 September 2025 in the Boardroom, Carseview House, Stirling and hybrid via MS Teams**

PRESENT

Voting Members
Councillor David Wilson **(Chair),** Stirling Council
Councillor Martin Earl, Stirling Council
Councillor Fiona Law, Clackmannanshire Council
Councillor Janine Rennie, Clackmannanshire Council
Councillor Denis Coyne, Clackmannanshire Council
Allan Rennie (**Vice Chair),** Non-Executive Board Member, NHS Forth Valley
John Stuart, Non-Executive Board Member, NHS Forth Valley
Gordon Johnston, Non-Executive Board Members, NHS Forth Valley
Stephen McAllister, Non-Executive Board Members, NHS Forth Valley

Non-Voting Members
Joanna Macdonald, Interim Chief Officer
Ewan Murray, Chief Finance Officer, IJB and HSCP
Natalie Masterson, Third Sector Representative, Stirling
Helen McGuire, Service User Representative, Clackmannanshire
Andy Witty, Carer Representative, Clackmannanshire
Moira Carmichael, Carer Representative, Stirling
Jennifer Rezendes, Chief Social Work Officer, Stirling Council
Robert Clark, Employee Director, NHS Forth Valley
Kevin McIntyre, Union Representative, Clackmannanshire
Abigail Robertson, Union Representative, Stirling
Anthea Coulter, Third Sector Representative, Clackmannanshire
Dr Kathleen Brennan, GP Clinical Lead, HSCP
Lorraine Robertson, Chief Nurse HSCP

Standards Officer
Lesley Fulford, Senior Planning Manager

In Attendance
Wendy Forrest, Head of Strategic Planning and Health Improvement
Ross Cheape, Head of Service, Mental Health & Learning Disability Services
Judy Stein, Interim Head of Community Health and Care
Jack Frawley, NHS Board Secretary
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:

Andrew Murray, Medical Director, NHS Forth Valley
Councillor Martha Benny, Clackmannanshire Council
Mike Evans, Localities Representative
Councillor Rosemary Fraser, Stirling Council
Martin Fairbairn, Non-Executive Board Member, NHS Forth Valley
Sharon Robertson, Chief Social Work Officer, Clackmannanshire Council
Eileen Wallace, Service User Representative, Stirling

2. NOTIFICATION OF SUBSTITUTES

Councillor Denis Coyne for Councillor Martha Benny, Clackmannanshire Council

3. DECLARATIONS OF INTEREST

None

4. DRAFT MINUTE OF MEETING HELD ON 13 AUGUST 2025

The draft minute of the meeting held on 13 August 2025 was approved.

5. ACTION LOG

The action log was approved and updated accordingly.

6. CHIEF OFFICER UPDATE

Ms Macdonald delivered a verbal update to the Integration Joint Board (IJB).

Ms Macdonald shared updates on the recruitment processes for the Chief Finance Officer and Head of Health and Community roles, highlighting recent stakeholder engagement sessions and upcoming interviews. The draft business case for the Integration Joint Board (IJB) has been postponed to the meeting on 26 November 2025 to allow time for full development.

In relation to care provision in rural Stirling, it was reported that one provider has entered insolvency. Alternative arrangements are being put in place, with commissioners and care providers collaborating to support affected individuals in their homes. Additional social work and commissioning staff are reviewing cases, although resourcing challenges were noted.

Ms Macdonald also reported significant progress in reducing delayed hospital discharges and emphasised the importance of the organ donation initiative, which is being actively promoted among NHS and Council staff.

She expressed appreciation to all who attended the joint development session with Falkirk IJB on 16 September 2025, focused on mental health and wellbeing. Further joint sessions are planned for 2026.

Item 12 was withdrawn from the agenda following a request from Stirling Councils legal services. Once the relevant policies have undergone further review, a paper will be presented to the IJB.

Following the BBC documentary aired on Monday 22 September 2025 regarding Castle Hill Care Home in Inverness, Ms Forrest provided an update on the actions taken in response. She emphasised the importance of processes of assurance relating to the quality of local care home delivery standards, confirming that inspection reports have been reviewed, clinical and social work leadership teams briefed, and staffing levels and training verified as appropriate.

Ms Robertson reported on a recent unannounced inspection of the acute mental health unit at Forth Valley Royal Hospital. The feedback received was positive, particularly in relation to care and safety, with minor environmental issues already addressed. A formal inspection report is expected within 10 weeks.

7. REVIEW OF HOUSING ADAPTATIONS

The IJB considered the paper presented by Wendy Forrest, Head of Strategic Planning and Health Improvement.

Ms Forrest presented the findings of the review, emphasising the complexities within both Clackmannanshire and Stirling Councils and the need for tailored approaches to hospital discharge and prevention. She noted that issues with social work recording systems had led to delays in data retrieval and operational inefficiencies but confirmed that new systems are in the process of being procured

The Board discussed the importance of enhancing data systems and standardising processes across both Councils to improve service delivery.
The review incorporated input from the Professional Advisory Group as well as, service users, and carers. Recommendations included the development of improved processes, standard operating procedures, and greater consistency across the HSCP areas.

Concerns were raised about the capacity of Council teams and the need for stronger collaboration with energy advice services and building standards.
After discussion, the Board approved the actions outlined in the delivery plan and requested regular updates, including detailed breakdowns by area and tenure. Ms Forrest acknowledged the need for clearer wording in the action points to ensure they are easily understood.

She also confirmed that significant changes had been proposed, with a key focus on addressing the waiting list. At the Finance, Audit and Performance (FAP) Committee meeting on 17 September 2025, Ms Forrest committed to presenting an updated paper at a future meeting, focusing on managing the demand and need entering the system.

The Integration Joint Board:

1) **Noted the findings of the review and the key recommendations as set out in Appendix 1.**
2) **Agreed the actions to be taken forward in the Adaptations Delivery Plan 2025/26 as set out in Appendix 2.**
3) **Agreed and issued the Direction as set out in Appendix 3 of this report.**

8. FINANCIAL REPORT

The IJB considered the paper presented by Ewan Murray, Chief Finance Officer

Mr Muray provided an update on 2024/25 financial position and overview of the financial projections for 2025/26 based on financial performance to month four.

The Scottish Draft Budget and spending review has been delayed until 15 January 2026. This timing presents challenges for local budget-setting processes. In the interim, work will continue in collaboration with Scottish Government partners to plan based on the best available information.

Following the discussions held during the IJB private session on 20 August 2025, Mr Murray provided an assessment outlining the anticipated impact of the delivery plan for the remainder of the financial year, including his evaluation of associated delivery risks.

At this stage, Mr Murray is unable to provide the IJB with assurance that the budget can be fully recovered. As a result, ongoing consideration of further options is required, including further discussions with the constituent authorities. Additional proposals may be brought back to the IJB for decision with Direction as the situation develops.

The report outlines areas of material variance and provides an update on significant financial risk issues. An additional risk has been identified in relation to the prescribing budget, following Scottish Government's suspension of the proprietary discount scheme for a four-month period within the current financial year. This is expected to have an additional financial impact of approximately £150,000 to £180,000 on the Health and Social Care Partnership (HSCP) budget.

The report also includes three Directions for approval. These relate to:

1. Clarification of the additional £4 million payment made by NHS Forth Valley in 2024/25,
2. A pilot programme for prescribing GLP-1 weight loss medications with associated managed service support, and
3. The proposed use of Earmarked Reserves to help offset the projected overspend on the Integrated Budget.

In response to questions regarding the £4 million payment, Mr Murray clarified that it is the IJB, not the NHS Board, that determines how these resources are allocated and directed. Should a surplus arise, a partial repayment to the NHS may be considered; however, the IJB retains full decision-making authority. The payment was aligned with what could realistically be delivered through the delivery plan when initially presented to the IJB for approval.

Ms Macdonald explained that the purpose of the report is to identify what further action is required in relation to and further to the delivery plan. She highlighted the need for additional savings, particularly in areas where targets have not been met, such as care home placements and learning disability services. These areas are now subject to weekly review by the senior leadership team, supported by strengthened governance and enhanced reporting arrangements.

The Board discussed the impact of ongoing budget pressures, including increased workloads for remaining staff, potential reductions in service quality, and the importance of considering workforce implications when making decisions about service changes. Mr Murray provided an update on the benefits of having three new project managers in place to support delivery of the delivery plan.

Councillor Earl noted that the Annual Accounts were discussed in detail at the FAP Committee, during which Mr Murray committed to providing weekly updates, with a first update having been provided. He emphasised that this remains a matter of concern and is being actively addressed. As the Board has not yet received full assurance, there is a need for a shared understanding and a clear framework for assurance. A special meeting of the FAP Committee is being arranged before the IJB meeting on 26 November 2025.

Mr McAllister emphasised the urgency of presenting a detailed list of options and their consequences to achieve a balanced budget. This includes consideration of potential additional funding contributions. The Board agreed that this information should be provided as a priority, with updated narratives and clear explanations included in future reports.

The Board also stressed the importance of understanding what a balanced budget would look like in practice, along with the implications for future service delivery. It was agreed that this information must be shared with the constituent authorities to ensure they have a full understanding of the potential consequences for services and statutory obligations of the constituent authorities.

During the discussion, Councillor Earl raised concerns about the narrative notes provided in Appendix 5, stating that they lacked sufficient detail. He emphasised the importance of clarity, particularly in cases where actions have not been taken and/or estimated financial benefits are not being delivered, stressing that the narrative should clearly explain the reasons why and outline any additional measures under consideration. Mr Murray explained that some of the measures are more complex than others to measure the impact of and joint working between the project managers and finance officers would seek to address this over time.

He also highlighted that the narrative relating to Menstrie House had not been agreed by the Board. Councillor Earl reiterated that the Board had been clear in its position regarding responsibility for redundancy payments and expressed dissatisfaction that this point had been included in the current narrative without Board approval.

Ms Macdonald acknowledged that the narrative on the tracker remains a work in progress as project monitoring arrangements evolve. She also explained that she would work with the three Chief Executives to clarify the position on redundancy payments and the IJB would be further advised in due course.

Mr Rennie and Councillor Earl requested that a further paper be presented at the IJB meeting on 26 November 2025. This paper should set out the measures being brought forward and include an updated version of Appendix 5, populated with an updated narrative.

The Integration Joint Board:

1) **Noted the background and other updates specifically the timing of the UK Autumn Statement and likely impact on timing of the Scottish Draft Budget and Spending Review (Section 1)**
2) **Noted the revised final 2024/25 Financial Year Outturn, subject to statutory audit (Section 2)**
3) **Considered and discussed the content of the paper.**
4) **Noted the integrated finance report and narrative on areas of material variance. (Section 3)**
5) **Noted the assessment of the impact of the Delivery Plan on the projections which, assuming full delivery, would reduce the projected overspend to £3.961m. (Section 3.6)**
6) **Noted that in order to provide assurance on achieving a balanced budget position additional financial recovery measures and/or funding contributions would be required.**
7) **Approved the Directions appended to this report. (Appendix 4)**

9. ANNUAL PERFORMANCE REPORT 2024/25

The IJB considered the paper presented by Wendy Forrest, Head of Strategic Planning and Health Improvement.

Ms Forrest noted that the commentary in the Annual Performance Report incorporates both last year's commentary and insights from the quarterly performance reports presented throughout the year.

The report detailed the process for the three-year review of the Strategic Commissioning Plan. Board members discussed the inclusion of carer-focused indicators, emphasised the importance of co-production, and considered alignment with other local and national strategies, as well as the notable progress made in reducing delayed discharges.

In addition to the report's recommendations, Ms Forrest highlighted an update from Public Health Scotland regarding the MSG indicators. These reflect the most current data.

Following discussion, the Board agreed that the report should be updated with the latest data from Public Health Scotland and suggested replacing the front cover images to ensure neutrality. Ms Forrest confirmed that Scottish Government does not provide any feedback on the Annual Performance Reports.

The Integration Joint Board:

1) **Reviewed the Annual Performance Report (2024/25).**
2) **Approved Annual Performance Report Executive Summary (Appendix 1) & the full Report (Appendix 2), in line with recommendation from Finance, Audit and Performance Committee.**

10. REVIEWING THE STRATEGIC COMMISSIONING PLAN

The IJB considered the paper presented by Wendy Forrest, Head of Strategic Planning and Health Improvement.

Ms Forrest presented a high-level proposed approach for reviewing the Strategic Commissioning Plan. Work has commenced on drafting indicators aligned with the strategic priorities already set out in the plan. A review working group is to be established, and Ms Forrest has contacted all three chief executives to request representation in the review process. This is to ensure clear alignment with both Councils and the NHS, maximising priority delivery and providing assurance against the Strategic Commissioning Plan over the next ten years. She noted that the plan has already been reviewed in the context of the Annual Performance Report, which reflects the implementation of last year's strategic priorities.

The next step will be to update the Strategic Planning Group on the new approach. Ms Forrest is keen for the IJB to be aware that there is agreement on the proposed direction.

Further work is required with the third sector and local communities to support delivery. This approach has been shaped by feedback received.

Ms Forrest agreed to present the draft plan and consultation questions at the next IJB meeting on 26 November 2025.

The Integration Joint Board:

1) **Considered and approved the process for reviewing the Strategic Commissioning Plan 2023 - 2033.**
2) **Noted that the Strategic Planning Group has in principle agreed the proposed process and has agreed to oversee the review on behalf of the IJB. With the finalised review of the Strategic Commissioning Plan scheduled to be presented to the IJB in March 2026.**

11. MONITORING THE 2025/26 TO 2026/27 DELIVERY PLAN

The IJB considered the paper presented by Wendy Forrest, Head of Strategic Planning and Health Improvement.

Ms Forrest provided an update confirming that the three newly appointed project managers are now using Jira, a project management tool that enables clear tracking of activities aligned to their respective priority areas.

Each project manager is responsible for a dedicated workstream, supported by a detailed plan that includes weekly activity reporting. Finance officers have been assigned to each workstream to support the project managers. Senior Responsible Officers (SROs) oversee the weekly Jira reporting and hold accountability for spend activity. Monitoring arrangements are in place, including weekly meetings between Ms Forrest, the project managers, and finance officers, with structured reporting to the Senior Leadership Team (SLT).

The Board was assured that project management capacity is now in place, with weekly reporting and operational steering groups established. It was agreed that effectiveness will be reviewed every three months.

The Integration Joint Board:

1) **Considered and discussed the content of the paper.**
2) **Noted and drew assurance from arrangements being put in place.**
3) **Noted that the effectiveness of arrangements will be reviewed within 3 months.**

12. LONG TERM CARE AND ORDINARY RESIDENCE POLICIES

Item 12 was removed from the agenda at the request of Stirling Council legal services.

13. COMMISSIONING CHANGE TO THE MODEL OF BED BASED RESPTE IN CLACKMANNANSHIRE AND STIRLING

The IJB considered a paper presented by Judy Stein, Interim Head of Community Health and Care.

Given the heightened media and political sensitivity surrounding the changes, Ms Stein has aimed to keep the Board fully informed about the progress made so far and the timeline for reaching a decision with Direction. A short-life working group has been established to develop options, which will be presented to the SLT for a decision. Alongside this, there will be communications and consultations on the available options for staff, service users, and carers. The process will culminate in a paper, including the decision with Direction, being brought to the IJB meeting on 26 November 2025.

Ms Stein explained that, although formal communications have not yet commenced, initial discussions with staff are planned, to be followed by stakeholder events delivered both in person and via Teams. Carers and other stakeholders will be kept updated at each stage of the process.

Ms Macdonald reiterated to the Board that engaging with staff is a key priority and confirmed that staff are being kept informed directly as developments occur. She also advised that all overnight respite options across Clackmannanshire and Stirling remain under active review.

Mr McIntyre emphasised that, should a decision be required, it is essential that a formal trade union consultation meeting is held prior to the IJB making any decision, ensuring that the outcome of this consultation can be presented as part of the decision-making process. Although the IJB is not the employer, a comprehensive consultation is still necessary. In response, Ms Stein explained that the short life working group is currently considering a range of options, informed by data and financial analysis, and is adopting a joint approach across Clackmannanshire and Stirling. The options have not yet been confirmed or finalised. The Board agreed on the importance of maintaining access to respite and short breaks, and that there must be clarity regarding the nature of the service being provided. Mr McIntyre further stressed the need for all stakeholders to be fully aware of the potential consequences of the proposals, expressing concern that the process might be rushed, leaving insufficient time for a thorough review of the services involved. He emphasised that the process must be conducted properly to allow him to determine whether to support or oppose the proposals, depending on their impact on jobs, and that it is important to understand the longer-term implications.

The Integration Joint Board:

1) **Noted ongoing progress with commissioning change to bed based respite which will lead to a further report to the IJB for decision with directions at the 26 November 2025 IJB meeting.**

14. CLIMATE CHANGE REPORT 2024/25

The IJB considered a paper presented by Lesley Fulford, Senior Planning Manager

Ms Fulford explained that, as a public body, the IJB has a statutory duty to produce a climate change report. However, since the IJB does not have direct responsibility for staff, buildings, or fleet vehicles, the report contained limited detail. Relevant information on these aspects is included in the constituent authority reports, which are published on the Sustainable Scotland Network. The IJB's climate change report will also be made publicly available there.

Ms Forrest noted that both Stirling Council and the Finance Audit and Performance Committee have discussed the impact of disposable vapes on public health and the environment. A working group has been established to address these issues, and a paper on the environmental impact of disposable vapes will be prepared and presented at a future IJB meeting.

The Integration Joint Board:

1) **Noted statutory duty to produce a Climate Change Report under the Climate Change (Scotland) Act 2009.**
2) **Approved the draft Climate Change Report 2024 / 2025 for submission to Sustainable Scotland Network.**

15. MINUTES

a. Finance Audit and Performance Committee - 25.06.2025
b. Special Finance Audit and Performance Committee - 20.08.2025
c. Joint Staff Forum – 22.05.2025

18. ANY OTHER COMPETENT BUSINESS (AOCB)

The Board thanked Mr Murray for his service as Chief Finance Officer and wished him well in his new role.

19. DATE OF NEXT MEETING

26 November 2025

DIRECTION FROM CLACKMANNANSHIRE & STIRLING INTEGRATION JOINT BOARD	
Reference Number	CSIJB-2025_26/005
Does this direction supersede, vary or revoke an existing direction? If yes please provide reference number of existing direction.	No.
Approval Date	26 March 2025
Services/functions covered	Substance Use Services, Primary Care,3rd sector, C&S Strategic Planning Service
Full text of direction	NHS Forth Valley is directed to: • Contribute to the development of new financial accounting frameworks to enable full oversight by ADP and IJB of all funding allocated to Health Boards for onward delegation by the annual SG Funding Letter to ADPs; • Further to above, enable full oversight by ADP and IJB of all delegated spend on alcohol and drugs, including internally or externally commissioned resources, through a revised financial accounting framework; • Continue to support the practical rebalancing of specialist substance use investments in line with ADP recommendations and IJB directions. Clackmannanshire Council, and Stirling Council, are both directed to contribute as requested to the development of these new accounting arrangements in order to demonstrate effective whole system investment in improved outcomes for people at risk of substance use harm.
List of key stakeholders impacted and any specific engagement and consultation requirements	Primary Care, Third Sector, Substance Use Services and ADP partners are all stakeholders, however there are no outstanding engagement or consultation requirements from this paper.
Timescale(s) for Delivery	August 2025
Direction to	Clackmannanshire Council Stirling Council NHS Forth Valley
Link to relevant IJB report(s)	IJB-Meeting-Wednesday-26-March-2025-1.pdf
Budget/finances allocated	N/A
Performance measures	Revised financial arrangements allow for financial and performance reporting in relation to developed model of

	care for substance use.
Date direction will be reviewed	March 2026

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 31 October 2025** at **9.30 a.m.**

Voting Members:	Councillor Stacey Devine (Substitute) Councillor Jim Flynn Alison Jaap Gordon Johnston (Chair) Stephen McAllister
Non –voting Members:	Ian Dickson, Third Sector Representative David Herron, Medical Representative (Primary Care), NHS Forth Valley Marie Keirs, Chief Finance Officer (Items IJB43, IJB44, IJB 46, IJB47 and IJB49) Sara Lacey, Head of Social Work Children's Services/Chief Social Work Officer David McNiven, Service User Representative Victoria McRae, Third Sector Interface Sharon Mwale, Carer Representative Roger Ridley, Staff Representative, Falkirk Council Gail Woodcock, Chief Officer (Item IJB42)
Also Attending:	Tom Cowan, Head of Strategic Planning & Transformation (Item IJB48) Caroline Doherty, Head of Community Services Jack McLay, Democratic Services Graduate Ewan Murray, Business & Governance Lead Gemma Ritchie, Adult Support and Protection Lead Officer (Item IJB45) Carly Toland, Committee Officer Cheryl White, Falkirk HSCP Support Officer Nicola Wood, Chief Nurse

IJB38. Apologies

Apologies were submitted on behalf of Councillor Collie and Councillor Hannah.

Councillor Devine was attending as a substitute for Councillor Collie.

IJB39. Declarations of Interest

There were no declarations of interest.

IJB40. Minute

Decision

The Integration Joint Board approved the minute of the meeting held on 5 September 2025.

IJB41. Action Log

An action log detailing ongoing and closed actions following the previous meeting on 5 September 2025 was provided.

Decision

The Integration Joint Board noted the Action Log.

IJB42. Chief Officer Report

The Board considered a report by the Chief Officer highlighting current developments locally, regionally, and nationally which were likely to be of interest to Board members.

The Board extended its thanks to the staff of Grahamston House Care Home for their work in achieving a positive Care Inspectorate inspection.

Decision

The Integration Joint Board noted the report.

IJB43. 2026/27 Business Case and Medium-Term Financial Plan Update Budget Monitoring Report 2025/26 Q1

The Board considered a report by the Chief Finance Officer which provided an update to the Integration Joint Board on the budget pressures and assumed funding of the 2026/27 Revenue Budget and medium-term financial plan to 2030/31.

The Board asked about the possibility of service loss as a result of any savings proposals. The Chief Finance Officer advised that all proposals would undergo an Equality and Poverty Impact Assessment and would be brought to IJB for approval. She noted that every effort would be made to minimise the impact of any proposals on services, but that it would be unrealistic to assume zero impact. As a follow-up question, the Board asked how communications around savings proposals would be handled. The Chief Finance Officer advised that a budget consultation process would be carried out over a 6-week period to engage as many people as possible.

The Board asked about the impact of winter pressures on the budget. The Chief Finance Officer advised that the next item on the agenda, the Budget Monitoring Report October 2025/26, provided more detail on this. She noted that the budget included a 5% increase in expenditure to account for winter pressures, and increased projection equated to around £1.8m including recent increased hours.

The Board requested further information on the budget consultation process and engagement with communities outside of this process. The Chief Finance Officer advised that a lessons learned exercise had been carried out with IJB members, staff and management to gather data on how consultation could be improved, and officers continually welcomed feedback on this.

Decision

The Integration Joint Board noted the funding pressures set out in the paper, and risks identified at Section 5, and the actions required to bring forward the 2026/27 business case and medium-term financial plan.

IJB44. Budget Monitoring Report October 2025/26

The Board considered a report by the Chief Finance Officer which provided a high-level summary of the current 2025/26 projected financial position including consideration of risks to the financial position.

The Board asked about the outstanding savings still to be delivered, and whether this meant there were additional risks still to be realised. The Chief Finance Officer advised that the report set out a realistic position at this point, but the Strategic Planning and Transformation Board had oversight of this and would continue to monitor risk levels.

The Board noted concern around the financial position and the use of assumptions to project spend. It asked whether there was confidence that overspend was being managed properly. The Chief Finance Officer acknowledged the challenging position. She noted that, in line with the Integration Scheme, any additional burden would fall to the IJB's partners. She highlighted that assumptions were realistic, as they were based on the latest information held. The Chief Finance Officer explained that overspend was being managed through resource allocation panels and previously agreed budget recovery methods. However, she noted that, should the financial position worsen, a recovery plan would require to be brought to IJB.

The Board requested further information on the cost of care at home. The Chief Finance Officer advised that the NHS had identified over £2m for care

packages in relation to Shifting the Balance of Care, and work was currently ongoing to develop a business case to make this funding recurring.

Decision

The Integration Joint Board:-

(1) noted the current projected position for integrated budgets and set aside services;

(2) noted the non-recurring reserves position set out in Appendix 5 of the report, and

(3) authorised the Chief Officer to issue revised Directions to Falkirk Council and NHS Forth Valley as per the Directions provided at Appendix 6 of the report.

IJB45. Independent Advocacy Plan 2025 - 2029

The Board considered a report by the Adult Support and Protection Lead Officer which presented the Independent Advocacy Plan 2025 - 2029.

The Board asked whether the Plan would require any additional funding for the service. The Adult Support and Protection Lead advised that this was not anticipated at this stage. She noted that there was currently duplication in the referral system and there was a view to improve communication between referrers, and focus on early intervention and prevention.

The Board requested further information on how outcomes would be monitored. The Adult Support and Protection Lead advised that outcomes would be tracked frequently through a variety of mechanisms, such as case file audits, self-evaluations and would be reported through the Clinical Care Governance Management Group and Adult Protection Committee.

The Board requested that officers consider bringing a report back to a future meeting of the Board, in relation to the progress and impact of the Independent Advocacy Plan.

Decision

The Integration Joint Board approved the Independent Advocacy Plan as set out at Appendix 1 of the report.

IJB46. IJB Governance Update

The Board considered a report by the Chief Finance Officer which provided an overview and presented recommendations in relation to:

- the proposed Performance, Audit and Assurance Committee (PAAC) and Integration Joint Board (IJB) dates for 2026;
- changes to the depute IJB Carer Representative;
- new NHS nominated IJB member;
- additional non-voting membership of PAAC; and
- updated PAAC Terms of Reference

The Chief Finance Officer advised that the original agenda published included an error in the programme of meeting dates for 2026 set out in Appendix 1 of the report. This had been corrected on the Falkirk Council website, and the correct dates circulated to Board members.

Decision

The Integration Joint Board:-

(1) agreed the programme of meeting dates for 2026 at set out in Appendix 1 of the report, with the exception of the following dates:

- **IJB – 8 May 2026,**
- **PAAC – 24 April 2026;**

(2) welcomed Alison Japp as the new NHS nominated IJB member following the decision at NHS board on 30 September 2025;

(3) approved Amanda Winters as the new IJB depute carer representative from 31 October 2025;

(4) agreed the process for the recruitment of a third sector representative and their depute;

(5) approved the following additional non-voting members of the Performance, Audit and Assurance Committee: Ian Dickson, and David McNiven; and

(6) approved the updated PAAC Terms of Reference at Appendix 2 of the report.

IJB47. Ministerial Strategic Group Review

The Board considered a report by the Chief Finance Officer which provided an update on the Integration Joint Board's self-evaluation against the Ministerial Strategic Group recommendations from the Audit Scotland report on integration published in November 2018.

The Board asked about the support provided to IJB Section 95 Officers. The Chief Finance Officer advised that work was ongoing with partners to ensure appropriate financial support is provided, and that Lead officers

have access to information and training in relation to financial projections and budget management.

Decision

The Integration Joint Board noted:-

(1) the updated and final evaluation position;

(2) that the work of the Ministerial Strategic Group for Health and Community Care had now concluded, and

(3) that Senior Management would continue to recognise the guiding principles of integration to continue work towards improved outcomes and sustainability.

IJB48. Principles and Governance of Hosted Services

The Board considered a report by the Head of Strategic Planning and Transformation which set out the principles of approach to hosted services. This would be developed further through joint sessions with the Senior Management Teams of Falkirk and Clackmannanshire and Stirling HSCPs and a planned joint IJB development session early in 2026. The principles were grouped into four themes: Governance & Accountability, Operational Clarity, Finance & Risk and Strategic Alignment & Engagement.

The Board noted that the reported stated that there were no financial implications to this approach and requested further information on this. The Head of Strategic Planning and Transformation advised that there were no direct financial implications to establishing a set of principles, but further detail on this would emerge as this was developed.

Decision

The Integration Joint Board:-

(1) noted the outlined principles and governance arrangements relating to Hosted Services within Falkirk IJB;

(2) noted that a Joint IJB Session would be scheduled to examine these principles across the two IJB areas, and

(3) requested the Chief Officer to provide an Annual Progress Report on Hosted Services for consideration by the IJB.

IJB49. Assurance Report from Performance, Audit and Assurance Committee on 26 September 2025

The Board considered a report by the Chief Finance Officer which sought to provide assurance to IJB on the items considered at the Performance Audit & Assurance Committee (PAAC) held on 26 September 2025.

Decision

The Integration Joint Board noted the Assurance Report produced following the PAAC on 26 September 2025 at Appendix 1 of the report.

NHS Forth Valley

Forth Valley NHS Board

8 Strategic Risk Register Update – December 2025 – January 2026
Purpose: This report is for Decision

Executive Sponsor: Kerry Mackenzie, Acting Director of Strategic Planning & Performance
Author: Miss Vicky Webb, Head of Risk Management

Executive Summary

The enclosed report presents an update to the Strategic Risk Register for the period of December 2025 through to January 2026. The report reflects a point in time as the information held within the report is endorsed by each of the Standing Assurance Committees prior to final approval at Board, therefore the timescales indicated within the report reflect the conversations held at those meetings.

Action Required

The Forth Valley NHS Board is asked to:

(1) approve the changes to the Strategic Risk Register for this reporting period (Dec'25-Jan'26).
(2) note the progression of the mitigating actions identified.
(3) note the update on the focused reviews conducted within this period.
(4) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

This matter has previously been considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Strategic Planning, Performance & Resources Committee, 16 December 2025. The committee looked at the risks aligned to them and endorsed the current position to the Forth Valley NHS Board.
- Clinical Governance Committee, 13 January 2026. The committee looked at the risks aligned to them and endorsed the current position to the Forth Valley NHS Board.
- Staff Governance Committee, 20 January 2026. The committee looked at the risks aligned to them and endorsed the current position to the Forth Valley NHS Board.

Risk Assessment and Mitigation

The report details the current Strategic Risk position.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications

Financial and Infrastructure implications are detailed where relevant to risk.

Workforce Implications

Workforce implications are included in the body of the paper where relevant to risk.

Quality / Patient Care Implications
Patient Harm and Patient Experience implications are included in the body of the paper where relevant to risk.

Population Health & Care Strategy
Our Strategic Risks are risks that will impact on our ability to meet the overall aims of the Population Health & Care Strategy.

Climate Change / Sustainability Implications
Climate Change implications are included in the body of the paper where relevant to risk.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

- If yes, please provide details.

Appendices
Appendix 1 – Strategic Risk Register Update – Dec'25-Jan'26

Appendix 1 - Strategic Risk Review December 2025 – January 2026

Contents

1.Summary and Key Messages

During this reporting period, all the current strategic risks have been reviewed, and all remain static bar SRR009 which has decreased in risk score. Further detail on the Strategic Risks can be found in section two of this report.

To coincide with the standard review process, one Focused Review has been conducted in this reporting period. Section five of appendix one highlights specific details around:

- SRR005: Financial Sustainability

There is an improvement to the appetite profile of the Board for this reporting period. As it stands, there are currently 0% of risks within the Boards appetite, 33% are within the Boards tolerance and 67% are out with the Boards appetite and tolerance. Section 4 of the report provides further details on this.

There are no overdue actions to note for this reporting period.

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	Date Assessed	Score History	Risk Trend	Target Score	Owned By	Governance Group	Lead Impact Category
SRR 002	Urgent & Unscheduled Care	25	25	06-Jan-2026	25; 25; 25		10	Garry Fraser	Clinical Governance Committee	Patient Harm
SRR 005	Financial Sustainability	25	25	04-Dec-2025	25; 25; 25		15	Scott Urquhart	Strategic Planning, Performance and Resources Committee	Financial
SRR 004	Scheduled Care	20	20	06-Jan-2026	20; 20; 20		6	Garry Fraser	Clinical Governance Committee	Service Delivery/Business Interruption
SRR 011	Digital & eHealth - Infrastructure & Strategy	20	20	08-Dec-2025	20; 20; 20		6	Scott Jaffray	Strategic Planning, Performance and Resources Committee	Service Delivery/Business Interruption
SRR 015	Cyber Resilience	25	20	04-Dec-2025	20; 20; 20		16	Andrew Murray	Strategic Planning, Performance and Resources Committee	Service Delivery/Business Interruption
SRR 017	Environmental Sustainability & Climate Change	25	20	05-Dec-2025	20; 20; 20		16	Morag Farquhar	Strategic Planning, Performance and Resources Committee	Environmental Sustainability/ Climate Change
SRR 020	Health Inequalities	25	20	04-Dec-2025	20; 20; 20		10	Jennifer Champion	Strategic Planning, Performance and Resources Committee	Health Inequalities
SRR 009	Workforce Plans	25	15	07-Jan-2026	15; 20; 20		10	Kevin Reith	Staff Governance Committee	Financial
SRR 018	Primary Care Sustainability	20	15	05-Dec-2025	15; 15; 15		10	Gail Woodcock	Strategic Planning, Performance and Resources Committee	Patient Harm
SRR 019	Culture & Leadership	25	15	09-Jan-2026	15; 15; 15		10	Kevin Reith	Staff Governance Committee	Inspection/Audit
SRR 003	Information Governance	20	12	02-Dec-2025	12; 12; 12		8	Andrew Murray	Strategic Planning, Performance and Resources Committee	Inspection/Audit
SRR 010	Estates & Supporting Infrastructure	25	12	05-Dec-2025	12; 12; 12		6	Morag Farquhar	Strategic Planning, Performance and Resources Committee	Service Delivery/Business Interruption

2.2 Strategic Risks in Focus

2.2.1 Static Risks

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**
		06-Jan-2026		Zero

Latest Update
This risk has been reviewed and there is no change to the current score at this time. Progress has been made against the risk actions being progressed. Additionally, an action has been added around the implementation of the additional capacity of the Hospital at Home beds.

Internal Controls
Flow Navigation Centre Workstream
Hospital at Home Workstream
Front Door Workstream
DWD Collaborative
Dynamically using resources to reduce and mitigate risk of patient harm.
Whole System Frailty Workstream

Further Controls Required	Action Owner	Due Date	Latest Update
Enhance triumvirate support model within the Acute site to support implementation of the above.	Garry Fraser	30-Apr-2026	Progress has increased to 50% as work continues to be made on the full implementation of the Acute Triumvirate model. The due date on this action has been extended to April-26.
Development of a Plan to Optimise ED based on NHS Lothian model.	Deborah Lynch	30-Apr-2026	This action has been reviewed, as requested from the Clinical Governance Committee, and the description has been updated to remove the terminology 'Front Door Protocol' and updated with the terminology 'Plan to Optimise ED' to align with local plans. Due date has extended to Apr-26.
Access to electronic data to Flow Navigation Centre.	Deborah Lynch	31-Mar-2026	This action has not progressed as expected and has been extended to March-26.
Review the Flow Navigation Centre to review movement to a Senior Decision Maker Model.	Deborah Lynch	31-Mar-2026	Work is being progressed to review our current model and assess available options. Due date extended to March-26.

Implementation of a Frailty 7-day service.	Deborah Lynch	31-Mar-2026	Scoping exercise completed, funding received and we are now in the implementation phase of this piece of work. Action reframed to be Implementation of a 7-day frailty service.
Strengthen access to community frailty pathways.	Deborah Lynch	31-Mar-2026	Progress increased to 30% and the due date has been extended to March-26.
Development of Hospital at Home Electronic Virtual Ward.	Deborah Lynch	31-Mar-2026	Recruit to support expansion, develop risk register, improve data collection, and address virtual ward access to optimise capacity.
Develop Adults with Incapacity (AWI) Process.	Gail Woodcock	30-Apr-2026	This piece of work continues to be progressed by the partnerships and has increased to 90%. Due date has been extended to April-26.
Implement learning from the National DWD Collaborative.	Deborah Lynch	31-Mar-2026	Implement plan in two wards, embed best practice discharge planning, and monitor progress. Timely access to D2A remains a key challenge.
Increase Hospital at Home Capacity in line with SG request.	Fiona Murray	31-Dec-2026	

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**
		02-Dec-2025		Moderate (12-16)

Latest Update

Update from the Head of Information Governance: No change, risk remains static. Considerable progress is being made in the FOI project with the backlog nearly eliminated, and the organisation is meeting the targets set by the Information Commissioner. Recruitment processes have concluded for the Cyber and Information Security Manager and the Cyber and Information Security Technician and are progressing for the Cyber and Information Security Analyst and the Corporate Records Manager.

Internal Controls

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	Latest Update
SharePoint roll out (dependent on National O365 delivery)	Sarah Hughes-Jones	31-Jul-2026	Sharepoint roll-out requires to align with national delivery. Currently paused, awaiting direction. Due date extended of the action to reflect the above national changes but may change once national direction is confirmed.

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	30-Apr-2026	The majority of Information Assets logged on the Information Asset Register have been reviewed and risk assessed. The exception is Acute which will be tackled separately due to the number and nature of assets registered and process required to identify gaps. A report on progress and next steps is planned for the Information Governance Group in April 26.
The IGU will analyse the data available from the dashboard and engage with services to identify targeted training solutions.	Sarah Hughes-Jones	31-Jul-2026	This action has not progressed to schedule due to reduced capacity within the Data Protection Team.
Finalise the onboarding of TrakCare with FairWarning.	Sarah Hughes-Jones	27-Feb-2026	The Access to Intelligence Guidance has been drafted and submitted to the Information Governance Group for approval at the meeting on January 15 2026.
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-Jul-2026	This action has not progressed as planned due to capacity challenges within the Cyber team.
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-Jan-2026	The SLWG has disbanded with a recommended business as usual process being reported to the Information Governance Group on 15 January 2026.

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.	20	Garry Fraser	Marie Gardiner
		Target Score	**Lead Impact Category**	**Appetite Level**
		5	Service Delivery/Business Interruption	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		06-Jan-2026		Moderate (12-16)

Latest Update

This risk has been reviewed and there is no change to the scoring of this risk. The outputs of the focused review have also been reflected within the risk, thereby adding an additional action to this risk.

Following conversations at the Clinical Governance Committee on the 13/01/2026, it has been requested that this risk be reviewed in line with the national planning developments.

Internal Controls

Scheduled Care Performance Management

Scheduled Care - Cancer Pathways

Annual Delivery Plan

NRAC Funding

Consultant Job Plans.

Non-medical staff delivering clinic and surgical based interventions releasing consultant time to do complex cases.

Further Controls Required	Action Owner	Due Date	Latest Update
Implementation theatre efficiencies programme to improve efficiency and to address impacts of patients repatriated from GJ, and loss of additionality allocation from GJ across multiple services.	Marie Gardiner	31-Mar-2027	
Establish routine meetings of the Planned Care Programme Board.	Marie Gardiner	31-Mar-2026	
In line with the Financial Stewardship work on Mutual aid, develop robust governance processes to ensure appropriate measures are in place for agreeing mutual aid.	Marie Gardiner	31-Mar-2026	
Sign off all consultant job plans for 2026/27.	Marie Gardiner	31-Mar-2026	

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**
		04-Dec-2025		Moderate (12-16)

Latest Update
Risk has been subject to a Focused Review and the outputs of this are being discussed at SPPRC on the 16th of December.

Internal Controls
Optimise the Value from Medicines Spend.
Maximise the Value from Workforce Spend
Financial Sustainability Action Plan
Communications Programme
Cost Awareness Programme
Systems & Controls in Place to Maximise Income Generation.

Further Controls Required	Action Owner	Due Date	Latest Update
Medium Term: Develop a plan which allows services to re-design within available resources (VBH&C).	Scott Urquhart	28-Feb-2026	VBH&C will be delivered through a collaborative framework approach - focusing on a few areas at a time. A financial stewardship plan will be developed in line with this, to support the key services in understanding financial requirements. Due date extended to Feb-26.
Finalise decisions around unfunded services.	Scott Urquhart	31-Mar-2026	Finance meeting with Service leads to get a decision on these services. Plan to be developed by March-25. Progress increased to 70%.
Implementation of the Finance Recovery Plan.	Scott Urquhart	31-Mar-2026	Significant progress has been made on the implementation of the Finance Recovery Plan. Progress increased to 60%.
Development of a Financial Stewardship Toolkit.	Jillian Thomson	31-Jan-2026	Progress has been made on the development of a financial stewardship toolkit.

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.	15	Kevin Reith	Linda McGovern
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Financial	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		07-Jan-2026		Moderate (12-16)

Latest Update
Strategic workforce planning board in place, chaired by director of people, Workforce planning manager in place and will commence 26/27 workforce plan on the 8th of January involving a full data capture of the full workforce and each service being asked to evidence their workforce plans to articulate their future workforce needs

Internal Controls
Overarching Workforce Plan
Demographic Profiling
Directorate/Service Workforce Plans
Wellbeing Controls
Sustainable Workforce Initiatives
e-Rostering Solution
Attendance Management Action Plan
Nursing, Midwifery & Allied Health Professional (NMHAP) Workforce Tools
Safe Staffing Legislation
Regional Workforce Solutions

Further Controls Required	Action Owner	Due Date	Latest Update
Increasing employability through Anchor Institution Work.	Jenny McCusker	31-Mar-2026	Agreement in principle for increasing employability as it was endorsed by WSLT. A plan is in progress for being developed to outline our commitment. 75% progress.
Delivery of Action Plan with definitive and quantifiable actions.	Michael Brown	31-Mar-2026	workforce planning manager recruited, workforce plan work commences 8th January 2026, with workforce data and the commencement of directorate service workforce plans, full-service involvement will take place
Completion of the workforce actions in relation to the financial sustainability plan.	Kevin Reith	31-Mar-2026	Clarity on the workforce actions and understanding of what needs to happen to get to this position. Increased demand at acute means increased pressures. Sickness rate also impacting this. Staffing, specifically in medical workforce.

Develop a joined-up approach to the whole-system workforce plan.	Michael Brown	31-Mar-2026	
Establish confirmed baselines of our workforce across NHS Forth Valley.	Michael Brown	31-Mar-2026	
Undertake exercise to understand what capacity is needed to address and support staff regarding the implementation of attendance management controls and develop plan to address capacity needs.	Kevin Reith	31-Mar-2026	Attendance management group chaired by Director of Acute Services. We know where we have gaps and where we need to provide support. An Attendance Manager has been appointed on an interim basis within acute to support this piece of work as a test of change. Assessing value and considering whether this should be extended to wider organisational application. Extend to Dec-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.	12	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**
		05-Dec-2025		Cautious (8-10)

Latest Update

This risk has been reviewed by the Director of Facilities and there is no change to the risk score at this review. The risk has been updated to reflect the outputs from the Focused Review, therefore reflects the additional actions presented to SPPRC. Alongside this, the risk description has been reviewed and updated - noting that this is subject to change from the work conducted by the Risk Appetite SLWG.

Internal Controls

NHS Board Capital Plan

Strategic Asset Management System

Rolling estate survey programme carried out within 5-year cycle

Planned Preventative Maintenance

Prioritisation of Revenue and Capital Budget

Horizon scanning

SCART - Statutory Compliance Audit and Risk Tool

Estates and Capital Planning Service Delivery

Facilities Management Tool.

Further Controls Required	Action Owner	Due Date	Latest Update
Engage with national process around primary care premises (national baseline) to inform first steps around the business case processes for primary care estate in FV.	Morag Farquhar	30-Jun-2026	Initial national meetings are in place to initiate conversation on the above. No immediate progress to note at this time. SG will start discussions with each HB in early 2026 to further support this work.
Development of a property strategic plan to support the implementation of the Population Health & Care Strategy which will help inform the Board's capital plan. This should consider the resources available to deliver this.	Morag Farquhar	31-Dec-2026	

Develop a report to provide oversight on the backlog of maintenance which will be supplied as part of good governance.	Morag Farquhar	31-Mar-2026	
Assess options to ring-fence other funds within a year to fully complete the rolling Estate Survey Programme.	Morag Farquhar	31-Mar-2026	
Prioritise recruitment based on areas of risk.	Morag Farquhar	31-Mar-2026	One senior post is in the vacancy review process.
Engage with national process around primary care premises (national baseline) to inform first steps around the business case processes for primary care estate in FV.	Morag Farquhar	30-Jun-2026	Initial national meetings are in place to initiate conversation on the above. No immediate progress to note at this time. SG will start discussions with each HB in early 2026 to further support this work

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.	20	Scott Jaffray	Rachel Marshall
		Target Score	**Lead Impact Category**	**Appetite Level**
		6	Service Delivery/Business Interruption	Averse (1-6)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		08-Dec-2025		Cautious (8-10)

Latest Update
Risk remains the same - Digital IT/Cyber continue to work through NIS Recommendations. Cyber Vault requires refresh - in Planning

Internal Controls
Annual Digital and eHealth Delivery Plan
Lifecycle System matrix
Cyber Security
Windows/Office Programme
FVRH ICT Infrastructure Upgrades
Disaster Recovery and Business Continuity Plans
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.

Further Controls Required	Action Owner	Due Date	Latest Update
Increase the number of digital champions across the organisation to enhance digital/clinical partnership working.	Scott Jaffray	31-Mar-2026	Progress has been marked to 10% as some progress has been made on starting this process. However further work is needed to embed this throughout the organisation, therefore, due date has been extended to March-26.
Establish a benefits realisation process to document and report on all identified benefits within digital projects.	Scott Jaffray	31-Mar-2026	Benefits realisation process has been put in place. However, the reporting on benefits will start as projects complete. Due date extended to March-26. 40%.

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**
		04-Dec-2025		Cautious (8-10)

Latest Update
Work continues to progress in accordance with timescales set out at focused review
Internal Controls
NIS Audit Recommendations
Enhanced ICT Infrastructure Business Continuity / Disaster Recovery
Digital Delivery Plan 22/23
Cyber Security Awareness Strategy.
Cyber Resilience Awareness Training
Cyber Resilience Framework
Digital and eHealth Strategy to outline funding arrangements for cyber.
Local Policies & Procedures
Change Management processes to include cyber.
Cyber Training & Simulations.
Asset Management
System Management
Threat Intelligence Processes
Vulnerability & Patch Management
Utilisation of Security Tools
Communication and awareness
Cybersecurity & Operational Staffing and Capability Development
Supplier Management
Access Control
Media Management
Operational & Network Security Management
Business Continuity & Disaster Recovery
Privileged Access Management (PAM) & Administration account management
Cyber Change Management Processes

Further Controls Required	Action Owner	Due Date	Latest Update
Continuous improvements and monitoring of our awareness material and training for all staff.	Sarah Hughes-Jones; Scott Jaffray	31-July-2026	Q2 Simulation starting next week. SANS maturity model paper drafted and on course for communication to relevant governance groups.
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-July-2026	Work has progressed on this and is awaiting consultation from the next Better Information Governance Group in December 2025, which will formal approval at the Information Governance Group in January-26. Therefore, due date extended to this.
Business Continuity Plans – Embedding and testing - BCPs should be widely known, understood, and regularly tested for effectiveness.	Sarah Hughes-Jones; Scott Jaffray	31-July-2026	Due date has been extended to further strengthen the BCP utilisation throughout the organisation. Date has been extended to Dec-25.
Develop a Gatekeeping process for third party access.	Scott Jaffray	31-July-2026	This will form part of our NIS submission, moving to the due date of NIS (26th January 2026).
Conduct a review of the current cyber resources to support effective change management. This will be included by the Digital Directorate Review. Further review to also be scheduled within IGU.	Sarah Hughes-Jones; Scott Jaffray	31-Mar-2026	Job Evaluation process has re-evaluated CISM to a Band7, enabling immediate recruitment process can commence. Review still required around the overall risk as retention issues not mitigated. Due date reviewed and extended to December-25 to allow for recruitment to occur.
Complete a full review and refresh of the Acceptable Use Policy.	Kurt McLay	31-July-2026	Due to the Better Information Governance Group refresh and to ensure proper consultation, the due date has been moved to 31st January 2026. The AUP is in its final draft form before consultation.
Implement medical devices and IoTs device coverage to action effective vulnerability management.	Kurt McLay	31-Mar-2026	The governance documentation is now complete awaiting sign off. However, there will be a need for Digital support with implementation of this procedure and testing. The due date has been moved to 31st March 2026.
Conduct a penetration test for key systems.	Kurt McLay	31-May-2026	We have sent out an SBAR to highlight the need for a dedicated penetration test budget to be a yearly allocation. We are awaiting an update or award. This is needed to schedule key system penetration tests.
Set clear ownership and response times (SLA) so fixes are actioned within a clear timeframe.	Kurt McLay	31-July-2026	VMG Terms of Reference being finalised. It will need to be approved in November's Cyber Resilience Working Group. The due date has been moved to 31st January 2026.
Establish a Vulnerability Management Group (VMG) operating under existing governance frameworks.	Kurt McLay	31-July-2026	VMG Terms of Reference being finalised. It will need to be approved in November's Cyber Resilience Working Group. The due date has been moved to 31st January 2026.
Conduct Board-wide phishing simulation test.	Kurt McLay	30-Nov-2025	We are on track for completion of this item.
Diversify the communication methods of the cyber team.	Kurt McLay	31-July-2026	We are on track to complete this action.

Complete recruitment to key roles; define career pathways/retention.	Kurt McLay	31-July-2026	Cyber Security Manager Role has been recruited to. We are on track to recruit to key other roles within the team.
Define career progression pathways and retention strategy	Kurt McLay	31-July-2026	
Conduct a physical penetration test across key buildings to validate the effectiveness of existing access control measures and identify any residual vulnerabilities.	Kurt McLay	31-Mar-2026	Reliance on a dedicated penetration budget in the Cyber team/Digital. SBAR has been sent by the Cyber team. Moving to March 2026 as we have no control in the Cyber team and are awaiting an update.
Develop an audit trail for media management.	Kurt McLay	31-July-2026	Moving due date to fall in line with NIS submission (26th January 2026).
Review and provide recommendations to meet control requirement	Kurt McLay	31-Mar-2026	

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**
		05-Dec-2025		Open (20-25)

Latest Update

This risk has been reviewed by the Director of Facilities and there is no change to the score at this review. The team are still experiencing workforce issues which impacts on the ability to progress the actions listed against the risk.

Internal Controls

Climate Emergency Response and Sustainability Team

Climate Change & Sustainability Team

Board Papers Contain Section on Environmental Sustainability Considerations

Climate Emergency & Sustainability Strategy and Action Plan

Continual review and identification of funding sources.

Further Controls Required	Action Owner	Due Date	Latest Update
Successful Implementation of the Environmental Management System.	Derek Jarvie	31-Mar-2026	One of the trained members of staff has left the team and we need to recruit to backfill this post. Work still ongoing to identify where the environmental management system will be held. Progress remains static at this time.
Recruit the Waste and Compliance Support Officer role.	Derek Jarvie	31-Mar-2026	Work is still ongoing to recruit to this post. Next steps are to place this on JobTrain. Due date extended to March-26 to cover any notice periods that the new applicant may have.
Development of an energy strategy.	Derek Jarvie	30-Jun-2026	Progress has been made on a draft version, however, this has been paused due to vacancies within the team. To allow for the recruitment process to occur, the due date has extended to June-26. Progress has increased to 50%.

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 to patients across Forth Valley, resulting in an impact on patient care through failure to meet our statutory responsibilities and deliver on the aims of the Population Health & Care Strategy.	15	Gail Woodcock	Scott Williams
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Patient Harm	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		05-Dec-2025		Zero

Latest Update

This risk has been reviewed by the Primary Care Lead and there is no change to the risk at this review. Two action deadlines have been re-assessed and extended as work is still underway to complete these. The first meeting of the reinstated Primary Care Programme Board is scheduled for December and it is hoped that this will provide enhanced oversight and governance for the Primary Care Services.

Internal Controls

GP Sustainability Loans in Place (Finance, Recruitment & Retention).

Primary Care Improvement Plan (Capacity & Demand).

Expansion of community pharmacy services (Further development of Pharmacy First Service) (Capacity & Demand).

Regular engagement with SG and BMA in place regarding national MOU funding (Capacity & Demand).

Recognised process to consider all options when a practice is handed back to NHS FV (Capacity & Demand).

Targeted recruitment to build GP and MDT capacity and capability (Recruitment & Retention).

Capital Investment Programme (Recruitment & Retention, Premises).

Further Controls Required	Action Owner	Due Date	Latest Update
Development of Governance routes and escalation procedures following the delegation of PC to FHSCP.	Tom Cowan; Scott Williams	27-Feb-2025	The Primary Care Programme Board is still being established, and a date will be agreed for the start the new year. The initial meeting is to scope and agree the Terms of Reference for the group. Joint SMT workshop will explore Primary Care Governance and principles for hosted services. Due date extended to Feb-26 to allow for the first meeting to occur.
Development of a whole-system Community Health & Wellbeing Transformation Programme.	Tom Cowan; Scott Williams	31-Mar-2026	Work is progressing to further develop elements of this programme including shifting the balance care, enhanced services and urgent care in the community. Progress increased to 25%. However further work is needed on this document.
Communicate with GPs around the NHS recruitment process and assess data to identify if	Louise McCallum	30-Apr-2026	Work has started to progress on this action but it will not be completed by the due date of December-25. Therefore this action has been extended to April-2026.

variance occurs between these processes (understanding that some differences are due to national availability of the workforce).			
Engage with national process around primary care premises (national baseline) to inform first steps around the business case processes for primary care estate in FV.	Morag Farquhar	30-Jun-2026	Initial national meetings are in place to initiate conversation on the above. No immediate progress to note at this time. SG will start discussions with each HB in early 2026 to further support this work
Further analysis required to detail current and potential future services delivered through this model.	Clare Colligan; Louise McCallum	27-Feb-2026	This action will be picked up through the Primary Care Programme Board as it is recognised that we need to have a collaborative approach to any new initiatives developed. Due date extended to Feb-26.
Long term strategy and recurring resource needed to deliver on recommendations such as Golden Hello recruitment grants, coaching and mentoring, infrastructure	Louise McCallum	27-Feb-2026	This action is also contingent on the development of the Programme Board as there needs to be clear governance and structure around the decision making for this action. Recommendations of this sort will be brought to the Programme Board through there GP Sustainability Group. Additional investment in the coaching and mentoring of GPs was agreed in 25/26. Due date extended to Feb-26.
Quicker turnaround of vacancies within PCIP.	Nickola Jones	30-Apr-2026	PCIP Oversight Group review service level vacancies and review actions for the recruitment process. This action is being progressed by the team but will not be completed by the initial timescales set, therefore the action has been extended to April-2026.

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**
		09-Jan-2026		Moderate (12-16)

Latest Update
This has been reviewed by the Director of People and there is no change to the scoring of this risk. Work is progressing on the mitigating actions and is on track to transfer to BAU in March-26.

Internal Controls
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.
Celebrating Success
Culture Change and Compassionate Leadership Programme
Organisational Development Programme
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	Latest Update
Create an OD Plan aligned to the organisational needs, supporting the people strategy.	Jenny McCusker	31-Mar-2026	OD Plan focus for 25/26 has been the refresh of our Leadership Development Framework with focus on initial management core and transformational change management programmes launching this year. The OD Plan will be developed as a delivery element of the People Strategy and so will be built into the 2026/27 work plan
Strengthen educational governance to ensure educational activity is supporting delivery of our strategic aims. The introduction of the Strategic Workforce Programme Board will support this.	Jenny McCusker	31-Mar-2026	Educational Governance has been strengthened through collaboration between Educational Leads within NHS Forth Valley with work progressing to ensure effective governance by reporting to the Strategic Workforce Programme Board. Target date updated to 31 March 2026 to allow this work to be concluded.

Reviewing mandatory/statutory training and align with the national developments.	Jenny McCusker	31-Mar-2026	National Statutory training standards have been approved and all Boards are directed to plan for implementation from April 2026. Work progressing to align our existing training to the new framework and manage the transition from April.
Great communications team to review ways in which we can engage effectively beyond staff net alone.	Sarah Hughes-Jones	31-Mar-2026	One of the outputs of the Values workstream from Culture Change Programme has been the agreement to use our Interactive Employee journey as focus for our staff engagement work. In addition a plan is being developed for a practical toolkit guide which will sit within a new communications framework refresh. This work will be completed as part of mainstreaming activity by 31 March 2026.
Engage with Head of OD regarding the communication aspect of leadership development.	Jenny McCusker	31-Mar-2026	Comprehensive organisational engagement on our new Leadership Development Framework and agreement with soft launch on intranet in January. Target date extension proposed to 31 March 2026 to support planning and communications for Leadership Event in April
Get connected team looking at improving communication between FV and partnership organisations.	Sarah Hughes-Jones	31-Mar-2026	Initial actions progressed on communications but further assessment being completed to inform updated plans and associated target dates
Develop cultural indicators which will be used to inform assessment of progress around improving culture.	Jo Tolland	31-Mar-2026	Work has progressed in relation to Culture Indicators and associated dashboards although staffing changes have affected delivery timescales. Target date adjustment being reviewed based on agreement on next steps.
Directorates to come up with action plans to increase compliance with PDPs.	Jenny McCusker	31-Dec-2025	Update from the Head of OD - There has been some improvement in areas of both Corporate and Clinical services however this will be followed up with Directors again this month. Due date has extended to December-25 to create effective action plans.
Develop the process which identifies leadership talent, directs to the appropriate development activity and evaluates effectiveness.	Jenny McCusker	31-Mar-2026	Work being overseen by PDP Steering Group
Review the leadership development programme and make recommendations to ensure it meets our leadership needs.	Jenny McCusker	31-Mar-2026	Main review completed with initial framework agreed with pilots of the initial priority programmes (Core Management Skills & Transformational Change Leadership) on track for commencement in January and February 2026 respectively.
Develop a measurement framework which is built into the leadership development plan to support evaluation of effectiveness in improving organisational performance.	Jenny McCusker	30-Jun-2026	Work on track with performance dashboard development progressing to align to the new framework.

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**
		04-Dec-2025		Moderate (12-16)

Latest Update

This risk is the subject of a Focused Review and the outputs of this are being discussed at the SPPRC meeting on the 24th of March.

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 for diverse and disadvantaged communities.

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.

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	Action Owner	Due Date	Latest Update
Development of a comprehensive healthcare inequalities delivery plan which supports investment in measures and embeds HI into all workstreams.	Jennifer Champion	31-Mar-2026	Work continues to be progressed regarding this however there remains limited capacity within PH to deliver this. Due date extended to March-26 when new staff will be in place. There is an advisory group in the form of the national health & care PHAcT workstream with a health inequalities workstream. Our Director of PH will be liaising with this group (as co-chair of the overarching PHAcT) and will be leading on the development of the

			national action plan for Health Boards as noted within the latest SG Policy Documents.
Health Inequalities delivery plan should be aligned with partnership plans - Discuss at ELT and Board Seminar.	Jennifer Champion	31-Mar-2026	There are examples of some plans aligned, for example ASK & ACT, where NHS & HSCP are working together. 10% progress made and due date extended to March-26.
Work with NES around staff accessing training to understand responsibilities around health inequalities - this is a key enabler to embedding prevention activity.	Jennifer Champion	31-Mar-2026	Due date extended to March-26.
Develop a systematic way to assess and monitor health inequalities.	Jennifer Champion	27-Feb-2026	Work is progressing nationally and the Director of PH is driving national discussions to get agreement on way forward for this. Due date extended to Jan-26.
Review NHS Forth Valley contribution to community planning partnerships.	Jennifer Champion	31-Mar-2026	There are examples of where delivery plans are aligned (Anchor & child poverty and whole family support.,) where we are working with CPPs. Progress has increased to 25%. Due date extended to March-26.

3.Risk Controls Progress Update

Graph 3.1 Summary of Strategic Risk Control Environment

In this reporting period, there are 132 current controls mitigating these risks, an increase from the previously reported 112. This is due the focused reviews conducted on the strategic risks for this period. Supporting our control environment, there were 3 actions completed in this reporting period which further mitigate the strategic risk profile (Table 3.1 highlights these actions). At the end of this reporting period there are no overdue actions reported, with a further 12 actions due to be completed by Quarter 3 25/26.

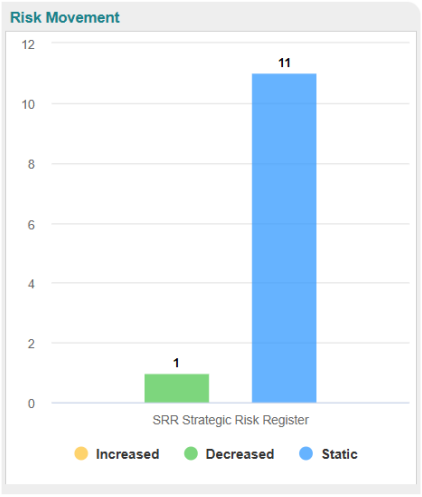
Table 3.1 Strategic Risk Completed Actions

Action Code	Action Title	Due Date	Status	Action Owner	Risk Owner
SRR004.15	Implementation of 24 month plan to improve efficiency and to address impacts of NTC	3-Mar-2026	Completed	Marie Gardiner	Marie Gardiner
SRR009	Recruit a Workforce Planning Manager	31-Dec-2025	Completed	Michael Brown	Kevin Reith
SRR015.21	Conduct a Board-wide phishing simulation test.	31-Jan-2026	Completed	Kurt McLay	Scott Jaffray
SRR019.07	Building on staff awards, work is progressing on other staff recognition opportunities.	31-Dec-2025	Completed	Kevin Reith	Kevin Reith

Action Code	Action Title	Due Date	Status	Action Owner	Risk Owner
SRR019.24	Development of a wellbeing plan.	30-Nov-2025	Completed	Rachel Tardito	Kevin Reith
SRR019.25	Conduct a review of the induction process and develop action plan to enhance this compliance.	31-Dec-2025	Completed	Jenny McCusker	Kevin Reith

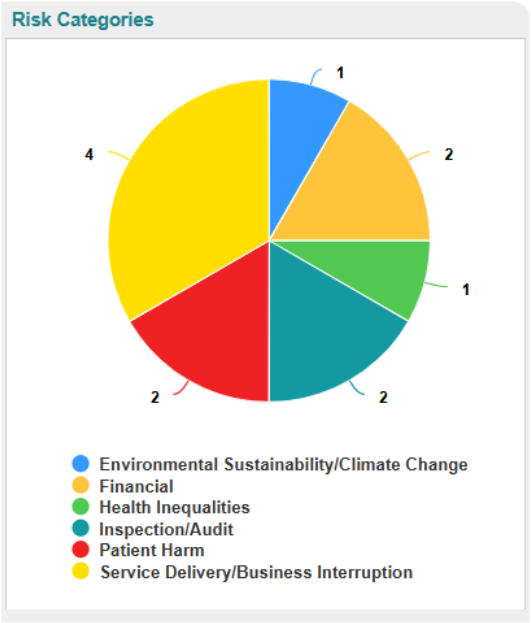
4.Risk Trend Analysis

Table 4.1 Risk Register Activity



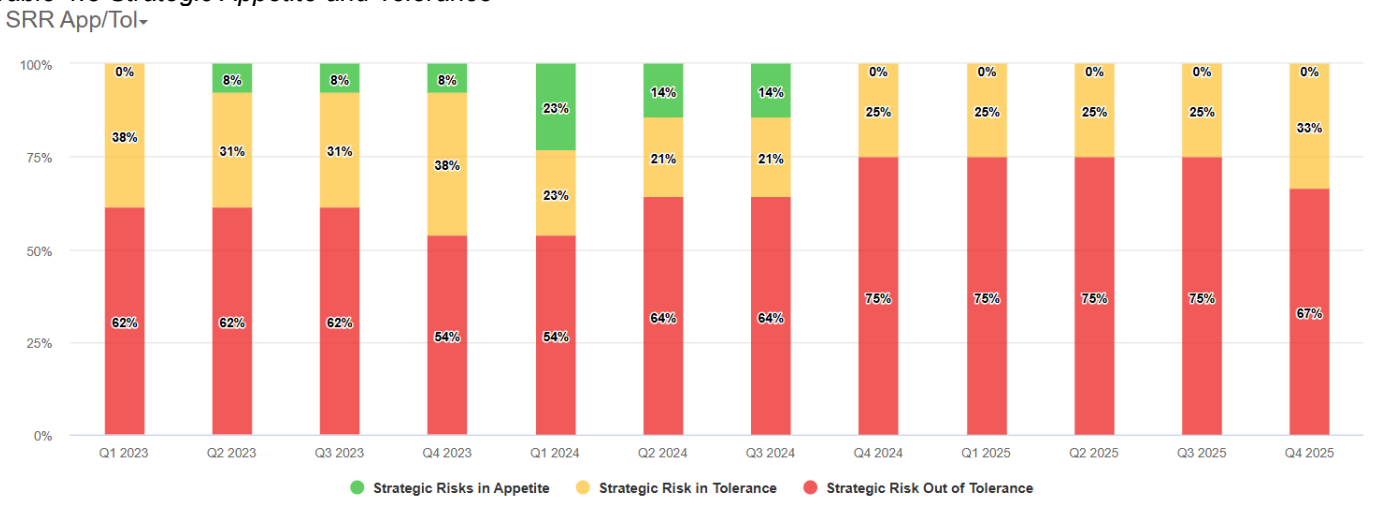
The chart to the left shows that across the Strategic Risk Register, eleven out of the twelve strategic risks have remained

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 Harm, Public Confidence, Environmental Sustainability and Climate Change and Health Inequalities.

Table 4.3 Strategic Appetite and Tolerance



A graph depicting the risk appetite profile of the strategic risks across the previous financial year:

- Quarter 1 (25/26) remained static, despite the increase in risk score for SRR011 as it was already listed as out with the Boards appetite and tolerance.
- Quarter 2 (25/26) remained static, despite the decrease in score for SRR010, as it remains outside the Boards appetite and tolerance.
- Quarter 3 (25/26) remained static.
- Quarter 4 (25/26) is on track to reduce the number of risks out with the Boards appetite and Tolerance with SRR009 reducing in risk score. 33% of the Boards Strategic Risks are within Tolerance levels and 67% of the Boards Strategic Risks are out with 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 Reviews

During this period, three Focused Reviews were conducted on:

- **SRR005: Financial Sustainability –** This was presented to the December 2025 Strategic Planning, Performance & Resources Committee with an assurance rating of reasonable (internal controls) and limited (external environment) and was endorsed for further reporting.

SRR005: Financial Sustainability

Commentary
During this focused review process, there was a 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 a variety of ratings for these controls. As depicted below – specifically 6 received an amber rating. One control was added as subsequent work had been completed to the control. The final assurance assessment was assessed as reasonable for internal processes and limited for external factors.

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 provision.	25	Optimise the Value from Medicines Spend.		X	X	X	Reasonable/Limited
			Maximise the Value from Workforce Spend		X	X	X	
			Financial Sustainability Action Plan		X	X	X	
			Communications Programme		X	X		
			Cost Awareness Programme		X	X		
			Systems & Controls in Place to Maximise Income Generation.		X	X		
			Further scrutiny of Service Level Budgets		X	X		

NHS Forth Valley

Forth Valley NHS Board

9(a) Quality and Assurance Report
Purpose: This report is for Assurance

Executive Sponsor: Andrew Murray, Medical Director and Professor Karen Goudie, Executive Nurse Director
Author: Wendy Nimmo, Interim Head of Efficiency, Improvement and Innovation. Ashley Calvert, Head of Clinical Governance. Lucy Atalla, Quality and Safety Lead. David Watson, Director of Nursing. Lesley Fulford, Operations Manager Patient Relations.

Executive Summary

This Quality and Assurance Report provides an overview of NHS Forth Valley's current position in relation to key areas of Quality and Safety performance. All of these items were discussed at Clinical Governance Committee January 2026.

The appendices provide further detail on the following key areas:

- **SAERs:** Appendix 1 highlights ongoing work to further improve the Significant Adverse Event Review (SAER) process along. The improvement plan focuses timely reporting, early escalation, panel formation, and shared learning.
- **Complaints Management:** Significant improvement is demonstrated showing a 50% reduction in open complaints. An improvement plan has been implemented to reduce the stage 2 complaints backlog since Aug 25. Appendix 2 provides further graphical detail.
- **Quality & Safety Steering Groups:** This report in Appendix 3 highlights the success of the Safer Together Celebration Event and overall success of the Breakthrough Series Collaborative, demonstrating strong system-wide progress in patient safety through a quality improvement approach. It outlines the submission of the final STC report to CGC and notes that a full programme evaluation will be presented following CGWG in February 2026.
- **HIS Unannounced Inspections:** Healthcare Improvement Scotland (HIS) carried out two unannounced Safe Delivery of Care - (SDC) inspections covering the acute Mental Health Unit and Maternity Services. As part of the inspection process comprehensive evidence submissions were provided in as part of the Safe Delivery of Care inspection assurance process. The SDC Maternity report identified nine areas of good practice, two recommendations, and eleven requirements. Its improvement plan is at Appendix 4.The Acute Mental Health report is due to be published by HIS on 28 January 2026. The Executive Nurse Director and Quality team have established Inspection Oversight Groups to lead and monitor the delivery of action in response to the recommendations and requirements from both reports.

Action Required

The Forth Valley NHS Board is asked to:

(1) review the key areas of Quality and Safety contained within the report, noting the areas of progress and risk.
(2) note that the issues contained herein have been reviewed by the Clinical Governance Committee of the Board, and

(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

- Senior Leadership Team
- Issues covered on Clinical Governance Committee agenda Jan 2026

Risk Assessment and Mitigation

There is one current operational risk relating to Significant Adverse Event Reviews (SAER) – CLINGOV 02 SAER Framework. This risk is presently assessed as high (score 15), with a target risk assessment of medium (score 10). Further discussions regarding resources required to expand the SAER process, led by Corporate Clinical Governance team are advancing, with a business case for fixed term resource prepared for early 2026.

Complaints Performance Risk - The Patient Relations Team has experienced heightened challenges due to previous delays in response times. Sustainability of improvements will become clearer as the outstanding responses diminish. Next steps will focus on agreeing SOPs, launching development and wellbeing initiatives, monitoring staff feedback, and ensuring visible leadership engagement. Additional resource was added to the Patient Relations Team for a period of 12 months to support the reduction of the backlog, with further input and oversight from the Executive Nurse Director and Corporate & Acute Director of Nursing.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No

If yes, please confirm this is attached. Attached ☐ Not required ☒

Financial, Digital and Infrastructure Implications

There are potential financial implications arising from this report in relation to the resources required to sustain and improve the SAER facilitation process. There are potential infrastructure implications arising from this report, regarding the adverse event reporting system used by NHS Forth Valley.

Temporary resource has been placed in the Patient Relations Team until June 2026; this is under ongoing review in conjunction with the systems and processes to respond and learn from patients' experiences.

Workforce Implications

The escalation of adverse events and the ongoing SAER process have notable workforce implications. There are current pressures on capacity and resources within both Corporate Clinical Governance and Health and Safety departments, given the demands of the existing work plan commitments. The mitigation programme requires sustained engagement from these teams to ensure effective management and oversight of significant adverse events. As work progresses, ongoing assessment of workforce capacity and resource allocation will be essential to support the delivery of planned improvements and maintain robust governance throughout the mitigation period.

Within the Maternity Services, safe delivery of care - (SDC) inspection report for NHS Forth Valley, a requirement was identified within Domain 2 (Leadership and Culture) relating to the management of adverse events and associated implementation of learning from significant adverse event reviews. This work is underway, and progress is being monitored via the delivery and oversight groups for the SDC improvement plan and aligns to the wider improvement plan relating to the management of adverse events within NHS Forth Valley. (see appendix 4 Maternity Action Plan).

At the recent Clinical Governance Working Group meeting support was expressed for additional resource on a fixed term basis, to increase the capacity of corporate CG staff to support and facilitate SAER, with a formal business case to be prepared in January for 2026 for consideration by the senior leadership team.

Quality / Patient Care Implications
NHS Forth Valley's participation in the newly launched Scottish Patient Safety Programmes (SPSP) for Mental Health and Adults in Hospital carries strategic, operational, and governance implications. These programmes align with national safety priorities and reinforce the Board's commitment to continuous improvement in patient care. Their implementation will require sustained workforce engagement, potential resource investment, and integration into existing governance structures via the Quality and Safety Steering Groups.

The programmes also support risk mitigation efforts and enhance assurance mechanisms, while contributing positively to NHS Forth Valley's compliance with national standards.

The newly established Quality and Safety Steering group will provide a reporting and assurance mechanism to the Quality Programme Board and the Clinical Governance Working Group, confirming progress against agreed national and local safety and quality measures. It will monitor implementation of safe care initiatives, improvement projects, and innovation within its remit, ensuring compliance with local and national standards.

Population Health & Care Strategy
The content of this report is intrinsically linked to NHS Forth Valley's Population Health & Care Strategy through its commitment to continuous improvement in patient safety, organisational learning, and the delivery of high-quality care.

Climate Change / Sustainability Implications
No immediate sustainability implications

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

Appendices
Appendix 1 – SAER update
Appendix 2 – Complaints update
Appendix 3 – Quality and Safety Steering Group update
Appendix 4 – Women and Children's Improvement Plan

Appendix 1- SAER update

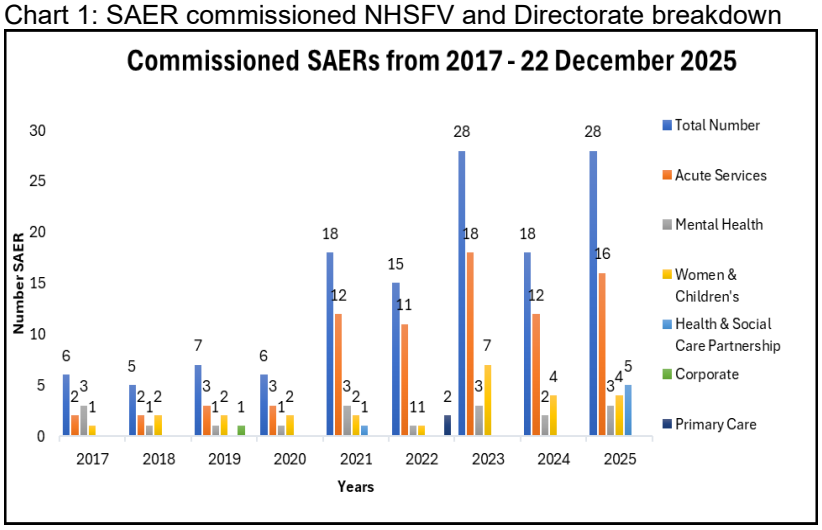
Current Situation

Healthcare Improvement Scotland - (HIS) produced a revised framework in February 2025 to promote standardisation of processes for managing significant adverse events and are now engaged in an evaluation and workshop cycle to standardise and improve the SAER process collaboratively with all NHS Scotland Boards.

Internally NHS Forth Valley have identified several specific quality improvement and assurance aims, both short and longer-term stretch aims, to support measurement of progress of both Adverse Event management and escalation and the SAER process itself.

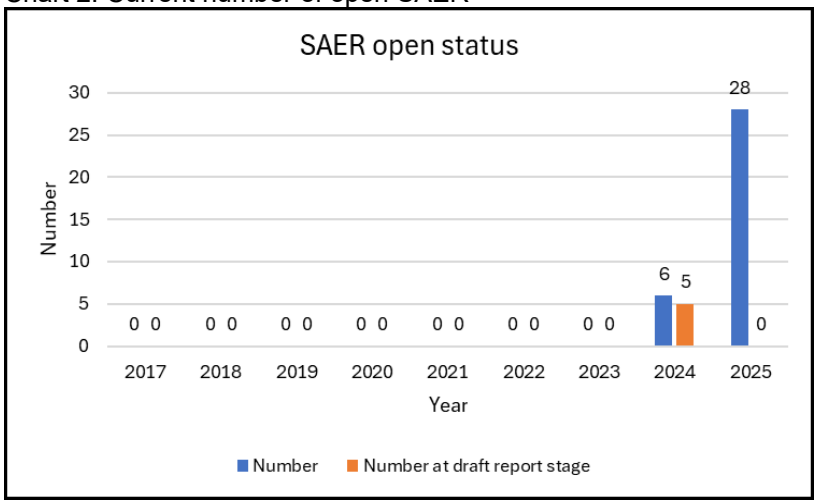
NHS Forth Valley's current data for all SAER commissioned from 2020-2025 shows:

Chart 1: SAER commissioned NHSFV and Directorate breakdown



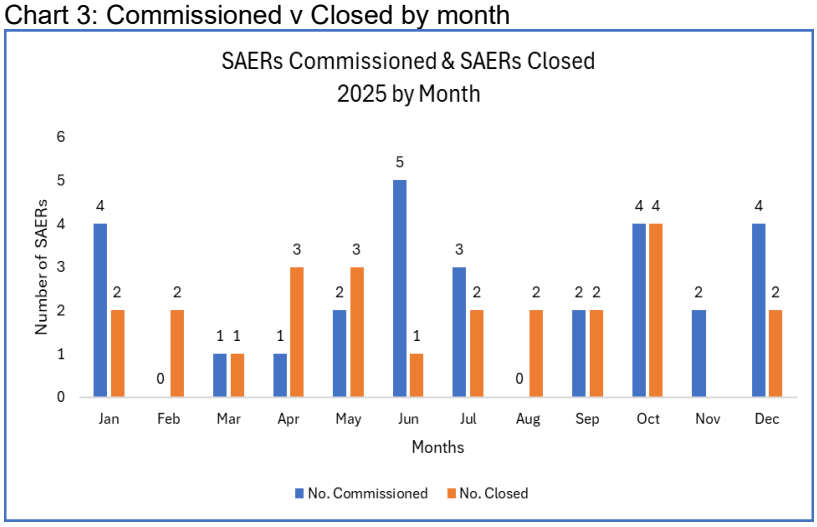
NHS Forth Valley (NHS FV) currently have commissioned twenty-eight SAERs for the year 2025 and have thirty-four open SAERs. NHS FV has approximately closed the same number of SAERs as it commissioned for the last two years.

Chart 2: Current number of open SAER



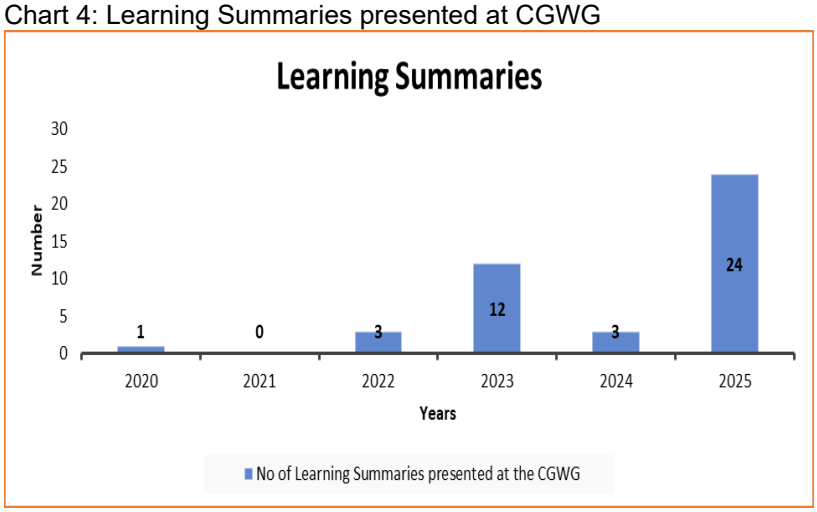
Of those open SAERs one is submitted for final report approval, four are at draft report stage, thirteen are at team meeting stage, with the remaining sixteen at panel formation stage. Enhanced integration between the complaints process and adverse event escalation has led to improved commissioning of SAERs.

Chart 3: Commissioned v Closed by month



Following the completion of each review a learning summary is produced and fed back to the relevant Directorate/Service AERG/CRG along with the executive summary and recommendations. The CCG Team ensures that all completed learning summaries are at the next CGWG. The learning summaries are also shared nationally via the SAE community of practice.

Chart 4: Learning Summaries presented at CGWG



Themes from commissioned SAERs include issues around diagnosis, care and treatment, unexpected outcomes and incidents involving slips, trips or falls.

Planned Improvements
The improvements to support the SAER process plan take a strategic approach to enhancing the management of adverse events (AEs) and the timely completion of Significant Adverse Event Reviews (SAERs) within NHS Forth Valley.

The plan is structured around four key domains:

1. Timely Reporting.
2. Early Escalation and Commissioning.
3. Panel Formation and Report Completion.
4. Shared learning and improvement plan development.

The overarching aim is to improve the speed, quality, and governance of adverse event reviews ensuring that events are escalated appropriately and reviewed within expected timeframes, in alignment with the Healthcare Improvement Scotland - (HIS) framework. Through the increased oversight of complaints process there have been cases identified that have subsequently processed through the SAER route.

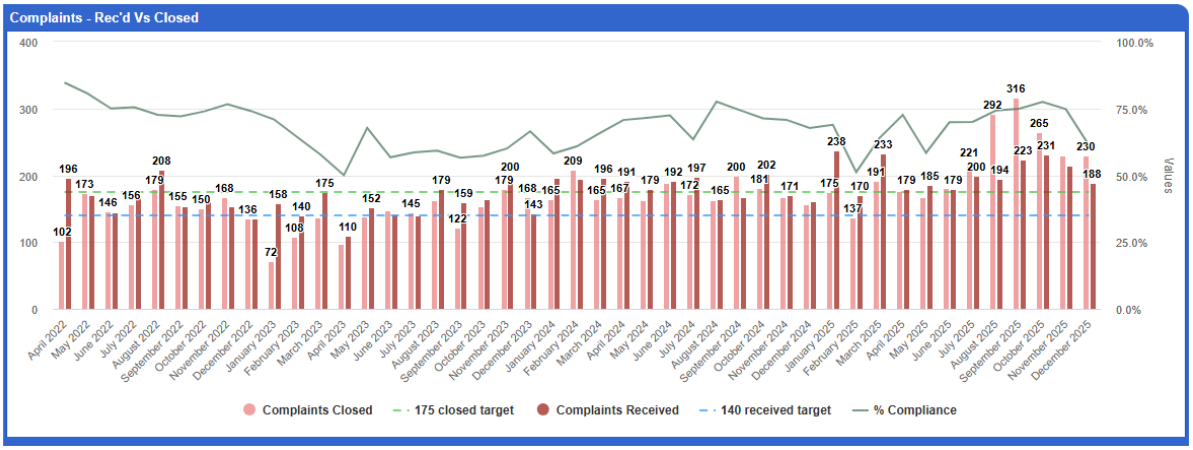
Key Highlights of the Improvement Plan:

- **Capacity Building**: Expansion of the facilitation team, via a supported business case, within the corporate Clinical Governance department to eliminate the current “backlog” of reviews and the training of 56 new Lead Reviewers has significantly increased review capacity and capability.
- **System Enhancements**: Modifications to the Ulysses Safeguard system support earlier escalation, and tracking of AEs, providing greater assurance of robust adverse event management and support shared learning.
- **Empowering Staff**: Staff are being empowered to report AEs within one working day, with immediate impact categorisation, promoting a just and transparent culture.
- **Process Agility**: Exploration of more responsive AERG/CRG and SIG processes aims to reduce delays in commissioning and review.
- **Communication and Engagement**: A new training package will support improved communication with patients, families and staff involved during SAERs.
- **Governance Oversight**: A RAG status tracker and timeline monitoring will ensure visibility of progress and potential breaches.

Appendix 2 – Complaints update

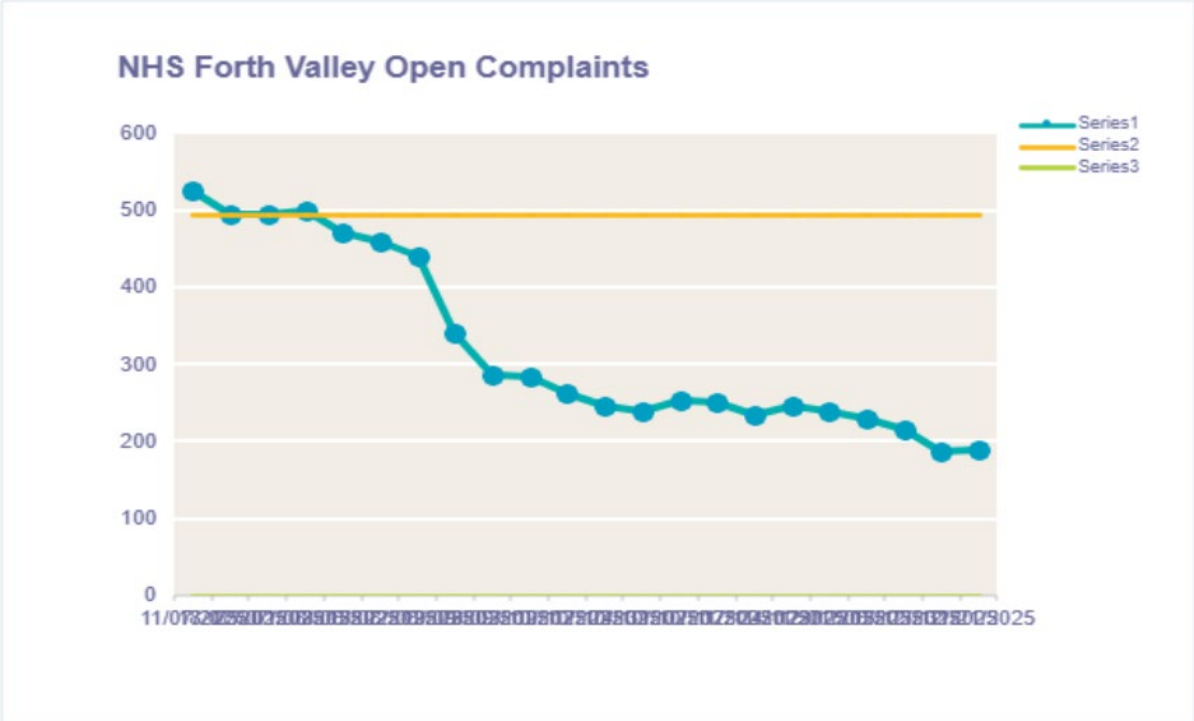
NHS Forth Valley has a significant backlog of complaints where people have waited more than the national standard of 20 days (stage 2). Total number of open complaints across all operational units totals 170 (as at 31/12), the oldest open complaint is from January 2025 (Emergency Department).

Chart 7: Complaints – Recorded Vs Closed



Significant efforts have been made to reduce the back log, and this has helped to achieve the above reduction. The chart above illustrates progress towards this goal with consistent cases closed above cases opened since July 2025. The run chart below demonstrates the significant improvement over time in open stage two complaints being closed:

Chart 8: Open Complaints



A quality improvement approach has been implemented to improve process, commissioning and complaint clinical oversight. Further improvement planning will be developed with the team to support improved performance regarding our statutory responsibility to respond to people and their families within the 20-day national standard. Data quality improvement is in progress through development of safeguard web-based functionality.

Appendix 3 – Quality & Safety Steering Group

The final Safer Together Celebration Event took place on 13 November at Falkirk College, bringing together 122 delegates from across the system. The day highlighted the quality improvement work of the collaborative, with 32 posters submitted showcasing high-quality projects and demonstrating QI methodology at the forefront of our approach. This whole-system event provided an invaluable opportunity to recognise outstanding efforts to improve patient safety, share learning, and celebrate collective achievements. The final STC report was submitted to CGC alongside this update, ensuring continued alignment with governance expectations and transparent reporting of progress to date.

A full evaluation of the Safer Together Collaborative will be shared following discussion at the CGWG in February 2026, supporting internal reflection, driving ongoing improvement, and enabling wider learning to be shared across Scotland.

Planning is underway to provide a platform for existing workstreams to provide assurance into the newly established Quality and Safety Steering Group which will provide a sustainable framework for ongoing improvement by embedding patient safety, quality assurance, and organisational learning into core governance structures. The Q&S Steering Group offers strategic oversight of operational unit level safety plans and measurement frameworks, ensuring alignment with both NHS Forth Valley's strategic priorities and national improvement programmes while maintaining whole-system visibility, connection and accountability.

Quality planning is underway to ensure memberships, terms of reference (ToR) robust reporting routes are in place. Governance reporting will feed into the Quality Programme Board and Clinical Governance Working Group (CGWG) to maintain transparency and assurance. With all former STC workstreams realigning under this model, the Steering Group will obtain assurance and long-term sustainability by embedding successful practices into routine systems, supporting national SPSP priorities and ensuring that momentum for improvement is maintained beyond the life of the Collaborative.

Figure 1: SPSP programmes launched in November 2025 and Excellence in Care

SPSP Programmes	**Areas of focus**
SPSP Adults in hospital	Cardiac arrests Falls with harm Pressure ulcers Medicines safety
SPSP Mental health	Mental Health safety at points of transition.

Excellence in Care (EIC)	**Areas of Focus**
	Inpatient falls rate Pressure Ulcer rate NEWS, MEWS and PEWS compliance

Assurance of Safer Together High-level aims

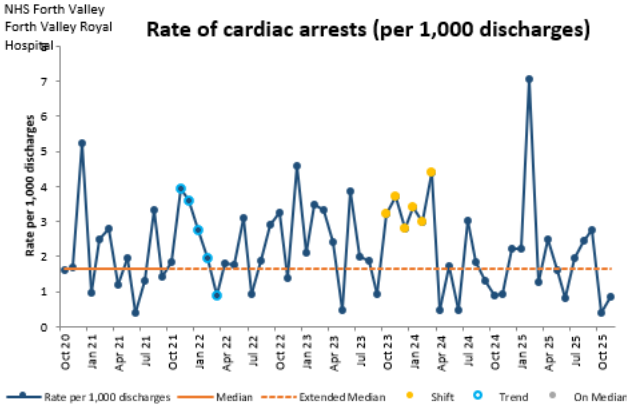
Deteriorating Patients - Cardiac arrest

Aim: Reduce Cardiac Arrest rate by 40% by November 2025 (NCAA).

Outcome: NCAA improvement noted from 90th centile to 25th-75th centile. SPSP data: chart 9 is showing random variation. Rate at the start of the collaborative Aug 2024 was 1.83 and is now Nov 2025 0.86.

Next steps: Cardiac arrests will continue to be closely monitored, with improvement actions supported through the Safety Steering Group governance model. Ongoing improvement work will remain aligned to the SPSP Adults in Hospital Programme.

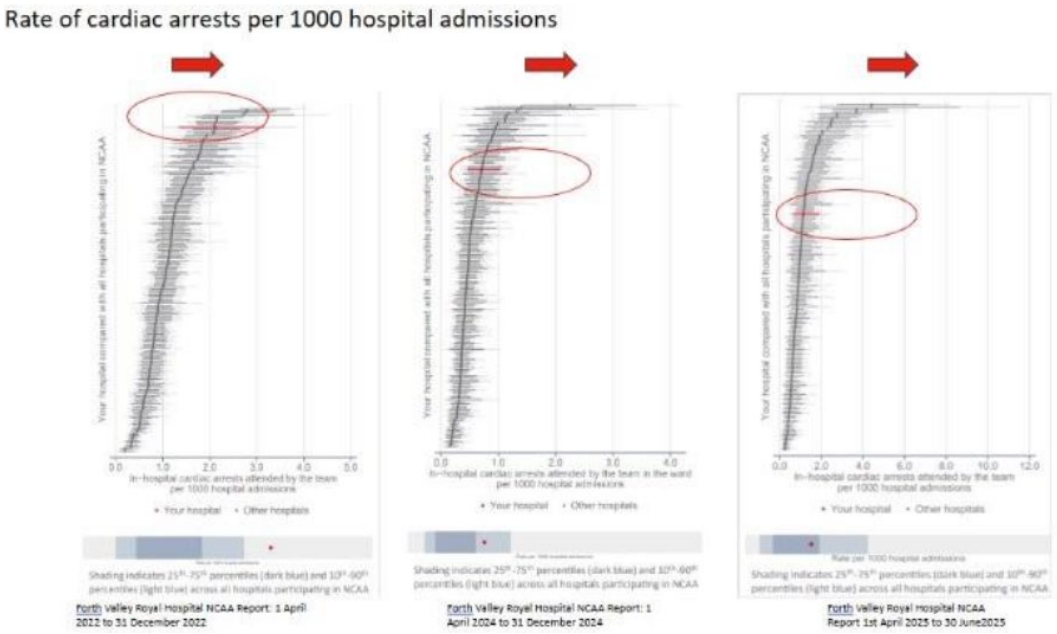
Chart 9: Rate of Cardiac Arrests (October 2020 – November 2025)



As demonstrated in the chart above, at the start of the collaborative the rate was 1.83 when HIS and NHS FV noted a six-point shift (the rate was 4.40) the rate post collaborative is 0.86, there was an astronomical data point noted in February 2025. This was discussed with Healthcare Improvement Scotland at the time to provide assurance. Review of this data set both locally and nationally demonstrated increased rate across many other health boards at that time also due to acuity.

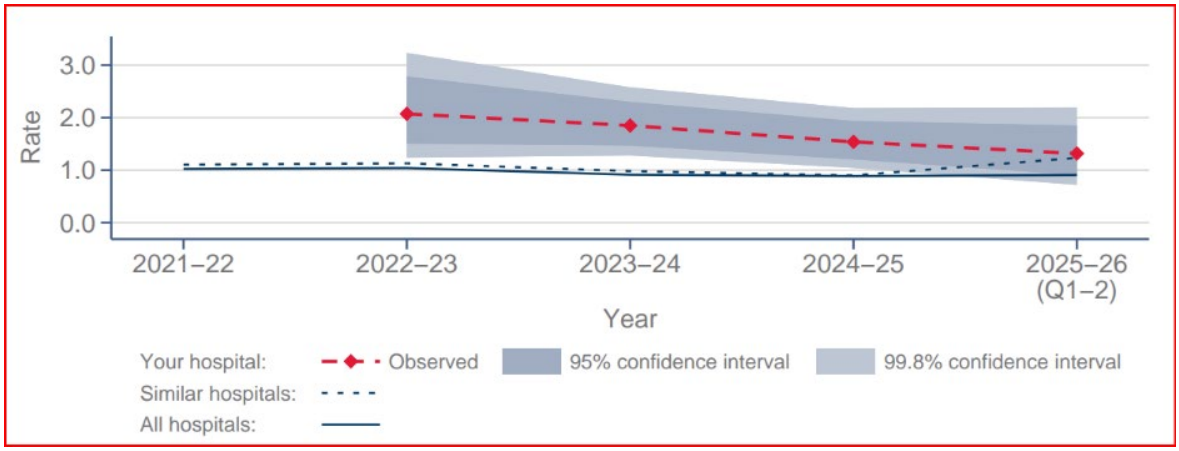
FVRH participates in the National Cardiac Arrest Audit. The following series of charts demonstrates the improvement in the reduction in cardiac arrests rates for NHS Forth Valley when compared to other hospitals in the UK (there are 214 acute hospitals currently participating in the National Cardiac Arrest Audit across UK). NCAA data are collected for any resuscitation event, commencing in-hospital with the exception of neonates.

Chart 10: National Cardiac Arrest Audit Data



In the Caterpillar charts above, the bars in all rate plots are ordered by the arrest rate, with the hospital with the highest arrest rate at the top. As demonstrated, FVRH was originally in the top 90th centile, however, the ongoing reporting through the period of the collaborative demonstrates a year-on-year improvement in this position, with FVRH now placing within the 25th –75th centile.

Chart 11: National Cardiac Arrest Audit Data observed value for FVRH



The trend graph above from the National Cardiac Arrest Audit data shows the observed value for FVRH, compared with the observed values for hospitals with a similar admission profile and for all hospitals in NCAA. In this report, hospitals with a similar admission profile are other hospitals that are similar to FVRH in number of hospital admissions. As demonstrated, there has been a year-on-year reduction, with the last quarter reporting that FVRH is now in alignment with other comparable hospitals and no longer an outlier demonstrating significant improvement.

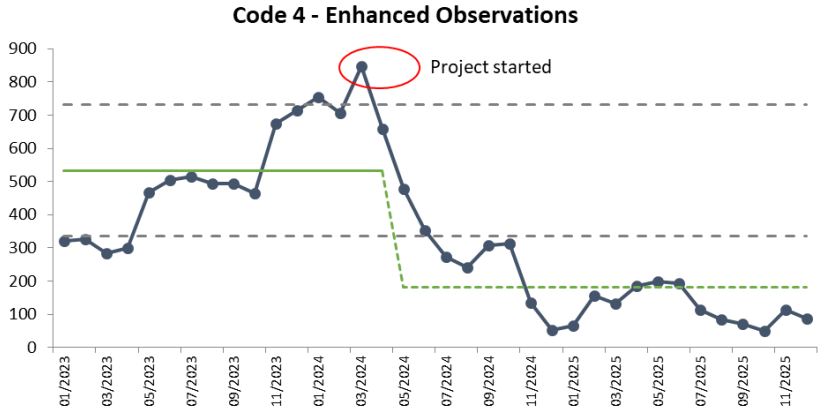
Enhanced Observations

Aim: Reduce enhanced observations by 50 % by July 25.

Outcome: Aim overachieved with 87% reduction in enhanced observations with an estimated £2.6million cost avoidance.

Next steps: Continued assurance oversight and monitoring is provided via the Workforce Governance group and locally through the patient safety and safe staffing huddles.

Chart 12: Enhanced Observation data (January 2023 – November 2025)



As demonstrated in the section below regarding falls the reduction in the enhanced observations through the appropriate application of the policy and guidance has not had a detrimental impact on patient safety or increased harm.

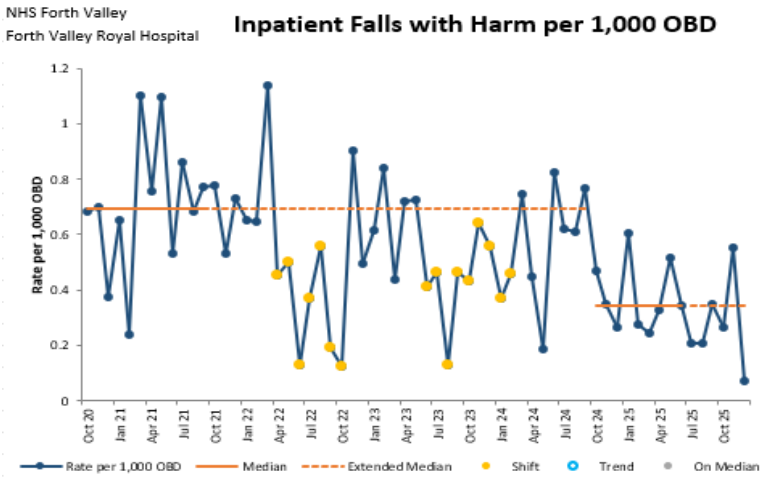
Safer Mobility – Falls and Falls with harm

Aim: Reduce total falls and falls with harm (Moderate to severe) by 30% by November 2025.

Outcome: 35% reduction noted for Falls with harm chart 13. Five-point trend below the current median noted between June - October 2025 in overall Falls: chart 14.

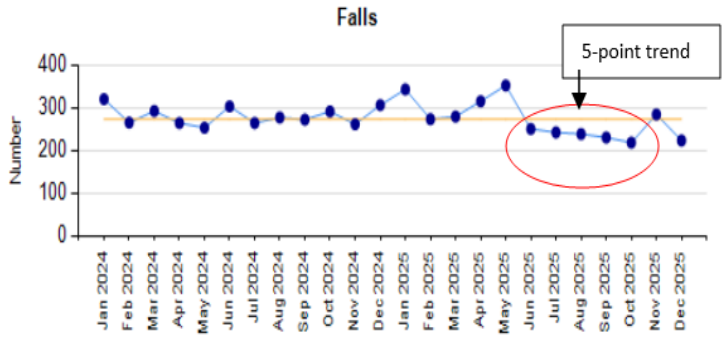
Next Steps: Falls and falls with harm will continue to be closely monitored, with improvement actions supported through the Safety Steering Group governance model. Ongoing improvement work will remain aligned to the SPSP Adults in Hospital Programme launched in November to ensure sustained progress and compliance with national standards.

Chart 13: SPSP Falls with harm per 1,000 OBD



Verification processes and adherence to safer mobility guidelines have been maintained throughout the reporting period. The Safer Together Collaborative (STC) set an outcome target of a 30% reduction in falls with harm, which was surpassed with a 35% reduction, as confirmed by Healthcare Improvement Scotland (HIS) in the latest Scottish Patient Safety Programme (SPSP) submission.

Chart 14: Whole System Falls (June 2025 – October 2025)



Comprehensive system-wide data above of whole system falls incorporates broader test teams included in the collaborative beyond the SPSP dataset. This chart demonstrates a consistent five-point improvement trend between June and October 2025.

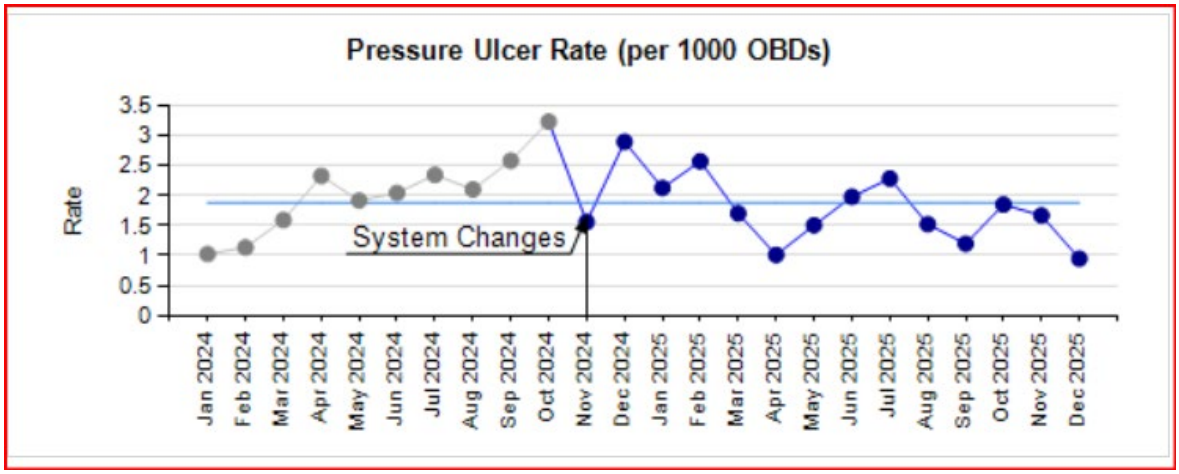
Pressure Ulcers

Aim: Reduce all pressure ulcers by 30% by November 2025. For context the numbers of reported pressure ulcers via the complaints process triggered a case review to understand the reliability of PU reporting across Forth Valley. This review discovered under reporting and variation of categorisation of harm via the safe guard system which has had a direct impact on outcome data (see data Jan-Feb 2024). A clinical review and validation process was put in place which increased the rate (note the 7-point shift from April to October above the median).

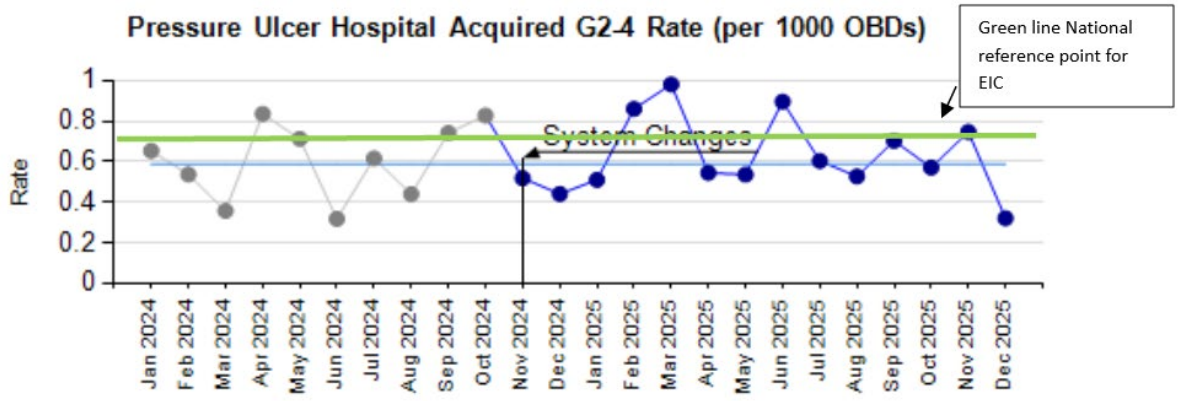
Outcome: All Pressure Ulcer data shows early signs of improvement with the last 5 data points below or on the median. In October 2024 at time of assured reporting the rate was 3.23. At the end of the collaborative the rate is now 0.95.

Next steps: Continuous education and system-wide verification efforts are being maintained to ensure robust and reliable reporting. Monitoring will continue through the Safety Steering Group governance model. Ongoing improvement work will align to the SPSP Adults in Hospital Programme for ongoing improvement efforts.

Chart 14: Pressure Ulcers (All) (January 2024 – December 2025)



All pressure ulcer data reflects the comprehensive, whole system focus on prevention, supported by robust verification processes and enhanced reporting mechanisms. Current analysis shows five consecutive data points below or on the current median.



The chart above demonstrates our performance against the national reference points for Excellence in Care The data indicates random variation in hospital-acquired pressure ulcer rates, with a stable median of just under 0.6 per 1,000 OBD over the past two years. The national reference point for performance remains 0.7 or below, providing a clear benchmark for improvement.

Catheter care

Aim: Reduce catheter by 30% by November 25.

Outcome: Whole-system baseline data was established through the collaborative and continues to be collected.

Process data within test teams shows that statistical improvements have been achieved.

Next Steps: Ongoing measurement / outcomes will be reported via the Infection Control Committee for ongoing oversight feeding into the Safety Steering group model.

Appendix 4

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Improvement Action Plan

Healthcare Improvement Scotland:
Unannounced Maternity Services safe delivery of care inspection

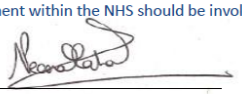
Forth Valley Royal Hospital, NHS Forth Valley

25 – 26 August 2025

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: 

Full Name: Neena Mahal

Date: 17/11/2025

NHS board Chief Executive

Signature: 

Full Name: Ross McGuffie

Date: 17/11/2025

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
Recommendation 20. Domain 1.1	NHS Forth Valley should consider adopting a continuity approach to maternity telephone triage	January 2026	Director of Midwifery	NHS Forth Valley Women & Children's services will implement the dedicated telephone triage by Jan 2026. NHS Forth Valley Maternity Services is undertaking a comprehensive assessment of midwifery staffing levels to support the optimal approach for implementing this recommendation within maternity triage. A detailed measurement plan containing process and outcome measures will support the implementation and evaluation of this improved process. Outcomes from these measurements and patient feedback will be reviewed at the monthly triage improvement group.	

Recommendation 20. Domain 1.2	NHS Forth Valley should consider improving bereavement training compliance rates for all staff providing bereavement care to families	31 March 2026	Director of Midwifery / Associate Medical Director	Training compliance for the department has increased from 59% to 72% since the inspection observation visit. The Woman and Childrens directorate have establish an AIM of 95% of all relevant staff will have completed the training by March 2026. To give assurance around the reliability of the bereavement training provided, staff feedback is being measured. Patient feedback is forming learning, through patient questionnaires including the Maternity Voices Partnership. In addition, assurance will be strengthened by: • Development of an additionally Bereavement Training Module within TURAS for all disciplines of staff by March 2026. • Board oversight will take place via Performance reviews and the data to support the work will be	

				presented on the Maternity pentana dashboard by Jan 26.	

Requirement 21. Domain 1.1	NHS Forth Valley must ensure effective oversight of activity within the maternity unit to support safe delivery of care for women including but not limited to: 1. Maternity triage 2. Delays to care, including inductions	Jan 2026	Director of Midwifery	NHS Forth Valley will improve oversight of maternity triage service through the dedicated improvement group. This group reviews current practice and drives the following improvements aims aligned to the specific measurement plan s in relation to the maternity triage process. Oversight will be provided via the newly established Quality and Safety Steering Group. NHS Forth Valley has strengthened oversight of the induction of labour (IOL) pathway to ensure safe, timely, and person-centred care. A driver diagram has been developed to clarify the aim and establish clear timeframe workstreams focused on reducing delays, improving consistency in clinical decision-making, and enhancing women's experience. An improvement group has been established which will also	

				report through the newly established Quality and Safety steering group.	

Requirement 21. Domain 1.2	NHS Forth Valley must ensure that patients are provided with the right care, in the right place, at the right time.	Jan 2026	Director of Midwifery/ Associated Medical Director	NHS Forth Valley is committed to delivering safe, effective, MEWS and person-centred care by ensuring timely access to appropriate services across all care settings. This principle underpins our clinical governance framework and aligns with national guidance on *Right Care, Right Place* This will also include the implementation of the Modified Early Warning Score (MEWS) across clinical areas beyond maternity by Jan 2026. The Clinical Observations Policy is currently under development and will set out best practice for MEWS application across the Acute setting, ensuring consistency and compliance with HIS standards by FEB 2026 is allow approval at Clinical Governance Working Group These improvement actions will be reported to the Quality and Safety Steering Group.	

Requirement 21 Domain 2.3	NHS Forth Valley must ensure effective governance and oversight to ensure all adverse events are reliably reported and changes to clinical practice identified through adverse events are compliant with the adverse events framework.	Dec 2026	Director of Midwifery / Head of Clinical Governance /Associated Medical Director	Woman & Children's directorate are reviewing current processes to improve reporting, reporting verification processes conducted by leads by Dec 2026. This will ensure reliable reporting to the Clinical Governance Groups. NHS Forth Valley is undertaking a review and implementing changes to our current adverse events reporting system (Safeguard) Regarding the Adverse Events Process and the Ulysses Safeguard System, a review is currently underway to enhance the system's usability and effectiveness. This review includes refining workflows for reporting, escalation, investigation quality, and learning dissemination. Our goal is to ensure the system supports timely, high-quality reviews and facilitates meaningful learning across the organisation within a robust reporting process, clearly aligned with the HIS national framework.	

				to align with the HIS National Framework by FEB 2026. NHS Forth Valley has reviewed and updated the Adverse Event Policy, SAER policy. These policies and procedures are now more closely aligned with the HIS national framework. A new training package has been identified to support consistent application across all staff levels. In addition, NHS Forth Valley is undertaking a benefits analysis process of the nationally procured Healthcare Guardian (In-Phase) adverse events management system by FEB 2026. Additionally, work is in progress to develop an internal Community of Practice for NHS Forth Valley of which Women and Children's will form a key constituent part This will enable the widespread sharing of learning from adverse events among all staff and staff groups. Furthermore, we are	

				engaging at a national level with HIS to participate and collaborate with the NHS Scotland Community of Practice, which aims to share learning across all NHS Boards in Scotland.	

Requirement 21. Domain 4.1.4	NHS Forth Valley must ensure clinical guidelines are up to date and reviewed within agreed timescales.	31 January 2026	Director of Midwifery/Associated Medical Director/Head of Clinical Governance	NHS Forth Valley is conducting a thorough review of existing clinical guideline and policy documents, implementing a RAG status approach to prioritise critical clinical policies and guidelines. This effort includes standardising the development, consultation, approval, and accessibility processes to ensure clarity, consistency, and alignment with best practices. This review will be complete by JAN 26 , W&C policy. The NHS Forth Valley Clinical Governance Working Group (CGWG) will oversee this process, with responsibility and accountability at the Directorate Clinical Governance group level. Updates on the progress of policy and guideline development and reviews will be a standing agenda item at all Directorate level Clinical Governance groups and the CGWG.	

				NHS Forth Valley W&C have a local Clinical Guidelines Working Group which will prioritise any expired clinical guidelines with an expected completion trajectory of 72% by January 2026. The wider NHS Forth Valley Board policy and guideline aim is that 95% will be within their review timescale by Dec 2026 .	

Requirement 21. Domain 4.1.5	NHS Forth Valley must ensure that women accessing acute care out with maternity services are consulted with appropriate risk assessments, such as the maternity early warning system (MEWS)	31 January 2026	Director of Midwifery/Associate Medical Director	NHS Forth Valley is implementing the Maternity Early Warning System (MEWS) across all acute clinical areas outside maternity services. This work forms part of the ongoing development of the clinical observations policy. NHS Forth Valley will ensure that any pregnant woman / birthing person admitted out with maternity services is clearly highlighted via the site safety huddles, enabling robust management plans and timely transfers where required. NHS Forth Valley is also implementing eObs across the system and we are currently scoping the function of a pregnant signifier in TRAK by Jan 26. This will provide digital oversight for all teams to understand where woman who are pregnant are positioned in our whole system.	

Requirement 21. Domain 4.1.6	NHS Forth Valley must ensure the safe and secure use of medicines at all times, including the storage and administration of medicines	March 2026	Head of Service	NHS Forth Valley maternity services have engaged with the Director and Associate Director of Pharmacy to ensure alignment with governance and HIS expectations. NHS Forth Valley will progress with an SBAR for review at the Safe and Secure Handling of Medications SLWG and subsequently to the Medical Devices Committee for approval of funding. NHS Forth Valley is exploring swipe access improvements to drug storage areas to improve access and safety in alignment with this requirement by March 2026. In the interim, NHS Forth Valley is mitigating risk around medicine storage within maternity services through the following measures: • Ongoing audits by Controlled Drug Officers to ensure compliance with safe	

				storage standards. • NHS Forth Valley maternity services carry out regular reviews of Care Assurance outputs to validate adherence to these standards. • NHS Forth Valley maternity services have introduced daily audits to provide real-time assurance, with compliance rates reported through established governance processes.	

Requirement 21. Domain 4.1.7	NHS Forth Valley must ensure that all staff complete statutory fire training	31 March 2026	Director of Midwifery / Associate Medical Director	Under the *Fire (Scotland) Act 2005*, NHS Forth Valley is required to ensure that all staff receive the appropriate fire safety training. TURAS Fire Training e-learning module remains the primary method for all staff to complete within NHS Forth Valley. Current compliance for online training is 80% with an AIM set for 95% by Jan 2026. Face-to-Face Sessions are provided for staff undertaking the Fire Warden role, as per legislation, in collaboration with the Fire Safety Training Team. Current compliance 53% with an AIM Set for 95% by FEB 2026. NHS Forth Valley maternity services will strengthen compliance by prioritising the following actions: • Targeted support for	

				areas requiring additional training. • Updates as part of the Women & Children's Performance Report and Women & Children Health & Safety Meeting which will provide oversight of this training compliance.	

Requirement 21. Domain 4.3.8	NHS Forth Valley must ensure that there are clear, consistent systems and processes in place to support management of any potential identified staffing risks within maternity services. This includes accurate recording of any escalation, mitigation/inability to mitigate, communication of outcomes with all relevant clinical teams and any disagreements with decisions made	31 March 2026	Director of Midwifery/Associate Medical Director	NHS Forth Valley is working towards full implementation of Safecare as a real-time staffing resource to monitor staffing levels and identify risks. Maternity services are using the TURAS platform as an interim solution. Safecare will be implemented by FEB 2026 in Maternity Services. When risks are identified (e.g., staffing below safe levels), NHS Forth Valley maternity service uses local developed escalation cards and decision-making checklists to guide staff through the process. If risks cannot be mitigated locally, they are escalated to senior staff, including the "lead of the week" and professional on-call, with clear documentation of actions taken. This escalation is be documented in three key areas to ensure transparency and enable ongoing review:	

				• Unit / huddle reports • Real Time Staffing platform • Decision-making checklists This process ensures that all escalations are tracked, reviewed, and addressed appropriately and tabled at relevant governance groups.	

Requirement 21. Domain 4.3.9	NHS Forth Valley must ensure that clear and robust systems and processes are in place, including guidance and support for staff, to allow consistent assessment and capture of real-time staffing risk across all professional clinical groups. Assessments should consider skill mix of available staff, dependency, and complexity of patients to support staff to confidently apply and record professional judgement in relation to required staffing when declaring "safe to start"		Director of Midwifery / Associate Medical Director	NHS Forth Valley maternity services are committed to embedding a culture of proactive and informed staffing risk management. The organisation's strategic direction prioritises: Safecare will be fully implemented by FEB 2026 in Maternity. • NHS Forth Valley maternity services are using integrated digital platforms to enable leadership and clinical teams to make informed, real-time decisions regarding workforce deployment and patient safety. • NHS Forth Valley is committed to embedding this digital platform (Safecare) within the medical	

				rotas by March 2026 • NHS Forth Valley maternity services are creating an environment where staff are supported to exercise professional judgement confidently, with clear frameworks that recognise the complexity and diversity of clinical settings. The Rostering and Staffing escalation Policy will be implemented by FEB 2026. This will support standards and wellbeing requirement for all NMAHP staff. • NHS ForthValley maternity services are ensuring robust oversight through workforce governance structures. NHS Forth Valley maternity services are currently aligning	

				reporting against the workforce governance com template including timeline alignment for reporting purposes by FEB 2026.	

Requirement 21 Domain 4.3.10	NHS Forth Valley must ensure that maternity and obstetric services are appropriately and effectively staffed in order to reduce delays to care, preserve patient safety and support staff wellbeing	31 March 2026	Director of Midwifery/Associate Medical Director	NHS Forth Valley recognises that safe, timely, and person-centred care depends on having the right staff in the right place at the right time. To reduce delays, preserve patient safety, and support staff wellbeing, the following measures are being implemented: Time frame for Safecare implementation FEB 2026. • NHS Forth Valley maternity services utilise an electronic staffing roster that shows the allocation of staff across all maternity areas. • NHS Forth Valley maternity services conduct daily huddles to review scheduled and unscheduled care, enabling timely adjustments to staffing levels. • NHS Forth Valley	

				maternity services have in place escalation pathways supported by standard operating procedures and daily multidisciplinary reviews which are utilised to ensure safe provision of care • NHS Forth Valley will support staff participation in leadership development days and NMAHP forums to foster resilience and collaborative problem-solving.	

Requirement 21. Domain 4.3.11	NHS Forth Valley must ensure that there are systems and processes in place to support clinical leaders within maternity services being able to access appropriate protected leadership time to fulfil their leadership and management responsibilities, also ensuring that its employees receive time and resources to undertake training which is essential to their role. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls	31 March 2026	Director of Midwifery	NHS Forth Valley maternity services will ensure leadership time will be rostered and monitored through a centralised monitoring system, ensuring transparency and accountability. This process will be fully implemented by DEC 2026 NHS Forth Valley maternity services is implementing monitoring via the SafeCare digital platform for robust compliance tracking, with a test of change in January 2026, with full roll-out in February 2026 highlight NHS Forth Valley maternity services will monitor staff wellbeing through structured monthly feedback, assessing how dedicated leadership time contributes to:	

				• reducing stress • strengthening morale • creating opportunities for professional development. NHS Forth Valley will evaluate the data to ensure alignment with the Nursing & Midwifery Taskforce principles of compassionate leadership and staff wellbeing. This will be reported through the board NMAHP Worforce group NHS Forth Valley is currently developing a rostering policy with a predicted date for completion in FEB 2026.	

9(b). Healthcare Associated Infection (HAI) Report December 2025
Purpose: This report is for Assurance

Executive Sponsor: Karen Goudie, Executive Nurse Director
Author: Jonathan Horwood, Infection Control Manager & Clinical Lead

Executive Summary

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.

- Total SABS remain within control limits. There were two hospital acquired SABs in December.
- Total DABs remain within control limits. There were three hospital acquired DABs in December.
- Total CDIs remain within control limits. There were two hospital acquired CDIs in December.
- Total ECBs remain within control limits. There were three hospital acquired ECBs in December.
- There were four mandatory surgical site infections in December.
- There was one outbreak reported in December.

Action Required

The Forth Valley NHS Board is asked to:

(1) note the HAIRT report.
(2) note the performance in respect for SABs, DABs, ECBs & CDIs.
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

This report was discussed at the Clinical Governance Committee meeting on 13 January 2026, issues raised included the decrease in hand hygiene compliance, actions to be taken as a result of the decrease, local surgical site infections, and the ward visit programme.

Risk Assessment and Mitigation

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.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications

None.

Workforce Implications

None.

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.

Population Health & Care Strategy
None.

Climate Change / Sustainability Implications
None.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

Infection Prevention & Control Team, Infection Control Committee and Clinical Governance Committee.

Appendices
Appendix 1 – Main Report

NHS Forth Valley

Healthcare Associated Infection Reporting Template (HAIRT)

December 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.
- There were no nursing home acquired SABs this month.
- Total SAB case numbers remained within control limits this month.

Device associated bacteraemia – total number this month: 6

- There were three hospital acquired DABs this month.
- There were three healthcare acquired DABs this month.
- Total DAB case numbers remained within control limits this month.

***Clostridioides difficile* infection – total number this month: 3**

- There were two hospital acquired CDIs this month.
- There was one healthcare acquired CDI this month.
- There were no nursing home acquired CDIs this month.
- Total CDI case numbers remained within control limits this month.

***E coli* bacteraemia – total number this month: 10**

- There were three hospital acquired ECBs this month.
- There were seven healthcare acquired ECBs this month.
- Total ECB case numbers remained within control limits this month.

Surgical site infection surveillance

- There were four mandatory reported surgical site infections this month.

Outbreaks

- There was one outbreak reported this month.

LDP interim targets for 2025-2026

The publication of **Further Update on Standards on Healthcare Associated Infections DL (2025) 05** sets out the local delivery plan standards for year 2025/2026.

The agreed standard **should be no increase in the incidence (number of cases) of *Clostridioides difficile* infection (CDI), *Escherichia coli* bacteraemia (ECB), and *Staphylococcus aureus* bacteraemia (SAB) in the period between April 2025 and March 2026, from the 2023/2024 case numbers baseline.**

In accordance with this ARHAI have provided FV with our 2023/2024 baseline number of healthcare associated CDI, ECB and SAB cases to enable local monitoring. This number reflects the number of cases that should not be exceeded in 2025/26 to meet the new standard.

Healthcare associated case numbers of CDI, ECB and SAB, NHS Forth Valley.

	2023/2024 case numbers (maximum number of cases for 2025/2026)	2025/2026 case numbers to date
CDI	40	25
ECB	142	93
SAB	57	38

Ongoing work to support the targets

- Regular reporting of AOP targets on a monthly basis to Executive Team and Service Leads.
- AOP targets reported to ICC, Board and Clinical Governance Committees to ensure appropriate scrutiny and progress towards targets.
- ECBs in particular urinary catheter sepsis case numbers are anticipated to fall following assessment of urinary catheter prevalence across FV as part of the Safety Collaborative work.
- Research near completion regarding PPI and biliary sepsis. Results shared with primary care and to be shared with surgical teams.
- IR1s generated for all hospital infections (ECBs, SABs, DABs and CDIs)

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 **1** last month.
There was no data exceedance for SABs this month.

Total number of SABs (April 2025 – date) = **38**

- Hospital acquired = **2**
  - Porta catheter (No attributed ward)
  - PVC (No attributed ward)

  There was no data exceedance for hospital acquired SABs this month.

- Healthcare acquired = **1**
  - unknown

  There was no data exceedance for healthcare acquired SABs this month.

- Nursing Home acquired = **0**

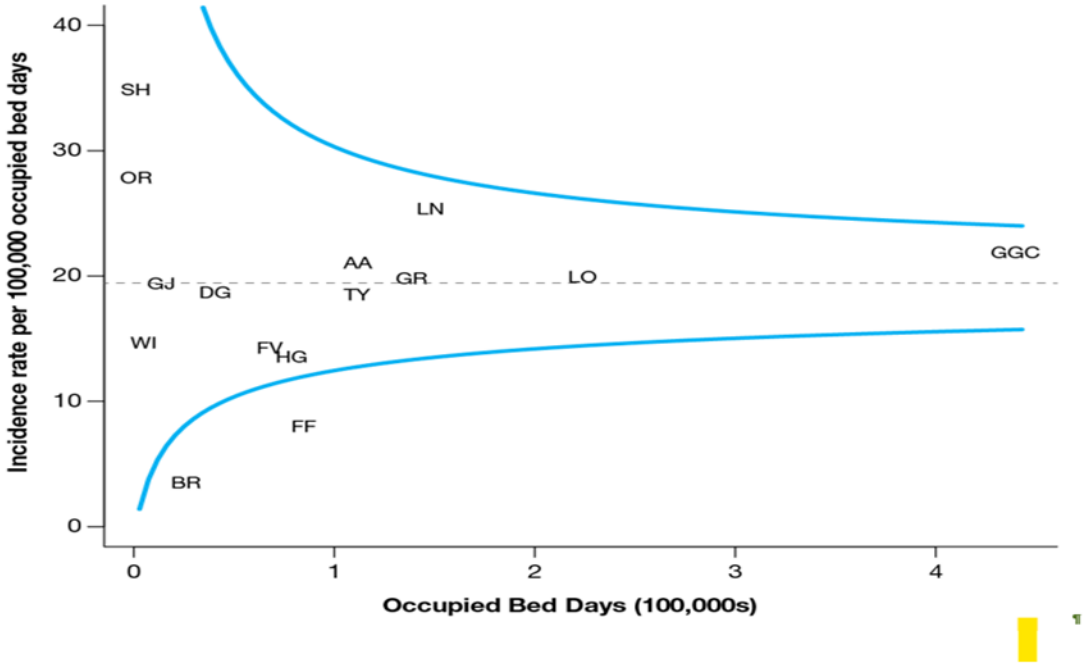
Hospital SABs

- **Porta catheter**; No ward attributed due recurring infection.
- **PVC**; No ward attributed due to completed documentation prior to infection.

NHS Forth Valley's approach to SAB prevention and reduction
All *Staph aureus* bacteraemias 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 publish is 3 months in arrears compared to the local data presented. The funnel plot below is based on the new national AOP targets ie hospital and healthcare are represented as healthcare and provides an indication of FVs position nationally. Below is an extract from the ARHAI Quarter 3 report (July – September 2025) 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; **6** compared to **5** last month.
There was no data exceedance for DABs this month.

Total number of DABs (April 2025 – date) = **53**

- Hospital acquired = **3**
  - Porta catheter (No attributed ward) x 2
  - PVC (No attributed ward) x 1

  There was no data exceedance for hospital acquired DABs this month.

- Healthcare acquired = **3**
  - CVC x 1
  - Hickman line x 1
  - Nephrostomy x 1

  There was no data exceedance for healthcare acquired DABs this month.

- Nursing Home acquired = **0**
  There was no data exceedance for nursing home acquired DABs this month.

Hospital DABs

- **Porta catheter**; No ward attributed due recurring infection.
- **Porta catheter;** Infection identified following spike in temperature. Ward not attributed due to fully completed documentation prior to infection
- **PVC**; No ward attributed due to completed documentation prior to infection.

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 ie 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 going to be set by the Scottish Government shortly. 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 **11** last month.
There was no data exceedance for ECBs this month.

Total number of ECBs (April 2025 – date) = **93**

- Hospital acquired = **3**
  - Respiratory tract x 1 (No attributed ward)
  - Unknown x 1 (No attributed ward)
  - Osteomyelitis x 1 (No attributed ward)

  There was no data exceedance for hospital acquired ECBs this month.

- Healthcare acquired = **7**
  - Hepatobiliary x 1
  - Renal x1
  - UTI x2
  - Urinary Catheter long term x1
  - Ulcer x1
  - Nephrostomy x1

  There was no data exceedance for healthcare acquired ECBs this month.

- Nursing Home acquired = **0**
  There was no data exceedance for nursing home acquired ECBs this month.

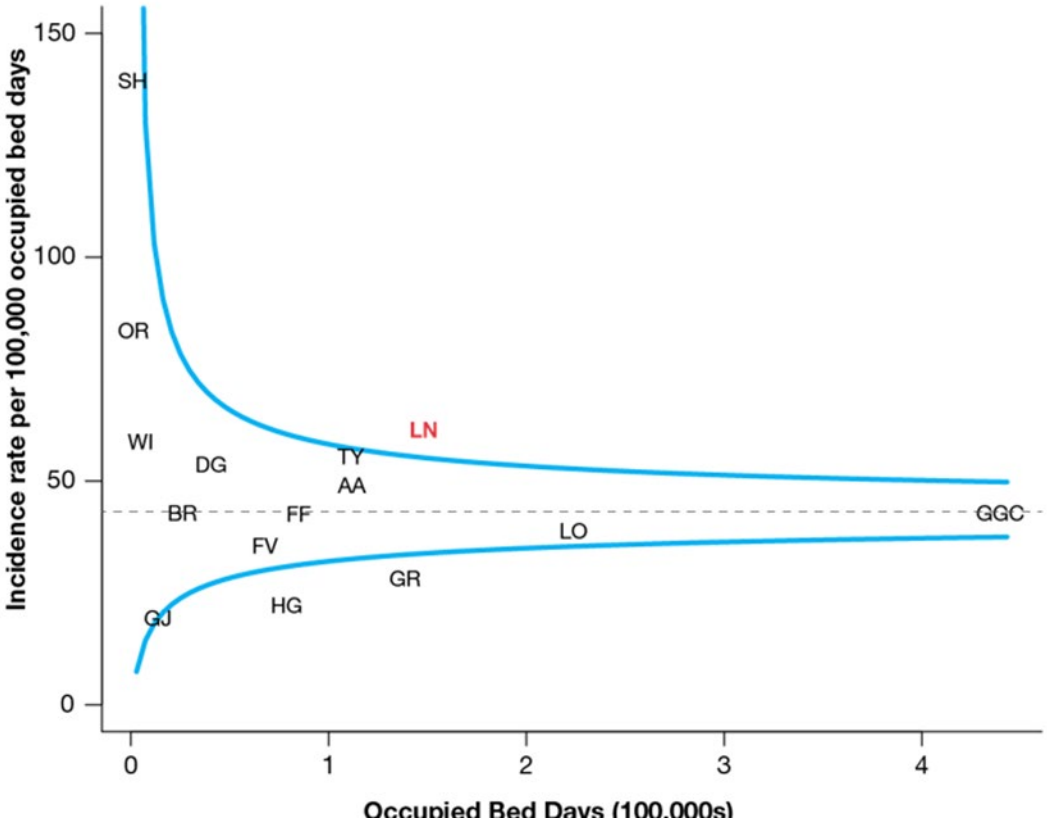
Hospital ECBs

- **Respiratory tract;** Patient developed hospital acquired pneumonia following admission.
- **Osteomyelitis;** Osteomyelitis suspected during admission due to progressive foot ulcers
- **Unknown;** following investigation cause of infection was not determined.

.

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 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 ARHAIs Quarter 3 report (July – September 2025) highlighting Forth Valley's position compared to all other boards in Scotland.



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; **3** compared to **3** last month.
There was no data exceedance for CDIs this month.

Total number of CDIs (April 2025 – date) = **25**

- Hospital acquired = **2**
  There was no data exceedance for hospital acquired CDIs this month.

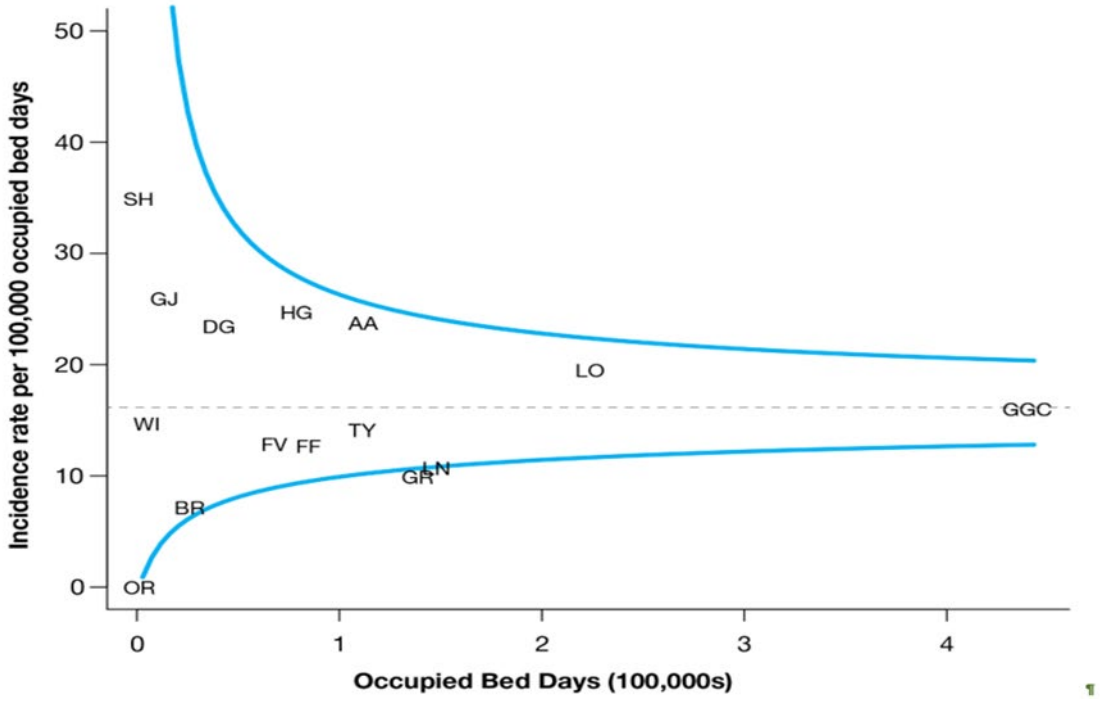
- Healthcare acquired = **1**
  There was no data exceedance for healthcare acquired CDIs this month.

- 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 plots below are based on the new national AOP targets ie hospital and healthcare are represented as healthcare and provides an indication of FVs position nationally. Below is an extract from the ARHAI Quarter 3 report (July – September 2025) highlighting 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. The NHS Forth Valley infection rates are comparable to national infection rates.

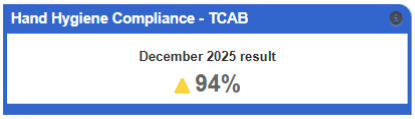
NHS Forth Valley's approach to SSI prevention and reduction

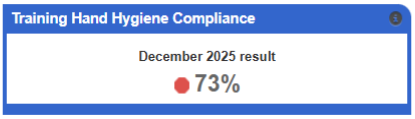
Surgical site infection criteria is determined using the European Centre for Disease Control (ECDC) definitions. Any infection identified is investigated fully and information gathered including the patient's weight, duration of surgery, grade of surgeon, antibiotics given, theatre room, elective or 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.

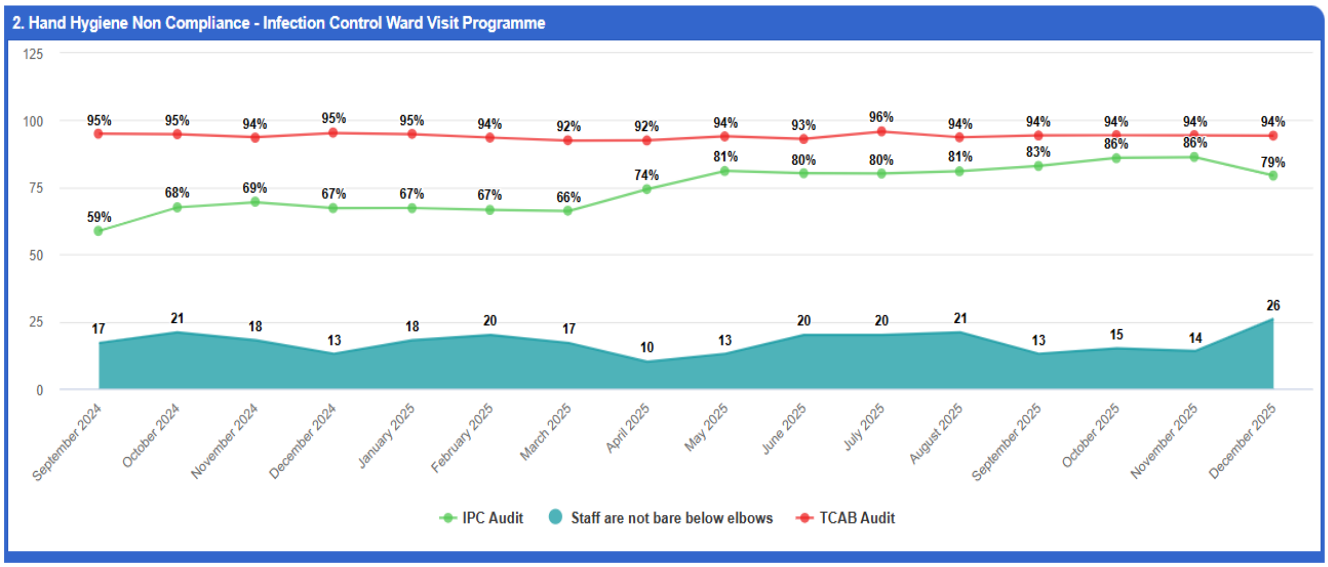
Procedure	**No of Procedures this month**	**No. of Confirmed SSIs this month (Mandatory 30 days)**	**No. of Confirmed SSIs this month (Local 90 days)**
Abdominal Hysterectomy	9	0	0
Breast Surgery	36	0	0
Caesarean Section	76	2	3
Hip Arthroplasty	56	1	0
Knee Arthroplasty	47	1	0
Large Bowel Surgery	8	0	0

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.







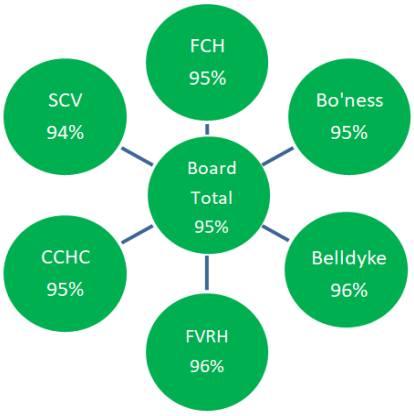
Estate and Cleaning Compliance (per hospital)

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.

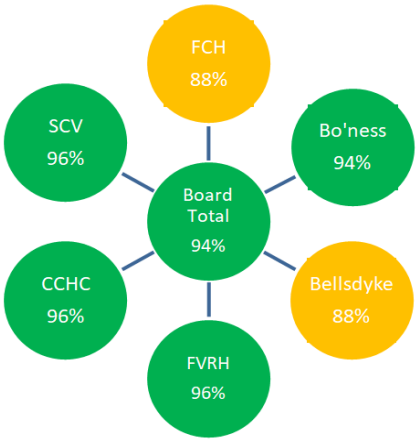
Falkirk Community Hospital and Bellsdyke Hospital Estate Scores

This quarter, the estate scores have remained relatively stable, Falkirk Community Hospital and Bellsdyke Hospital scores have decreased this quarter. Falkirk Community hospital is 88% compared to 88% the previous quarter and Bellsdyke is 88% compared to 89% the previous quarter.

Estates & Domestic Cleaning Scores from Cleaning Dashboard July – September 2025



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

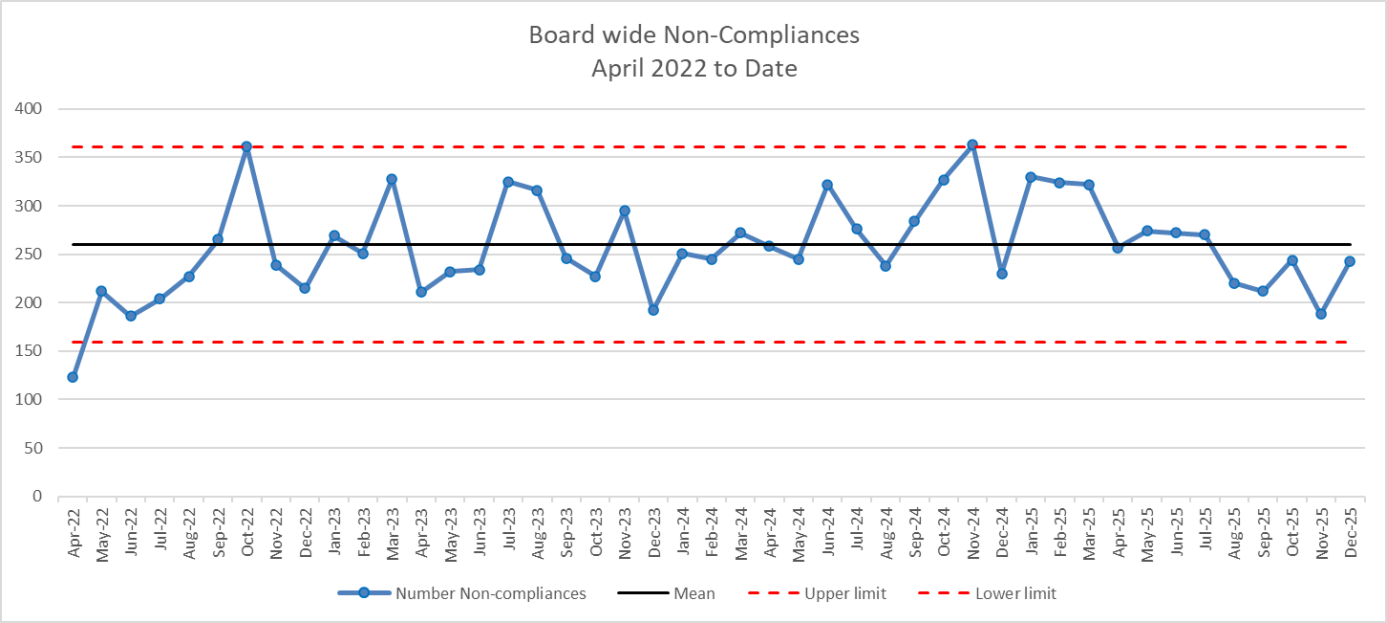
Ward Visit Programme

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 increased this month from 212 non-compliances reported in September.

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 an SPC chart detailing the non-compliances identified during the ward visits.



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).

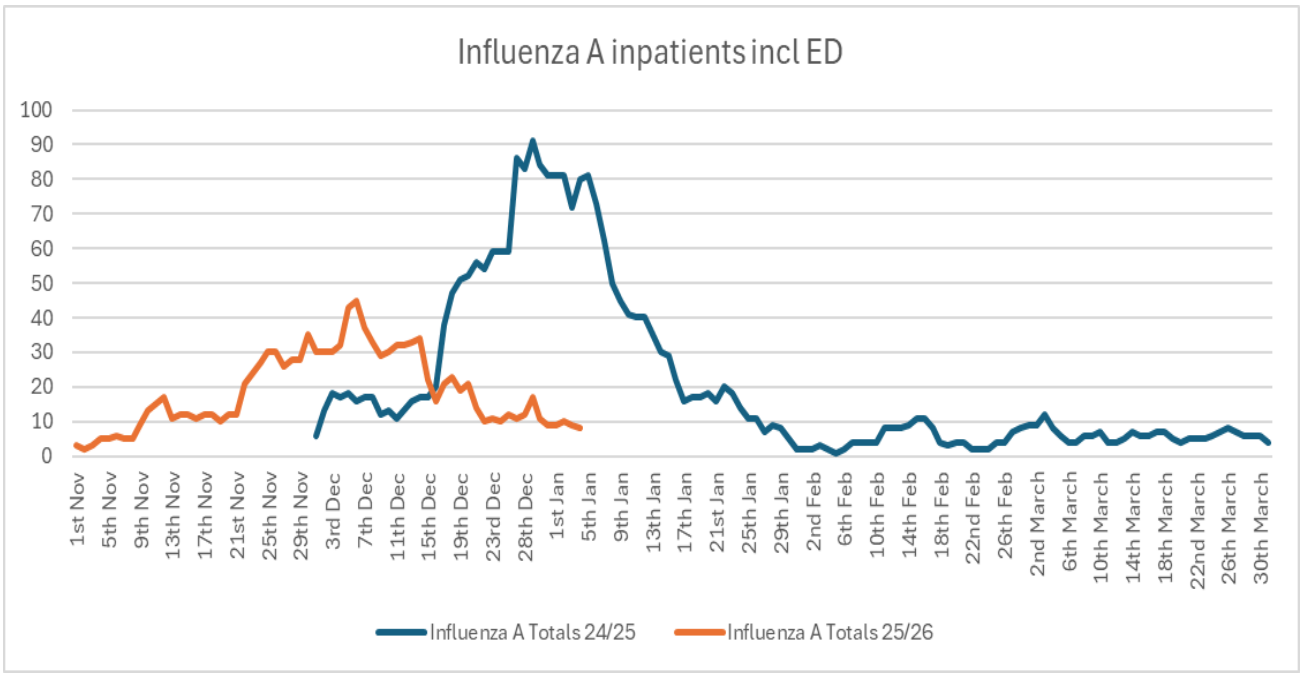
Healthcare Acquired Infection Incident Template (HAIIT)
The HAIIT is a tool used by boards to assess the impact of an incident or outbreak. The tool is a risk assessment and allows boards to rate the incident/outbreak as a red, amber, or green. The tool also directs boards whether to inform ARHAI Scotland/SG of the incident (if amber or red), release a media statement etc.

There was one outbreak reported this month:

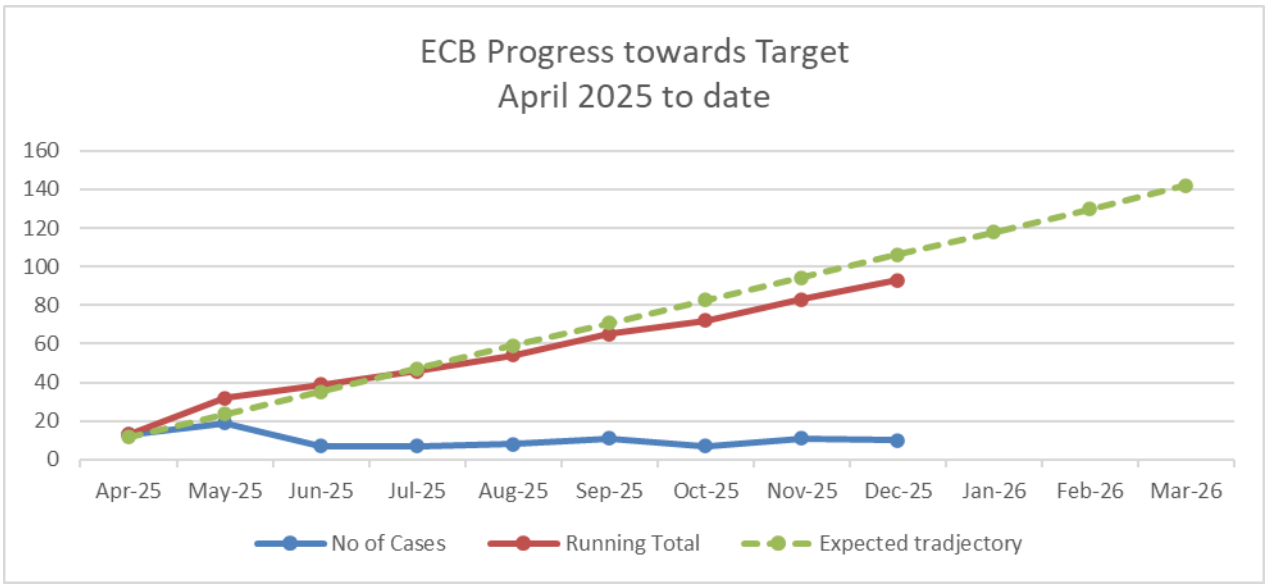
Month	Ward	Type of Outbreak	No of patients affected
Dec-25	Ward B31, FVRH	Norovirus	10

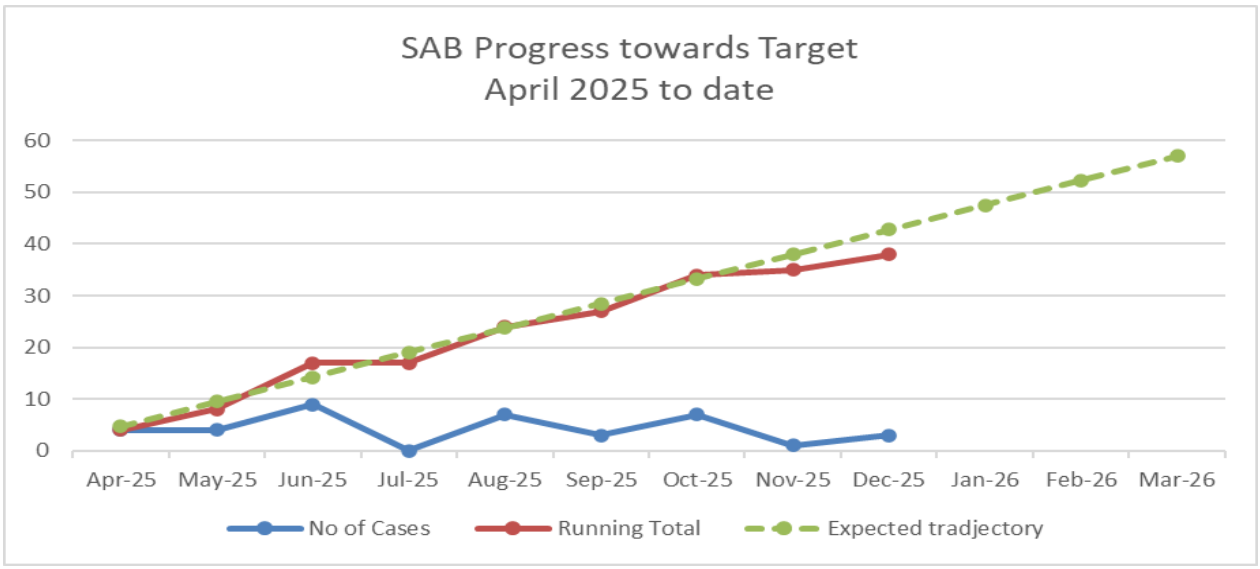
Influenza

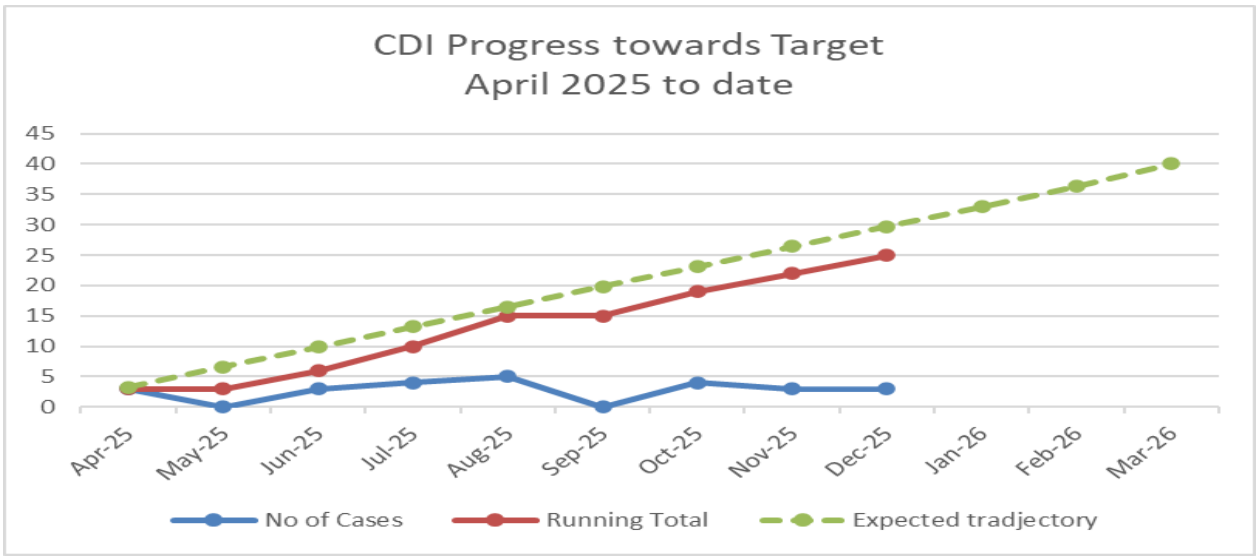
Influenza rates increased earlier than in previous years peaking in the beginning of December with 45 inpatients. Fortunately, following this peak there was a steady decline over the proceeding weeks with a daily average of 10 inpatients. See graph below.



LDP Targets

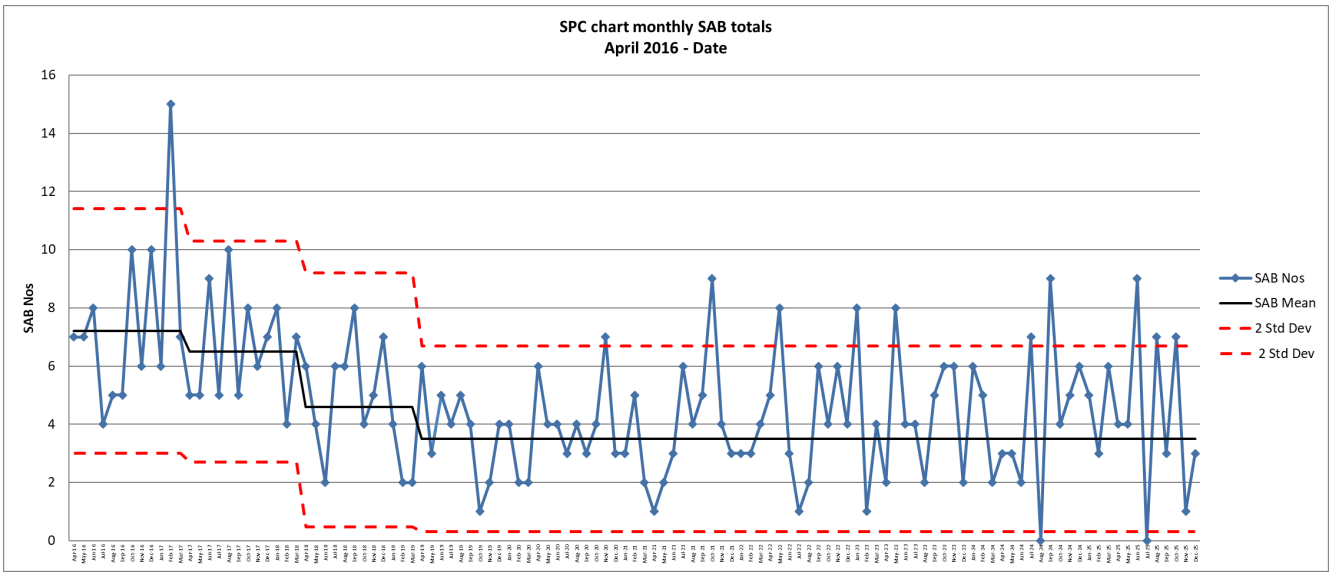

ECB Progress towards Target
April 2025 to date
160
140
120
100
80
60
40
20
0
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
No of Cases
Running Total
Expected tradjectory

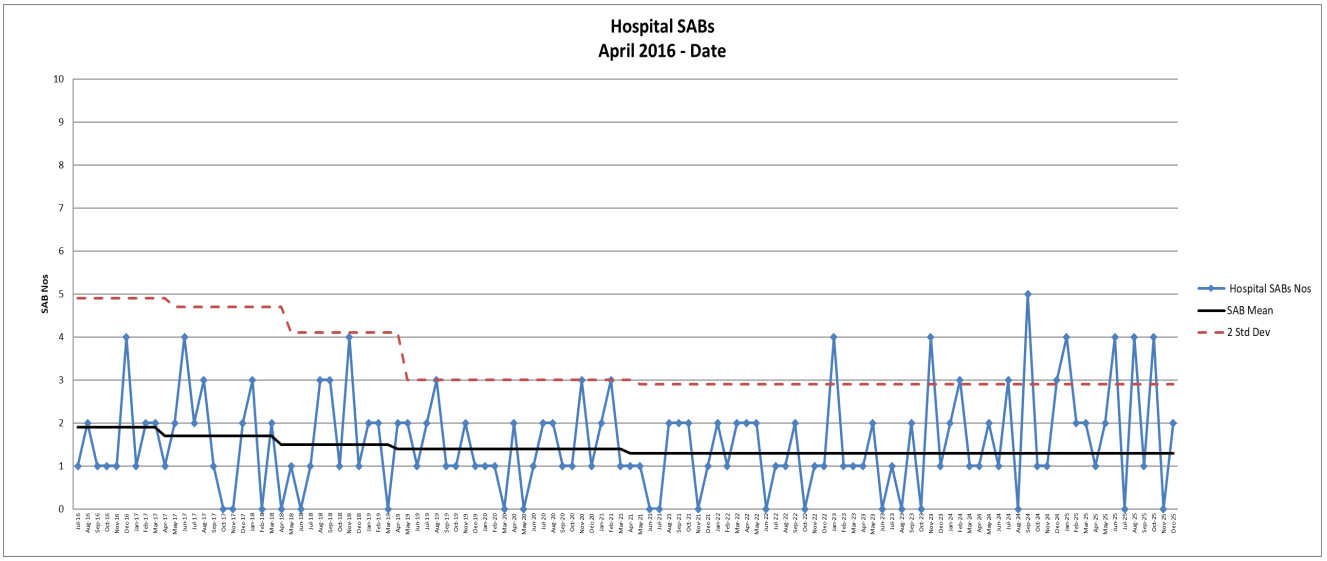

SAB Progress towards Target
April 2025 to date
60
50
40
30
20
10
0
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
No of Cases
Running Total
Expected tradjectory

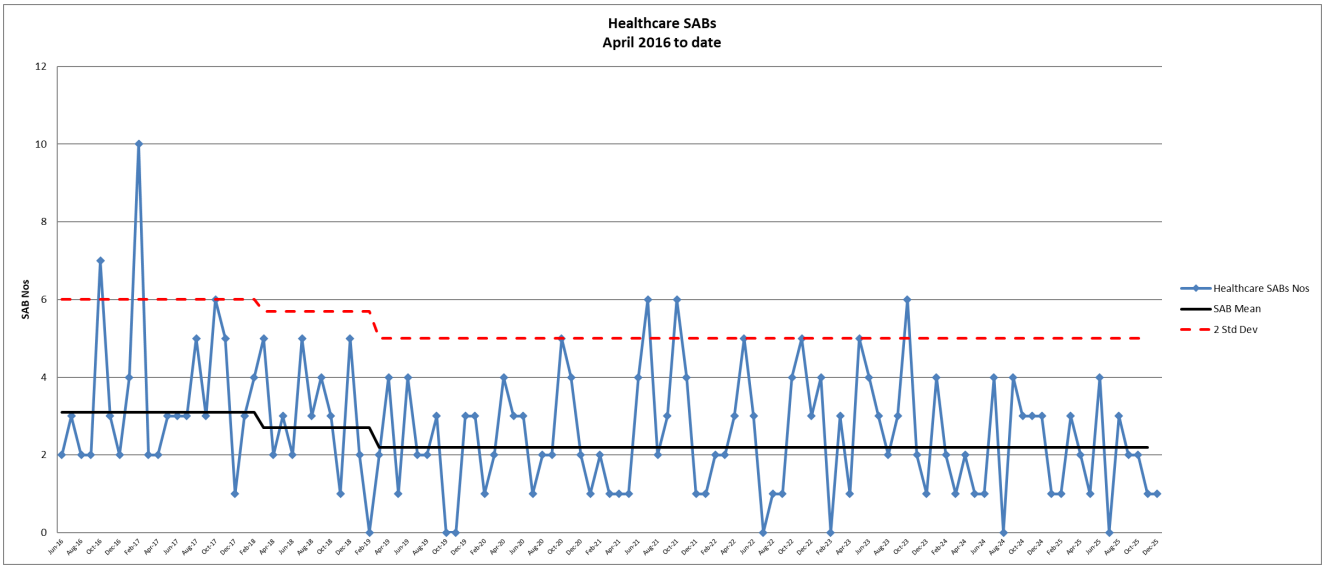

CDI Progress towards Target
April 2025 to date
45
40
35
30
25
20
15
10
5
0
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
No of Cases
Running Total
Expected tradjectory

HAI Surveillance Statistical Processing Charts

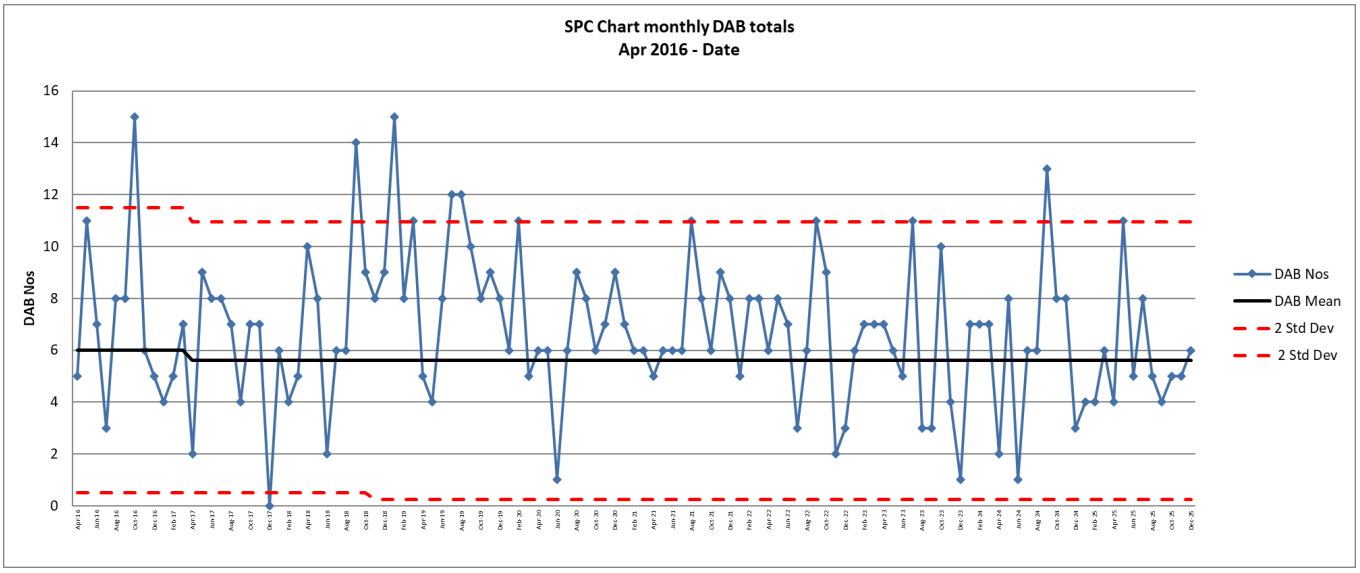
Staphylococcus aureus Bacteraemias (SABs)

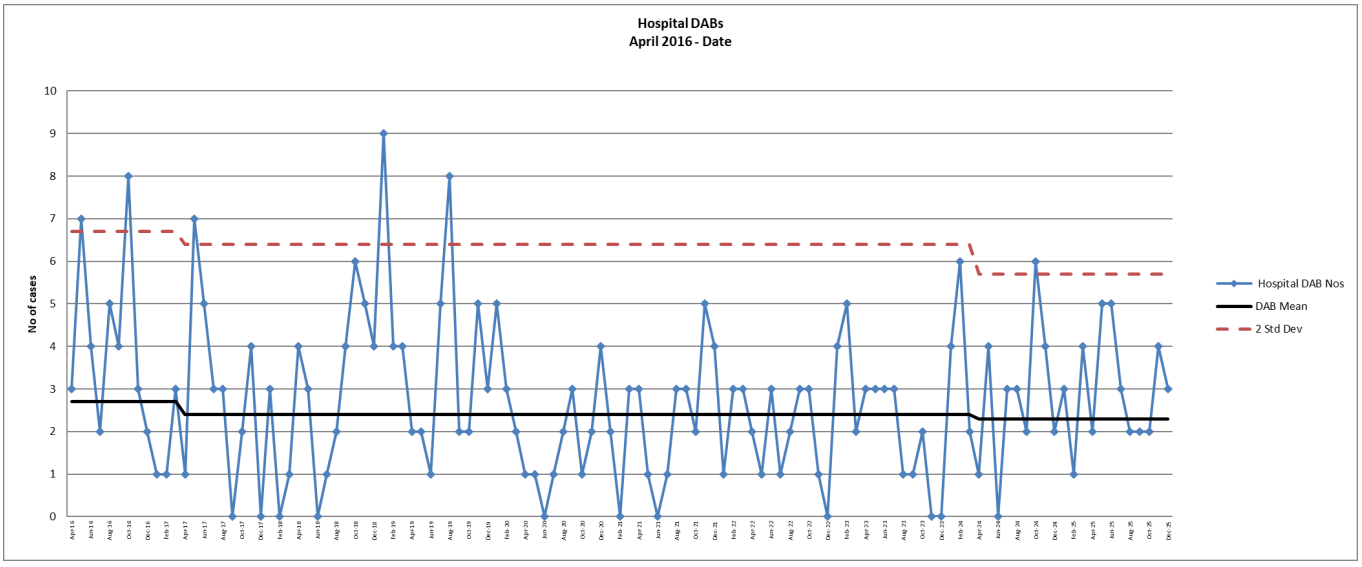


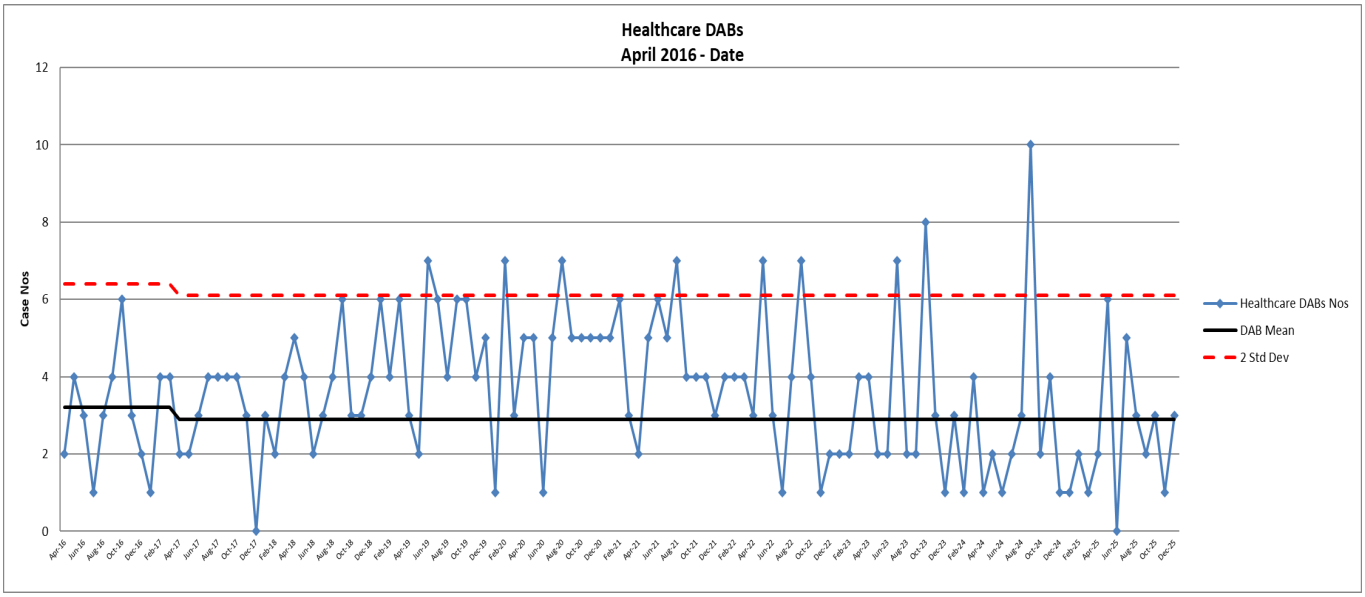




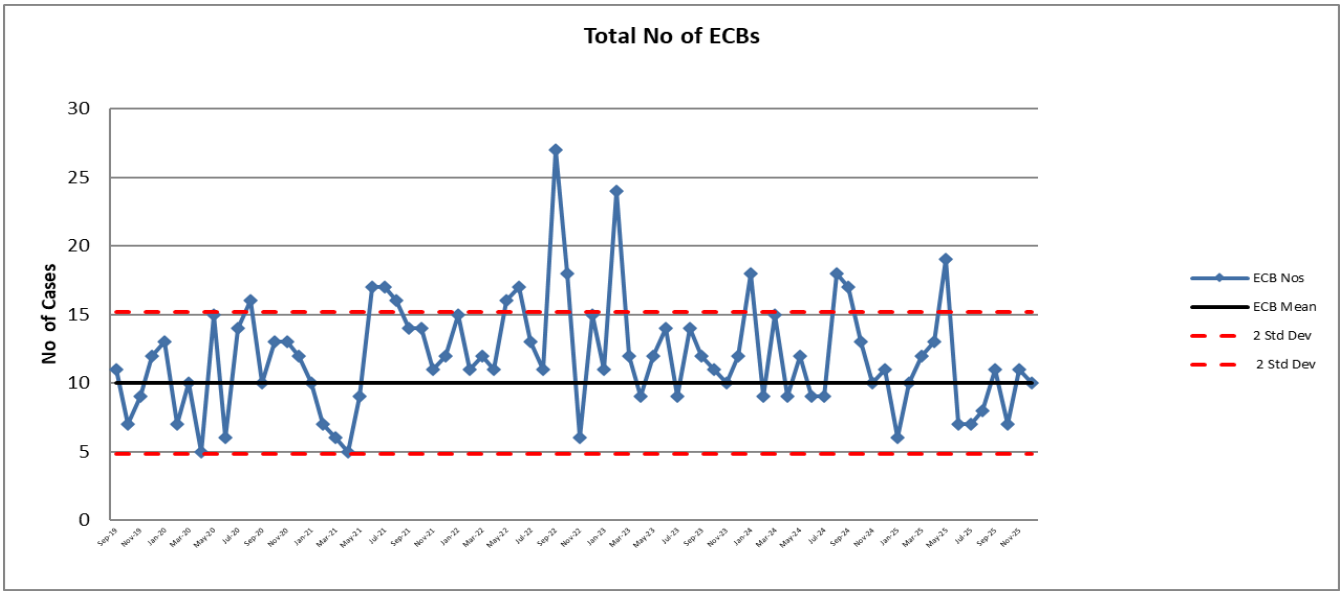
Device Associated Bacteraemias (DABs)

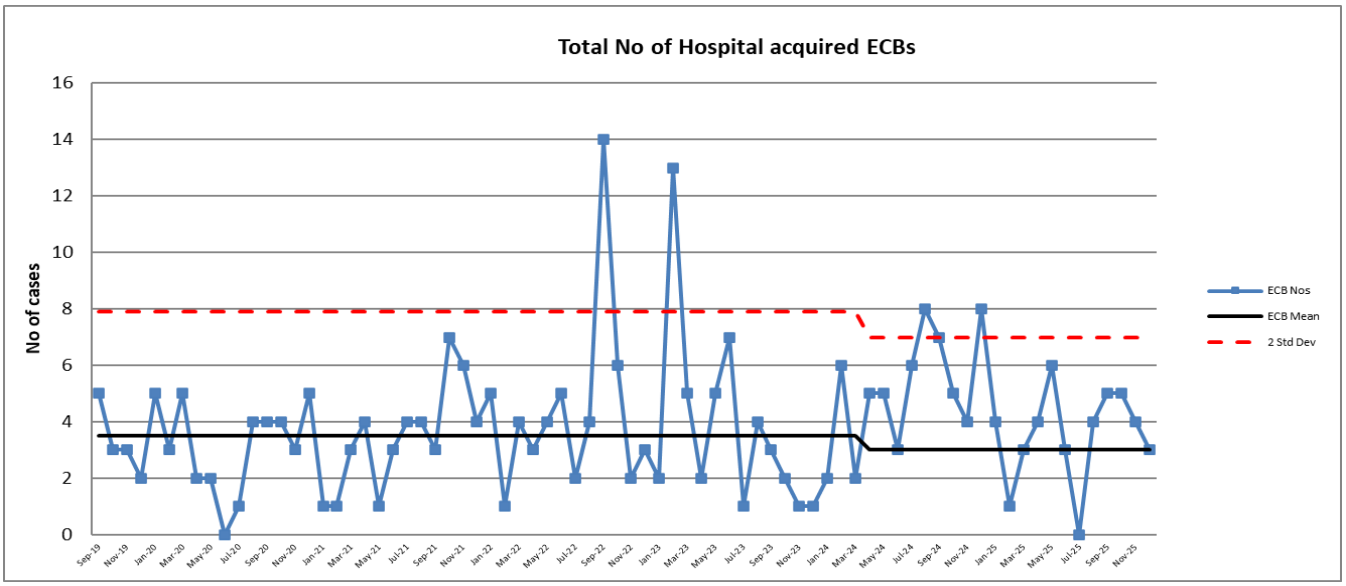


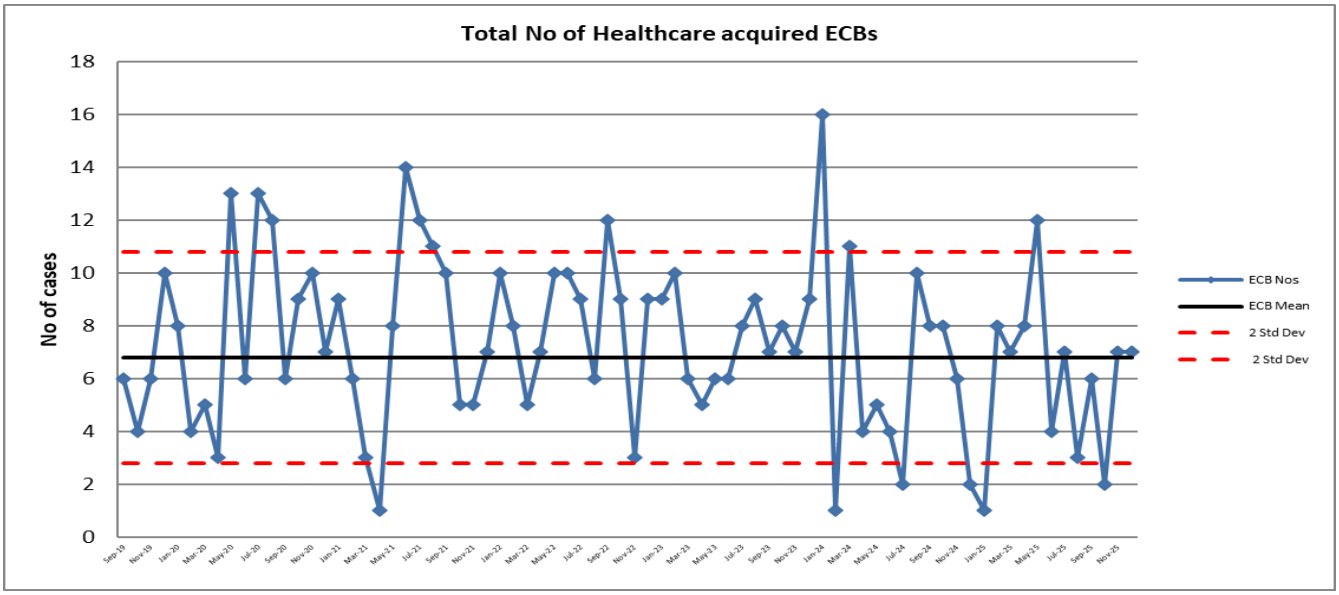




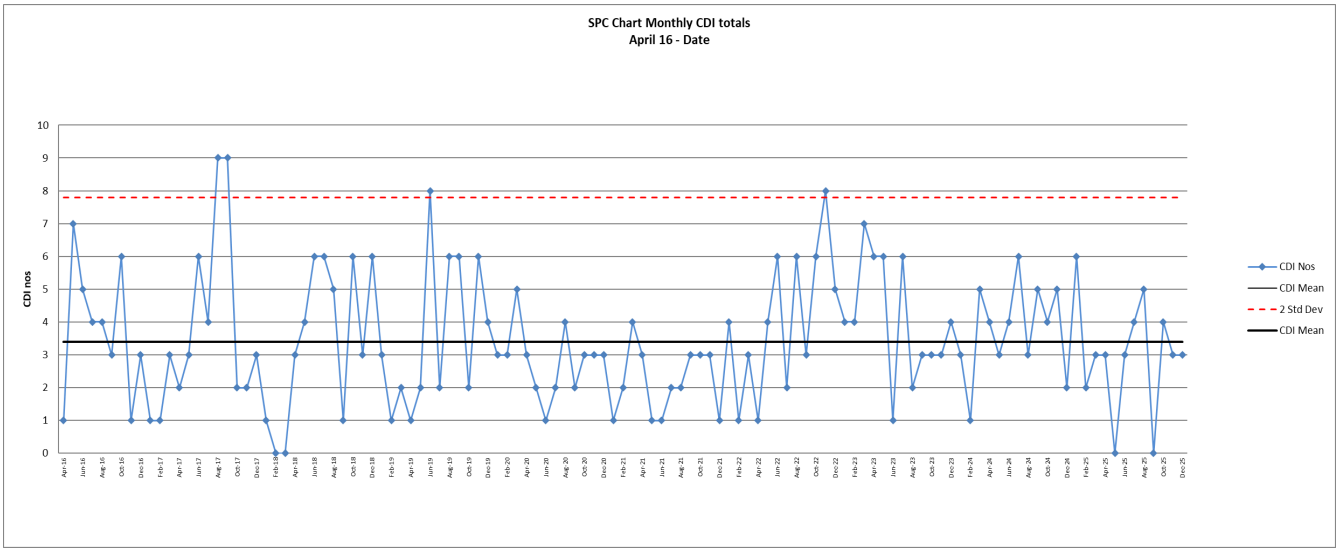
Escherichia coli Bacteraemias (ECBs)

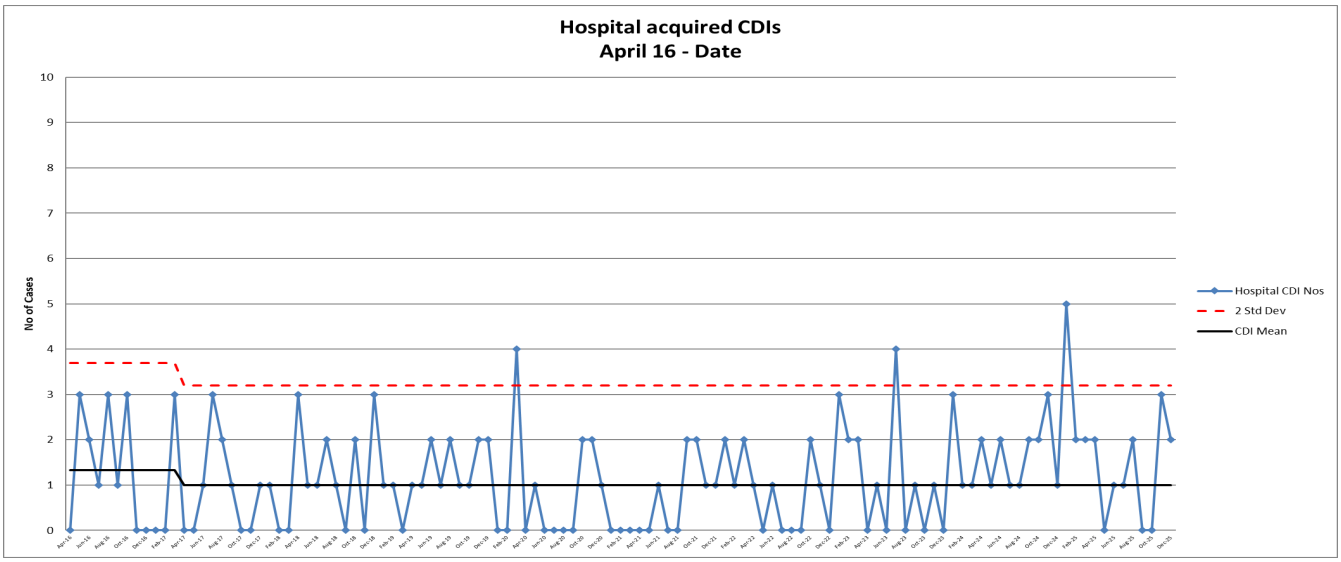


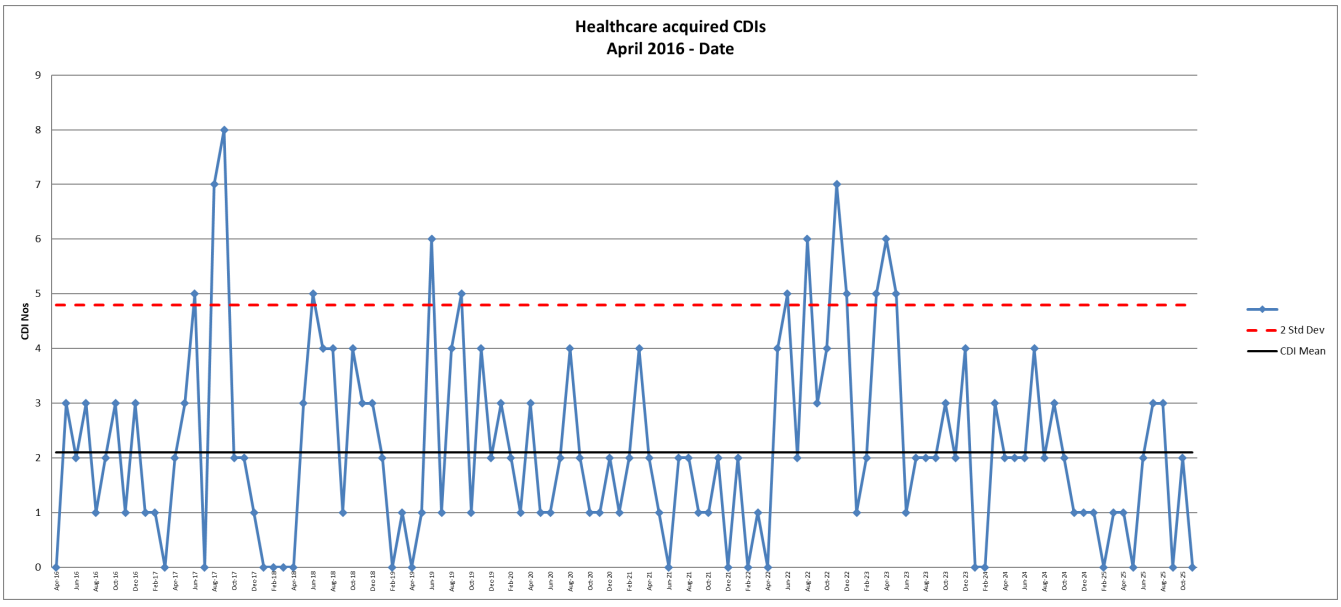




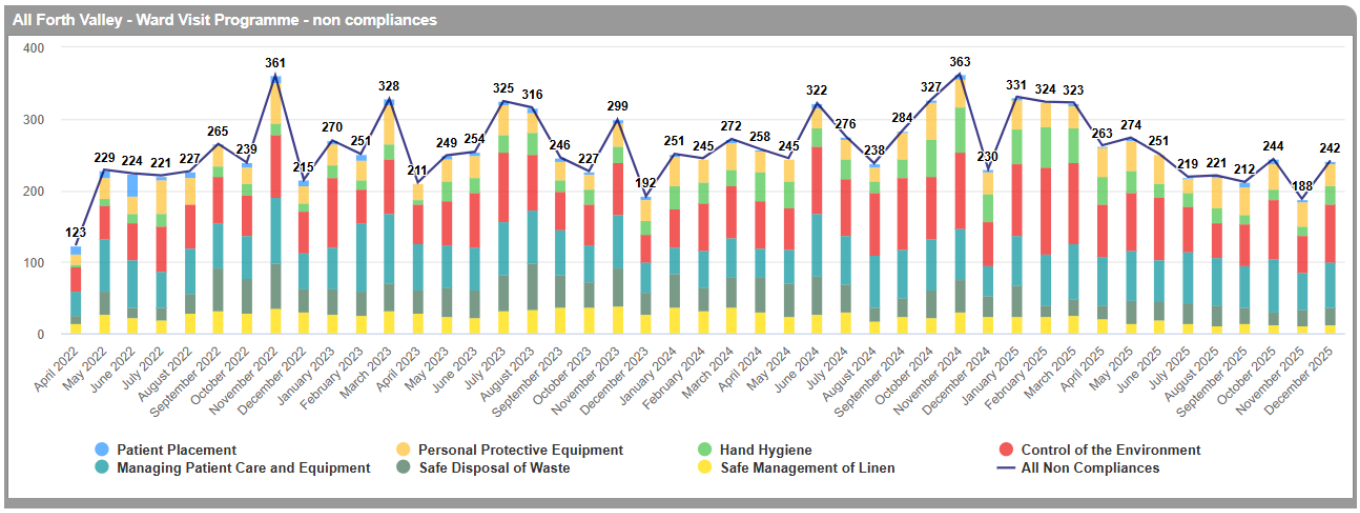
Clostridioides difficile Infections (CDIs)

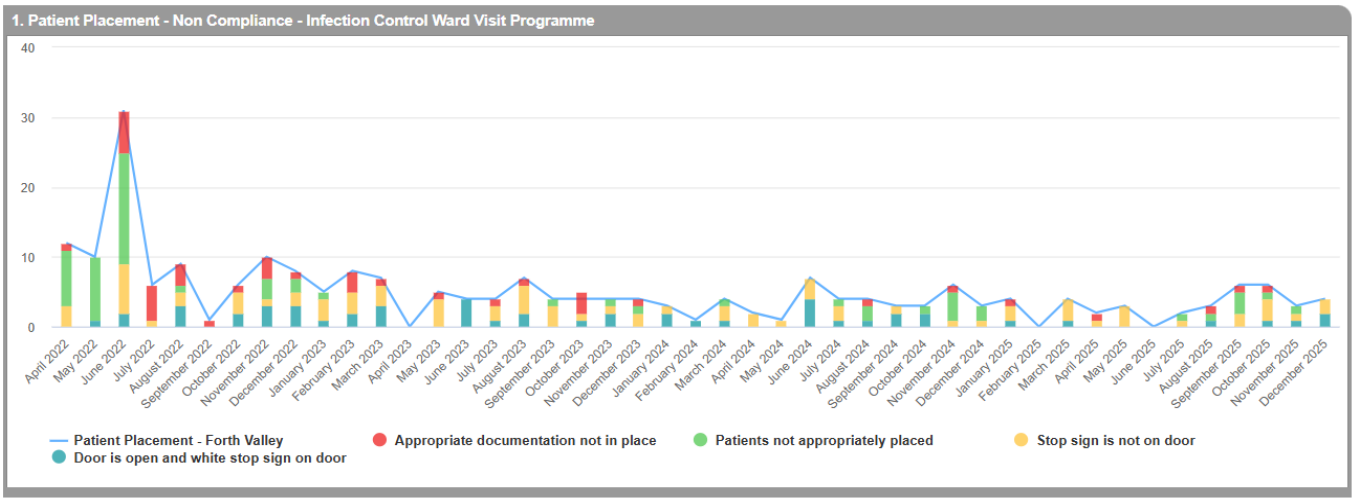


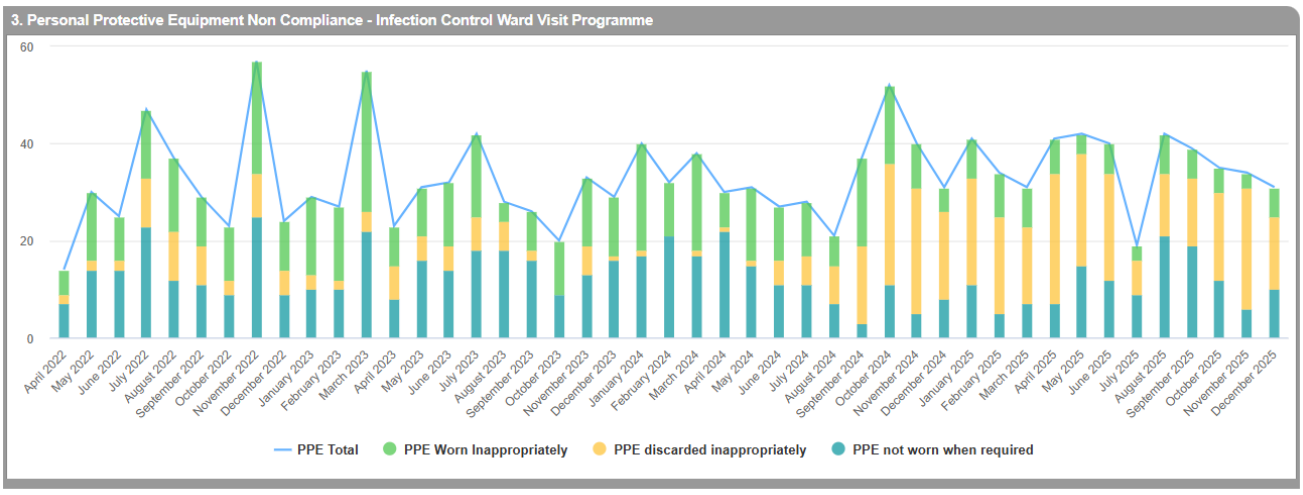


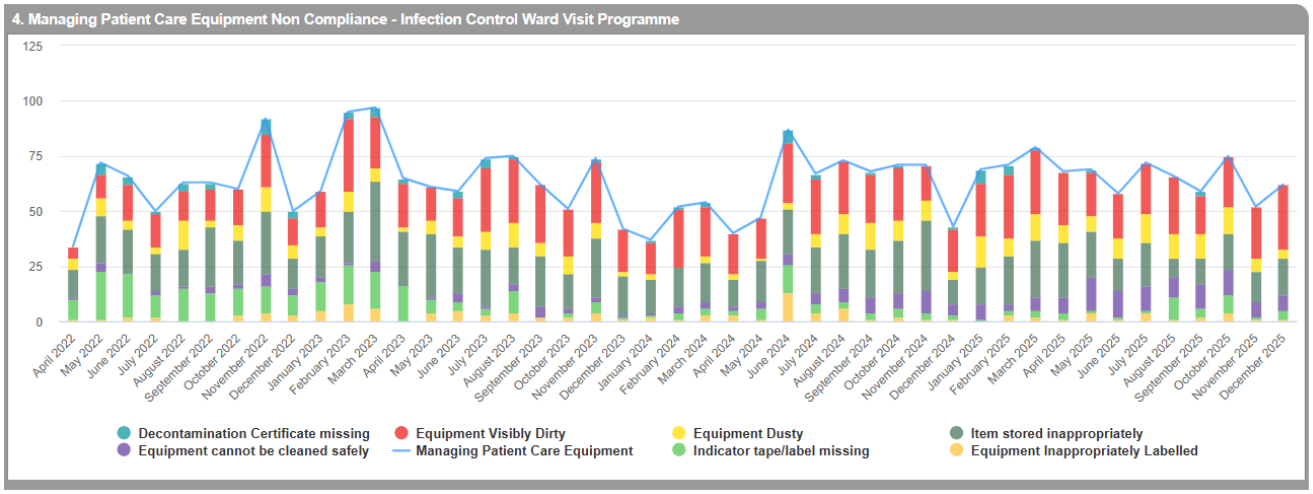


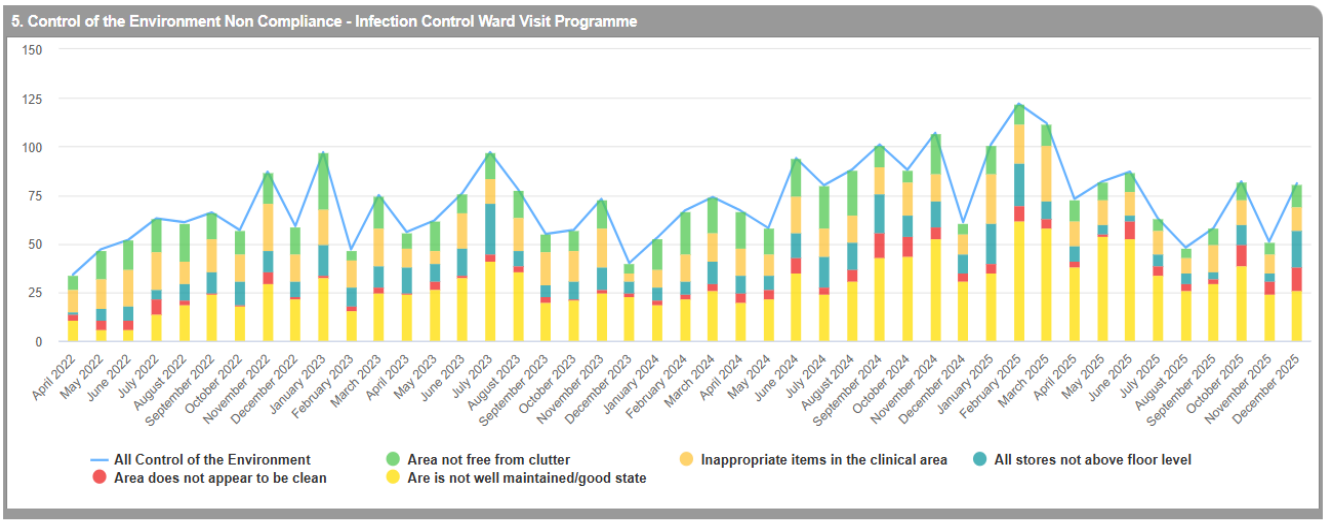
Ward Visit Non-Compliances by SICP

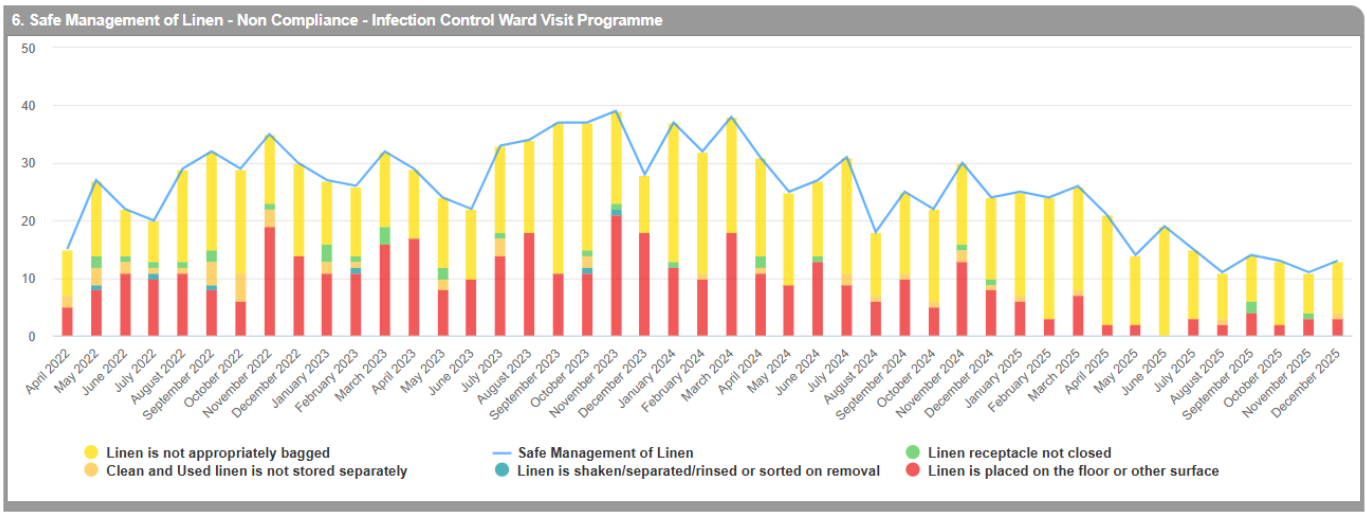


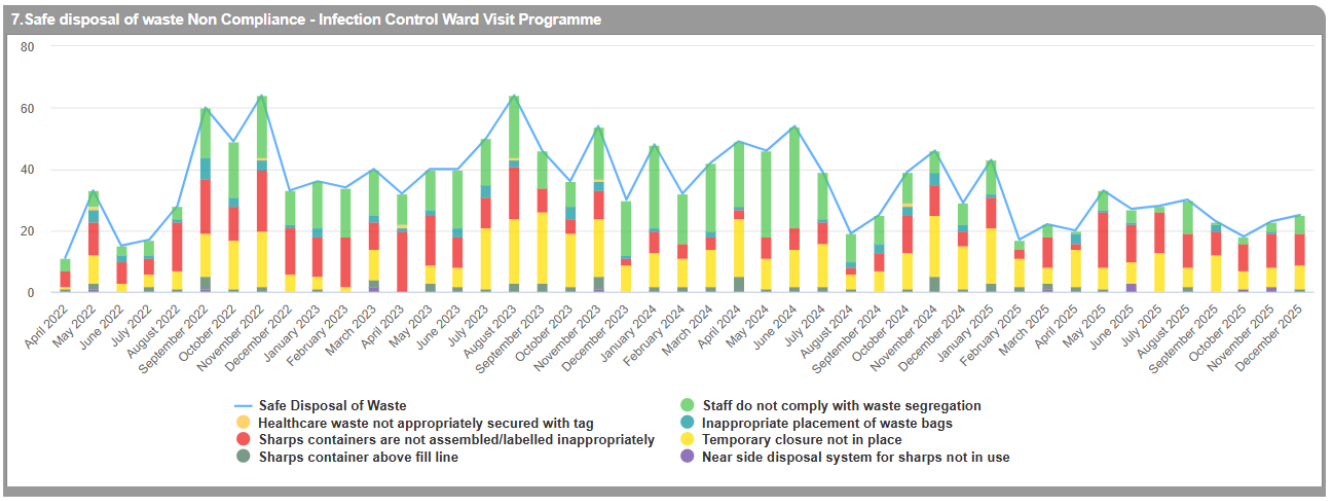





4. Managing Patient Care Equipment Non Compliance - Infection Control Ward Visit Programme
125
100
75
50
25
0
April 2022
May 2022
June 2022
July 2022
August 2022
September 2022
October 2022
November 2022
December 2022
January 2023
February 2023
March 2023
April 2023
May 2023
June 2023
July 2023
August 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
March 2025
April 2025
May 2025
June 2025
July 2025
August 2025
September 2025
October 2025
November 2025
December 2025
Decontamination Certificate missing
Equipment Visibly Dirty
Equipment Dusty
Item stored inappropriately
Equipment cannot be cleaned safely
Managing Patient Care Equipment
Indicator tape/label missing
Equipment Inappropriately Labelled


5. Control of the Environment Non Compliance - Infection Control Ward Visit Programme
150
125
100
75
50
25
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
March 2025
April 2025
May 2025
June 2025
July 2025
August 2025
September 2025
October 2025
November 2025
December 2025
All Control of the Environment
Area not free from clutter
Inappropriate items in the clinical area
All stores not above floor level
Area does not appear to be clean
Are is not well maintained/good state


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
March 2025
April 2025
May 2025
June 2025
July 2025
August 2025
September 2025
October 2025
November 2025
December 2025
Linen is not appropriately bagged
Safe Management of Linen
Linen receptacle not closed
Clean and Used linen is not stored separately
Linen is shaken/separated/rinsed or sorted on removal
Linen is placed on the floor or other surface


7.Safe disposal of waste Non Compliance - Infection Control Ward Visit Programme
80
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
March 2025
April 2025
May 2025
June 2025
July 2025
August 2025
September 2025
October 2025
November 2025
December 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

NHS Forth Valley
Forth Valley NHS Board

10. HIS Unannounced Maternity Inspection-NHS Forth Valley.
Purpose: This report is for Assurance

Executive Sponsor: Karen Goudie, Executive Nurse Director
Author: Helena Marshall, Head of Service/Chief Midwife/Dr Julie Christie, Associate Medical Director

Executive Summary

Healthcare Improvement Scotland (HIS) conducted an unannounced Safe Delivery of Care inspection of Maternity Services at Forth Valley Royal Hospital, with the observational component of the inspection taking place between 25 and 26 August 2025.

The assessment reviewed compliance with national standards, focusing on the safe delivery of care, governance structures, and workforce resilience.

The resulting report was published on 27 November. The HIS report identified

- 9 areas of good practice
- 2 recommendations
- 11 requirements

NHS Forth Valley subsequently provided HIS with an action plan (Appendix 2) addressing the associated recommendations and requirements. NHS Forth Valley have developed a local action plan to ensure that the recommendations and requirements are being addressed accordingly. A high-level summary of progress can be found at (Appendix 3).

Key Issues Identified

- **Triage:** Maternity Triage processes and timely access were highlighted.
- **Induction of Labour:** Time to induction of labour reviewed.
- **Adverse Events Process:** Oversight, categorisation of events, escalation and reporting.
- **Workforce Governance:** Staffing escalation processes and l protected leadership time.
- **Training Compliance:** Mandatory training reviewed across a number of themes.

Action Required

The Forth Valley NHS Board is asked to:

- note the findings of the HIS inspection and the associated risks;
- note the proposed action plan addressing HIS recommendations, including governance, workforce, and safety improvements;
- take assurance that the correct actions are in place and being progressed as per timescales, and
- consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration
Governance Routes detailed below:

- NHS Forth Valley Working Clinical Governance Group 10 December 2025. Highlighted as part of the W&C Assurance Report
- O&G Consultants and Seniors meeting 12 Dec 2025
- Acute Directorate Performance Review 20 November 2025
- Women & Children's Clinical Governance Group, 21 November 2025.
- Women & Children's Professional Assurance Meetings, 8 January 2026
- Acute Strategic Management Group Meeting, 9 January 2026

Risk Assessment and Mitigation

- **Patient Safety:** Delays in the implementation of HIS recommendations may adversely affect the safe delivery of care.
- **Regulatory Compliance:** Non-compliance with HIS standards and statutory obligations outlined in the Health and Care (Staffing) (Scotland) Act 2019 may lead to referral or escalation to external regulatory bodies.
- **Reputational Impact:** Failure to comply or negative outcomes identified during follow-up inspections may compromise the organisation's credibility and diminish public trust.
- **Immediate Clinical Safeguards:** Ongoing work to enhanced triage protocols and escalation pathways to ensure timely intervention for high-risk- cases.
- **Governance Reporting Enhancements:** Oversight has been reinforced with weekly HIS Delivery Group reviews, revised action logs within the Delivery Tool, and data visualisation demonstrating improvement aims integrated into Pentana to offer real-time assurance and track progress.
- **Workforce Monitoring:** Deployment of Safecare workforce management system scheduled for February 2026, enabling dynamic staffing reviews and compliance with Safe Staffing- legislation.
- **Evidence Tracking:** The oversight group will deliver progress to date and provide governance arrangements for delivery of the action plan. Escalation Framework**:** Clear escalation routes to NHSFV HIS Oversight Group, Women & Children's Clinical Governance Group, Acute Clinical Governance and Clinical Governance Committee and Board level for any deviation from agreed milestones or emerging risks.

Impact Assessments
Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial, Digital and Infrastructure Implications
Financial: Minimal capital cost; revenue impact from workforce adjustments absorbed within existing budgets.
Digital: Safecare implementation for real-time staffing oversight. Adoption of new National MEWS into Badgernet and as part of electronic observation implementation
Infrastructure: There may need to be an assessment of Wi-Fi within triage area if moving towards consultant/ senior connect and recorded calls.

Workforce Implications
The report identifies staffing pressures and training cancellations as risks. Actions aim to improve staff support, leadership time, and workforce sustainability.

Population Health & Care Strategy
The HIS inspection findings and subsequent action plan directly contribute to NHS Forth Valley's Population Health & Care Strategy by strengthening the safety and quality of maternity services, which are critical to improving maternal and neonatal outcomes across the region. Enhancing triage responsiveness and governance processes ensures that care is delivered promptly and equitably, reducing avoidable harm and supporting population health objectives.

Climate Change / Sustainability Implications
No direct implications identified.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

NHS FV HIS Deliverable Weekly Group weekly meetings in place are chaired by Head of Service/Chief Midwife with NHS FV Oversight Group two weekly meetings chaired by Executive Nurse Director.

Appendices
Appendix 1 – Main Report and HIS Action Plan
Appendix 2 – Local Action Plan Summary of Progress

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Forth Valley Royal Hospital

NHS Forth Valley

25 – 26 August 2025

Published November 2025

www.healthcareimprovementscotland.scot

About our inspection

Background

In November 2021 the Cabinet Secretary for Health and Social Care approved Healthcare Improvement Scotland inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. Taking account of the changing risk considerations and sustained service pressures, the methodology was adapted to minimise the impact of our inspections on staff delivering care to women and families. Our inspection teams are carrying out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records.

From April 2023 our inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland Quality Assurance Framework. Further information about the methodology for acute hospital safe delivery of care inspections can be found on our website.

Our Focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

Whilst this report uses the term ‘women’ the inspection team acknowledge the importance of including all people who give birth.

About the hospital we inspected

Forth Valley Royal Hospital is a district general hospital located in Larbert, Scotland. It provides 24-hour emergency care, intensive care facilities, surgical specialties, maternity, neonatal and paediatrics, major trauma and oncology services.

About this inspection

We carried out an unannounced inspection to Forth Valley Royal Hospital, NHS Forth Valley on Monday 25th and Tuesday 26th August 2025 using our safe delivery of care inspection methodology. We inspected the following areas:

- ward 7 (labour ward)
- ward 8 (mixed antenatal postnatal ward)
- maternity triage

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with women such as during mealtimes
- spoke with women, visitors and ward staff, and
- accessed women's health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Forth Valley to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On Friday 19 September 2025, we held a virtual discussion session with key members of NHS Forth Valley staff to discuss the evidence provided and the findings of the inspection.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Forth Valley, and in particular all staff at Forth Valley Royal Hospital, for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection.'

During inspection we observed staff providing compassionate and responsive care to women and their families. Women we spoke with were complimentary of care received and of the staff providing the care.

We observed good teamwork, including extended members of the multidisciplinary team such as obstetricians, anaesthetists, midwives and the health care support team. Visible senior midwifery leadership and positive interactions with staff were also

observed, with student midwives describing a friendly and supportive learning environment. Staff described a visible senior hospital management team and felt able to raise concerns.

We observed a variety of initiatives implemented for staff wellbeing and received feedback from staff of supportive senior leadership.

During inspection we identified areas for improvement, including improved oversight of activity within the maternity unit to support the safe delivery of care, including delays to care within maternity triage. We also observed the need for improved governance and oversight of adverse events to ensure these are reliably reported and that identified improvement actions are implemented timeously.

Other areas for improvement have been identified, including systems and processes to ensure consistent and accurate assessment of real-time staffing risks with clinical leaders receiving protected time to lead. Fire safety training, mandatory training compliance for obstetricians and midwives, and the safe storage of medicine are also areas for improvement detailed within this report.

What action we expect the NHS board to take after our inspection

This inspection resulted in nine areas of good practice, two recommendations and 11 requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on women and families using the hospital or service. We expect all requirements to be addressed, and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Forth Valley to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: http://www.healthcareimprovementscotland.scot.

Areas of good practice

The unannounced inspection to Forth Valley Royal Hospital resulted in nine areas of good practice.

Domain 1	
1	NHS Forth Valley supports parents to stay overnight supporting the family unit and facilitates the provision of transitional care within the postnatal ward (see page 16).
2	NHS Forth Valley has good indicators for ethnicity completeness data for all women booking for perinatal care (see page 16).

Domain 2	
3	We observed signs of positive working relationships and culture within the areas inspected (see page 18).
4	Student midwives described a friendly and supportive learning environment (see page 18).

Domain 4.1	
5	We observed compliance with standard infection control procedures within areas inspected (see page 21).
6	We observed compliance with COSHH regulations in relation to cleaning products (see page 21).

Domain 4.3	
7	NHS Forth Valley utilise a variety of initiatives to support staff health and wellbeing (see page 25).

Domain 6	
8	All observed interactions between women, staff and visitors were respectful and dignified (see page 27).
9	We observed the use of positive birth language within the service (see page 27).

Recommendations

The unannounced inspection to Forth Valley Royal Hospital resulted in two recommendations.

Domain 1	
1	NHS Forth Valley should consider adopting a continuity approach to maternity telephone triage (see page 16).
2	NHS Forth Valley should consider improving bereavement training compliance rates for all staff providing bereavement care to families (see page 16).

Requirements

The unannounced inspection to Forth Valley Royal Hospital resulted in 11 requirements.

Domain 1	
1	NHS Forth Valley must ensure effective oversight of activity within the maternity unit to support safe delivery of care for women, including, but not limited to: (i) Maternity triage (ii) Delays to care, including inductions (see page 16). This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) criteria 2.5 and 2.6.
2	NHS Forth Valley must ensure that patients are provided with the right care, in the right place, at the right time (see page 16). This is to comply with Health & Social Care Standards (2017) Standard 1, criteria 1.19, 1.20, and Standard 3, criteria 3.14-3.19, and Standard 4, criteria 4.11,4.14,4.27.

Domain 2	
3	NHS Forth Valley must ensure effective governance and oversight to ensure all adverse events are reliably reported and changes to clinical practice identified through adverse events are compliant with the adverse events framework. (see page 18). This will support compliance with: Healthcare Improvement Scotland A national framework for reviewing and learning from Adverse events in NHS Scotland and Healthcare Improvement Scotland Quality Framework (2018) criteria 2.5.

Domain 4.1	
4	NHS Forth Valley must ensure clinical guidelines are up to date and reviewed within agreed timescales (see page 22). This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) criteria 5.4 and the Health and Social Care Standards (2017) criteria 4.11.
5	NHS Forth Valley must ensure that women accessing acute care out with maternity services are consulted with appropriate risk assessments, such as the maternity early warning system (MEWS) (see page 22).

	This will support compliance with: The Health Social Care Standards (2017) criteria 4.11 and 4.14 and Healthcare Improvement Scotland Quality Assurance Framework (2022).
6	NHS Forth Valley must ensure the safe and secure use of medicines at all times, including the storage and administration of medicines (see page 22). This will support compliance with: The Royal Pharmaceutical Society Professional guidance on the safe and secure handling of medicines (2024) and relevant codes of practice of regulated healthcare professions.
7	NHS Forth Valley must ensure that all staff complete statutory fire training (see page 22). This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).

Domain 4.3	
8	NHS Forth Valley must ensure that there are clear, consistent systems and processes in place to support management of any potential identified staffing risks within maternity services. This includes accurate recording of any escalation, mitigation/inability to mitigate, communication of outcomes with all relevant clinical teams and any disagreements with decisions made (see page 26). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
9	NHS Forth Valley must ensure that clear and robust systems and processes are in place, including guidance and support for staff, to allow consistent assessment and capture of real-time staffing risk across all professional clinical groups. Assessments should consider skill mix of available staff, dependency and complexity of patients to support staff to confidently apply and record professional judgement in relation to required staffing when declaring "safe to start" (see page 26). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
10	NHS Forth Valley must ensure that maternity and obstetric services are appropriately and effectively staffed in order to reduce delays to care, preserve patient safety and support staff wellbeing (see page 26). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
11	NHS Forth Valley must ensure that there are systems and processes in place to support clinical leaders within maternity services being able to access appropriate protected leadership time to fulfil their leadership and

management responsibilities. They must also ensure that employees receive time and resources to undertake training which is essential to their role. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls (see page 26).

This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

Despite increased acuity, areas inspected were calm and well led with staff working hard as a team to deliver compassionate and responsive care. We observed multidisciplinary oversight of the elective workload within the unit and an organised response to acute emergency presentations at the time of inspection. However, we did not observe an evaluated approach within maternity triage to assure clinical prioritisation that supports the safe delivery of care.

The vision for maternity services in Scotland was set out in 2017 by Scottish Government within The Best Start: A five-year forward plan for maternity and neonatal care in Scotland. Further information can be read here.

At the time of inspection, maternity services within the Forth Valley Royal Hospital were experiencing pressures, like many of NHS Scotland services, such as reduced staff availability.

Maternity triage within Forth Valley Royal Hospital is a specialised assessment area which provides 24 hours a day, seven days a week unscheduled (emergency) care to pregnant women from 14 weeks of pregnancy until birth and from birth to six weeks postnatal. Obstetric emergencies and concerns over the wellbeing of the unborn baby are time sensitive requiring a systematic approach which identifies women of the highest clinical priority to improve outcomes. There is currently no national standardisation of maternity triage system available. However, the Royal College of Obstetricians and Gynaecologists good practice paper No. 17 recommends each board develops their own guidance based on an evaluated system. Further information can be found here.

Best practice described by the Royal College of Obstetricians and Gynaecologists recommends the telephone assessment is undertaken by a midwife dedicated to triaging calls for all or part of their shift. This can result in signposting women to other available care such as their general practitioner, telephone advice or attending the maternity unit for review. During onsite inspection we observed, and staff advised us, that no current systematic approach was in place, for example the role was not

designated to a specific midwife on shift. A recommendation has been given to support improvement in this area.

The triage service is provided within two areas of the hospital. Monday to Sunday 0700-1800. The service is provided within a four bedded area situated alongside the maternity daybed unit which provides scheduled (planned) care. Out with these times, it is undertaken within the labour ward, by an allocated midwife. We observed signage in place to direct women out of hours and on discussion with senior managers, we were informed this change in location was discussed with women during their scheduled antenatal care. Additionally, written information was provided to women during pregnancy and during the telephone assessment, women were informed where to attend. We also observed the department had a dedicated telephone line known as the red phone, solely used for emergency communication with the Scottish Ambulance Service if required.

Best practice guidance from the Royal College of Obstetricians and Gynaecologists recommends a prompt and brief assessment is carried out to assess the clinical urgency by which women are reviewed. Senior managers told us NHS Forth Valley have a short life working group considering the triage process including potentially implementing an evaluated system. However, this work continues to progress, and an evaluated system is not yet in place. Whilst staff endeavoured to ensure women attending the service were assessed within 30 minutes, due to staffing or lack of available space, this was not always possible. During the onsite inspection we observed the use of the NHS Forth Valley designed “triage documentation tool.” NHS Forth Valley had adopted a system to clinically prioritise patients, colour coded to red (seen immediately), orange (seen within 15 minutes), yellow (seen within 60 minutes) and green (seen within four hours). Senior managers told us that clinical prioritisation, timings of initial assessment and ongoing care were monitored through department audits. Within evidence received we observed an audit of compliance of initial assessment timings for the two most urgent category of presentations, red and orange. This showed a deterioration in compliance with timings of initial assessment from 79% to 59% for the three months provided. A requirement has been given to support improvement in this area.

Best practice described by the Royal College of Obstetricians and Gynaecologists recommends only women requiring unscheduled care are seen within maternity triage, to prevent competing priorities and allow for the provision of focused unscheduled emergency care. During inspection we observed a shared waiting room with the maternity daybed area utilised for both unscheduled and scheduled care appointments. In the evidence provided by NHS Forth Valley we noted that an issue had been identified previously through their adverse events system which related to a loss of situational awareness of who was attending for what service. As a mitigation, clinical support staff now have delegated responsibility for oversight of the waiting area to ensure all women attending the waiting area are identified clearly for scheduled or unscheduled care.

Best practice also recommends a process for centralised overview which demonstrates the present workload. This should enable staff to establish how many women have not yet had their initial assessment to determine their level of clinical urgency and to understand the level of clinical urgency assigned to each woman within the department. As part of our inspection, we observed a patient board which was designed to maintain oversight of women attending the service and to monitor their time of arrival in the department. On the first day of inspection, we observed the board was not utilised by staff to support situational awareness and oversight within the department. Furthermore, within evidence, we observed scheduled care was regularly undertaken within the area. We discussed this with senior managers who recognised the need to make improvements to maternity triage and ensure effective oversight and situational awareness within the area. A requirement has been given to support improvement in this area.

MBRRACE 2024 report Saving Lives, Improving Mothers' Care details the maternal deaths between 2020-2022. Over half of the women who died (56%) were known to have a pre-existing medical condition. The report recommends pregnant and postpartum women presenting to the emergency department with medical problems should be discussed with a member of the maternity medical team. Further information can be found here. Best practice described by the Royal College of Obstetricians and Gynaecologists recommends a system is in place to ensure women are directed to the correct department. During inspection, the criteria for women presenting to maternity triage was unclear and we observed pregnancy related complications were not the only reason for women to attend the service for review. An example of this observed was women attending with chest pain and for investigation for suspected thromboembolism. To ensure the safe delivery of care, women should be reviewed in the right place, at the right time by the right professional team to meet their clinical needs. Staff we spoke with told us at times of high occupancy within the acute emergency department, pregnant women may be redirected to maternity triage for assessment and treatment. Maternity staff reported feeling pressure to assist to prevent the patient waiting longer in the emergency department. Evidence reviewed from learning following a serious adverse event review recognised the need for strengthened communication and referral protocols between NHS Forth Valley emergency department and maternity services. During our virtual discussion session with the board, we asked senior managers how they are assured women attending Forth Valley Royal Hospital are receiving the right care in the right place by the right team. They advised training simulations were carried out which combined maternity and acute staff within the emergency department, and in discussion with senior medical staff they spoke highly of the support they received from other specialties within the hospital to ensure timely review of women when this was required. However, conflicting information regarding appropriate criteria and pathways was highlighted during inspection in discussion with staff and within evidence provided. A previous outstanding action following a serious adverse event review within NHS Forth Valley maternity services identified the need for strengthened communication and referral protocols between the emergency

department and maternity services however, actions to implement a robust maternity pathway for the emergency department remains incomplete a year post adverse event review. A requirement has been given to support improvement in this area.

The labour ward is situated on the second floor of the women's services unit and is well signposted from the main entrance. At the time of inspection, the senior charge midwife post for the ward was vacant and senior managers informed us recruitment was in progress. As an interim measure clinical oversight was provided by band 7 midwives who reported good support from senior managers. The area has access to 14 labour rooms and care provision supports labour and birth including planned caesarean birth. We did not observe any delays to care within the area at the time of inspection. The area was calm, well organised and well led. Evidence of supportive multidisciplinary team interactions were observed. We observed respectful relationships between staff and senior managers.

Delays to the induction of labour process are associated with increased risk of adverse maternal and perinatal outcomes. In discussion with senior managers, they informed us that the current induction of labour rate within NHS Forth Valley sits above the current Scottish national average which impacts on the delays to the process.

At the time of inspection, there were no delays to the induction of labour process. However, in discussion with staff and within evidence provided by NHS Forth Valley, we observed delays occurred frequently. There were delays of up to 72 hours due to patient acuity and staff availability within the labour ward. Induction of labour is a practice that is undertaken to artificially induce labour; this can be in response to concerns with the mothers or unborn baby's health. We observed good oversight of ongoing and planned induction of labours being discussed by the multidisciplinary team at the obstetric huddles which occurred throughout the day. As part of evidence, we observed escalation cards to support staff escalation when delays to care, including delays to the induction of labour process, occurred. The escalation cards utilised a traffic light system of red, amber and green which classified delays to the induction of labour process over 24 hours as significant, assigning this an amber rating which required a review of the current delay every two hours until the induction of labour process could be continued. National Institute for Health and Care Excellence guideline Safe Midwifery staffing for maternity setting (2015) states any delays to care or delays of more than two hours from admission to commencing induction of labour is a red flag. More information can be found here. Red flag events are a warning sign that midwifery staffing may not be optimal and National Institute for Health and Care Excellence recommend analysing reported red flags for ensuring effective staffing for workload.

We asked senior managers how delays to care with regard to induction of labour are monitored and how this information informs improvement. We were advised of mitigations that are undertaken in the event of delay such as focused multidisciplinary oversight at safety huddles and senior manager oversight which can result in escalation of concern. During inspection we observed the use of QR codes to

encourage any women who had undergone the induction of labour process to feedback their experience in an aim to improve the experience for others. Within the evidence provided, we observed that a scoping exercise had been undertaken to understand the delays faced by women during the induction of labour process. However, this did not capture delays of less than 24 hours. This is a missed opportunity for learning. We were not assured that the current data collection undertaken by NHS Forth Valley would allow for effective analysis or oversight of any delays to induction of labour that could inform improvement. A requirement has been given to support improvement in this area.

The National Bereavement Care Pathway Scotland is a project funded and developed by Scottish Government in partnership with Sands, the stillbirth and neonatal death charity, with the aim of standardising and improving the quality of bereavement care for the families of Scotland. Further information can be found here. During our inspection we observed a dedicated bereavement area which allowed the full in hospital bereavement journey to be undertaken. This also provided a private area to discuss options, birth and spend family time following the death of a baby. Evidence supplied by the board highlighted options for local bereavement training available for all staff. However, senior managers were unable to provide compliance rates for all staff who had undertaken bereavement training. Staff bereavement training is a recognised standard recommended by the National Bereavement Care Pathway. A recommendation has been given to support in this area.

Antenatal and postnatal care provision within Forth Valley Royal Hospital is based in one ward which consists of 29 beds and incorporates an area for transitional care. Transitional care units offer additional support to babies above normal neonatal care with the aim to prevent separation of mum and baby and unnecessary admissions to the neonatal unit. The vision for maternity services across Scotland set within The Best Start: A five-year forward plan for maternity and neonatal care in Scotland, is one in which parents and babies are offered truly family-centred and compassionate care. We observed no restrictions to visiting and options for partners staying within the ward, with shower facilities available if required. Inspectors also observed those within transitional care experiencing a longer inpatient stay are encouraged to personalise their postnatal space.

Ethnicity data is vital information in pregnancy as it helps to identify and address inequalities in maternal and perinatal adverse outcomes. Ethnicity data reviewed through NHS Forth Valleys' latest perinatal mortality review report demonstrated 100% compliance with recording of ethnicity data for stillbirths and neonatal deaths which occurred within the board. The inspectors were also aware from published board papers that maternity services were included within the boards oversight of projects to target racialised inequalities in care, with ongoing work to gain feedback from people of ethnic minorities accessing maternity services.

Areas of good practice

Domain 1	
1	NHS Forth Valley supports parents to stay overnight supporting the family unit and facilitates the provision of transitional care within the postnatal ward.
2	NHS Forth Valley has good indicators for ethnicity completeness data for all women booking for perinatal care.

Recommendations

Domain 1	
1	NHS Forth Valley should consider adopting a continuity approach to Maternity telephone triage.
2	NHS Forth Valley should consider improving bereavement training compliance rates for all staff providing bereavement care to families.

Requirements

Domain 1	
1	NHS Forth Valley must ensure effective oversight of activity within the maternity unit to support safe delivery of care for women, including, but not limited to: (i) Maternity triage (ii) Delays to care, including inductions.
2	NHS Forth Valley must ensure that patients are provided with the right care, in the right place, at the right time.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

We observed good teamwork, including extended members of the multidisciplinary team such as obstetricians, anaesthetists, midwives and the health care support team. Visible senior midwifery leadership and positive interactions with staff were also observed. Student midwives described a friendly and supportive learning environment.

We observed positive interactions between staff and senior managers. Senior clinical leaders within maternity services were approachable and engaging with all team members. New members of the multidisciplinary team including medical staff and midwives reported feeling able to discuss concerns and escalate any issues. We observed supportive interactions between the clinical team around care provision with prompt escalation to activate the multidisciplinary team when clinical need arose. Inspectors had the opportunity to speak to student midwives during inspection who described a friendly and supportive learning environment within NHS Forth Valley and

were hopeful of achieving a midwifery post within maternity services once qualified. This was reflected within evidence received that highlighted student celebration days following end of placement, outlined work on preceptorship programmes and detailed mock interviews that were arranged for senior students to support their transition.

Staff we spoke with were welcoming and spoke openly about their experiences. Midwifery and clinical support staff all described the service as a good place to work and felt supported. Positive interactions were observed between midwifery, obstetric, anaesthetic and clinical support staff. Some staff described their role as rewarding but also challenging, particularly when staffing was not optimal for the clinical care need, which can often prevent them from delivering the standard of patient care they aspire to provide. On discussion with senior managers, they highlighted work being undertaken to improve communication with staff when staffing challenges occur. Staff and senior managers described actions to support the clinical team when they had raised concerns regarding staffing. These included quality improvement projects to ensure staff breaks were taken and the scheduling of joint ward meetings to discuss improvements and maintain relationships. The service vision appeared to be communicated and supported by staff members who acknowledged the actions taken had a positive impact on team culture and dynamic.

The consistent reporting and learning from adverse events are essential in assuring learning, quality improvement and patient safety within a service. The learning from adverse events national framework highlights all adverse incidents should be reviewed. The level of the review will be determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. More information on the adverse event framework can be found here. All staff spoken to report a positive attitude to the submission of patient incident forms. However, staff reported mixed views on the level of feedback received following submission of patient incident forms. We had the opportunity to discuss the adverse events process with senior managers who described the management of reviews and the process undertaken within the service. Any adverse event meeting the criteria for further investigation is escalated for briefing note completion and consideration of commissioning of a significant adverse event review (SAER) by the executive team. Within evidence provided we observed regular dissemination of information to staff following completed reviews in the form of learning summaries. Ockenden 2022 states incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner. It recommends that change in practice arising from an incident investigation must be seen within six months after the incident occurred. Adverse events framework recommends SAER's are completed within 140 working days. Within evidence we observed five SAER's overdue with the longest delay up to 18 months. Where delays to the SAER occurred, senior managers advised families are assigned a family liaison to keep them informed throughout the process. There were also completed SAER's within evidence with overdue actions relating to clinical practice. A requirement has been given to support improvement in this area.

We requested details of any reported patient safety incidents that had occurred over the six months prior to our inspection. Review of incident reports submitted identified discrepancies in local incident reporting and available national data. We raised this with senior managers during our virtual discussion to understand their assurance process for oversite of adverse events. An example of this was highlighted within available Public Health Scotland dashboard data which captures a higher number of women who had sustained obstetric anal sphincter injuries during birth than was reported through NHS Forth Valley's local incident reporting system. This may indicate that not all adverse events are being reported through the incident reporting system. We were supplied with NHS Forth Valley adverse events "cause picklist" which senior managers confirmed obstetric and anal sphincter injury were a "must" report event. At the time of virtual discussion senior managers were unable to describe the discrepancies between available local and national data. Senior managers acted promptly in reviewing and providing a plan of assurance to improve governance and oversight of the available data to support quality improvement. Incomplete incident reporting has an impact on the learning from adverse events within the system, reducing opportunities to improve safety. Delays to completing serious adverse event reviews and implementing learning from these into clinical practice also impacts the safe delivery of care. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 2	
3	We observed signs of positive working relationships and culture within the areas inspected.
4	Student midwives described a friendly and supportive learning environment.

Requirements

Domain 2	
3	NHS Forth Valley must ensure effective governance and oversight to ensure all adverse events are reliably reported and changes to clinical practice identified through adverse events are compliant with the adverse events framework.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

All areas inspected were calm and well organised with staff working hard to support the safe delivery of care. We observed areas for improvement in the governance of clinical guidelines and safe storage of medications.

Evidenced based clinical guidelines are used to assist clinicians in decision making regarding treatment and care in specific circumstances. They are a resource within clinical practice to improve communication between patients and health professionals

and help patients make informed decisions. NHS Forth Valley have undertaken recent work to improve the process of oversight of clinical guidelines. A responding to concerns report, six months prior to the inspection, had identified that the majority of clinical guidelines within maternity services were overdue for review. Within evidence submitted we observed 12 out of 22 of the clinical guidelines had expired review dates ranging from a few months to three years. Ensuring clinical guidelines are consistent with evidenced based practice requires oversight and a system of review to ensure they remain relevant. Whilst we acknowledge the ongoing improvement work, we have raised a requirement to sustain improvement in this area due to the risk to the safe delivery of care whilst guidelines remain outdated.

Quality improvement initiatives can improve safety, effectiveness and experience of care. We asked for evidence of quality improvement initiatives to improve patient safety and experiences within the maternity services. The Scottish maternity early warning score (MEWS) is a bedside screening tool which supports observation of physiological parameters such as blood pressure and heart rate in an aim to improve the recognition of pregnant and postnatal women at risk of clinical deterioration. This facilitates early intervention to improve outcomes. NHS Forth Valley shared with us their findings from observation audits for the two months prior to inspection for the initial set of observations, which demonstrated an improvement in staff compliance from 70% to 100%. This improvement work was part of the Scottish Patient Safety Programme to improve recognition of deteriorating patient as part of the national approach. The Scottish Patient Safety Programme is a national quality improvement programme which aims to improve the safety and reliability of care and reduce harm. Whilst initial observations were improving, we observed evidence of audits and focused work on completing the action plan for subsequent observations, and the most recent audits reflected an 80% staff compliance. However, in evidence we reviewed there was an outstanding action from a serious adverse event review around the use of the maternity early warning score observations. This action related to women attending for medical care within the wider hospital acute setting, and the lack of appropriate risk assessment to aide in the monitoring of a deteriorating patient. For example, applying the acute risk assessment would not identify concerns with diastolic blood pressure and have lower sensitivity to systolic blood pressure concerns, therefore fail to identify hypertension in pregnancy and potentially delaying treatment in an emergency. A requirement has been given to support improvement in this area.

Major obstetric haemorrhage is a critical condition defined as significant blood loss in the antenatal, intrapartum and postnatal period and is generally defined as blood loss exceeding 1.5 litres. NHS Forth Valleys most recent Scottish Patient Safety Programme progress report highlights there is currently no oversight to direct quality improvement work in this area. We observe from NHS Forth Valley's trigger list for adverse events reporting there is no staff prompt to submit a patient incident form unless postpartum haemorrhage reaches and exceeds 2.5 litres, which means there is a missed opportunity for oversight, learning and quality improvement.

The MBRRACE 2024 report Saving Lives, Improving Mothers' Care details the leading cause of maternal deaths between 2020-2022 remains as thrombosis and thromboembolism. The report highlights a need for continuous evidence-based risk assessment throughout pregnancy and following birth. We were provided with evidence of quality improvement work which included compliance audits of the venous thromboembolism risk assessments carried out in NHS Forth Valley during the six months prior to inspections. These demonstrate compliance with venous thromboembolism risk assessments of 98% at clinical point of booking, 83% for any admission and 97% within the postnatal period. Overall compliance was 89%. Staff we spoke with were aware of quality improvement projects, and many staff groups spoke of involvement and collaboration with senior midwives, for example, on improving postnatal contraception discussions post birth and cited that they felt supported to undertake projects within their areas.

During inspection we observed mealtimes which were well organised and staff were aware of women's dietary requirements. We observed food and fluid being available to women within all areas of maternity services. We also observed improvement to infant feeding support within the postnatal ward through recruitment of a team lead in this area.

Hand hygiene is an important part of standard infection control precautions to minimise the risk of infection. Other standard infection control precautions include patient placement, the use of personal protective equipment (such as gloves and aprons), management of the care environment, safe management of blood and fluid spillages, linen and waste management and prevention and exposure management (such as sharps injuries). On inspection we observed good hand hygiene practice and appropriate personal protective equipment use throughout wards, including mealtimes. All rooms inspected had a compliant hand hygiene basin exclusively for use of hand washing. Evidence requested from NHS Forth Valley in the form of audits and ward walk rounds demonstrated assurance of good practice compliance regarding standard infection control precautions.

Inspectors observed the maternity environments were well maintained and appeared clean. All equipment inspected appeared to be well maintained, stocked, clean and clear of the corridors. Staff reported no issues with accessing equipment for use in times of need and emergency trolley checks within all areas inspected were appropriate.

We spoke with staff regarding water flushing regimes within maternity services. Water flushing regimes support the prevention of the build-up of bacteria within the water system. Evidence provided demonstrated processes were in place and compliance noted throughout areas inspected demonstrated water flushing was conducted in line with guidance.

We observed medication trollies were locked and adequately secured. However, medicine preparation rooms and medication fridges were unlocked and could have been accessed by women or members of the public. This is not in line with the Royal Pharmaceutical Society Professional guidance on the safe and secure handling of medicines or the Nursing and Midwifery Council code of professional standards. We fed this back to the senior charge midwife for the area and senior managers on the first day of inspection who acted promptly to ensure the safe storage of medication was complied with. Senior managers advised us the unlocked medicine preparation room was added to the risk register for oversight, with discussions ongoing regarding the potential addition of swipe access for the room. The previous acute safe delivery of care inspection of Forth Valley Royal Hospital and subsequent follow-up inspection, both in 2024, detailed a requirement for the safe storage of medication within Forth Valley Royal Hospital. A requirement has been given to support improvement in this area.

Inspectors observed that in all areas chlorine-based cleaning products were stored securely, in line with The Control of Substances Hazardous to Health (COSHH) Regulations 2002 which stipulate that these products must be kept in a secure area such as a locked cupboard. Chlorine-based cleaning products had a designated locked cabinet in all wards which was utilised by staff and on discussion, appeared to be common practice within the area.

During our inspection we observed the safe storage of medical gases was not being adhered to. Inspectors highlighted issues around storage of medical gases in two rooms. We observed a lack of signage to reflect the storage of medical gases and a lack of fire door signage which we raised at the time of the inspection with the senior charge midwife for the area. We also highlighted this in our feedback to senior managers, requesting immediate action. Managers responded quickly with the appropriate actions. Following this, NHS Forth Valley provided further evidence on request that included the latest fire risk assessment for the unit which included an action plan to address the issues we raised. However, evidence of staff fire safety mandatory training was also provided which demonstrated gaps in staff compliance for mandatory TURAS fire safety module, with 54% of obstetric staff and 74% of midwifery inpatient staff having completed the module. Senior managers were unable to provide evidence of face-to-face fire safety training and provided information of plans to prioritise this. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 4.1	
5	We observed compliance with standard infection control procedures within areas inspected.
6	We observed compliance with COSHH regulations in relation to cleaning products.

Requirements

Domain 4.1	
4	NHS Forth Valley must ensure clinical guidelines are up to date and reviewed within agreed timescales.
5	NHS Forth Valley must ensure that women accessing acute care out with maternity services are consulted with appropriate risk assessments, such as the maternity early warning system (MEWS).
6	NHS Forth Valley must ensure the safe and secure use of medicines at all times, including the storage and administration of medicines.
7	NHS Forth Valley must ensure that all staff complete statutory fire training.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

We observed a variety of initiatives around staff wellbeing and feedback from staff regarding supportive senior leadership. However, we observed areas for improvement regarding escalation processes and assurance of safe staffing within the unit.

NHS Forth Valley maternity services use a bespoke staffing system which monitors real-time staffing levels in relation to patient care needs. This uses a traffic light system, green, amber and red, with red areas having the highest shortfall of staff available to meet women's needs. This enables informed decisions to be made when deploying staff to help mitigate risk and considers the acuity of the women and babies versus available staffing numbers, allowing for professional judgement to be made on required staffing.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024. It stipulates that NHS boards have a duty to apply the Common Staffing Method (CSM), which includes a staffing level tool run and requires this to be applied rigorously and consistently. The application of the common staffing method and staffing level tools supports NHS boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high-quality care. As part of evidence, we observed staffing level tool runs had been undertaken. However, senior managers reported the outputs from these tool runs were inaccurate due to the design of the bespoke staffing system used within NHS Forth Valley resulting in an inability to capture the maternity service staffing needs. There were also incomplete data submissions to the tool by the maternity team. To mitigate this, NHS Forth Valley have maintained a higher than predicted necessary workforce. Whilst applying higher than predicted staffing ratios may mitigate some risk regarding safe staffing levels, NHS Forth Valley are not able to ascertain an accurate predicted staffing level for assurance within the maternity unit to promote the safe delivery of care. Inaccuracies in the data may impact on the ability to determine if there are any potential gaps in skill mix,

experience and leadership that may impact on quality, safety and staff wellbeing. Application of the common staffing method to accurately represent the staffing requirements would support senior managers to better understand this at all agenda for change bands within the midwifery team. A requirement has been given to support improvement in this area.

During the onsite inspection it was unclear how real-time staffing assessments are undertaken and recorded by professions such as obstetricians and anaesthetists who work within maternity services at Forth Valley hospital. Onsite we observed discussion around consultant shortages for part of shifts during the multidisciplinary huddle and were aware junior doctor staffing levels were on the risk register for maternity through evidence reviewed. We asked senior managers how they monitored safe staffing for these professional groups and how risks within these groups were captured, escalated and mitigated. On discussion with senior managers, it remains unclear as to how professional groups other than midwives associated with maternity services are assessing and managing real-time staffing risk within NHS Forth Valley. A requirement has been given to support improvement in this area.

We had the opportunity to attend different maternity services staffing, capacity and safety huddles led by different members of the multidisciplinary team. The huddles included midwifery workforce planning for both onsite and offsite maternity services within NHS Forth Valley. However, the process for assurance around real-time staffing and risk assessment within maternity services was not clear. We raised this with senior managers during our virtual discussion who told us about their “lead for the week” approach. This is a role undertaken by one of the senior managers on a rotational basis to maintain oversight and responsibility for escalation at times of high acuity, capacity or patient safety concerns.

Feedback from clinical staff we spoke with was mixed in relation to the response they received from senior managers when staffing concerns were escalated. All staff described supportive senior leadership which encouraged clinical staff to escalate concerns, however at times, staff described receiving variation in responses to concerns raised depending on the senior manager on call at the time. We raised this with senior managers who advised us that within hours, senior maternity managers are available for escalation of concern when required and out of hours they ensure the on-call manager is a professional lead for the service.

Within evidence provided we observed NHS Forth Valley have a detailed escalation policy in relation to staffing issues and managing levels of high acuity impacting safe delivery of care. We observed the availability of escalation cards to support professional decision making during periods of high activity. However, within evidence received we observed that inconsistent use of the escalation cards was a recurring theme. We also noted obstetric staffing concerns were not part of the unit escalation cards which may delay escalation of concerns when obstetric staffing is not adequate for the unit. Analytical review of patient incident reports submitted highlighted when

delays to the induction of labour process occurred that would warrant an escalation action within the escalation cards. This process was not followed as per policy or details reflected in the senior managers oversight report. Inconsistent records of escalation and noncompliance with policy could result in limited assurance regarding real-time capacity, staffing and patient safety concerns leading to delays in escalation. A requirement has been given to support improvement in this area.

We were able to observe how maternity services fed into the wider hospital safety huddle. The hospital safety huddle was attended by members of the multidisciplinary team including nursing, midwifery, allied health professionals, hospital discharge team and facilities colleagues. The wider hospital safety huddle supports site wide situational awareness, including patient flow, patient safety concerns, review of staffing and identifying wards or areas at risk due to reduced staffing levels. However, we observed only maternity services inpatient bed capacity was highlighted for oversight at this huddle limiting NHS Forth Valleys senior managers oversight of real-time staffing, acuity and safety concerns within maternity services. A requirement has been given to support improvement in this area.

During inspection we were informed of different staff wellbeing initiatives within maternity services. We observed the wellbeing room, a dedicated area for staff to relax on break times, and wellbeing walks. Student midwives' wellbeing initiatives were also demonstrated in the use of gatherings to celebrate the end of their placements. Staff spoke of initiatives utilising the local facilities which provided therapy sessions such as massage. Midwifery staff spoke of development opportunities in the form of leadership courses being available and encouraged at both band 6 and band 7 midwifery level in an aim to support ongoing succession planning within the service.

NHS Forth Valley operates a continuity of care midwifery model which requires staff to work in different areas depending on care needs. Staff described being moved frequently to different wards to work part of, or all of, their shift in an aim to support this model of working. Staff having the right skills and knowledge within their area of practice is essential in the safe delivery of care. On inspection and discussion with senior managers, we asked how staff are supported to maintain skills and knowledge to enable transition safely between areas of maternity services. Staff appraisals are essential to assessing and supporting staff performance, resulting in a positive work culture. In evidence received we observed assurance of completed appraisals for midwifery (87.5%) and obstetric staff (95%).

In 2018 the Scottish Government published the core mandatory training requirements for midwives and obstetricians. This required each NHS board to establish training around fetal (unborn baby) heart monitoring, obstetric emergencies and neonatal resuscitation. Wider national reports on the provision of safe maternity care over the last decade such as Ockenden (2022), each baby counts (RCOG 2019) and Kirkup (2015) have highlighted the essential safety feature of teams working and training

together to improve outcomes for families. During inspection, staff were complimentary about inhouse training and facilitators. However, we were made aware of training being cancelled in times of high activity and this being first steps of mitigation when the unit required to activate the escalation policy in times of low staffing or high acuity. Evidence received on mandatory training programmes demonstrated learning from staff feedback and patterns of cancellation prompting restructuring sessions to support staff attendance. Midwifery compliance with mandatory training was reported to be 59%, with no records available for obstetric staff attendance of these sessions. A requirement has been given to support improvement in this area.

Each senior charge midwife is responsible for a midwifery team. This includes quality and performance management, HR requirements, ensuring training is up to date and wellbeing support for their team. Time to lead is a legislative requirement under the Health Care Staffing (Scotland) Act (2019). This is to enable clinical leaders to provide and oversee the delivery of safe, high-quality and person-centred healthcare. In discussion with clinical leaders, we were told that time to lead was regularly impacted on due to clinical capacity, with one manager advising they had no protected time to lead due to sickness absence levels within the department for several months. We raised this with senior managers during our virtual discussion who described oversight when time to lead was impacted on and mitigations used to support staff when this occurred, which include senior managers working clinically when required. However, interruptions to time to lead significantly impacts on the capacity to complete their leadership and management responsibilities. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 4.3	
7	NHS Forth Valley utilise a variety of initiatives to support staff health and wellbeing.

Requirements

Domain 4.3	
8	NHS Forth Valley must ensure that there are clear, consistent systems and processes in place to support management of any potential identified staffing risks within maternity services. This includes accurate recording of any escalation, mitigation/inability to mitigate, communication of outcomes with all relevant clinical teams and any disagreements with decisions made.
9	NHS Forth Valley must ensure that clear and robust systems and processes are in place, including guidance and support for staff, to allow consistent assessment and capture of real-time staffing risk across all professional clinical groups. Assessments should consider skill mix of available staff, dependency and complexity of patients to support staff to confidently apply and record professional judgement in relation to required staffing when declaring "safe to start."
10	NHS Forth Valley must ensure that maternity and obstetric services are appropriately and effectively staffed in order to reduce delays to care, preserve patient safety and support staff wellbeing.
11	NHS Forth Valley must ensure that there are systems and processes in place to support clinical leaders within maternity services being able to access appropriate protected leadership time to fulfil their leadership and management responsibilities. They must also ensure that employees receive time and resources to undertake training which is essential to their role. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

All interactions observed between women and their families during the inspection were respectful and dignified. Women described feeling listened to and having their needs met. They spoke of positive discussions with staff when deviations from their care plan occurred and feeling safe during their stay. They also noted good involvement of partners within the service.

Birth language refers to the communication used between healthcare professionals and women to describe their pregnancy and birth journey. Birth language can significantly impact on birth trauma experienced by women with negative language such as those implying failure, impacting and increasing feelings of distress and trauma. During our inspection we observed the use of positive birth language within maternity services has been fully integrated. The Re:Birth project was released in 2022 by the Royal College of Midwives (RCM) to support both maternity professionals and women utilising maternity services to develop a shared respectful language for

pregnancy, labour and birth. The aim of the project was to find a language around labour and birth which "could be shared and understood both by those delivering maternity care and those receiving it." As part of our inspection, we observed the use of Re:Birth guidance to support the multidisciplinary teams description of birth outcomes and birth choices throughout the service.

All patients had access to call bells and looked well cared for. They were familiarised with the ward environment on arrival and all patients spoken to reported they felt confident they could ask for assistance if required.

The service was exploring new avenues to gain patient feedback. We observed a new initiative within wards where all women attending were given a QR code on discharge requesting feedback from their visit with an aim to support and inform service improvement.

The national maternity voices partnership supports the co-production of maternity services ensuring the "voices of all women including those from diverse backgrounds" are heard and used to plan, design and improve maternity services. NHS Forth Valley maternity voice partnership has been recently reestablished with recent actions including ensuring women receive information on care opinion to provide feedback.

Areas of good practice

Domain 6	
8	All observed interactions between women, staff and visitors were respectful and dignified.
9	We observed the use of positive birth language within the service.

Appendix 1 - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- Antenatal care (NICE, August 2021)
- CMO(2018)18 - Core mandatory update training for midwives and obstetricians (Scottish Government, December 2018)
- Delivering Together for a Stronger Nursing & Midwifery Workforce (Scottish Government, March 2025)
- Fire (Scotland) Act 2005 (Fire Scotland Act, Acts of the Scottish Parliament, 2005)
- Food Fluid and Nutritional Care Standards (Healthcare Improvement Scotland, November 2014)
- Generic Medical Records Keeping Standards (Royal College of Physicians, October 2015)
- Guidance — NHS Scotland Staff Governance (NHS Scotland, June 2024)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection prevention and control standards (Healthcare Improvement Scotland, 2022)
- Intrapartum care (NICE guideline, September 2023)
- Maternity Triage (RCOG Maternity Triage good practice paper, December 2023)
- MBRRACE-UK (Maternal, Newborn and Infant Clinical Outcome Review Programme, 2024)
- National Infection Prevention and Control Manual (NHS National Services Scotland, June 2023)
- NMC Record keeping: Guidance for nurses and midwives (NMC, August 2012)
- Operating Framework: Healthcare Improvement Scotland and Scottish Government: (Healthcare Improvement Scotland, November 2022)
- Person-centred care - NMC (The Nursing and Midwifery Council, December 2020)
- Prevention and management of pressure ulcers standards (Healthcare Improvement Scotland, October 2020)

- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2024)
- Recommendations | Postnatal care | Guidance | NICE (NICE, April 2021)
- Scottish Patient Safety Programme (SPSP) (Healthcare Improvement Scotland)
- The best start: five-year plan for maternity and neonatal care - gov.scot (Scottish Government, January 2017)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)
- The UNCRC Act - UNCRC (Incorporation) (Scotland) Act 2024 (Scottish Government, September 2024)
- https://www.healthcareimprovementscotland.scot/publications/the-quality-assurance-system-and-framework/ (Healthcare Improvement Scotland, September 2022)

Published November 2025

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email contactpublicinvolvement.his@nhs.scot

Healthcare Improvement Scotland

Edinburgh Office	Glasgow Office
Gyle Square	Delta House
1 South Gyle Crescent	50 West Nile Street
Edinburgh	Glasgow
EH12 9EB	G1 2NP
0131 623 4300	0141 225 6999

www.healthcareimprovementscotland.scot

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Improvement Action Plan

Healthcare Improvement Scotland:

Unannounced Maternity Services safe delivery of care inspection

Forth Valley Royal Hospital, NHS Forth Valley

25 – 26 August 2025

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involve ·ved in developing the improvement action plan.

NHS board Chair

Signature: _____

Full Name: Neena Mahal

Date: ___17/11/2025_____

NHS board Chief Executive

Signature: _____ _____

Full Name: Ross McGuffie

Date: __17/11/2025_____

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
Recommendation 20. Domain 1.1	NHS Forth Valley should consider adopting a continuity approach to maternity telephone triage	January 2026	Director of Midwifery	NHS Forth Valley Women & Children's services will implement the dedicated telephone triage by Jan 2026. NHS Forth Valley Maternity Services is undertaking a comprehensive assessment of midwifery staffing levels to support the optimal approach for implementing this recommendation within maternity triage. A detailed measurement plan containing process and outcome measures will support the implementation and evaluation of this improved process. Outcomes from these measurements and patient feedback will be reviewed at the monthly triage improvement group.	

Recommendation 20. Domain 1.2	NHS Forth Valley should consider improving bereavement training compliance rates for all staff providing bereavement care to families	31 March 2026	Director of Midwifery / Associate Medical Director	Training compliance for the department has increased from 59% to 72% since the inspection observation visit. The Woman and Childrens directorate have establish an AIM of 95% of all relevant staff will have completed the training by March 2026. To give assurance around the reliability of the bereavement training provided, staff feedback is being measured. Patient feedback is forming learning, through patient questionnaires including the Maternity Voices Partnership. In addition, assurance will be strengthened by: • Development of an additionally Bereavement Training Module within TURAS for all disciplines of staff by March 2026. • Board oversight will take place via Performance reviews and the data to support the work will be	

				presented on the Maternity pentana dashboard by Jan 26.	

Requirement 21. Domain 1.1	NHS Forth Valley must ensure effective oversight of activity within the maternity unit to support safe delivery of care for women including but not limited to: 1. Maternity triage 2. Delays to care, including inductions	Jan 2026	Director of Midwifery	NHS Forth Valley will improve oversight of maternity triage service through the dedicated improvement group. This group reviews current practice and drives the following improvements aims aligned to the specific measurement plan s in relation to the maternity triage process. Oversight will be provided via the newly established Quality and Safety Steering Group. NHS Forth Valley has strengthened oversight of the induction of labour (IOL) pathway to ensure safe, timely, and person-centred care. A driver diagram has been developed to clarify the aim and establish clear timeframe workstreams focused on reducing delays, improving consistency in clinical decision-making, and enhancing women's experience. An improvement group has been established which will also	

				report through the newly established Quality and Safety steering group.	

Requirement 21. Domain 1.2	NHS Forth Valley must ensure that patients are provided with the right care, in the right place, at the right time.	Jan 2026	Director of Midwifery/ Associated Medical Director	NHS Forth Valley is committed to delivering safe, effective, MEWS and person-centred care by ensuring timely access to appropriate services across all care settings. This principle underpins our clinical governance framework and aligns with national guidance on *Right Care, Right Place* This will also include the implementation of the Modified Early Warning Score (MEWS) across clinical areas beyond maternity by Jan 2026. The Clinical Observations Policy is currently under development and will set out best practice for MEWS application across the Acute setting, ensuring consistency and compliance with HIS standards by FEB 2026 is allow approval at Clinical Governance Working Group These improvement actions will be reported to the Quality and Safety Steering Group.	

Requirement 21 Domain 2.3	NHS Forth Valley must ensure effective governance and oversight to ensure all adverse events are reliably reported and changes to clinical practice identified through adverse events are compliant with the adverse events framework.	Dec 2026	Director of Midwifery / Head of Clinical Governance /Associated Medical Director	Woman & Children's directorate are reviewing current processes to improve reporting, reporting verification processes conducted by leads by Dec 2026. This will ensure reliable reporting to the Clinical Governance Groups. NHS Forth Valley is undertaking a review and implementing changes to our current adverse events reporting system (Safeguard) Regarding the Adverse Events Process and the Ulysses Safeguard System, a review is currently underway to enhance the system's usability and effectiveness. This review includes refining workflows for reporting, escalation, investigation quality, and learning dissemination. Our goal is to ensure the system supports timely, high-quality reviews and facilitates meaningful learning across the organisation within a robust reporting process, clearly aligned with the HIS national framework.	

				to align with the HIS National Framework by FEB 2026. NHS Forth Valley has reviewed and updated the Adverse Event Policy, SAER policy. These policies and procedures are now more closely aligned with the HIS national framework. A new training package has been identified to support consistent application across all staff levels. In addition, NHS Forth Valley is undertaking a benefits analysis process of the nationally procured Healthcare Guardian (In-Phase) adverse events management system by FEB 2026. Additionally, work is in progress to develop an internal Community of Practice for NHS Forth Valley of which Women and Children's will form a key constituent part This will enable the widespread sharing of learning from adverse events among all staff and staff groups. Furthermore, we are	

				engaging at a national level with HIS to participate and collaborate with the NHS Scotland Community of Practice, which aims to share learning across all NHS Boards in Scotland.	

Requirement 21. Domain 4.1.4	NHS Forth Valley must ensure clinical guidelines are up to date and reviewed within agreed timescales.	31 January 2026	Director of Midwifery/Associated Medical Director/Head of Clinical Governance	NHS Forth Valley is conducting a thorough review of existing clinical guideline and policy documents, implementing a RAG status approach to prioritise critical clinical policies and guidelines. This effort includes standardising the development, consultation, approval, and accessibility processes to ensure clarity, consistency, and alignment with best practices. This review will be complete by JAN 26 , W&C policy. The NHS Forth Valley Clinical Governance Working Group (CGWG) will oversee this process, with responsibility and accountability at the Directorate Clinical Governance group level. Updates on the progress of policy and guideline development and reviews will be a standing agenda item at all Directorate level Clinical Governance groups and the CGWG.	

				NHS Forth Valley W&C have a local Clinical Guidelines Working Group which will prioritise any expired clinical guidelines with an expected completion trajectory of 72% by January 2026. The wider NHS Forth Valley Board policy and guideline aim is that 95% will be within their review timescale by Dec 2026 .	

Requirement 21. Domain 4.1.5	NHS Forth Valley must ensure that women accessing acute care out with maternity services are consulted with appropriate risk assessments, such as the maternity early warning system (MEWS)	31 January 2026	Director of Midwifery/Associate Medical Director	NHS Forth Valley is implementing the Maternity Early Warning System (MEWS) across all acute clinical areas outside maternity services. This work forms part of the ongoing development of the clinical observations policy. NHS Forth Valley will ensure that any pregnant woman / birthing person admitted out with maternity services is clearly highlighted via the site safety huddles, enabling robust management plans and timely transfers where required. NHS Forth Valley is also implementing eObs across the system and we are currently scoping the function of a pregnant signifier in TRAK by Jan 26. This will provide digital oversight for all teams to understand where woman who are pregnant are positioned in our whole system.	

Requirement 21. Domain 4.1.6	NHS Forth Valley must ensure the safe and secure use of medicines at all times, including the storage and administration of medicines	March 2026	Head of Service	NHS Forth Valley maternity services have engaged with the Director and Associate Director of Pharmacy to ensure alignment with governance and HIS expectations. NHS Forth Valley will progress with an SBAR for review at the Safe and Secure Handling of Medications SLWG and subsequently to the Medical Devices Committee for approval of funding. NHS Forth Valley is exploring swipe access improvements to drug storage areas to improve access and safety in alignment with this requirement by March 2026. In the interim, NHS Forth Valley is mitigating risk around medicine storage within maternity services through the following measures: • Ongoing audits by Controlled Drug Officers to ensure compliance with safe	

				storage standards. • NHS Forth Valley maternity services carry out regular reviews of Care Assurance outputs to validate adherence to these standards. • NHS Forth Valley maternity services have introduced daily audits to provide real-time assurance, with compliance rates reported through established governance processes.	

Requirement 21. Domain 4.1.7	NHS Forth Valley must ensure that all staff complete statutory fire training	31 March 2026	Director of Midwifery / Associate Medical Director	Under the *Fire (Scotland) Act 2005*, NHS Forth Valley is required to ensure that all staff receive the appropriate fire safety training. TURAS Fire Training e-learning module remains the primary method for all staff to complete within NHS Forth Valley. Current compliance for online training is 80% with an AIM set for 95% by Jan 2026. Face-to-Face Sessions are provided for staff undertaking the Fire Warden role, as per legislation, in collaboration with the Fire Safety Training Team. Current compliance 53% with an AIM Set for 95% by FEB 2026. NHS Forth Valley maternity services will strengthen compliance by prioritising the following actions: • Targeted support for	

				areas requiring additional training. • Updates as part of the Women & Children's Performance Report and Women & Children Health & Safety Meeting which will provide oversight of this training compliance.	

Requirement 21. Domain 4.3.8	NHS Forth Valley must ensure that there are clear, consistent systems and processes in place to support management of any potential identified staffing risks within maternity services. This includes accurate recording of any escalation, mitigation/inability to mitigate, communication of outcomes with all relevant clinical teams and any disagreements with decisions made	31 March 2026	Director of Midwifery/Associate Medical Director	NHS Forth Valley is working towards full implementation of Safecare as a real-time staffing resource to monitor staffing levels and identify risks. Maternity services are using the TURAS platform as an interim solution. Safecare will be implemented by FEB 2026 in Maternity Services. When risks are identified (e.g., staffing below safe levels), NHS Forth Valley maternity service uses local developed escalation cards and decision-making checklists to guide staff through the process. If risks cannot be mitigated locally, they are escalated to senior staff, including the “lead of the week” and professional on-call, with clear documentation of actions taken. This escalation is be documented in three key areas to ensure transparency and enable ongoing review:	

				• Unit / huddle reports • Real Time Staffing platform • Decision-making checklists This process ensures that all escalations are tracked, reviewed, and addressed appropriately and tabled at relevant governance groups.	

Requirement 21. Domain 4.3.9	NHS Forth Valley must ensure that clear and robust systems and processes are in place, including guidance and support for staff, to allow consistent assessment and capture of real-time staffing risk across all professional clinical groups. Assessments should consider skill mix of available staff, dependency, and complexity of patients to support staff to confidently apply and record professional judgement in relation to required staffing when declaring "safe to start"		Director of Midwifery / Associate Medical Director	NHS Forth Valley maternity services are committed to embedding a culture of proactive and informed staffing risk management. The organisation's strategic direction prioritises: Safecare will be fully implemented by FEB 2026 in Maternity. • NHS Forth Valley maternity services are using integrated digital platforms to enable leadership and clinical teams to make informed, real-time decisions regarding workforce deployment and patient safety. • NHS Forth Valley is committed to embedding this digital platform (Safecare) within the medical	

				rotas by March 2026 • NHS Forth Valley maternity services are **c**reating an environment where staff are supported to exercise professional judgement confidently, with clear frameworks that recognise the complexity and diversity of clinical settings. The Rostering and Staffing escalation Policy will be implemented by FEB 2026. This will support standards and wellbeing requirement for all NMAHP staff. • NHS ForthValley maternity services are ensuring robust oversight through workforce governance structures. NHS Forth Valley maternity services are currently aligning	

				reporting against the workforce governance com template including timeline alignment for reporting purposes by FEB 2026.	

Requirement 21 Domain 4.3.10	NHS Forth Valley must ensure that maternity and obstetric services are appropriately and effectively staffed in order to reduce delays to care, preserve patient safety and support staff wellbeing	31 March 2026	Director of Midwifery/Associate Medical Director	NHS Forth Valley recognises that safe, timely, and person-centred care depends on having the right staff in the right place at the right time. To reduce delays, preserve patient safety, and support staff wellbeing, the following measures are being implemented: Time frame for Safecare implementation FEB 2026. • NHS Forth Valley maternity services utilise an electronic staffing roster that shows the allocation of staff across all maternity areas. • NHS Forth Valley maternity services conduct daily huddles to review scheduled and unscheduled care, enabling timely adjustments to staffing levels. • NHS Forth Valley	

				maternity services have in place escalation pathways supported by standard operating procedures and daily multidisciplinary reviews which are utilised to ensure safe provision of care • NHS Forth Valley will support staff participation in leadership development days and NMAHP forums to foster resilience and collaborative problem-solving.	

Requirement 21. Domain 4.3.11	NHS Forth Valley must ensure that there are systems and processes in place to support clinical leaders within maternity services being able to access appropriate protected leadership time to fulfil their leadership and management responsibilities, also ensuring that its employees receive time and resources to undertake training which is essential to their role. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls	31 March 2026	Director of Midwifery	NHS Forth Valley maternity services will ensure leadership time will be rostered and monitored through a centralised monitoring system, ensuring transparency and accountability. This process will be fully implemented by DEC 2026 NHS Forth Valley maternity services is implementing monitoring via the SafeCare digital platform for robust compliance tracking, with a test of change in January 2026, with full roll-out in February 2026 highlight NHS Forth Valley maternity services will monitor staff wellbeing through structured monthly feedback, assessing how dedicated leadership time contributes to:	

				• reducing stress • strengthening morale • creating opportunities for professional development. NHS Forth Valley will evaluate the data to ensure alignment with the Nursing & Midwifery Taskforce principles of compassionate leadership and staff wellbeing. This will be reported through the board NMAHP Worforce group NHS Forth Valley is currently developing a rostering policy with a predicted date for completion in FEB 2026.	

Local Action Plan Summary of Progress

The Improvement Action Plan was developed following the HIS: Unannounced Maternity Services Safe Delivery of Care Inspection and signed by the Board Chair and Chief Executive on 17 November 2025. The actions require to be implemented across the Board and all actions are on track to deliver to timescale. Ongoing monitoring will be through the Clinical Governance Working Group and Clinical Governance Committee.

Action	Timescale to meet action	Status
1. NHS Forth Valley should consider adopting a continuity approach to maternity telephone triage	January 2026	**On track**: NHS Forth Valley Women & Children's services will implement the dedicated telephone triage by Jan 2026
2. NHS Forth Valley should consider improving bereavement training compliance rates for all staff providing bereavement care to families	31 March 2026	**On track**: Training compliance for the department has increased from 59% to 72% since the inspection observation visit.
3. NHS Forth Valley must ensure effective oversight of activity within the maternity unit to support safe delivery of care for women including but not limited to: 1. Maternity triage 2. Delays to care, including inductions	January 2026	**On track**: A dedicated improvement group has been established, reporting through the Quality and Safety Steering Group.
4. NHS Forth Valley must ensure that patients are provided with the right care, in the right place, at the right time.	January 2026	**On track**: NHS Forth Valley is committed to delivering safe, effective, MEWS and person-centred care with ongoing monitoring through the Quality and Safety Steering Group.
5. NHS Forth Valley must ensure effective governance and oversight to ensure all adverse events are reliably reported and changes to clinical practice identified through adverse events are compliant with the adverse events framework.	December 2026	**On track**: NHS Forth Valley is undertaking a review and implementing changes to our current adverse events reporting system and has reviewed and updated the Adverse Event Policy, and the SAER policy.

6. NHS Forth Valley must ensure clinical guidelines are up to date and reviewed within agreed timescales.	31 January 2026	**On track**: NHS Forth Valley is conducting a thorough review of existing clinical guideline and policy documents with the Clinical Governance Working Group overseeing this work.
7. NHS Forth Valley must ensure that women accessing acute care out with maternity services are consulted with appropriate risk assessments, such as the maternity early warning system (MEWS).	31 January 2026	**On track**: NHS Forth Valley is implementing the Maternity Early Warning System (MEWS) across all acute clinical areas outside maternity services.
8. NHS Forth Valley must ensure the safe and secure use of medicines at all times, including the storage and administration of medicines.	March 2026	**On track**: NHS Forth Valley maternity services have engaged with the Director and Associate Director of Pharmacy to ensure alignment with governance and HIS expectations.
9. NHS Forth Valley must ensure that all staff complete statutory fire training.	31 March 2026	**On track**: Targeted support in place for areas requiring additional training. Compliance with TURAS Fire Training module Aim set for 95% by January 2026.
10. NHS Forth Valley must ensure that there are clear, consistent systems and processes in place to support management of any potential identified staffing risks within maternity services. This includes accurate recording of any escalation, mitigation/inability to mitigate, communication of outcomes with all relevant clinical teams and any disagreements with decisions made.	31 March 2026	**On track**: NHS Forth Valley is working towards full implementation of Safecare as a real-time staffing resource to monitor staffing levels and identify risks. Safecare will be implemented by February 2026 in Maternity Services.

11. NHS Forth Valley must ensure that clear and robust systems and processes are in place, including guidance and support for staff, to allow consistent assessment and capture of real-time staffing risk across all professional clinical groups. Assessments should consider skill mix of available staff, dependency, and complexity of patients to support staff to confidently apply and record professional judgement in relation to required staffing when declaring “safe to start”.		**On track**: NHS Forth Valley maternity services are currently aligning reporting against the workforce governance template including timeline alignment for reporting purposes by FEB 2026. Safecare will be fully implemented by FEB 2026 in Maternity.
12. NHS Forth Valley must ensure that maternity and obstetric services are appropriately and effectively staffed in order to reduce delays to care, preserve patient safety and support staff wellbeing	31 March 2026	**On track**: To reduce delays, preserve patient safety, and support staff wellbeing, a number of measures are being implemented including Safecare implementation February 2026.
13. NHS Forth Valley must ensure that there are systems and processes in place to support clinical leaders within maternity services being able to access appropriate protected leadership time to fulfil their leadership and management responsibilities, also ensuring that its employees receive time and resources to undertake training which is essential to their role. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls.	31 March 2026	**On track**: Implementation of monitoring via the SafeCare digital platform for robust compliance tracking full roll-out February 2026. A rostering policy is being developed with a predicted date for completion February 2026. NHS Forth Valley maternity services will ensure leadership time will be rostered and monitored through a centralised monitoring system, ensuring transparency and accountability to be fully implemented by December 2026.

NHS Forth Valley

Forth Valley NHS Board

11. The Specialist Rehabilitation Service
Purpose: This report is for Assurance

Executive Sponsor: Karen Goudie, Executive Nurse Director
Authors: SCN Craig Finlayson and AHP Team lead Linda Stevenson

Executive Summary

The Specialist Rehabilitation Service (SRU) within NHS Forth Valley was established in 2020 following funding from the Scottish Major Trauma Network, which allocated dedicated funding to every Health Board to strengthen rehabilitation pathways for people recovering from major trauma. The funding enabled 4 additional specialist rehab beds to be created to supplement the 6 existing beds within FVRH. Admission to the SRU is based solely on rehabilitation need, supporting adults of all ages with complex neurological, trauma-related, or acquired brain injuries.

The SRU initially operated from Ward B22 at Forth Valley Royal Hospital from October 2020 until August 2021. In September 2021, the unit relocated to the Thistle Suite within the Bellfield Centre at Stirling Care Village, where it continues to deliver a nurse and AHP led, 10-bedded specialist rehabilitation service. Its purpose is to optimise recovery, reduce long-term disability, minimise the need for costly out-of-area placements, and support safe, effective transition back to community living. The service contributes directly to the Scottish Trauma Network and aligns with national rehabilitation standards.

The SRU operates through a highly skilled multidisciplinary team comprising nurses, nursing assistants, physiotherapists, occupational therapists, speech and language therapists, dietitians, therapy assistants, and neuropsychologists, with additional input from rehabilitation consultants, pharmacists, psychiatrists, and orthotists when required. Each patient is allocated a link therapist who coordinates all aspects of their rehabilitation journey. Therapy begins on the day of admission, with daily treatment from Monday to Friday and continued rehabilitation support from nursing teams at weekends. Patients participate in a range of individual and group therapies, with interventions focused on achieving personalised goals. Therapy also includes real-life practice such as meal preparation, shopping, and community engagement to promote independence and functional recovery.

A structured review pathway is in place, beginning with an initial family meeting approximately two weeks after admission and followed by progress reviews every 4–6 weeks. Length of stay varies depending on patient needs, ranging from a few weeks to several months. Discharge planning begins when goals can be more effectively met within the community.

The service has demonstrated major system-wide benefits. Since 2021, the SRU has generated an estimated £442,000 per week in avoided care costs—equivalent to approximately £23 million annually—largely due to improved rehabilitation outcomes reduced length of stay and fewer out-of-area placements. Staffing levels meet British Society of Physical and Rehabilitation Medicine (BSPRM) guidance, with high staff retention and positive wellbeing reported.

The SRU also plays a key role in national networks, contributes to the Scottish Acquired Brain Injury Network, Scottish Head Injury Forum, and Neurological Network, and is collaborating with the University of Edinburgh on research involving young brain-injury survivors. The service aligns strongly with Realistic Medicine and Value-Based Health & Care principles through person-centred, goal-oriented interventions and system-wide cost avoidance.

Action Required
The Forth Valley NHS Board is asked to:

(1) note what specialist rehabilitation is, the multidisciplinary service being provided and the positive outcomes for FV patients and their families;
(2) note the data highlighting whole system clinical effectiveness and the estimated cost avoidance generated by the impact of the specialist rehab service, and
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified

Governance Route to the Meeting and Previous Board Consideration
Chair and chief executive previously visited the unit and invited staff to present to the Board.

Risk Assessment and Mitigation
Risks: The current medical model and overall workforce is under review.
Mitigations: A paper will be presented to acute strategic management group which will consider the highlighted risk with a view to securing the appropriate workforce model**.**

Impact Assessments
Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required x☐

Financial and Infrastructure Implications
Since September 2021 there has been overall system wide cost avoidance in care costs of approx. £442,000 per week, based on a total of 249 patients (Approx £23 million annually calculated using the UK ROC database). The UK Rehabilitation Outcomes Collaborative (UK ROC) was established in September 2008 to develop a national database for collating case episodes for inpatient specialist rehabilitation. They provide an evidence-based baseline for care needs and costs. By comparing: Projected needs after rehabilitation (lower NPDS → fewer hours, lower cost). Needs without rehabilitation (higher NPDS → more hours, higher cost)

- There has been a sustained reduction in length of stay for patients within the unit and a reduction in the requirement for out of area placement

Workforce Implications

- The specialist rehab service is a nursing and AHP led service with high levels of staff retention and satisfaction due to the rehab model, varied learning opportunities and excellent patient outcomes.

- Unit is staffed appropriately to a specialist rehab service standard as per the British society of physical and rehabilitation medicine (BSPRM) recommendations.

Quality / Patient Care Implications
The Quality and Patient Care aspects of the Service are summarised below:

- **Improved Patient Outcomes:** Reduces morbidity, long-term disability, and optimises recovery through evidence-based, multidisciplinary care.
- **Reduced Length of Stay:** Intensive rehabilitation shortens hospital stays and prevents unnecessary delays.
- **Avoids Out-of-Area Placements:** Minimises costly external referrals and supports care closer to home.
- **National Compliance:** Meets Scottish Trauma Network KPIs for Level 2b
- **Collaborative working across FV and beyond:** Providing advice and consultation with other clinical areas in FV, being an active part of the major trauma network – participating in MDT discussions prior to direct repatriation to SRU
- **Active participation in national groups** – sharing best practice and developments as part of the Scottish Acquired Brain Injury Network (SABIN), the Major Trauma Network, Scottish Head Injury Forum (SHIF), Neurological Network. Currently working with the University of Edinburgh on a potential research project involving young survivors of brain injury.

Population Health & Care Strategy
The Service is underpinned by the principles of Value Based Health and Care as outlined below:

- Aligns with Realistic Medicine and Value-Based Health & Care by offering accessible, person-centred care and goal setting. The positive impact on quality of life.
- Offering significant cost avoidance across the system.
- Supports specialist rehabilitation closer to home and early repatriation from the major trauma centres.
- Prevention of future complex secondary issues due to complex conditions
- Working collaboratively locally, nationally within the NHS and other agencies
- Developing a widely recognised specialist workforce

Climate Change / Sustainability Implications
There are no implications in relation to climate change / sustainability.

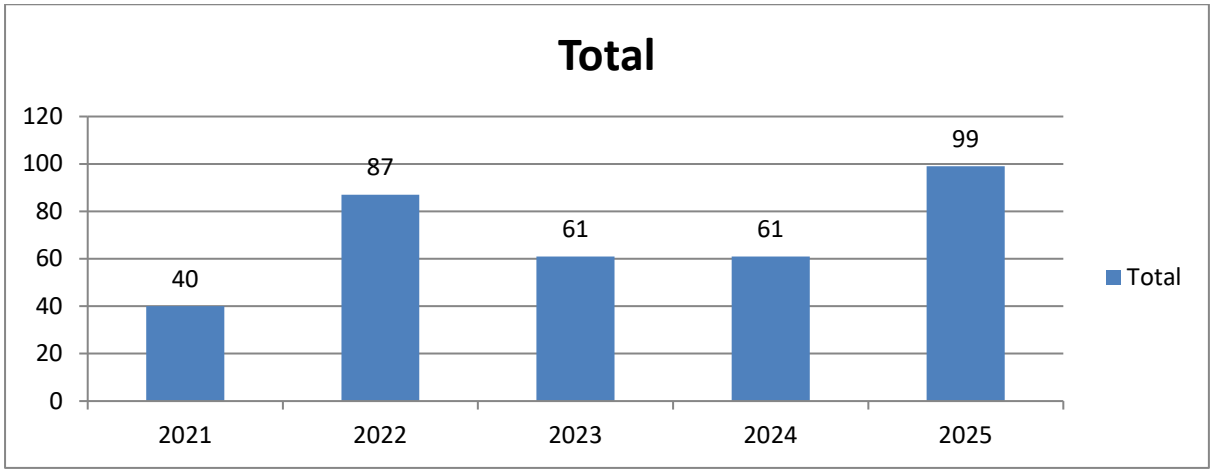
Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ **No**

Engagement Activity:
Launch of dedicated webpage in 2025 giving staff and the wider public an insight into our service.
NHS Forth Valley – Specialist Rehabilitation

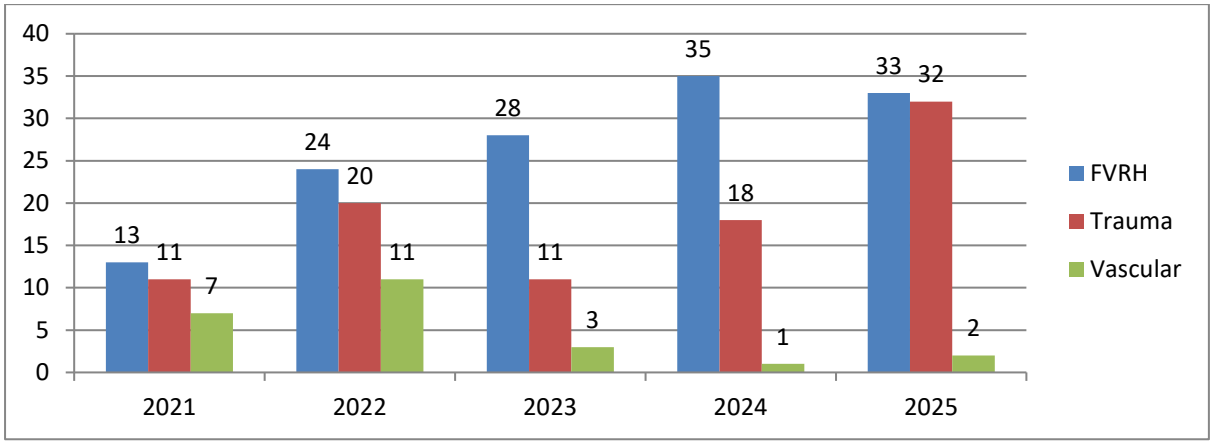
Appendices
Appendix 1 - SRU data from 08/09/21- 31/12/2025

SRU data from 08/09/21- 31/12/2025

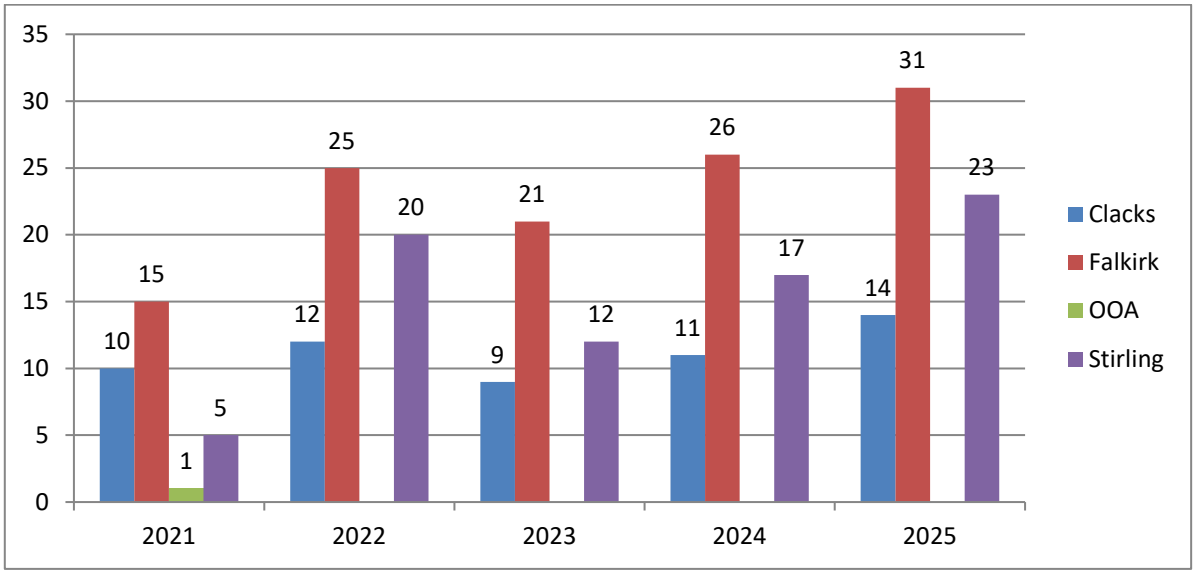
Total referrals to SRU



Total admissions to SRU per pathway



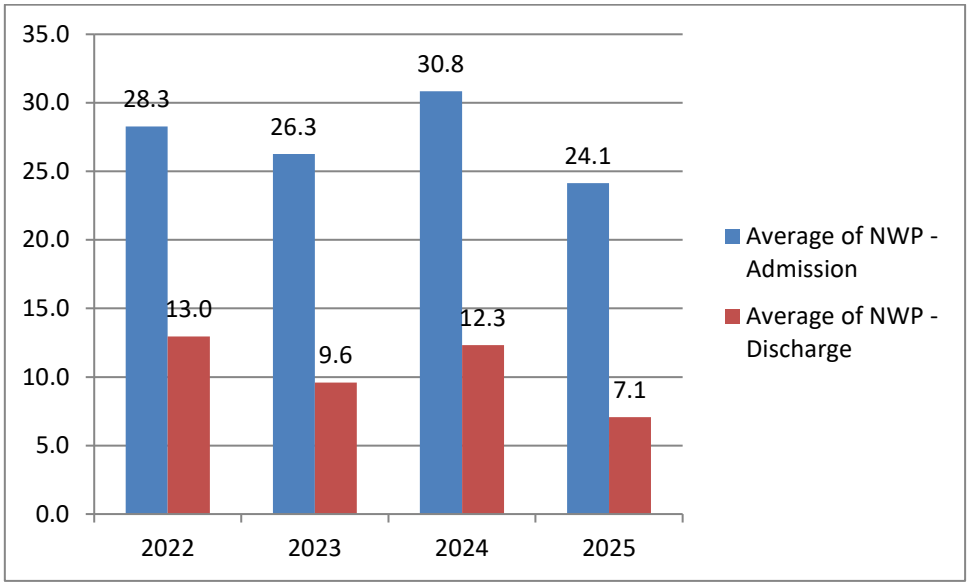
Locality Data



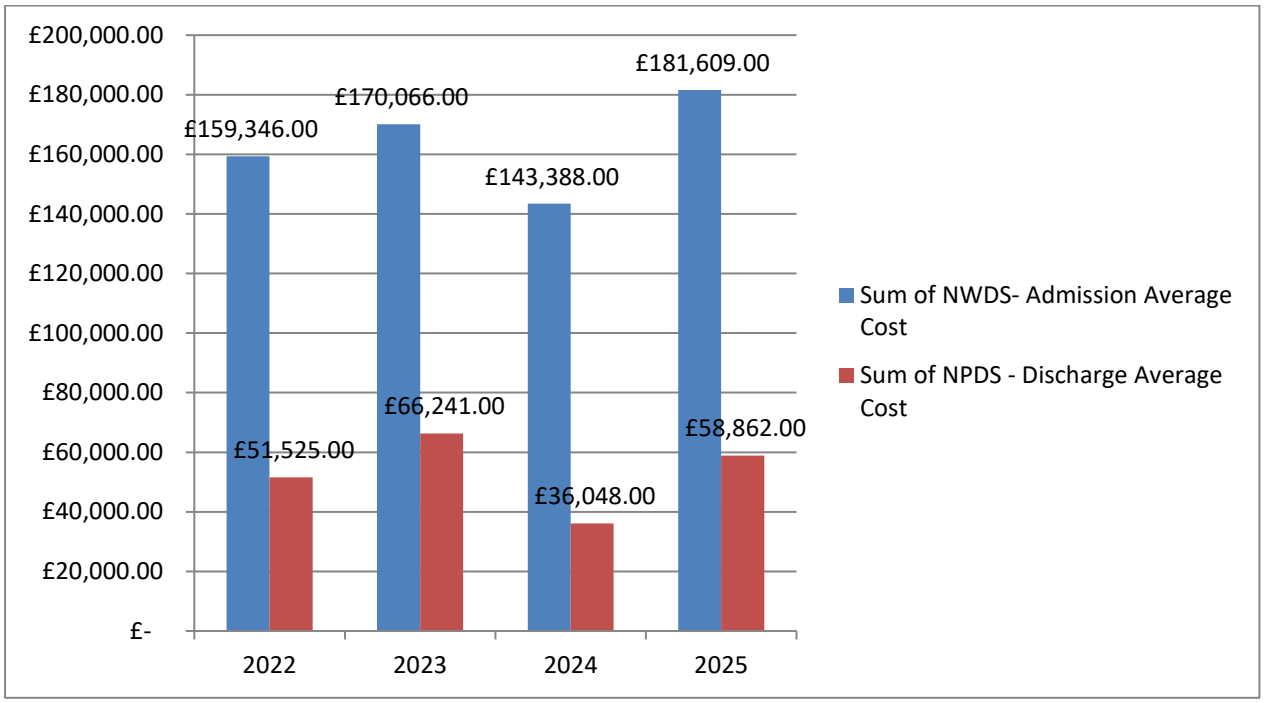
Average Length of Stay

Average of Length of Stay (SRU)				
Row Labels	**FVRH**	**Trauma**	**Vascular**	**Grand Total**
2022	66.4 Days	70.6	41.6	61.6 Days
2023	91.5 Days	143.1	38.0	108.7 Days
2024	64 Days	105	196	83 Days
2025	54 Days	48	27	51 Days
Grand Total	**66 Days**	**81 Days**	**53 Days**	**70 Days**

Northwick Park Dependency Scores



Northwick Park – Cost of Care Savings (per week)



Year	Sum of NWDS- Admission Average Cost	Sum of NPDS - Discharge Average Cost
2022	£159,346.00	£51,525.00
2023	£170,066.00	£66,241.00
2024	£143,388.00	£36,048.00
2025	£181,609.00	£58,862.00
Grand Total	**£654,409.00**	**£212,676.00**

Accumulative weekly difference of approx. £441,733 Yearly difference £22,970,116 – based on a total of 249 patients.

Calculations are made using UK ROC excel tool. A full description of the Northwick Park Dependency Score and Care Needs Assessment and how the approximate care costs are calculated using the UK ROC excel tool can be found via this link:

Northwick Park Dependency Score and Care needs Assessment (NPDS/NPCNA) | Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation | King's College London

Northwick Park Dependency Score and Care needs Assessment (NPDS/NPCNA)

The Northwick Park Dependency Score (NPDS) provides an assessment of patient care needs. It is an ordinal scale in which the scoring levels reflect:

a) the number of carers, and

b) the time required to complete activities of daily living.

In addition, it includes safety awareness, behavioural management, and communication. There is also a version to be used in hospital (NPDS-H).

The tool translates by way of a validated computerised algorithm into the Northwick Park Care Needs Assessment (NPCNA) which is a directly cost able generic assessment of care needs in the community. This provides:

- an approximate timetable of when care needs occur
- an estimate of weekly care hours
- the type and cost of care package which would normally need to be provided

The NPDS/NPDS-H/NPCNA can be used as a practical tool to inform discharge planning and ongoing evaluation of care needs once the patient is back at home.

Impact

- The NPDS/NPCNA forms part of the mandated toolset within the UK Rehabilitation Outcomes Collaborative (UK ROC) national clinical registry for specialist rehabilitation since 2012.
- It has been used extensively to demonstrate that rehabilitation provides value for money through savings in the ongoing costs of care (see Applications tab below for key publications).

Software

The UK ROC software that contains the algorithm to translate the NPDS to the NPCNA (Care Needs Assessment) is built on Microsoft Excel and is freely available from the UK ROC website.

Northwick Park Dependency Score - H (hospital version)

The Northwick Park Dependency Score – Hospital (NPDS-H) version is designed for hospital or residential care settings. It contains an extended version of the In-patient Nursing Needs containing eight dichotomous Yes/No items and eight ordinal items.

The total score for both NPDS and NPDS-H is 0-100.

NPDS AND NPDS-H scores may broadly be divided into three levels of dependency

Score	Level of dependency	Help required
0-10	Low dependency	Self-caring but may need incidental help
11-24	Medium dependency	Requires help from one person for most activities
25-100	High dependency	Requires help from two people for activities

Northwick Park Care Needs Assessment

- Once the NPDS/NPDS-H scores have been entered into the designated UK ROC software, an in-built computerised algorithm calculates the estimated care hours & care costs and produces a suggested care package to meet the needs identified.
- Graphs and tables provide a visual representation and are available within the software.

Development of the original NPDS (community version)

- The NPDS/NPCNA was developed during the 1990s using an iterative process to produce an ordinal scoring system and estimation of care needs/cost that would provide a seamless service into the community.
- The care costs were developed following extensive liaison with community care providers to establish hourly costs and live-in care costs. Care costs were updated in 2023 to reflect the care provider 12-hour shift patterns and associated costs.

Completion of the NPDS-H/NPCNA

- The NPDS/NPDS-H is designed to be completed by any nurse or carer who is familiar with the patient's care needs.
- Within the UK ROC dataset collection of NPDS/NPDS-H/NCNA is mandated for all Level 1 & 2 specialist rehabilitation units in England. At minimum, scores should be completed on admission and discharge.

The NPCNA does not necessarily represent the recommended care package for a given individual as this may vary with circumstances, but it provides an objective standard assessment which is not subject to bias.

Care is costed at standard rates regardless of whether it is provided by formal or informal carers, but basic care and skilled care (requiring a qualified nurse or specially trained carer) are separated. The output may then be interpreted in the light of individual circumstances.

Because the NPCNA is generic, it only provides an approximate estimate in the individual case, but offers the advantage of being able to predict care needs in relation to dependency, if this were to change over time or with rehabilitation

Using the NPDS/NPCNA to demonstrate cost efficiency of rehabilitation

- The NPDS/NPCNA has been used extensively to demonstrate that rehabilitation provides value for money.
- A primary aim of rehabilitation is to improve independence for self-care. Recorded on admission and discharge from the programme, the NPDS/NPCNA is used to quantify any reduction in care needs and the associated savings in the weekly cost of ongoing care in the community.
- Within the UK ROC database, cost efficiency of rehabilitation is calculated in terms of the time taken these weekly savings to offset the cost of the original rehabilitation programme.
- Annual savings, thereafter, extrapolated over the individual’s expected remaining years of life, may be used to estimate anticipated life-time savings in the cost of care. These calculations are now embedded in the UK ROC database for prospective patient-level reporting.

Key publications:

- Turner-Stokes L, Paul, S, Williams H. Efficiency of specialist rehabilitation in reducing dependency and costs of continuing care for adults with complex acquired brain injury.
  Journal of Neurology, Neurosurgery and Psychiatry. 2006; 77: 634-639. doi: 10.1136/jnnp.2005.073411.
- Turner-Stokes L. Cost efficiency of longer-stay rehabilitation programmes: Can they provide value for money? *Brain Injury* 2007; 21 (10): 1015-1021. doi: 10.1080/02699050701591445.
- Turner-Stokes L, Williams H, Bill A, Bassett P, Sephton K. Cost-efficiency of specialist inpatient rehabilitation for working-aged adults with complex neurological disabilities: A multicentre cohort analysis of a national clinical dataset *BMJ Open* 2016 Feb 24;6(2). doi: 10.1136/bmjopen-2015-010238.

- Turner-Stokes L, Bavikatte G, Williams H, Bill A, Sephton K. Cost-efficiency of specialist hyperacute in-patient rehabilitation services for medically unstable patients with complex rehabilitation needs: a prospective cohort analysis. *BMJ Open*. 2016 Sep 8;6(9). doi: 10.1136/bmjopen-2016-012112.

- Turner-Stokes L, Dzingina M, Shavelle R, Bill A, Williams H, Sephton K. Estimated life-time savings in the cost of on-going care following specialist rehabilitation for severe traumatic brain injury in the UK. *Journal of Head Trauma Rehabilitation*. 2019 Jul/Aug;34(4):205-214. doi: 10.1097/HTR.0000000000000473.

- Turner-Stokes L, Harding R, Peihan Y, Dzingina M, Wei G Cost-efficiency of specialist inpatient rehabilitation for adults with multiple sclerosis: A multicentre prospective cohort analysis of a national clinical dataset. *Multiple Sclerosis Journal – Experimental, Translational and Clinical.* 2020 Mar 16;6(1). doi: 10.1177/2055217320912789.

- Turner-Stokes l, LeFeuillee G, Francis R, Nayar M, Nair A. Functional outcomes and cost-efficiency of specialist in-patient rehabilitation following spinal cord injury: A multi-centre national cohort analysis from the UK Rehabilitation Outcomes Collaborative (UK ROC). Disability and Rehabilitation. J 2021 Jul 20:1-9. doi: 10.1080/09638288.

NHS Forth Valley
Forth Valley NHS Board

12. Whistleblowing Activity Performance Report
Purpose: This report is for Assurance

Executive Sponsor: Karen Goudie, Executive Nurse Director
Author: Claire Peacock, PA to Executive Nurse Director

Executive Summary

The National Whistleblowing Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS service providers to handle concerns that are raised with them, and which meet the definition of a 'Whistleblowing concern'.

The standards are applicable across **all NHS services** and are accessible to anyone working to deliver an NHS service, whether directly or indirectly. This includes current and former employees, bank and agency workers, contractors, including third sector providers, trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social care partnerships.

The National Whistleblowing Standards and Once for Scotland Whistleblowing Policy were introduced on 1 April 2021, and it is a requirement of the Standards to report Whistleblowing Performance to the NHS Board on a quarterly and an annual basis.

This paper is presented to the NHS Board to provide an update on Whistleblowing activity in NHS Forth Valley.

NHS Forth Valley Position at a Glance

To date NHS Forth Valley has received an overall **total of 26 cases**.

- 10 cases were managed under Stage 1 of the Whistleblowing procedure and
- 16 cases under Stage 2 of the procedure.

The table below provides a breakdown of areas and total number of concerns received and investigated at each stage of the procedure:

	Stage 1	Closed	Stage 2	Closed
Acute	4	4	6	6
Corporate	0	0	3	3
Community	0	0	1	1
MH/LD/Prisons	4	4	2	2
Women & Children	1	1	3	3
HSCPs	0	0	0	0
Estates & Facilities	1	1	1	1
Total	**10**	**10**	**16**	**16**

Action Required

The Forth Valley NHS Board is asked to:

(1) note Whistleblowing performance in NHS Forth Valley in Q2 and Q3 2025

(2) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

Noted below are the governance routes for assurance:

- Staff Governance Committee
- NHS Board

Risk Assessment and Mitigation

Effective Whistleblowing processes can act as both detective and preventative risk management controls to support the organisation and its staff.

NHS Forth Valley promote the use of Business-as-Usual reporting for all areas of concern, however where these have been exhausted, or are felt by the reporter to be closed to them, then Whistleblowing routes should be used.

There is also a public confidence and reputational risk if Whistleblowing standards are not fully implemented and visible across the organisation.

Risks to the wellbeing and psychological safety of staff may emerge if NHS FV Senior Leaders are not committed to the process of investigating and learning from any concerns and issues raised by staff.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No

If yes, please confirm this is attached. Attached☐ Not required X

Financial and Infrastructure Implications

No major impact other than the potential post noted in Workforce Implications below, and in addition a one-off cost of £4K and a recurring cost of approximately £300 per annum to support the further development of an additional incident page on Safeguard to data capture the Whistleblowing process.

Workforce Implications

An interim model of corporate support was initially agreed for the implementation of the standards and the ongoing co-ordination of the Whistleblowing process. The responsibilities associated with this role have now been formally integrated into the post holder's job description, ensuring clarity and alignment with organisational requirements.

Quality / Patient Care Implications

Whistleblowing is viewed by NHS Forth Valley as an important source of information that may highlight serious risks to the effectiveness and efficiency of the organisation, with individuals often being best placed to identify deficiencies and problems at the earliest opportunity. If the opportunity to investigate and address these concerns does not result in improvements then there is a potential risk to the quality, safety and experience of patients.

Population Health & Care Strategy

N/A

Climate Change / Sustainability Implications

None

Engagement and Communications

Was statutory engagement with stakeholders required? Yes ☐ No **X**

Appendices

Appendix 1 – Main Report

Appendix 1

Whistleblowing Activity Performance Report

1. Purpose of the Paper

1.1 This paper is presented to the NHS Board to provide an update on the Whistleblowing Performance in NHS Forth Valley during Q2 and Q3 2025.

2. Position

2.1 The introduction of the Independent National Whistleblowing Standards aims to ensure everyone delivering NHS services in Scotland is able to speak up to raise concerns when they see harm or wrongdoing, putting patient safety at risk, confident that they can do so in a protected way that will not cause them personal detriment. It also aims to promote a culture of speaking up in the NHS and continues to be a key priority in NHS Forth Valley.

2.2 The standards are applicable across all NHS services and are accessible to anyone working to deliver an NHS service, whether directly or indirectly. This includes current and former employees, bank and agency workers, contractors, including third sector providers, trainees and students, volunteers, and anyone working alongside NHS staff, such as those in health and social care partnerships.

2.3 NHS Forth Valley is committed to managing the organisation in the best way possible and follows the revised national whistleblowing standards introduced across NHS Scotland. We strive to ensure that staff feel safe, supported, and have confidence in the fairness of the process whilst raising their concerns under the whistleblowing arrangements.

2.4 Furthermore, it is worth noting that NHS Forth Valley's Culture Change and Compassionate Leadership Programme was developed over a period of time and was informed by comprehensive staff engagement through focus groups, conversations and surveys. This initiative established 8 strategic workstreams, which are now being implemented across the organisation, including the Safe, Well and Heard Project, which is dedicated to enhancing psychological safety and supporting Whistleblowing and Speak Up mechanisms.

3. Speak Up Service and Whistleblowing Arrangements

It was brought to the organisation's attention that there appeared to be some misperception regarding the distinction between the Speak Up Service and Whistleblowing Arrangements.

It was thought helpful to provide a clear explanation of the differences between these two services outlining their respective roles, scope, and how staff can access support through each of the services.

To support the Speak Up Service and Whistleblowing Arrangements there are Speak Up Advocates and Confidential Contacts available to provide a confidential, impartial service where employees can discuss concerns in a safe space or speak to someone in confidence for support and advice. The roles of the advocates and confidential contacts were combined to support both the Speak Up and Whistleblowing processes.

3.1 NHS Forth Valley Speak Up Service

The Speak Up Service was introduced to the organisation in 2021. The purpose being to empower staff at all levels to raise concerns in a safe and supportive environment.

The scope of the service covers a wide range of concerns, not limited to whistleblowing.

Some examples include:

- Health and Safety
- Terms and Conditions
- Patient Safety
- Quality of Induction
- Other workplace issues

The Speak Up Service provides an informal and supportive approach for staff to raise concerns and encourages intervention. Staff can raise concerns confidentially via speak up advocates/confidential contacts.

Any employee of NHS Forth Valley can use NHS Forth Valley's Speak Up Service.

3.2 Whistleblowing Arrangements

The Implementation of the National Whistleblowing Standards were also introduced in 2021.

The purpose of NHS Forth Valley Whistleblowing procedures is to ensure serious concerns are formally addressed under the Independent National Whistleblowing Standards.

The scope of the Whistleblowing arrangements focuses on harmful or unethical practices, such as:

- Patient safety or care issues
- Poor practice
- Unsafe working conditions
- Fraud (e.g. theft, bribery)
- Falsifying performance data
- Legal breaches
- Abuse of authority
- Cover-ups

Whistleblowing is a formal approach which covers a two Stage procedure. This includes

Stage 1: Local resolution
Stage 2: Formal investigation

The two Stage procedure is governed by the National Whistleblowing Standards

The Whistleblowing procedures is available to all NHS providers including:

- Anyone delivering NHS services in Scotland, including:
- Current and former employees
- Bank and agency staff
- Trainees and students
- Volunteers

The table below provides a summary of both the Speak Up Service and Whistleblowing Arrangements

Feature	Speak Up Service	Whistleblowing
Formality	Informal	Formal
Introduced	Local Initiative	National Standards
Scope	Broad (any concern)	Specific (harm, misconduct)
Examples	Induction quality, T&Cs, safety	Fraud, abuse, unsafe care
Support	Confidential, signposting	Confidential, structured process
Audience	All NHS Forth Valley staff	All NHS service providers in Scotland

3.3 NHS Forth Valley's whistleblowing arrangements continue to evolve and strengthen, driven by a commitment to continuous improvement. We actively seek and encourage feedback from individuals who have engaged with the process, enabling us to gain valuable insight into their experiences and identify opportunities for enhancement.

3.4 In response to this feedback, we have introduced improvements across several areas, including refining internal processes and enhancing communication with staff involved in whistleblowing investigations. These developments are designed to reinforce governance, provide assurance to the Board, and build greater confidence in whistleblowing procedures among staff.

4. National Speak Up Week

4.1 NHS Forth Valley participated in National Speak Up Week, which took place between 29th September and 3rd October 2025. The theme this year was "Listen, Act, Build and Trust.

4.2 Resources were shared widely with teams and staff were encouraged to discuss and promote a culture of speaking up, share resources and complete pledges. Pledges were greatly received from all levels of staff including our Executive Board members.

4.3 As part of the arrangements, we gathered perspectives from our new Executive Lead for Whistleblowing on the importance of "building trust", alongside NHS Forth Valley's Whistleblowing Champion. Recordings were shared widely with staff across the organisation and publicised on the Staff Intranet. In addition, a live forum was hosted by NHS Forth Valley's Lead Confidential Contact to provide further engagement and discussion.

There were also a series of live events hosted by SPSO (Scottish Public Services Ombudsman) which were publicised for interest on NHS Forth Valley Staff Intranet

5. Whistleblowing Key Performance Indicators Rag Status

The format of this section of the report reflects the Scottish Government's mandate to capture performance of the board against the 9 key performance indicators.

The table (1) below provides a summary of each of the Key Performance Indicators. Progress on each of the indicators is provided throughout the report.

Table 1 – Key Performance Indicators

KPI	Measure
KPI 1	Learning from Whistleblowing Concerns
KPI 2	Whistleblowing Procedure Experience
KPI 3	Self Awareness & Training
KPI 4	Total Number of Concerns Received
KPI 5	Concerns Closed at Each Stage
KPI 6	Concerns Upheld or Not Upheld
KPI 7	Average Times
KPI 8	Closed in full within the timescales
KPI 9	Number of Cases where an extension is authorised

Key Performance Indicator One: Learning from Whistleblowing Concerns
NHS Forth Valley continues to strengthen its whistleblowing arrangements by embedding learning from concerns into both local services and organisational practice. Improvements arising from whistleblowing are implemented through robust action planning within local teams, with progress monitored and tracked to completion by the Whistleblowing Administrator to ensure accountability.

To support wider organisational learning, updates are disseminated via whistleblowing reports, newly introduced learning summaries, and publications on the internal webpage. These communications outline the nature of concerns raised and detail subsequent improvements, ensuring transparency and reinforcing confidence in the process. This approach remains iterative, with ongoing efforts to identify innovative and effective methods for sharing learning across the organisation.

The whistleblowing network plays a pivotal role in driving organisational learning, providing a forum for sharing insights and demonstrating improvements resulting from concerns. This continues to be an area of development, aimed at ensuring learning extends beyond individual services to influence broader organisational practice. Through these measures, NHS Forth Valley demonstrates its commitment to continuous improvement, governance assurance, and fostering a culture of trust and openness.

Independent National Whistleblowing Officer (INWO)

If a colleague remains unhappy with the response received from NHS Forth Valley, they have the right to contact the Independent National Whistleblowing Officer (INWO) to request an investigation into their complaint. The INWO is the final opportunity for the colleague using the NHS Whistleblowing Procedure and offers an independent view on whether the NHS has reasonably responded to a Whistleblowing concern.

The INWO has to date received a total of 6 cases relating to NHS Forth Valley Whistleblowing concerns. NHS Forth Valley have provided additional information which informs the INWO's decision on whether a full investigation is undertaken in relation to these cases.

Table 3 Provides detail of the outcomes overall from the INWO's investigations:

INWO Outcomes	Total Number
Fully Upheld	5
Partly Upheld	0
Not Upheld	0
No Investigation Conducted	0
Withdrawn	0

The published reports can be found here Our findings | INWO (spso.org.uk).

Feedback from the Independent National Whistleblowing Officer (INWO) has provided NHS Forth Valley with valuable insights to refine whistleblowing processes, strengthen governance, and enhance staff confidence in the system. This feedback has highlighted opportunities to learn from reporters' experiences and ensure that our approach remains robust, transparent, and aligned with national standards.

Key Performance Indicator Two: Whistleblowing Procedure Experience
The Whistleblowing Procedure requires NHS Forth Valley to actively seek feedback from individuals who raise concerns, ensuring their experience of the process informs ongoing improvement. This commitment reflects our core values of transparency, accountability, and responsiveness.

Every individual who raises a concern under the whistleblowing procedure is supported by designated Confidential Contact. The Confidential Contact/s provide a safe, respectful, and confidential environment for reporting, helping staff feel secure and empowered to speak up.

To strengthen our approach, NHS Forth Valley has established a structured mechanism to encourage feedback from reporters at key stages of the process. This feedback is invaluable in:

- Gaining insight into the reporter's experience
- Identifying barriers or challenges within the process
- Highlighting opportunities for improvement

Feedback received has directly informed enhancements to our whistleblowing arrangements, including:

- Process Refinement: Streamlined systems to improve timeliness and clarity.
- Communication Improvements: Clearer updates for reporters throughout investigations
- Training and Awareness: Additional guidance for managers and Confidential Contacts to ensure consistency and sensitivity

These changes aim to build confidence in the whistleblowing process for all involved, reinforcing a culture of trust and openness across NHS Forth Valley.

NHS Forth Valley recognises that feedback is not a one-off exercise but an ongoing dialogue. Continuous engagement with reporters ensures the whistleblowing process remains dynamic, transparent, and aligned with best practice standards.

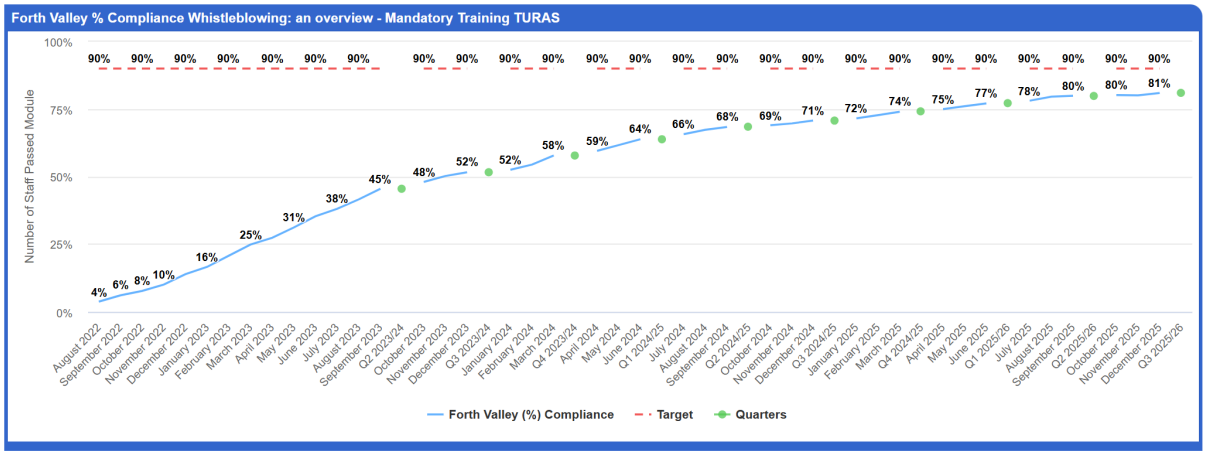
Key Performance Indicator Three: Self Awareness and Training
There is a requirement to report on levels of staff perceptions and awareness of training. As part of the Whistleblowing Standards there is requirement for staff to complete the training developed by the INWO. Whistleblowing training reports are now accessible from TURAS which in turn supports the developments of training arrangements.

Table 4 - provides an overview of numbers of staff who have completed the Whistleblowing Overview training to date, this equates to 81% of the organisation against a target of 90% and is an increase from the last reporting period.

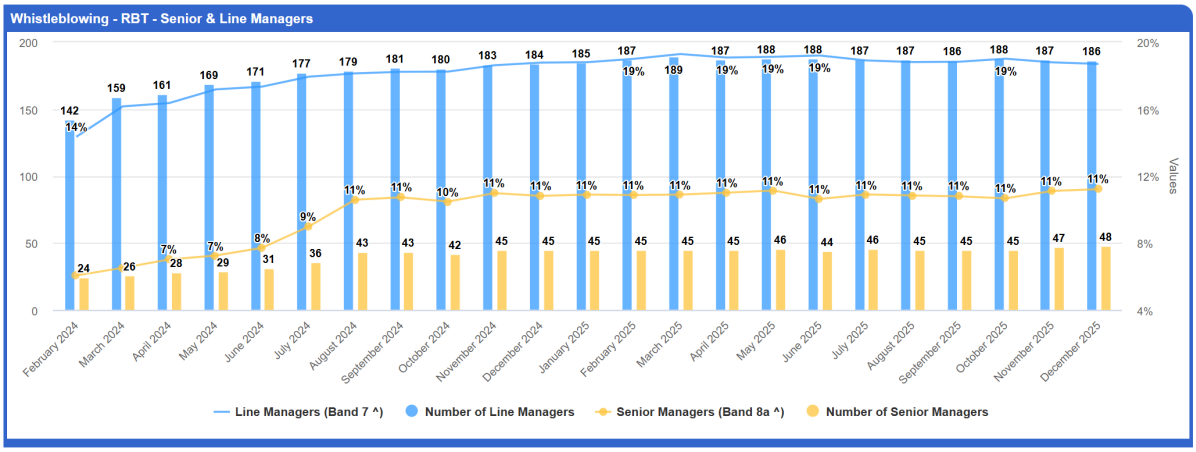
Whistleblowing Training	Completed Numbers	Eligible
All Staff "Overall"	5518	6816

The graphs below demonstrate the overall percentage of compliance of staff who have completed the training to date:

Graph 1 – An Overview



Graph 2 – Senior / Line Managers



The training modules are actively promoted across the organisation. Senior and Line Managers encouraged to complete the training and support staff in engaging with modules most relevant to their roles. While it is recognised that uptake has not yet reached the desired level, a focused and sustained effort is ongoing, and this remains a key priority.

Key Performance Indicator Four: Total number of Concerns Received
During this reporting period Q2 & Q3 there was a total number of 2 concerns received.

To date NHS Forth Valley have investigated or are investigating a total number of 26 concerns since the development of the whistleblowing arrangements. This includes 10 under Stage 1 and 16 under Stage 2 of the Whistleblowing Procedure.

Graph 2 – Overall number of concerns received to date

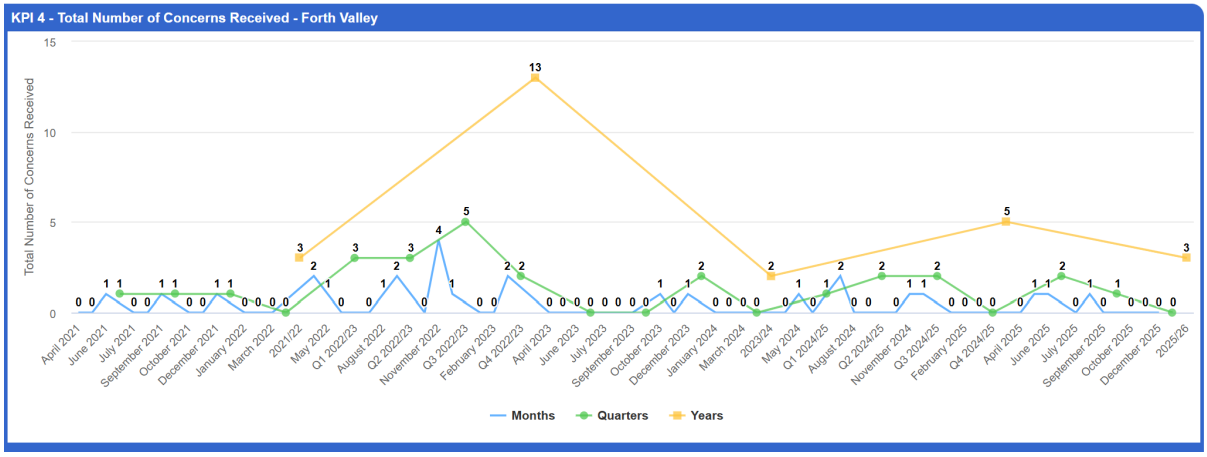


Table 5 – A breakdown of areas and total number of concerns received and investigated at each stage of the procedure:

	Stage 1	Closed	Stage 2	Closed
Acute	4	4	6	6
Corporate	0	0	3	3
Community	0	0	1	1
MH/LD/Prisons	4	4	2	2
Women & Children	1	1	3	3
HSCP	0	0	0	0
Estates & Facilities	1	1	1	1
Total	**10**	**10**	**16**	**16**

It is also worth noting that there have been occasions where individuals have raised concerns collectively. A breakdown of the number of reporters is provided below:

Table 6

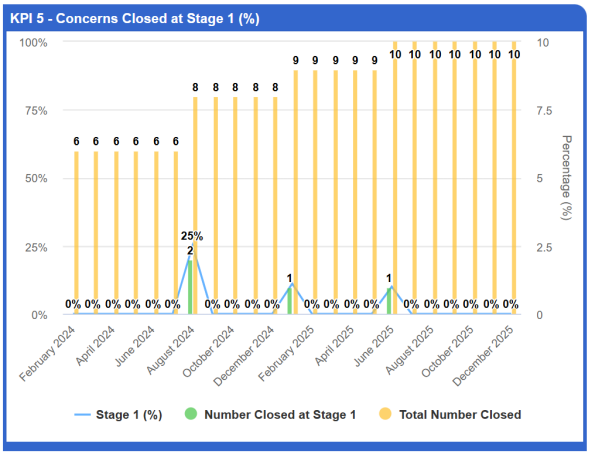
Area	Number of reporters raising concerns
Women & Children's Directorate	4
Mental Health	6
Mental Health	3

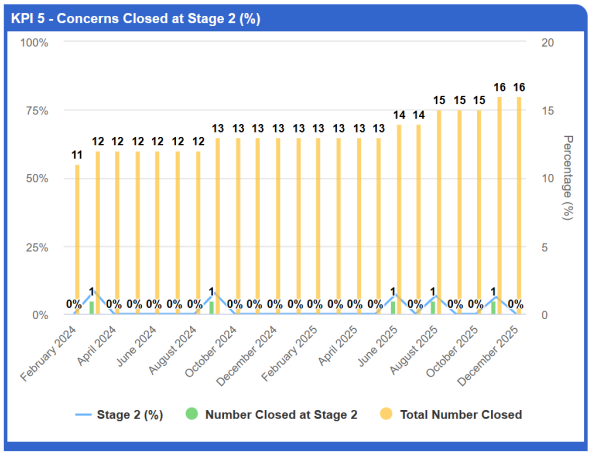
Key Performance Indicator Five: Concerns Closed at Each Stage
The data below captures the concerns closed at each stage of the procedure including as a percentage of all concerns closed.

Table 7 - Provides the total number of concerns closed to date:

	Total Number Received	Total Number Closed
Stage 1	10	10
Stage 2	16	16

Graph 3 Total number of concerns closed at Stage 1 and Stage 2 of the Whistleblowing Procedure as a percentage of all concerns closed:





Key Performance Indicator Six: Concerns Upheld and Not Upheld
To meet the requirements of Indicator Six, NHS Forth Valley provides a breakdown of formal outcomes—upheld, partially upheld, or not upheld—across Stage 1 and Stage 2 whistleblowing concerns.

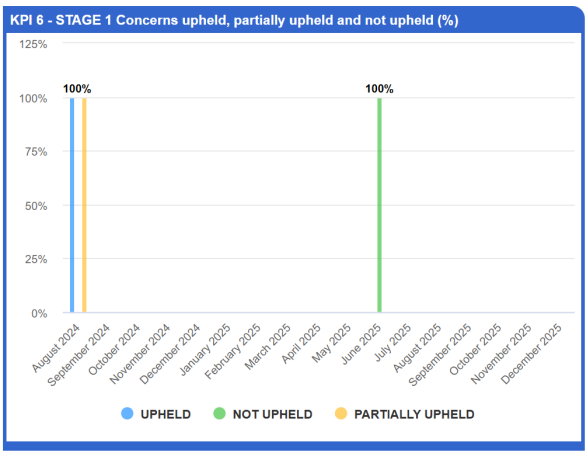
During Q2 & Q3 one Stage 2 case was formally investigated and was partially upheld.

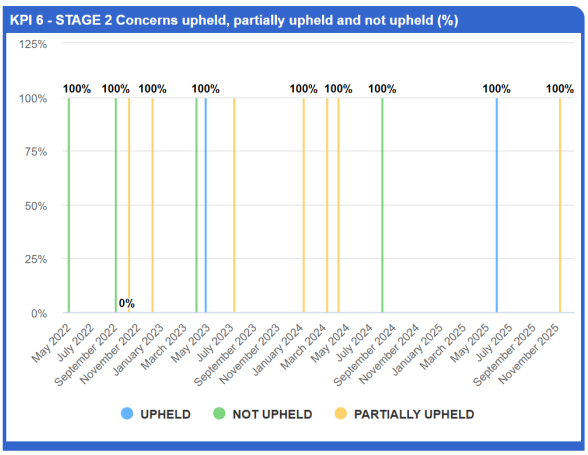
The data below demonstrates a cumulative breakdown of formal outcomes for Stage 1 and Stage 2 concerns since 2021.

Table 8

	Stage 1	Stage 2	Total
Upheld	1	2	3
Not Upheld	6	5	11
Partially Upheld	3	9	12

Graph 4 Concerns upheld, partially upheld and not upheld at each stage of the Whistleblowing Procedure as a percentage (%) of all concerns closed at each stage:

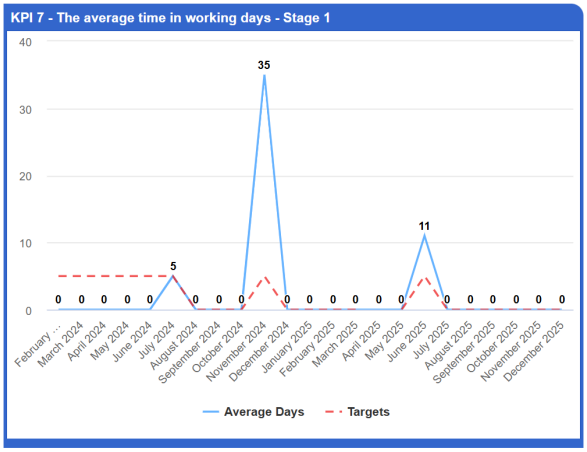


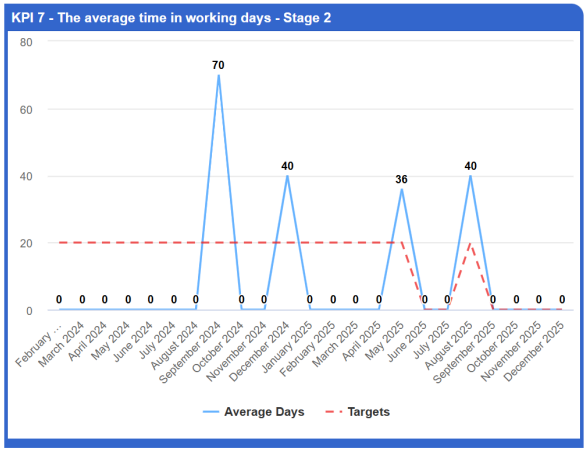


Key Performance Indicator Seven: Average Times
A reporting requirement of the Whistleblowing Procedure is to report on the average times in working days to close concerns at each stage.

A detailed breakdown of the total average time in working days for a full response to concerns at each stage of the Whistleblowing Procedure is demonstrated in the graph below:

Graph 5 – Total average times in working days





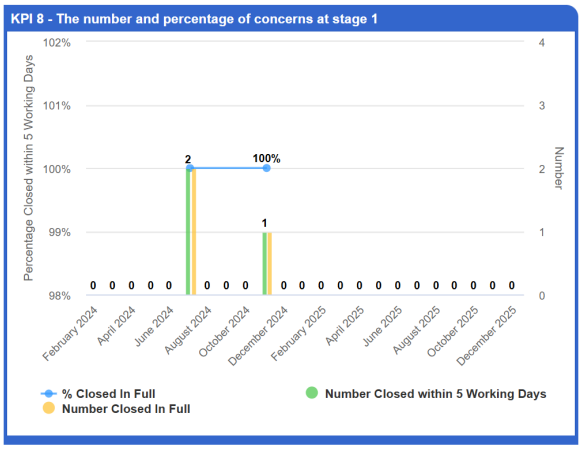
It has been acknowledged that the average response time in working days, particularly for Stage 2 cases, remains an area of concern. This is primarily due to the complexity of the issues raised and the detailed investigations required. The recent increase in the number of Lead Investigators has already helped to improve response times and is expected to drive further progress. Performance in this area continues to be closely monitored as part of the ongoing review process.

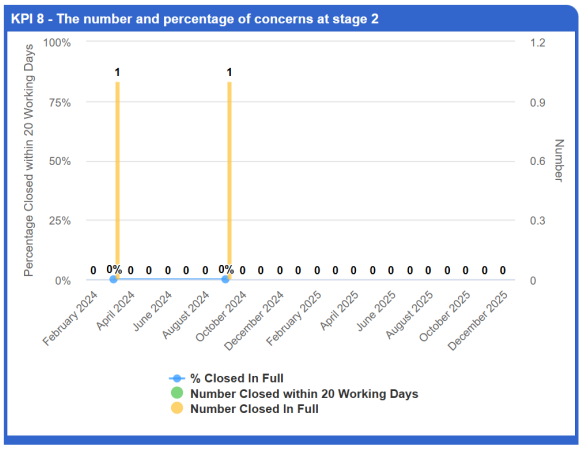
Key Performance Indicator Eight: Closed in Full within the Timescales
There were no concerns closed in full within the timescale in this reporting period.

Table 8 below provides the total number of concerns closed within timescale for each Stage of the procedure:

	Closed within timescale
Stage 1 (5 working days)	6
Stage 2 (20 working days)	3

Graph 6 Total number of concerns closed in full within the timescale:





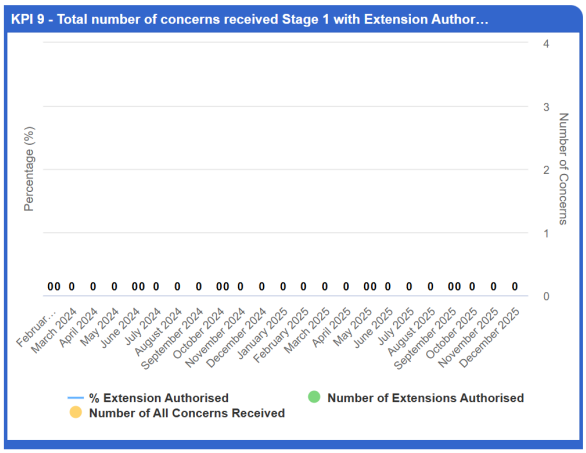
As highlighted above, the timescales may not always be met due to the complexity of the issues raised and the comprehensive level of investigation required, however this is an area of focus and continues to be monitored as part of the process.

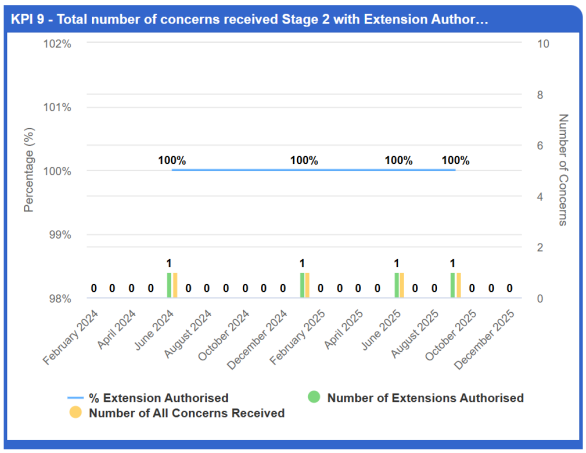
Key Performance Indicator Nine: Number of Cases where an Extension is Authorised

It is important that we respond to concerns timeously however not all investigations will be able to meet the timeline. The Whistleblowing Procedure allows an extension where it is necessary to complete the investigation.

During this reporting period there was one Stage 2 case with an extension authorised.

Graph 7 – total number of cases where an extension is authorised.





As highlighted previously there continues to be a particular focus on strengthening governance around the authorisation and management of extensions to whistleblowing investigations. In response, a structured monitoring system was implemented, which includes weekly check-ins between the administrator and the investigator to track progress and identify any challenges requiring escalation.

Significant work has also been undertaken to enhance the process including the introduction of regular progress updates and a formalised process for approving extensions to investigation timescales. These improvements aim to ensure greater transparency, accountability, and timeliness in the handling of whistleblowing concerns.

4. Additional

4.1 As previously reported, there were an additional 4 concerns received through Whistleblowing. The concerns were reviewed by the Whistleblowing Decision Making Panel and the panel agreed that the concerns did not meet the criteria for Whistleblowing. The reporters were made aware of the decision and advised that although whistleblowing was not the appropriate avenue to pursue their concerns, other options were suggested depending on the nature of the concerns.

4.2 In addition, it is worth noting that the Speak Up Service has received 65 enquiries since the arrangements were put in place in December 2021. To which some of these enquiries involved multiple staff members. The enquiries were managed, and staff were supported and signposted accordingly.

The main themes reported through the Speak Up Service include:

- Bullying & Harassment
- Patient & Staff Care, Staffing Levels
- Re-banding

5. Conclusion

5.1 NHS Forth Valley continues to demonstrate a strong commitment to the principles of the National Whistleblowing Standards, ensuring that all staff and stakeholders have

access to clear, safe, and effective mechanisms for raising concerns. The organisation has successfully managed and closed all whistleblowing cases received to date, embedding learning from these concerns into both local and organisational practice.

5.2 The integration of whistleblowing responsibilities alongside the expansion of Lead Investigator capacity, has strengthened governance and improved response times, particularly for complex Stage 2 cases. Ongoing monitoring and structured review processes are in place to ensure continued progress in this area.

5.3 Feedback from staff and the Independent National Whistleblowing Officer has informed further enhancements to internal processes and communication, reinforcing transparency and accountability. The Speak Up Service and Confidential Contacts remain vital in supporting staff, promoting a culture of openness and psychological safety.

5.4 NHS Forth Valley recognises that maintaining high standards in whistleblowing is an ongoing requirement. The Board can be assured that robust systems are in place to manage risks, support continuous improvement, and uphold the quality and safety of care. The organisation remains focused on learning from experience, acting on feedback, and ensuring that all staff feel empowered to speak up, confident that their concerns will be addressed appropriately.

NHS Forth Valley
Forth Valley NHS Board

13. Finance Report
Purpose: This report is for Assurance

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Scott Urquhart, Director of Finance / Jillian Thomson, Deputy Director of Finance

Executive Summary

This report provides an overview of the month 9 financial results and an updated forecast outturn for the year.

The projected year-end outturn reported to the NHS Board in November 2025 indicated a forecast overspend of £5m. Following a detailed review of the Quarter 3 financial results, alongside an updated assessment of savings delivery, confirmation of funding allocations, and favourable revisions to financial planning assumptions, the forecast year-end position has now improved to break-even.

Achievement of a break-even position remains subject to risk in the final quarter, particularly in relation to the confirmation of IJB outturns and potential risk sharing requirements. We will continue to work closely with IJB CFOs to confirm and manage the position.

The financial planning process for 2026/27 is now well underway following the recent Scottish budget announcement (see briefing note issued to Board members 14/01/26). A Board Seminar on 10th February will provide further detail and analysis of both the financial plan and associated savings proposals. The draft 3-year financial plan will be presented to the Strategic Planning, Performance and Resources Committee in February, with the final version to be considered by the NHS Board in March.

Action Required

Forth Valley NHS Board is asked to:

(1) Note that a break-even position against both revenue and capital sources is projected for 2025/26 subject to identified risks in the final quarter. which represents an improvement on the previously reported position.
(2) Note the ongoing work in relation to financial planning with an updated 3-year financial plan to be presented to the SPPRC in February.
(3) Consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

This matter has previously been considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- The Financial Stewardship Programme Board

- The SPP&RC and the NHS Board receive regular updates on the financial position, plans and risk as a standing agenda item.

Risk Assessment and Mitigation
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 demand pressures.

Impact Assessments
Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications
The Capital and Revenue 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 costs account for a significant proportion of total operating expenditure and is therefore a key financial risk area.

Quality / Patient Care Implications
It is imperative that quality of care and overall service provision is underpinned by a sustainable financial strategy aligned to the principles of Value Based Health and Care.

Population Health & Care Strategy
It is recognised that improving population health outcomes and shifting resources to early intervention/more preventative measures can reduce future demand on services. Adopting the principles of values-based health and care and Realistic Medicines is a key feature of our financial planning process.

Climate Change / Sustainability Implications
There are no direct climate change/sustainability implications arising from this report. Climate Change and Sustainability initiatives contribute to efficiency savings, reducing waste, cost avoidance and productivity gains across the five priority areas for NHS Scotland (i.e. Sustainable Buildings & Land; Sustainable Travel; Sustainable Goods & Services; Sustainable Care; and Sustainable Communities). A range of climate change and sustainability initiatives are already included in our cost improvement programme.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒
This report was prepared in consultation with Senior Finance colleagues.

Appendices
Appendix 1 – Overview of Financial Performance at month 9.

Appendix 1 - Overview of Financial Performance

1. NHS FV Financial Performance

The total annual budget for 2025/26 is estimated at £975.4m as summarised in table 1 below. Note that the overall budget includes a small number of anticipated revenue allocations that still require formal confirmation by the Scottish Government.

The estimated annual budget increased by £5.8m compared to the previous month, with a range of favourable movements between anticipated and confirmed allocation values for pay awards and other policy developments, including planned care initiatives and non-recurring sustainability funding (see annex A).

TABLE 1: NHS Forth Valley 2025/26 Financial performance	Annual Budget £m	April - December Budget £m	April - December Expenditure £m	Underspend/ (Overspend) £m	Forecast Outturn £m
Set Aside & Non-Delegated Functions*					
Acute Services	266.106	197.783	213.423	(15.639)	(20.317)
Woman Children and Families	68.070	50.826	51.700	(0.874)	(1.130)
Cross Boundary Flow/External SLAs	72.299	54.108	54.510	(0.402)	(0.746)
Non-delegated Community Services	42.187	32.692	33.285	(0.593)	(0.742)
Facilities	116.289	86.908	87.708	(0.800)	(0.528)
Digital	27.015	20.259	19.561	0.698	0.740
Corporate Functions	40.296	28.290	26.839	1.452	2.114
Ringfenced and Contingency Budgets**	38.452	13.500	0.000	13.500	20.551
Income	(39.799)	(29.778)	(29.866)	0.088	0.058
Sub total	**630.916**	**454.589**	**457.159**	**(2.570)**	**0.000**
Delegated Functions					
Operational Services	150.568	113.065	107.001	6.064	
Universal Services	186.233	146.932	152.513	(5.581)	
IJB reserves	7.726	(0.483)	0.000	(0.483)	
Sub total	**344.527**	**259.515**	**259.515**	**(0.000)**	
Reserve transfers (to)/from IJB					
Clackmannanshire & Stirling IJB	0.000	0.000	0.000	0.000	
Falkirk IJB	0.000	0.000	0.000	0.000	
Sub total	**0.000**	**0.000**	**0.000**	**0.000**	
TOTAL	**975.443**	**714.103**	**716.674**	**(2.570)**	

* 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 £631.7m above is £88.0m. An overspend of £7.026m is reported at month 9.

**The forecast outturn for Ringfenced & Contingency budget reflects expected slippage in allocations & favourable changes in financial planning assumptions & other unplanned financial benefits eg CNORIS contributions and New Medicines Fund (via additional receipts due under the Voluntary Scheme for Branded Medicines Pricing, Access, and Growth).

As outlined in table 1 above, an overspend of £2.6m is reported for the 9-month period ending 31 December 2025 (this represents an improvement of £1.99m compared to the position reported in the previous month). The majority of the overspend relates to ongoing pressures within the Acute Services Directorate (including women children & families), however material overspends are also reported in relation to Externals/Cross Boundary Flow, other non-delegated Community Services and Facilities. Key drivers of the overspend in these Directorates relate to pay costs (particularly in relation to medical staffing and unregistered nursing), drugs and devices (in terms of uptake of new drugs in Oncology and Dermatology and Diabetes technologies), ongoing

pressures regarding non-emergency patient transport and increased costs of SLAs with neighbouring NHS Boards and external providers.

In terms of the forecast outturn for the year, breakeven is now projected for 2025/26 following an in-depth review of the quarter 3 financial results, together with a reassessment of projected savings delivery and confirmation of funding allocations and favourable changes in financial planning assumptions.

It is recognised that there are a number of emerging risks which may adversely affect our outturn position in the final quarter of the year, including:

- winter planning and potential surge capacity requirements,
- the impact of Resident Doctor rota breaches and
- risk sharing arrangements with IJBs.

The position will be kept under close review between now and 31 March 2026, however the estimated impact of these risks is expected to be managed within the overall outturn projection.

In term of progress in reducing supplementary staffing costs, the latest information to 31 December 2025 confirms that expenditure is £5.4m or 18.5% lower than the same period in the previous year as summarised in Table 2 below.

Table 2: Non-Core Staffing Costs	Apr 24 to Dec 24 £	Apr 25 to Dec 25 £	Better/ (Worse) £	% Change
Admin agency	101,740	(1,019)	102,759	101.0%
Admin bank	1,000,363	864,447	135,916	13.6%
Medical agency	3,421,961	4,289,452	(867,491)	(25.4%)
Medical bank	1,871,351	2,534,323	(662,972)	(35.4%)
Medical locum	1,620,538	880,394	740,144	45.7%
Nurse agency	2,577,046	(3,789)	2,580,835	100.1%
Nurse bank	15,776,102	12,961,451	2,814,651	17.8%
Other agency	201,775	203,968	(2,193)	(1.1%)
Other bank	1,059,716	930,182	129,534	12.2%
Overtime	1,372,026	972,321	399,705	29.1%
Total	**29,002,617**	**23,631,729**	**5,370,888**	**18.5%**

The reduction is largely driven by the continued cessation of nurse agency; however, nurse bank cost reductions are also a positive factor with expenditure down £2.8m compared to the same period in the previous year. This reflects targeted work in this area by the Nursing Workforce Governance group to ensure that nurse bank usage remains appropriately authorised and cross referenced against sickness absence, vacancies and backfill requirements.

Overall medical supplementary pay costs remain higher than the previous year and action is now underway to recruit to additional substantive posts to reduce costs in key specialities as part of an invest to save proposal.

2. Efficiency Savings

The Financial Sustainability Action Plan for 2025/26 sets out the broad range of local and national cost improvement initiatives and efficiency schemes to mitigate the initial £38.0m funding gap identified as part of the development of our 2025/26 financial plan.

The action plan includes savings schemes across 4 workstreams which are aligned to the refreshed national "15-point grid" and the 3% recurring savings target set by the Scottish Government. To date total savings of £23.1m have been delivered which is £4.9m behind the planned trajectory. The majority of workstreams are behind plan to varying degrees with the exception of nurse agency staffing, prescribing and non-pay and other measures workstreams.

Annual plan £m	TABLE 3: 2025/26 Finanical Sustainability Action Plan - YTD saving delivery	Apr - Dec plan £m	Apr - Dec actual £m	Variance £m
	15 Box Grid: Innovation & Value-Based Healthcare			
0.035	Clinical Variation Review	0.026	0.024	(0.002)
0.392	Digital savings	0.294	0.088	(0.206)
1.965	Energy Efficiency Schemes	1.474	0.000	(1.474)
3.691	Prescribing savings	1.939	3.138	1.199
6.083	**Sub total: Innovation & Value-Based Healthcare**	**3.733**	**3.250**	**(0.483)**
	15 Box Grid: Workforce Optimisation			
0.999	Agency Reduction	0.749	2.581	1.832
4.949	Sustainable staff bank usage	3.712	1.656	(2.056)
0.500	Sickness absence reduction	0.375	0.000	(0.375)
1.044	Non-compliant rotas review	0.783	0.000	(0.783)
0.000	Central functions job family review	0.000	0.000	0.000
7.492	**sub total: Workforce Optimisation**	**5.619**	**4.237**	**(1.382)**
	15 Box Grid: Service Optimisation			
0.500	Theatres optimisation	0.375	0.051	(0.324)
1.909	Remote outpatient appointments	1.432	0.000	(1.432)
0.200	PLICS roll out	0.200	0.200	0.000
0.000	Length of stay reductions	0.000	0.000	0.000
0.221	Non-pay spend review	0.166	0.118	(0.048)
2.830	**sub total: Service Optimisation**	**2.173**	**0.369**	**(1.804)**
	Other local savings plans			
2.482	Estates & Infrastructure	2.133	1.467	(0.666)
8.603	Service redesign & reform	6.452	1.468	(4.984)
10.409	Non-pay & other measures	7.689	12.150	4.462
0.163	Savings under development	0.122	0.120	(0.002)
21.657	**sub total: Other local savings plans**	**16.397**	**15.206**	**(1.190)**
38.062	**TOTAL**	**27.921**	**23.062**	**(4.859)**
21.899	Recurring	17.032	16.731	**(0.301)**
16.163	Non-recurring	10.889	6.331	**(4.558)**
38.062	**TOTAL**	**27.921**	**23.062**	**(4.859)**

Of the £23.1m total saving achieved to date, £16.7m (72%) is classed as recurring (at this stage last year approximately £11m of recurring savings were delivered). Excellent progress has been made in relation to ongoing impact of nurse agency reductions with further savings reported this year. In addition, Prescribing savings through

implementation of a range of technical switches and the review of stock management and off contract spend are also being delivered in line with plan.

Key areas of concern include the workforce optimisation savings category in terms of the risk around non-compliant rotas and high sickness absence levels in certain service areas. The service optimisation category is also under review, particularly in relation to the saving attached to remote outpatient appointments which is considered high risk in terms of likely delivery of cash releasing savings. Service redesign and reform through the Value Based Health and Care programme is now underway, with the savings delivered to date relating to the closure of ward A11 as part of whole system work to shift the balance of care (note that estimated savings linked to A11 may reduce given its proposed role in providing additional surge capacity as part of winter planning).

3. Directorate Financial Performance

3.1. Clinical Directorates (Set Aside & Non-Delegated Functions)

Clinical Directorates reported a combined overspend of £3.9m as at 31 December 2025 as summarised in Table 4 below.

TABLE 4: Clinical Directorates*	Annual Budget £m	April - December Budget £m	April - December Expenditure £m	Underspend/ (Overspend) £m	Forecast Outturn £m
Acute Services	266.106	197.783	213.423	(15.639)	(20.317)
Woman Children and Families	68.070	50.826	51.700	(0.874)	(1.130)
Cross Boundary Flow/External SLAs	72.299	54.108	54.510	(0.402)	(0.746)
Non-delegated Community Services	42.187	32.692	33.285	(0.593)	(0.742)
Ringfenced and Contingency Budgets	38.452	13.500	0.000	13.500	20.551
Income	(39.799)	(29.778)	(29.866)	0.088	0.058
Sub total	**447.316**	**319.132**	**323.051**	**(3.920)**	**(2.326)**

* 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 £88.0m. An overspend of £7.026m is reported at month 9.

Acute services – an overspend of £15.6m is reported as at end December 2025 (an adverse movement of £1.6m compared to the position reported in November). The position reflects a £12.1m overspend in respect of Emergency Care & Inpatient Services and an overspend of £3.5m relating to Planned Care Services. Key pressure areas include pay costs, particularly in respect of medical staffing which is overspent by £5.1m and nurse pay budgets (primarily relating to unregistered nursing staff) which are overspent by £2.3m to date due to ongoing use of contingency areas and other unfunded services (including the flow navigation centre). Proposals to address unfunded areas have recently been agreed by the Financial Stewardship Group and work is now underway across several SLWGs to take forward the redesign process. Pressures are also reported in relation to the cost of drugs and devices (particularly in relation to the uptake of oncology drugs and diabetes technology such as insulin pumps and continuous glucose monitors).

Women, Children & Families – an overspend of £0.9m is reported at end of December 2025, which is broadly in line with the position reported at end November. The overspend is largely driven by non-pay items including complex care packages provided through external providers, surgical sundries (mainly Paediatric Diabetes technologies) and equipment.

Cross boundary flow/external SLAs – this budget covers treatment for Forth Valley residents outwith Foth Valley, mainly through SLAs with other Scottish Health Boards, and UNPACs. An overspend of £0.4m is reported at the end of December 2025 which reflects pressures in Acute UNPACs (ie high cost, low volume treatments and procedures recharged on a cost per case basis by NHS Lothian and NHS GG&C). These costs are difficult to forecast due to timing delays in receiving information and volatility, but early indications show rising costs for oncology drugs and bone marrow transplants along with a continuation of increasing numbers of Transcatheter Aortic Valve Implantations (TAVIs). Additional costs have also been incurred in relation to SLAs with NHS Lothian following their implementation of PLICS (Patient Level Information & Costing System) SLA methodology. For financial planning purposes, it is anticipated that further cost increases will be incurred in 2026/27 onwards as SLAs are updated following the removal of the Covid pause and as NHS Scotland transitions to PLICS.

Non-delegated community services – an overspend of £0.6m is reported as at 31 December 2025. This is largely due to ongoing financial pressures in Prison healthcare settings due to the new prison pharmacy contract, changes to working practices and the impact of decisions taken by the Scottish Prison Service (SPS) to realign the prisoner population across the entire Scottish prison estate in order to relieve accommodation pressures (resulting in additional prisoners being transferred to Polmont and Glenochil above historic establishment levels).

Ringfenced and contingency budgets – this refers to centrally held funding for key policy developments that have slipped or where amounts have still to be formally confirmed by the Scottish Government (eg AfC reform, the national LIMS replacement programme and CNORIS). Any additional unplanned funding received in year from the Scottish Government is also included in this line, together with Annually Managed Expenditure (AME) which typically relates to non-cash or technical accounting items. £13.5m has been released from this budget in the month 9 reports.

Income – income received at end December 2025 is broadly in line with the planned level. Note that we have rebased the 3-year average activity levels used to calculate SLA payments from other NHS Boards for services provided by Forth Valley, this is expected to generate additional income in year.

3.2. Set Aside & Non-Delegated Functions - Corporate Directorates

A combined underspend of £1.3m is reported for Corporate Services, Facilities and Digital Directorates as at 31 December 2025 as summarised in table 5 below.

TABLE 5: Corporate Functions and Facilities & Infrastructure	Annual Budget £m	April - December Budget £m	April - December Expenditure £m	Underspend/ (Overspend) £m	Forecast Outturn £m
Facilities	116.289	86.908	87.708	(0.800)	(0.528)
Digital	27.015	20.259	19.561	0.698	0.740
Corporate Functions					
Director of Finance	7.301	5.411	5.435	(0.024)	(0.045)
Area Wide Services	(0.884)	(2.232)	(1.543)	(0.688)	(0.792)
Medical Director	13.954	10.419	9.084	1.335	1.865
Director of Public Health	3.268	2.391	2.259	0.132	0.255
Director of HR	7.007	5.273	5.220	0.053	(0.028)
Director of Nursing	5.906	4.267	4.128	0.139	0.152
Chief Executive	0.878	0.637	0.549	0.088	0.145
Strategic Planning & Performance	2.867	2.123	1.706	0.417	0.562
Corporate Functions sub total	40.296	28.290	26.839	1.452	2.114
Sub total	**183.600**	**135.457**	**134.108**	**1.349**	**2.326**

Facilities – an overspend of £0.8m is reported at the end of December 2025 which is a favourable movement of £0.183m compared to the position reported in November. Ongoing pressures remain in relation to non-emergency patient transport, clinical waste, postages and energy. A number of immediate actions were taken forward to strengthen financial controls around 1st class and 2nd class postage (mainly relating to letters), however overall postage costs remain higher than the same period in the previous year which appears to be due to the costs of parcels and other bulky deliveries. New franking machines have been installed which will enable more granular data on postage costs to be investigated and support targeted savings initiatives in this area.

Digital - an underspend of £0.7m is reported at the end of December 2025 (which is broadly in line with the position reported at end November) due to non-recurring underspends in Health Records and eHealth due to the lead in time to fill vacancies.

Corporate Functions – a combined underspend of £1.5m is reported at the end of December (an improvement of £0.1m compared to the position reported in November). This is largely driven by non-recurring underspends in the Medical Director budget in relation to vacancies in Pharmacy, Quality and Innovation and the Information Governance teams. This is offset by timing issues relating to legal claims and associated provisions which accounts for the majority of the overspend reported against the Area Wide Services budget.

3.3. Delegated Functions – Health & Social Care Partnerships

Delegated health functions reported under the Health and Social Care Partnerships (HSCPs) returned a combined overspend of £0.5m as at 31 December 2025 as summarised in table 6 below, however this is assumed to be offset by corresponding reserve movements which brings both HSCPs to breakeven.

TABLE 6: Health & Social Care Partnerships	Annual Budget	April - December Budget	April - December Expenditure	Underspend/ (Overspend)
Clackmannanshire and Stirling HSCP				
Operational Services	67.720	50.189	47.110	3.079
Universal Services	94.240	74.350	78.402	(4.052)
Ringfenced and Contingency Budgets	4.058	0.973	0.000	0.973
Subtotal	166.018	125.512	125.512	(0.000)
Falkirk HSCP				
Operational Services	82.848	62.876	59.891	2.985
Universal Services	91.993	72.582	74.111	(1.529)
Ringfenced and Contingency Budgets	3.668	(1.456)	0.000	(1.456)
Subtotal	178.509	134.002	134.002	(0.000)
TOTAL	**344.527**	**259.515**	**259.515**	**(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 £88.0m. Responsibility for the operational and financial management of Set Aside functions currently resides with NHS Forth Valley.

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 accounts for the overspend reported under universal services in table 6. This reflects ongoing volume growth in the number of items prescribed, tariff adjustments as part of the Community Pharmacy funding settlement and short supply issues. Delays in achieving prescribing efficiency savings also contribute to the adverse position reported to date.

As reported in table 6, the pressure on the primary care prescribing budget is 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 and community based AHP services.

Similarly, Falkirk HSCP are also experiencing ongoing vacancies and associated non-recurring underspends in community Mental Health services, community based AHP services, community Learning Disability services and Health Improvement.

In terms of potential risk sharing arrangements, an upfront payment was made to both IJBs during the 2024/25 financial year for projected risk share requirements in 2025/26 (based on the historic the risk share agreement for each IJB). However current projections for the HSCPs suggest that there is a potential for further risk sharing payments to be required. We continue to work closely with the IJB CFOs to monitor and confirm the position.

4. Capital Financial Performance

The total net capital budget for 2025/26 is currently estimated at £13.4m as summarised in table 7 below. This reflects the core formula allocation of £6.7m as advised by the Scottish Government, together with £6.7m of net anticipated allocations (including £6.3m of approved funding through the Business Continuity Plan submission).

TABLE 7: 2025/26 NHS Forth Valley Capital Position	Annual Budget £m	Apr- Dec Budget £m	Apr - Dec Expenditure £m	Underspend/ (Overspend) £m
Elective Care	0.000	0.320	0.320	0.000
Information Management & Technology	5.761	1.929	1.929	0.000
Medical Equipment	3.649	2.180	2.180	0.000
Facilities & Infrastructure	5.239	2.101	2.101	0.000
NHS Board corporate projects	(0.601)	0.004	0.004	0.000
Right of Use Assets IFRS16	0.343	0.252	0.252	0.000
Total Available Capital Funding	**14.391**	**6.786**	**6.786**	**0.000**
Indirect Capital Charged to Revenue	(1.000)	0.000	0.000	0.000
Forecast NET Capital Resource Limit	**13.391**	**6.786**	**6.786**	**0.000**

As reported in Table 7 above, a balanced position is reported against the Capital Resource Limit (CRL), with total expenditure of £6.8m reported to date, leaving a net balance of £6.6m to be spent during the remaining 3 months of the financial year.

Key areas of expenditure to date are described below:

Elective Care – £0.3m has been incurred to date on advisor and professional fees due to ongoing delays associated with the new National Treatment Centre Inpatient Ward. The delay reflects outstanding technical issues relating to the pipework and fire compliance regulations. A potential solution has been submitted to Falkirk Council's building control team for review and we are currently awaiting feedback. There is currently no budget for these fees in the 25/26 capital plan, however the Scottish Government are aware of the position and we have an agreed way forward.

Information Management & Technology – to date the sum of £1.9m has been spent on a range of infrastructure refresh projects, primarily relating to the new Radiology Information System (RIS), upgraded Picture Archiving and Communication System (PACS) and the new Digital Pathology system.

Medical Equipment – £2.2m has been incurred to date in relation to replacement beds, new Ultrasound Probes and Max Fax dental equipment. Procurement of other medical equipment, in line with the planned replacement plan, is scheduled for the final quarter of the financial year in line with supplier lead in times.

Facilities & Infrastructure – to date the sum of £2.1m has been spent on improvements works at Dunblane Health Centre, professional fees in relation to the proposed ASDU extension, improvements to the footpaths at the Bungalows, Legionella Remedial works, refurbishment of the Resident Doctors accommodation at FCH and the initial roll out of the anti-ligature works at FVRH.

NHS Board Corporate Projects and Property Sales – the overall budget includes planned capital to revenue grants (reported as a negative budget in table 7 above). Note that there are currently no anticipated capital receipts linked to property sales during 2025/26. Discussions with property developers have concluded in relation to sale of land at Stirling Care Village with a preferred bidder identified and approved, however the sale is not expected to conclude until late 2026/27.

Annex A – In year revenue budget movements

NHS Forth Valley 2025/26 reconciliation of Annual Budget movement	Budget Movement £m
Total estimated revenue budget as at month 8	**969.663**
New Scottish Governement allocations	
Centre for excellence for children's care and protection - NSS	0.006
Prisoner Healthcare - Improvements to clinical IT	0.062
Breast screening radiology training	0.099
Financial Sustainability	5.000
Sub total	**5.167**
Movement between anticipated and confirmed allocation value	
Resident Doctors 25-26 Pay Award - Tranche 2	0.376
HNC Backfill - Q1&2 academic year 25/26	0.040
Open University backfill - Q1&2 academic year 25/26	0.025
Planned Care Targeted Funding	0.458
Improving Flow, Dwd & Frailty Services	0.026
Additional Non-Core Funding	0.080
Capital To Revenue	(0.391)
Sub total	**0.613**
Total net budget movement during montth 9	**5.780**
Revised total estimated revenue budget as at month 9	**975.443**

NHS Forth Valley

Forth Valley NHS Board

14. Performance Report
Purpose: This report is for Assurance

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Kerry Mackenzie, Acting Director of Strategic Planning & Performance; Claire Alexander, Senior Performance Manager; Garry Fraser, Director of Acute Services; Marie Gardiner, Head of Acute Services; Deborah Lynch, Unscheduled Care, Programme Manager; Fiona Murray, Head of Emergency Care & Inpatients.

Executive Summary

NHS Forth Valley routinely reports performance against a range of non-financial performance metrics. The Performance Report is presented to update the Committee in respect of NHS Forth Valley's performance against a range of national and local measures with information provided to support effective monitoring and management of system-wide performance.

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 scorecard provides an '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 scorecard is continually reviewed to ensure appropriate revisions or amendments are included in a responsive and timely manner.

Action Required

The Forth Valley NHS Board is asked to:

(1) consider the latest performance data within the Performance Report noting the Area of Focus – Urgent & Unscheduled Care and Priority Areas of Performance.
(2) consider the progress made in reducing the number of patients waiting over 52 weeks for a new inpatient appointment and for an inpatient/daycase procedure.
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

This paper has previously been considered by the Strategic Planning, Performance & Resources Committee received the Performance Report on 16 December 2025 with questions invited.

Risk Assessment and Mitigation

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.

In addition, there is linkage to Organisational Risks in respect of Waiting Times, Radiology/Imaging Capacity, Delayed Discharge, Mental Health Services – Psychological Therapies and the 62-day cancer target.

These risks are reviewed and updated by the responsible risk owners with the Strategic Risk Register update presented as a standing item to NHS Board Assurance Committees and the NHS Board.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure 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.

Quality / Patient Care Implications
There are no specific quality or patient care implications in respect of this paper.

Population Health & Care Strategy
Monitoring performance and the ongoing development of relevant performance frameworks will support the monitoring of local and national strategy implementation.

Climate Change / Sustainability Implications
Describe any implications in relation to climate change / sustainability.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

- If yes, please provide details.

Cognisance has been taken of feedback and comments from Non-Executive and Executive Director colleagues.

Appendices
Appendix 1: Performance Report December 2025

- Section 1: Performance Summary
- Section 2: Area of Focus – Urgent & Unscheduled Care
- Section 3: Performance Report
- Section 4: Performance Scorecard

Performance Report

December 2025

Report format

- The report is split into 4 sections
    - Section 1: Performance Summary
    - Section 2: Area of Focus
    - Section 3: Performance Report
        - Priority Areas of Performance
        - Other Areas of Performance
    - Section 4: Performance Scorecard

- Section 1: Performance Summary
    - Section 1 provides a summary overview of key areas of performance.

- Section 2: Area of Focus
    - Section 1 will focus on a particular area of performance with a detailed discussion in respect of areas of challenge and key areas of improvement.

- Section 3: Performance Report
    - This section details key performance issues, measures, and graphs.
    - 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.

- Section 4: Performance Scorecard
    - The Performance Scorecard details the measure, target, current position (monthly or quarterly), previous reported position, previous year position and the Scotland position (where available).
    - The notes section provides a definition and detail in relation to the indicators and targets.

Performance data and graphs continue to be developed within the Pentana Performance and Risk Management System with graph and table detail from Pentana informing the report.

Section 1: Performance Summary

Area of Focus – Urgent & Unscheduled Care

Headline Performance – December 2025

- **Emergency Department (ED) 4-hour Standard**
  Compliance improved from 55.5% to 65.9% (Forth Valley) and 43.4% to 57.2% (ED) following Criteria to Reside (CtR) implementation, reflecting better hospital capacity and patient flow.

- **Average Length of Stay (LoS)**
  Reduced to 6.9 days (target: 7.0 days by March 2026), with further improvement to 5.4 days in late December.

- **Hospital Occupancy**
  Acute occupancy dropped from a mean of 107.3% to a low of 93.5%. Continued focus is needed to reach the 95% target by March 2026.

- **Delayed Discharges**
  Achieved a 22.6% reduction (mean now 113, target: 25% reduction by January 2026).

- **Hospital at Home**
  Utilisation ranged from 83.8% to 89.5%. Funding secured to expand capacity to 114 beds by December 2026.

- **ED Attendances**
  Fell by 3.5% in December (5,455 vs. 5,654 in November).

- **Flow 1 (Minor Injury Unit**
  86.5% compliance with the 4-hour standard; ongoing work to increase pathway utilisation.

- **Time to First Assessment**
  Median reduced to 111 minutes; afternoon ED occupancy remains a challenge.

- **Pre-noon Discharges**
  Averaged 15.6% (target: 20%).

- **LoS >14 days**
  Reduced by 23% since CtR introduction.

- **Contingency Beds**
  Usage declined, indicating improved patient flow.

- **Acute Frailty Unit**
  Direct discharge rates remain below target (21.3% vs. 50%); further investigation required.

Priority Areas of Performance

Unscheduled Care
Overall compliance with the 4-hour emergency access standard (EAS) in November 2025 was 58.3%; Minor Injuries Unit 99.7%, Emergency Department 46.7%. A total of 2,891 patients waited longer than the 4-hour target across both the ED and Minor Injuries Unit (MIU); with 1,436 waits longer than eight hours, 701 waits longer than 12 hours and 69 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 1,772 patients, noting this was 1,713 in November 2024. Wait for a bed accounted for 617 patients waiting beyond 4 hours with Clinical reasons accounting for 197 breaches. In November there were 522 new attendances to Rapid Assessment and Care Unit (RACU), 115 of which were via ED. It is worth noting 999 patients that attended ED did not wait in November 2025 compared with 781 in November 2024.

Delayed Discharges
The November 2025 census position in relation to standard delays (excluding Code 9 and guardianship) is 57 delays; this is compared to 82 in November 2024. There was a total of 60 code 9 and guardianship delays, with the total number of delayed discharges noted as 117. The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the September 2025 census was 2,886, this is a reduction from 3,276 in November 2024.

Scheduled Care
At the end of November 2025, the number of patients on the waiting list for a first outpatient appointment was 17,046 (16,738 excluding mutual aid) compared with 12,639 in November 2024 with the number waiting beyond 12 weeks 5,517 (5,289 excluding mutual aid) compared to 3,396 in November 2024.

In November 2025, the number of inpatients/daycases waiting was 7,588 (7,329 excluding mutual aid and NTC) compared with 6,223 in November 2024. An increase from the previous year in those waiting beyond 12 weeks from 3,521 to 4,475 was also noted.

At the end of October 2025, 2,166 patients were waiting beyond the 6-week standard for imaging with 79 patients were waiting beyond 6 weeks for endoscopy.

Cancer target compliance in September 2025:

- 62-day target – 85.3% of patients waited less than 62 days from urgent suspicion of cancer referral to first cancer treatment. This is compared with the September 2024 position of 84.1%.
- 31-day target – 100%.

The position for the July to September 2025 quarter is that 86.3% of patients were treated within 62 days of referral with a suspicion of cancer. This is an increase from 72.4% the previous quarter. During the same period, 100% of patients were treated within 31 days of the decision to treat.

Psychological Therapies
In October 2025, data shows that 77.0% of patients started treatment within 18 weeks of referral.

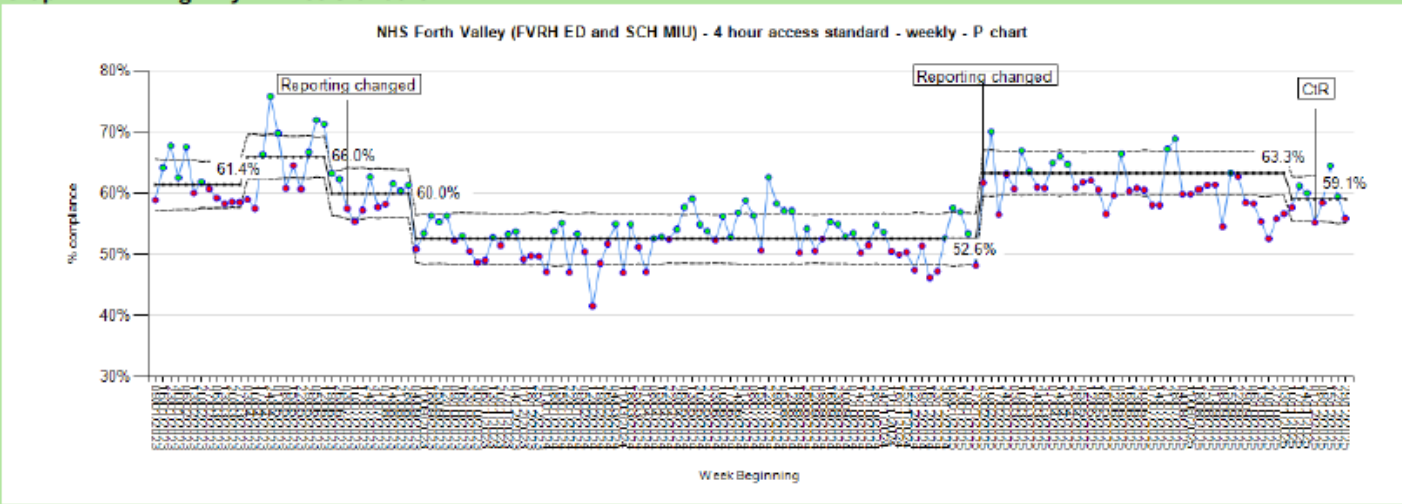
Section 2: Area of Focus

Urgent and Unscheduled Care

Urgent and Unscheduled Care Performance Metrics, December 2025	
4-hour EAS	Since implementing *Criteria to Reside (CtR)* (1-21st December), ED performance against the 4-hour access standard improved steadily. Forth Valley compliance rose from **55.5% to 65.9%**, while ED compliance increased from **43.4% to 57.2%**. This improvement reflects enhanced downstream hospital capacity and the ability to maintain space within ED for assessment and treatment, rather than changes in demand.
Average LoS	The current mean emergency LoS stands at **6.9 days**, outperforming the **March 2026 target of 7.0 days** and confirming progress against the trajectory. Performance has continued to improve, with LoS reducing further to **6.0 days** and then **5.4 days** during the final two weeks of December.
Hospital occupancy	Since the introduction of CtR, average acute occupancy at FVRH has reduced significantly. Levels have fallen below the current **mean of 107.3%**, with the lowest point reaching **93.5%**. The target of **95% Occupancy by March 2026**, will require a continued focus on discharge reliability, and community flow to maintain momentum and achieve this goal.
Delayed discharges	The target trajectory is a **25% reduction in delayed discharges by January 2026**, based on a baseline of 146. The current mean of 113 reflects a 22.6% reduction. Although this is slightly below the target, it demonstrates substantial progress and positions us within reach of achieving the goal.
Hospital at Home Capacity	Hospital at Home utilisation ranged from **83.8% to 89.5%** in December. Forth Valley have been allocated additional funding to **increase Hospital at Home Capacity to 114 beds, by December 2026.**
ED occupancy at 8am	Following a sustained rise in 8am ED occupancy prior to CtR, the intervention appears to have reset the level (rebased) from which performance has since stabilised around a **97.3% mean,** now within striking distance of the **≤95% trajectory for March 2026.**
ED attendances	Emergency Department attendances decreased in December to **5,455 from 5,654** in November, representing a 3.5% reduction.
Flow 1	Flow 1 Performance against the 4-hour standard was **86.5% in December.** High utilisation of the Minor Injury Unit has a positive impact on our 4-hour performance and work to increase the number of patients on this pathway continues.
Time to First Assessment	Median time to first assessment was **111 minutes in December.** Our Discovery data showed that ED occupancy exceeds physical capacity in the afternoon, and each hour the ED is over occupancy is associated with a growing backlog of activity, increasing time to first assessment.
12-hour breaches	The number of patients waiting over 8 and 12 hours remains high, suggesting that patients are staying longer due to delays in admission or discharge. Regular breach analysis would help pinpoint why patients are breaching the 4-hour target (e.g. delays in specialty review, diagnostics, bed availability) and highlight bottlenecks in the patient journey.
Pre-noon discharges	In December, the average proportion of discharges completed before noon was **15.6%**, compared to the **current target of 20%.**
LoS >14 days	Since the introduction of CtR, the average number of patients with a length of stay greater than 14 days has fallen from **167.6 to 129.1**, representing a 23% reduction.
Discharges from acute	Since the introduction of CtR, weekly discharges from Acute services have increased. By Week 3, discharges rose to 623, well above the current mean of 574, and surpassed admissions.
Contingency beds	Contingency bed usage has declined significantly during December, indicating improved patient flow and reduced reliance on surge capacity following the introduction of CtR.
Acute Frailty Unit Direct Discharges	Direct discharge rates from the Acute Frailty Unit remain well below the 50% target, reaching only **21.3% in December.** The underlying reasons for this shortfall require further investigation to determine whether process inefficiencies, capacity constraints, or patient complexity are contributing factors.

1. Whole System Measurement

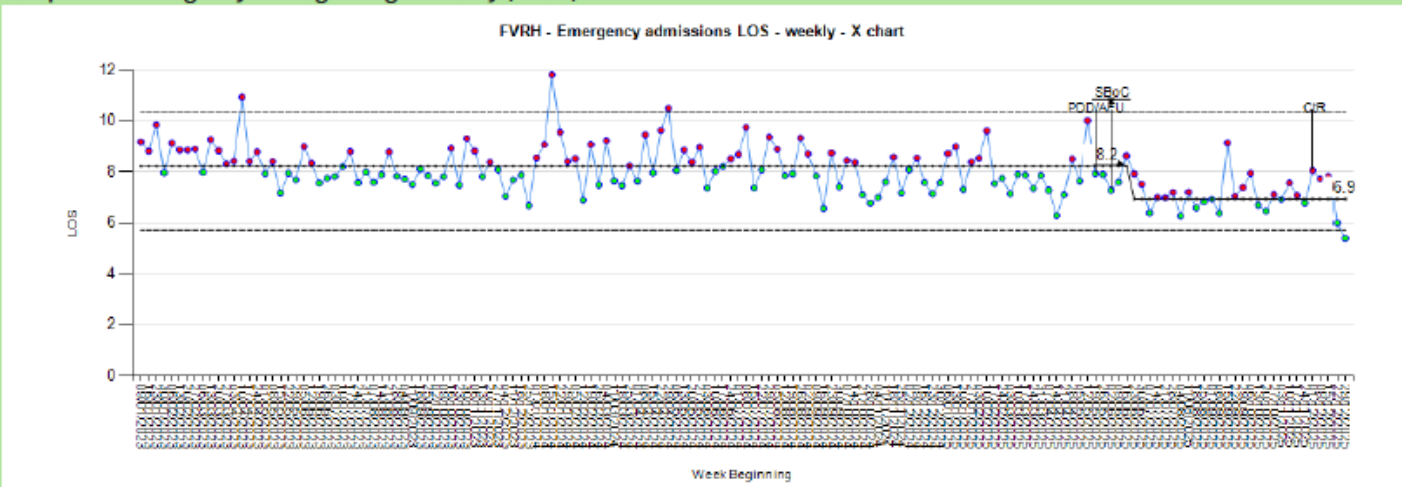
Graph 1.1: Emergency Access Standard



Since implementing *Criteria to Reside (CtR)* (1-21st December), ED performance against the 4-hour access standard improved steadily. Forth Valley compliance rose from **55.5% to 65.9%**, while ED compliance increased from **43.4% to 57.2%.**

This improvement reflects enhanced downstream hospital capacity and the ability to maintain space within ED for assessment and treatment, rather than changes in demand, with CtR accelerating discharge readiness and reducing congestion.

Graph 1.2: Emergency Average Length of Stay (ALoS)

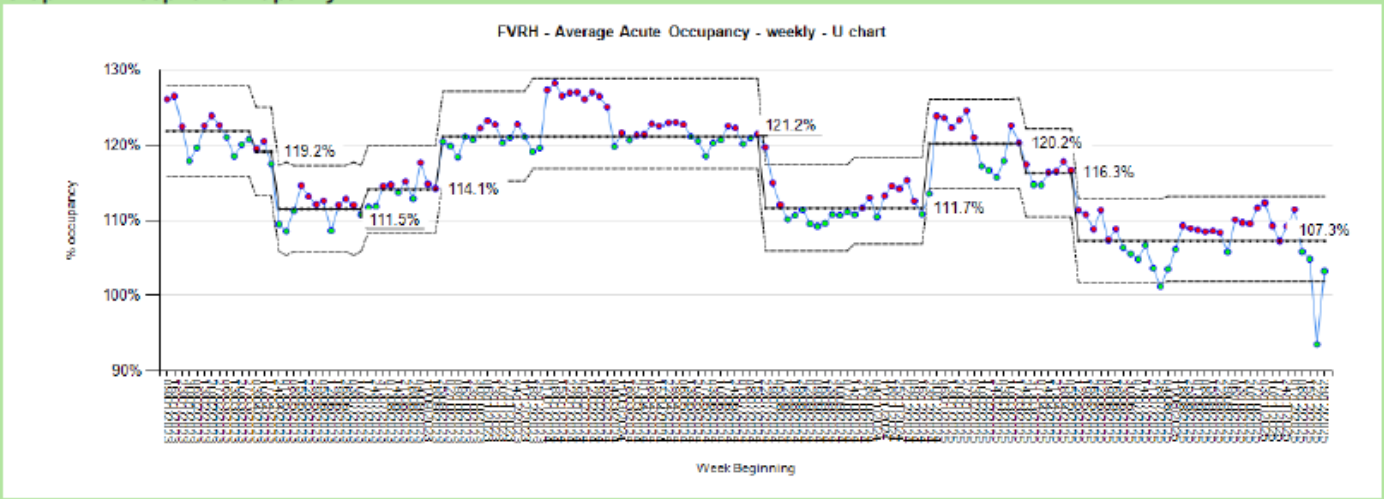


Emergency Length of Stay (LoS) temporarily increased as part of efforts to clear long-stay patients following the implementation of *Criteria to Reside (CtR)*.

The current mean emergency LoS stands at **6.9 days**, outperforming the **March 2026 target of 7.0 days** and confirming progress against the trajectory. Performance has continued to improve, with LoS reducing further to **6.0 days** and then **5.4 days** during the final two weeks of December.

1. Whole System Measurement (continued)

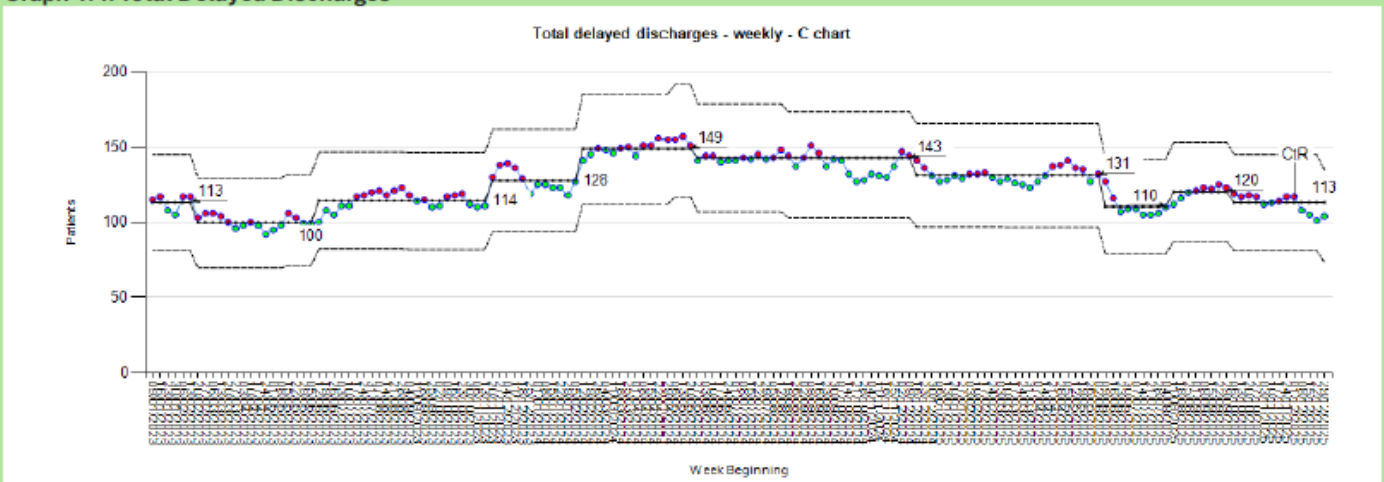
Graph 1.3: Hospital Occupancy



Since the introduction of CtR, average acute occupancy at FVRH has reduced significantly. Levels have fallen below the current mean of **107.3%**, with the lowest point reaching **93.5%**. This step-change demonstrates the impact of CtR in accelerating discharge readiness, freeing acute beds, and improving patient flow across the hospital.

The target of 95% Occupancy by March 2026, will require a continued focus on discharge reliability, and community flow to maintain momentum and achieve this goal.

Graph 1.4: Total Delayed Discharges



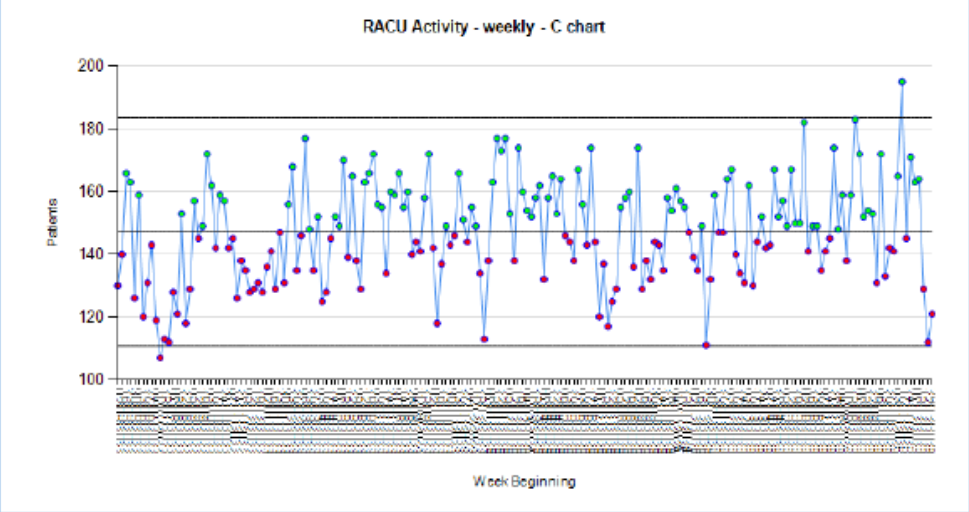
Since the introduction of CtR, the total number of delayed discharges has decreased. Significantly, the latest four data points are all below the current mean of 113,

The target trajectory is a **25% reduction in delayed discharges by January 2026**, based on a baseline of 146. The current mean of 113 reflects a 22.6% reduction. Although this is slightly below the target, it demonstrates substantial progress and positions us within reach of achieving the goal.

A breakdown of acute and community hospital delays can be seen in Graph 5.2 and Graph 5.3 respectively, on page 13 and 14.

2. Flow Navigation Centre (FNC) Workstream Measurement

Graph 2.1: Number of RACU patients per week (new and return)

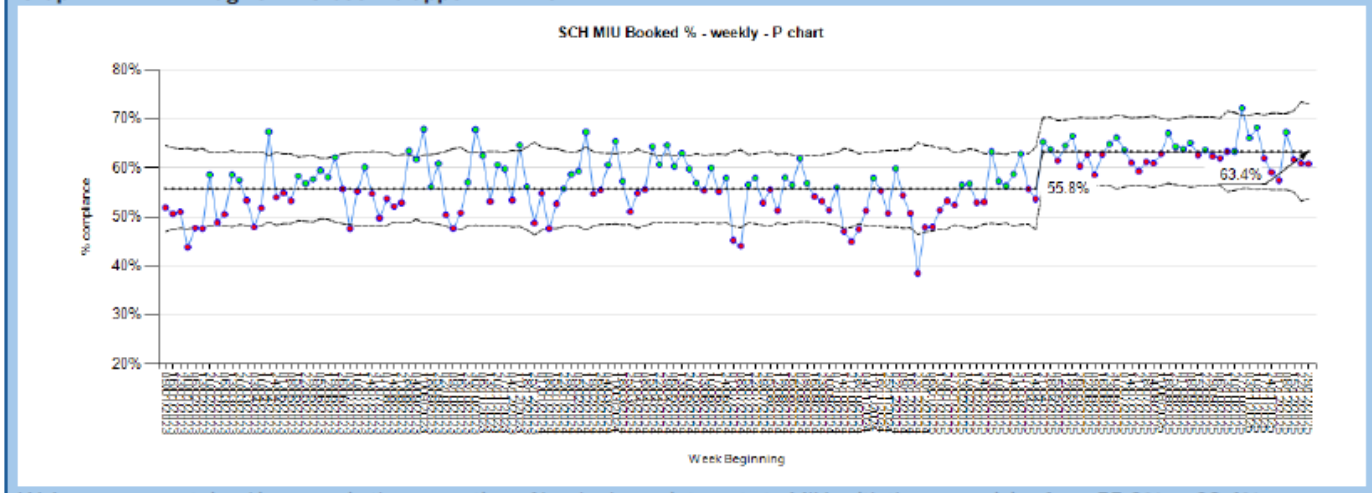


Our PHS Discovery data indicates that NHS Forth Valley has a higher proportion of GP admissions directly to RACU compared to other boards, which has had a positive impact on reducing ED attendances.

The recent dip in RACU activity coincides with the Christmas and New Year period. This seasonal effect is common and usually temporary, reflecting reduced elective and planned activity due to holiday schedules, staff leave and lower operating capacity. These factors typically limit throughput during late December and early January, with activity expected to rebound as normal service resumes in mid-January

Key constraints:
At present, we do not have access to electronic data that would allow us to fully evaluate the utilisation and effectiveness of our RACU pathways. Strengthening data capture and visibility will be key to understanding how these pathways are functioning in practice.

Graph 2.2: Percentage of MIU booked appointments



We have a high performing minor injury unit pathway which has a positive impact on our 4-hour performance.

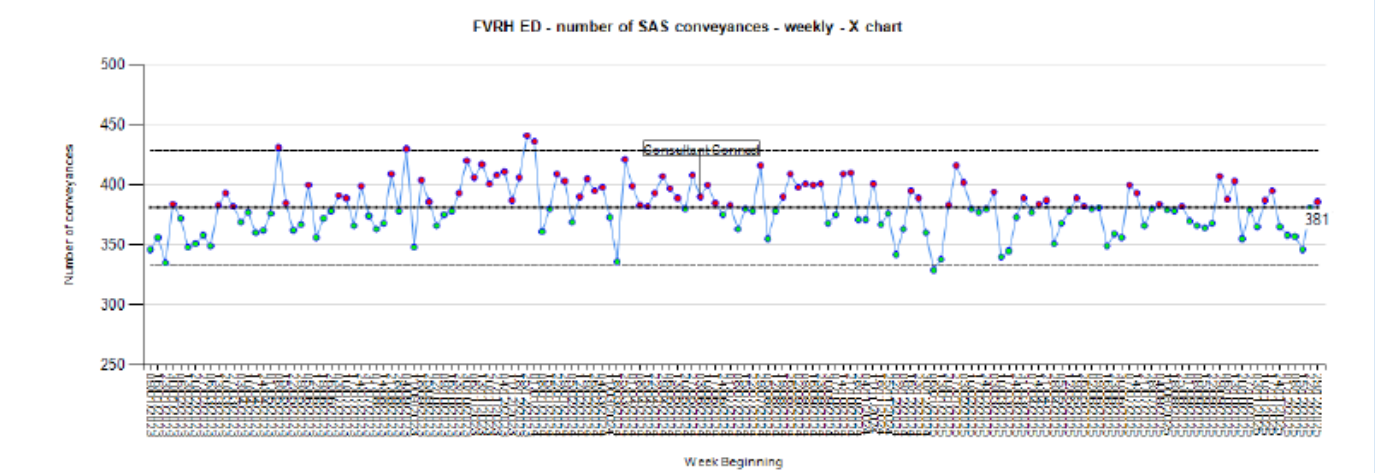
Improvements have been made to online and phone booking processes, including a walk-in with booking option. Appropriate patients are being directed to MIU at ED triage to reduce pressure on the department.

Patient education and awareness about when to use MIU and the benefits of booking appointments continues.

We've seen a sustained increase in the proportion of booked appointments to MIU, with the mean rising from **55.8% to 63.4%.**

2. Flow Navigation Centre (FNC) Workstream (continued)

Graph 2.3 Number of patients conveyed by SAS to ED



Our data on patients conveyed by SAS to ED remains variable. Currently, SAS Consultant Connect pathways include ED, Hospital at Home, RACU, Labour Ward, Maternity Triage, EPAS, High Impact User, MHAATs, and COPD.

However, utilisation levels across these pathways remain unclear, and further analysis is needed to understand their effectiveness and impact on conveyances.

Workstream constraints:

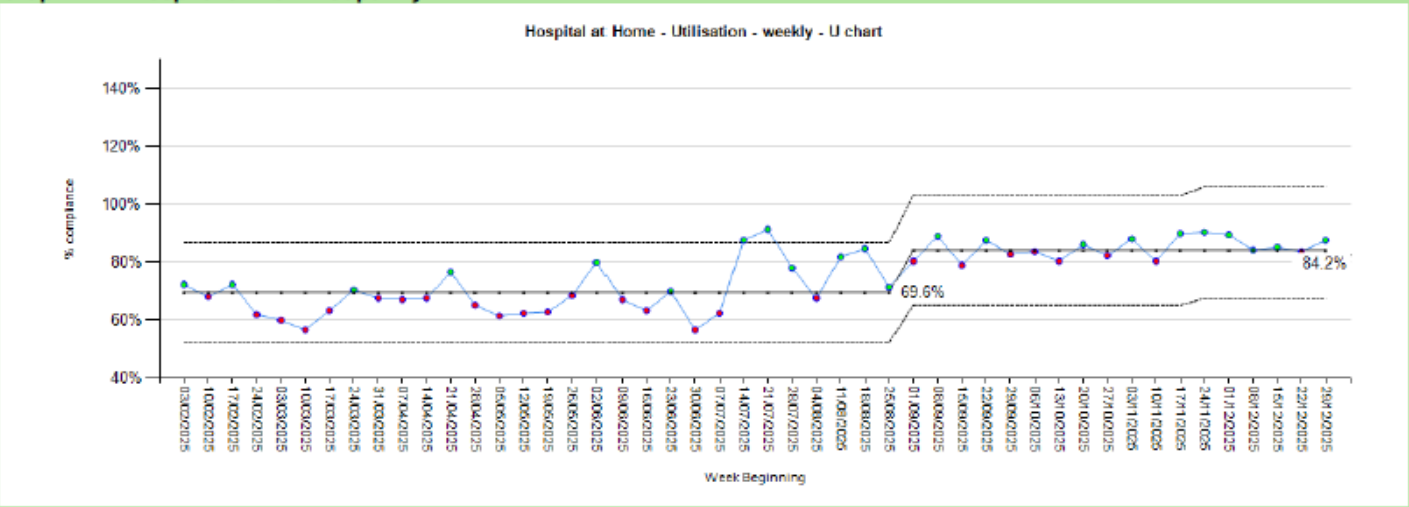
- Our FNC model is not a Senior Clinical Decision Maker (SCDM) model – due to the limitations of data collection we don't understand what impact this has on attendances to our urgent and unscheduled care services. We suspect that as we are currently limited with links to alternative pathways (for out of hospital care) that most routes are to the front door of the acute hospital.
- We don't have access to electronic data to fully understand our FNC activity. This includes outcomes of calls to the FNC and how well our RACU pathways are working/utilised.
- We have a limited number of RACU pathways due to workforce capacity.

Next steps:

- Design and implement a SCDM model within the FNC framework to enhance early decision-making, reduce unnecessary admissions, and optimise patient flow across urgent care pathways.
- Pilot Near Me Video Consultations in Flow Navigation Centre (ED clinic).
- Develop and scale up SDEC models and other services that support zero-day LoS, enabling patients to be assessed, treated, and discharged on the same day where clinically appropriate. This will reduce unnecessary admissions, improve patient experience, and support flow across the urgent care system.
- Scale up the use of Consultant Connect across urgent and unscheduled care pathways to support timely clinical decision-making, reduce unnecessary ED attendances, and improve access to specialist advice.
- Maintain and enhance the scheduling of appointments to MIU to improve patient flow, reduce waiting times, and minimise unscheduled attendances.
- Access to electronic FNC data to support national and local data collection requirements.

3. Hospital at Home Workstream

Graph 3.1 – Hospital at Home Capacity



Hospital at Home utilisation ranged from **83.8% to 89.5%** in December. While this indicates strong occupancy, it falls slightly below the optimal range (90–95%). Further review is needed to understand whether this reflects seasonal demand variation, staffing constraints, or process factors limiting throughput.

Current Older Adult Hospital at Home Capacity is 30 beds.

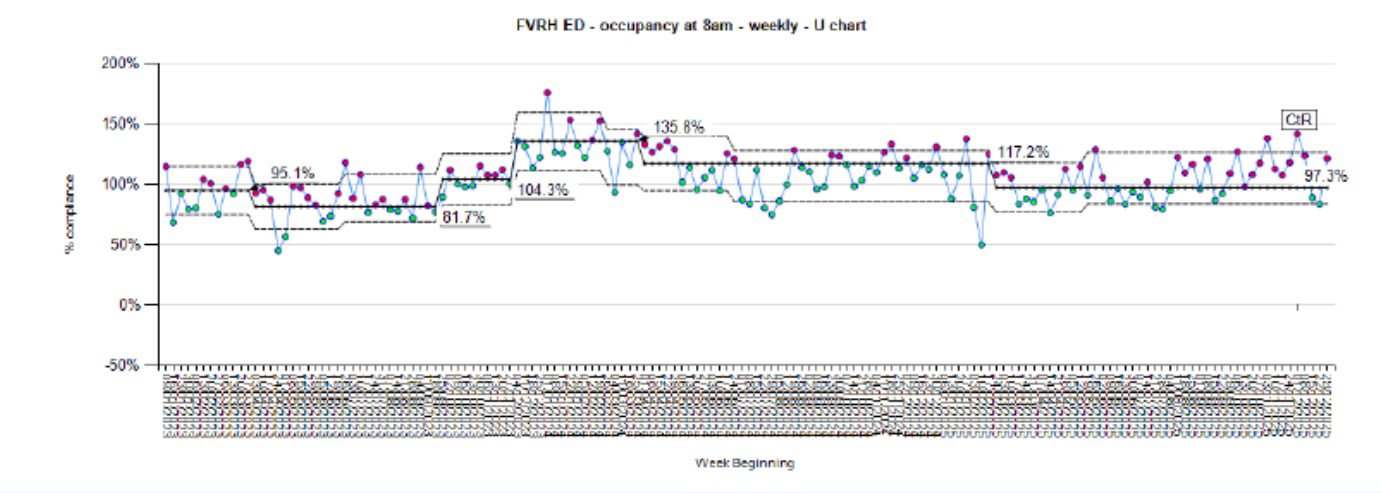
Next steps:

Forth Valley have been allocated additional funding to **increase Hospital at Home Capacity to 114 beds, by December 2026.** This expansion will include access to specialist pathways in Outpatient Parenteral Antimicrobial Therapy (OPAT), respiratory, and heart failure services. It will also include the development of admission avoidance and early supported discharge pathways across OPAT, respiratory, and heart failure domains, in alignment with national definitions of Hospital at Home+.

Local project plans to support the expansion are in development and Forth Valley have applied to join the new National Hospital at Home Programme 2025 – 2026 with Healthcare Improvement Scotland. Electronic virtual wards will be developed for each of the services as a platform for managing patient data, coordinating care and tracking key indicators.

4. Front Door Workstream

Graph 4.1: ED Occupancy at 8am

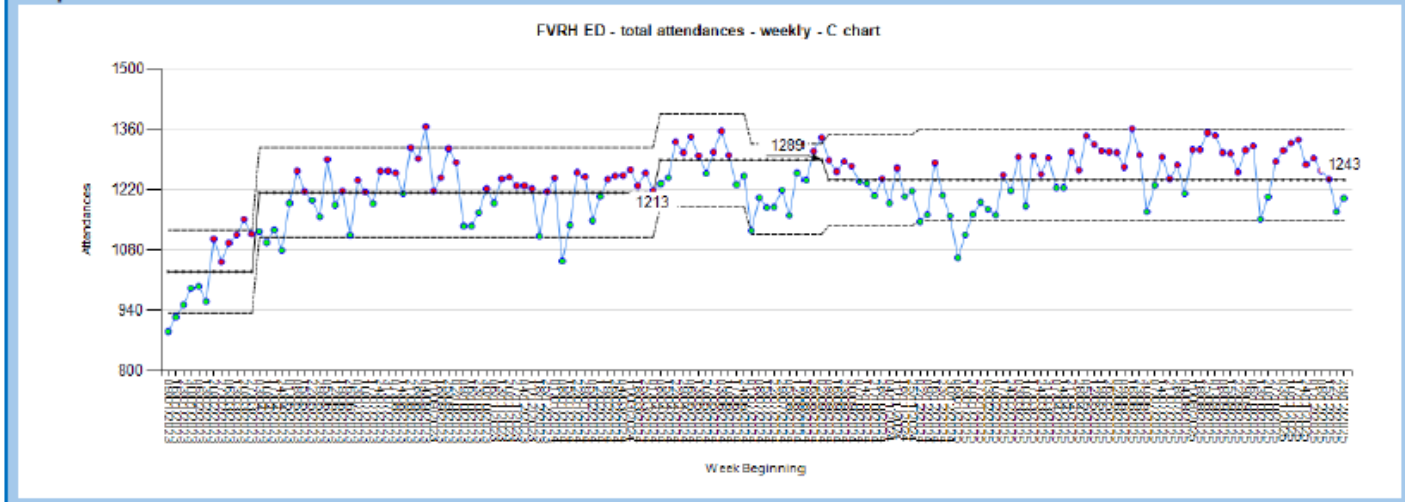


Our discovery data shows that ED occupancy at 8am has a statistically significant (negative) correlation with ED performance.

ED occupancy at 8am is tracking positively toward the March 2026 target (≤95%), with the current mean at 97.3%. The step-change seen during CtR (156.7% to 89.1%) accelerated discharge readiness and improved patient flow, freeing acute beds, easing ED congestion, and reducing bed waits.

Following a sustained rise in 8am ED occupancy prior to CtR, the intervention appears to have **reset the level (rebased)** from which performance has since stabilised around a **97.3% mean,** now within striking distance of the ≤95% trajectory for March 2026.

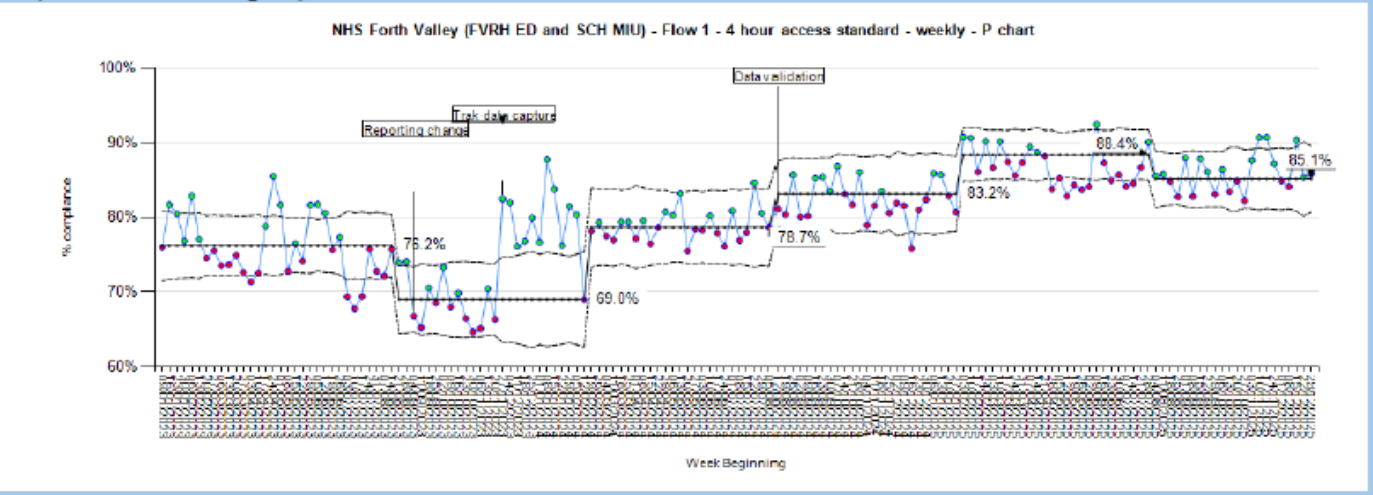
Graph 4.2: ED Attendances



Emergency Department attendances decreased in December to 5,455 from 5,654 in November, representing a 3.5% reduction.

4. Front Door Workstream (continued)

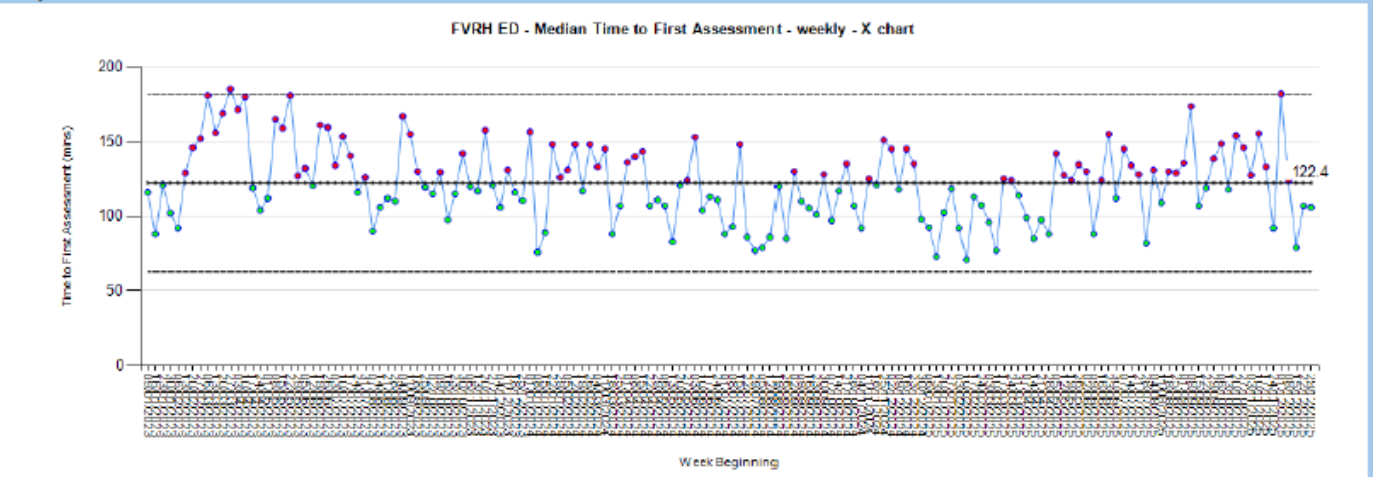
Graph 4.3: Flow 1 Emergency Access Standard



Flow 1 Performance against the 4-hour standard was **86.5%** in December.

High utilisation of the Minor Injury Unit has a positive impact on our 4-hour performance and work to increase the number of patients on this pathway continues.

Graph 4.4: Median time to first assessment



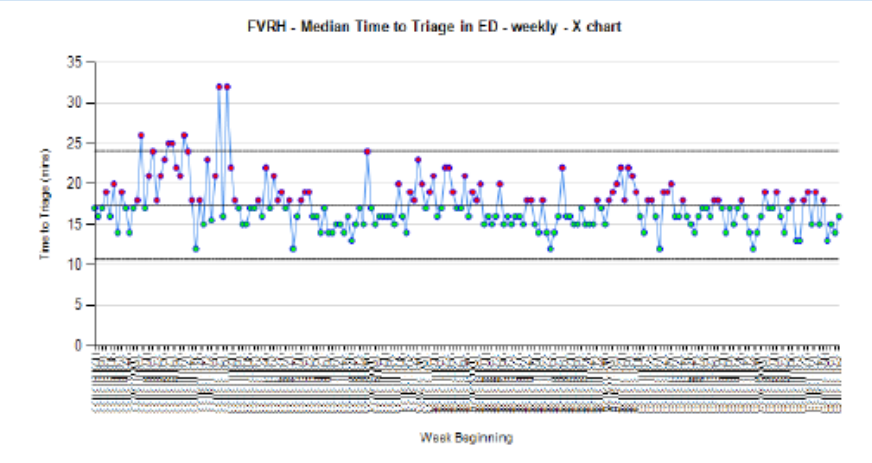
Our Discovery data showed that ED occupancy exceeds physical capacity in the afternoon, and each hour the ED is over occupancy is associated with a growing backlog of activity increasing time to first assessment, and a rise in ED length of stay.

The limited capacity of SCDMs within the ED overnight sees the day shift inherit a backlog of work from the overnight period which is associated with deteriorating performance outwith the 9am-5pm period.

Following the introduction of CtR, the median time to first assessment decreased from **131 minutes** in November to **111 minutes** in December. This improvement reflects enhanced patient flow and prioritisation of early assessment, supporting timely decision-making and discharge planning.

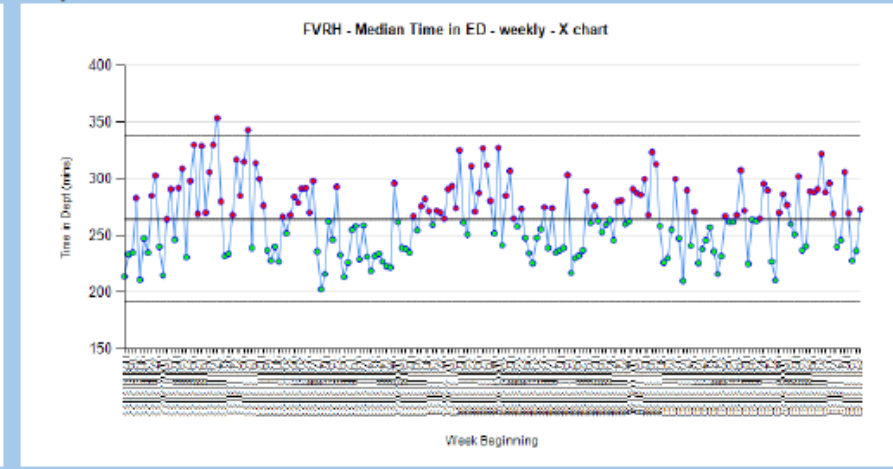
4. Front Door Workstream (continued)

Graph 4.5: Median time to triage



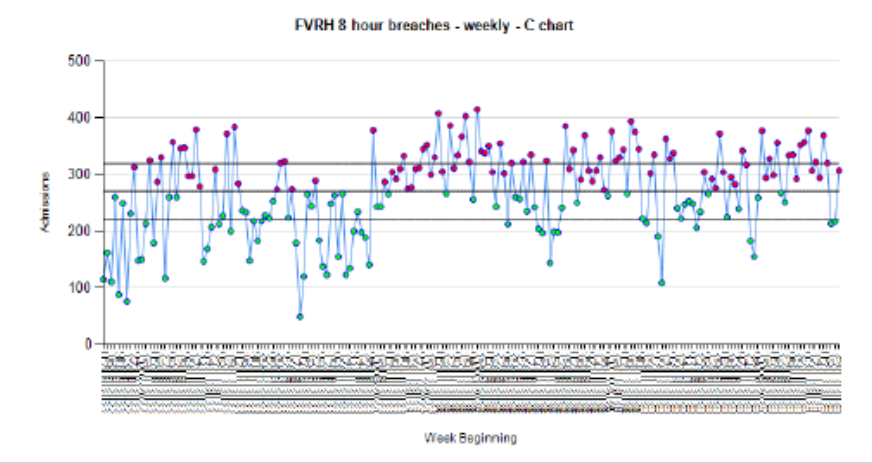
Median time to triage was **14 minutes** during December.

Graph 4.6: Median time in the ED

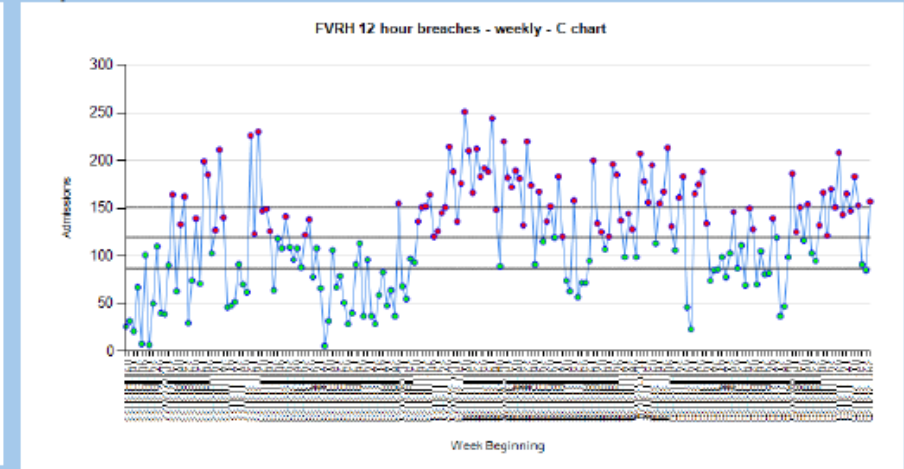


Median time in the ED was **248 minutes** during December.

Graph 4.7: 8-hour breaches



Graph 4.8: 12-hour breaches



The number of patients waiting over 8 and 12 hours remains high, suggesting that patients are staying longer due to delays in admission or discharge. Regular breach analysis would help pinpoint why patients are breaching the 4-hour target (e.g. delays in specialty review, diagnostics, bed availability) and highlight bottlenecks in the patient journey.

4. Front Door Workstream (continued)

Key constraints:

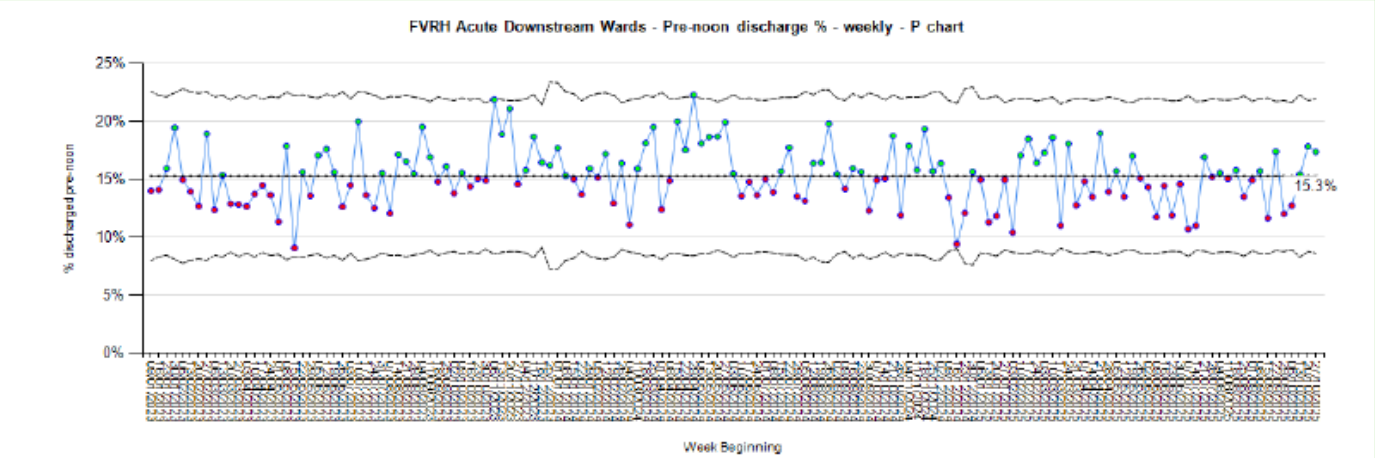
- ED occupancy at 8am has a statistically significant (negative) correlation with ED performance.
- Lack of real-time breach analysis limits our ability to identify root causes of 4-hour standard breaches, respond proactively, and implement targeted interventions to improve ED performance.
- Limited capacity of SCDMs within the ED overnight.
- We are not currently capturing data on redirection outcomes or the use of out-of-hospital care alternatives (Flow 5), which limits our ability to evaluate the effectiveness of diversion pathways and understand their impact on hospital attendances and admissions.
- Limited services (or in-reach to front door areas) to prevent admission and support care back into community services.

Next Steps:

- A focused 12-week improvement plan to address the ongoing and fluctuating pressures on Emergency Department attendances and improve patient flow. This plan will implement targeted actions (such as real-time breach analysis, rapid escalation protocols, and enhanced discharge processes) to deliver measurable improvements in ED performance and patient experience.
- CfSD to support an ED workforce benchmarking exercise to look at patient numbers, staffing ratios and 4-hour compliance.
- Flow 5 and redirection data – scoping how other boards capture this data / linked with our eHealth team to support.
- Redesign CAU triage to improve patient flow, clinical outcomes, and operational efficiency.
- Specialty zoning in the Acute Assessment Unit to support efficient patient flow, targeted clinical care, and safer working environments.

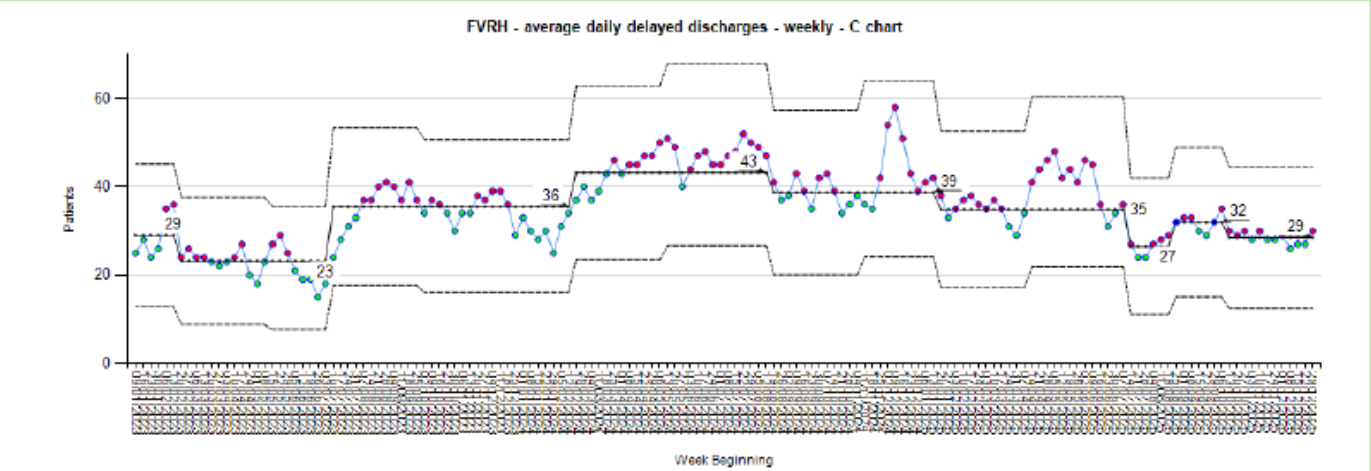
5. Discharge Without Delay Workstream

Graph 5.1: Pre-noon discharge



In December, the average proportion of discharges completed before noon was **15.6%**, compared to the **current target of 20%.**

Graph 5.2: FVRH delayed discharges



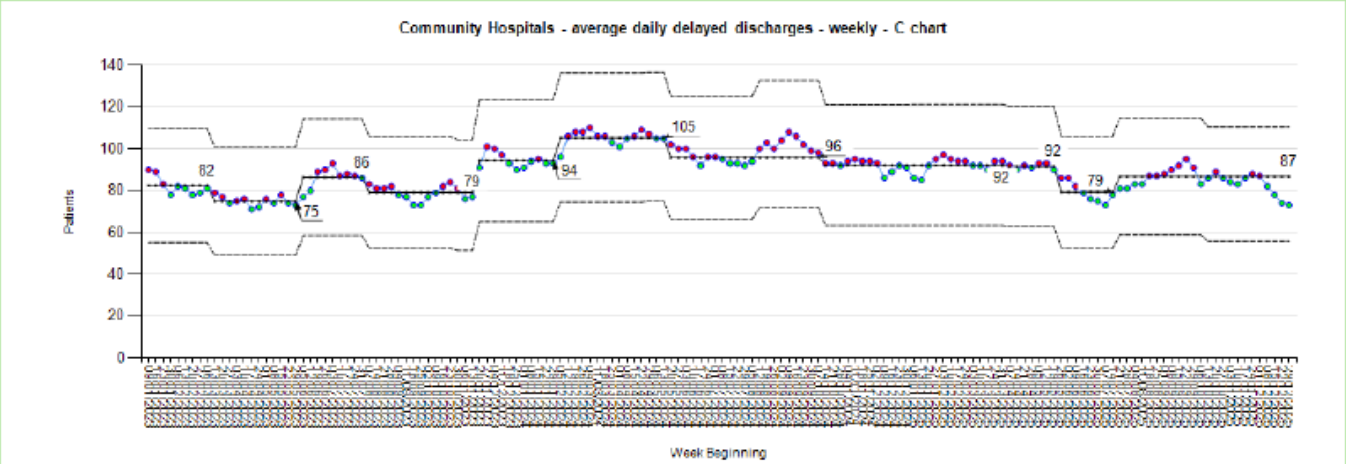
The mean for average daily delayed discharges has recently rebased from 32 to 29, indicating a sustained improvement.

While the reduction confirms progress, continued focus on CtR application and downstream capacity will be essential to maintain and build on this improvement.

The mean for average daily delayed discharges has reduced from the baseline of **34 to 29**, representing a **14.7% improvement**. While this is significant progress, it falls slightly short of the **20% reduction target (approximately 27) set for March 2026.**

5. Discharge Without Delay (continued)

Graph 5.3: Community Hospital delayed discharges

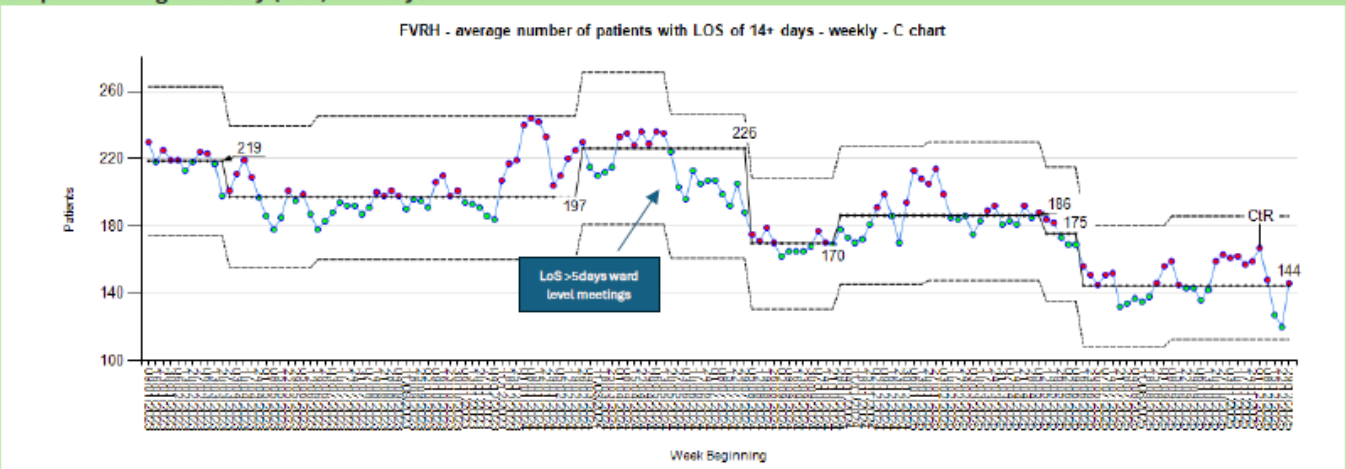


A key objective of the National DWD Collaborative is to achieve a **20% reduction in Community Hospital delayed discharges, by March 2026.**

Since the introduction of CtR, weekly average daily delayed discharges in Community Hospitals have dipped and are largely below the current mean (–87), indicating early signs of improvement.

However, FVRH Community Waiting Lists remain elevated, suggesting downstream capacity constraints persist. This implies that while CtR is supporting earlier discharge readiness, sustained reduction in delays will depend on relieving community bottlenecks to convert readiness into timely discharge.

Graph 5.4: Length of Stay (LoS) >14 days



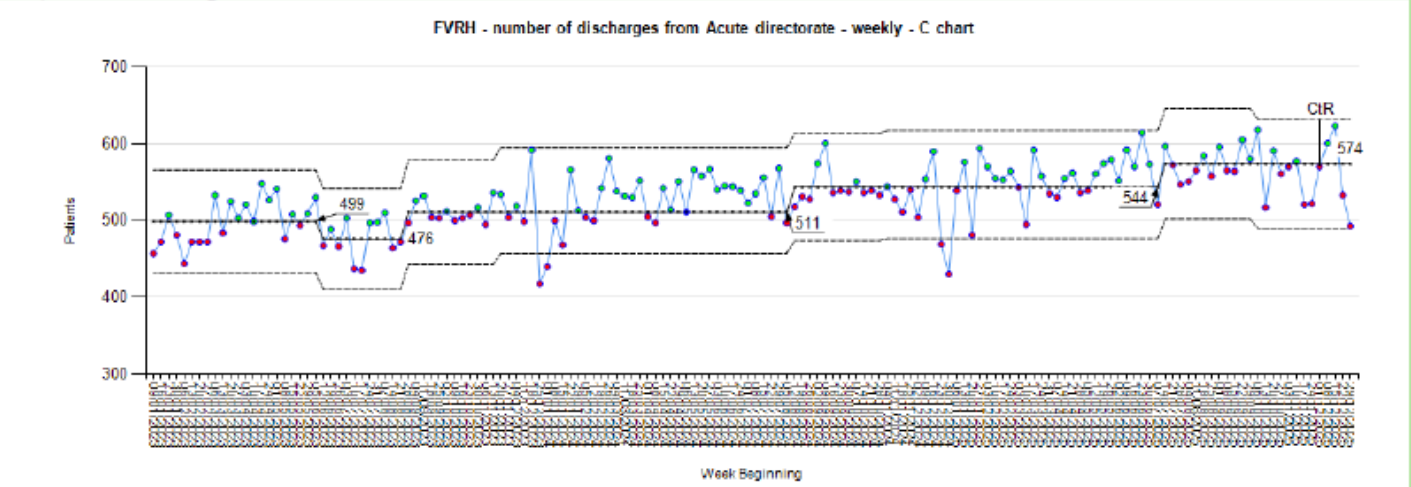
LoS >14 days, which has a statistically significant correlation with ED performance.

Since the introduction of CtR, the average number of patients with a LoS greater than 14 days has fallen from 167.6 to 129.1, representing a 23% reduction.

While this improvement suggests better discharge readiness and flow, a continued focus on discharge processes and community capacity will be essential to maintain and build on this improvement.

5. Discharge Without Delay Workstream (continued)

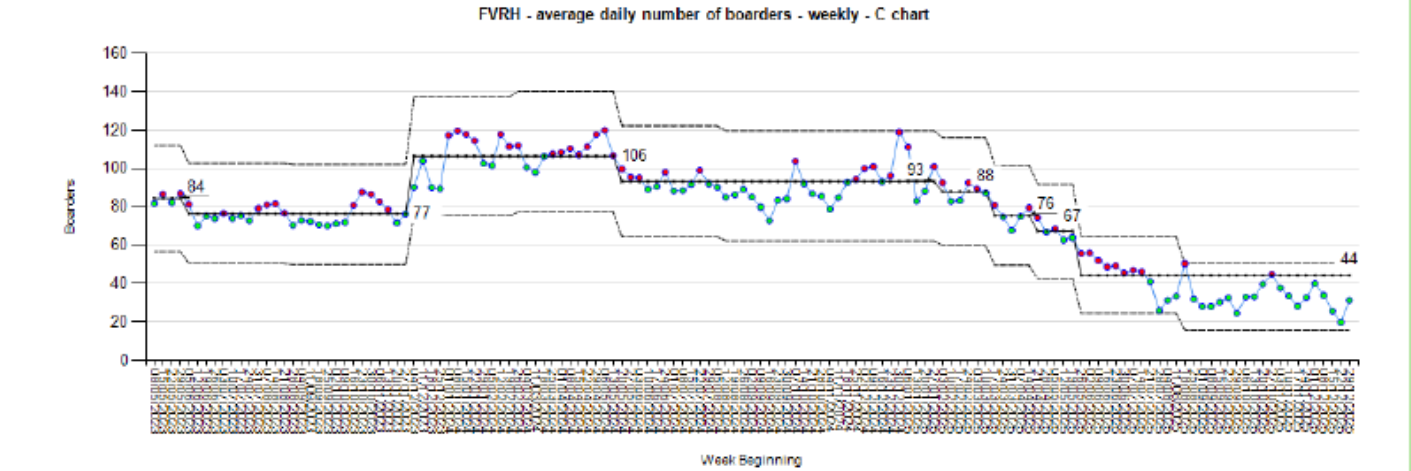
Graph 5.5: Discharges from FVRH acute directorate



Since the introduction of CtR, weekly discharges from Acute services have increased. By Week 3, discharges rose to 623, well above the current mean of 574, and surpassed admissions.

This reflects improved discharge readiness and flow. The slight dip in the last two data points likely reflects the impact of consecutive public holiday weeks over Christmas and New Year, which typically slow discharge processes.

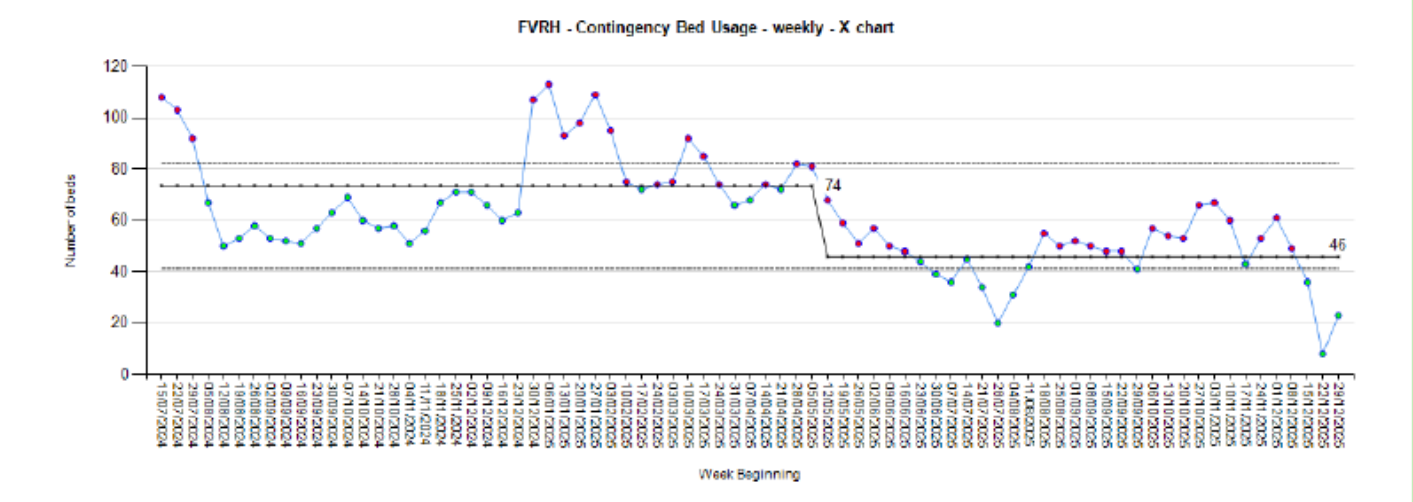
Graph 5.6: Patients boarded to other areas



The average daily number of boarders has fallen significantly, with the mean rebased from 67 to 44, representing a 58% reduction from earlier peaks.

5. Discharge Without Delay Workstream (continued)

Graph 5.7: Contingency beds



Contingency bed usage has declined significantly in recent weeks, indicating improved patient flow and reduced reliance on surge capacity following the introduction of CtR.

Key constraints:

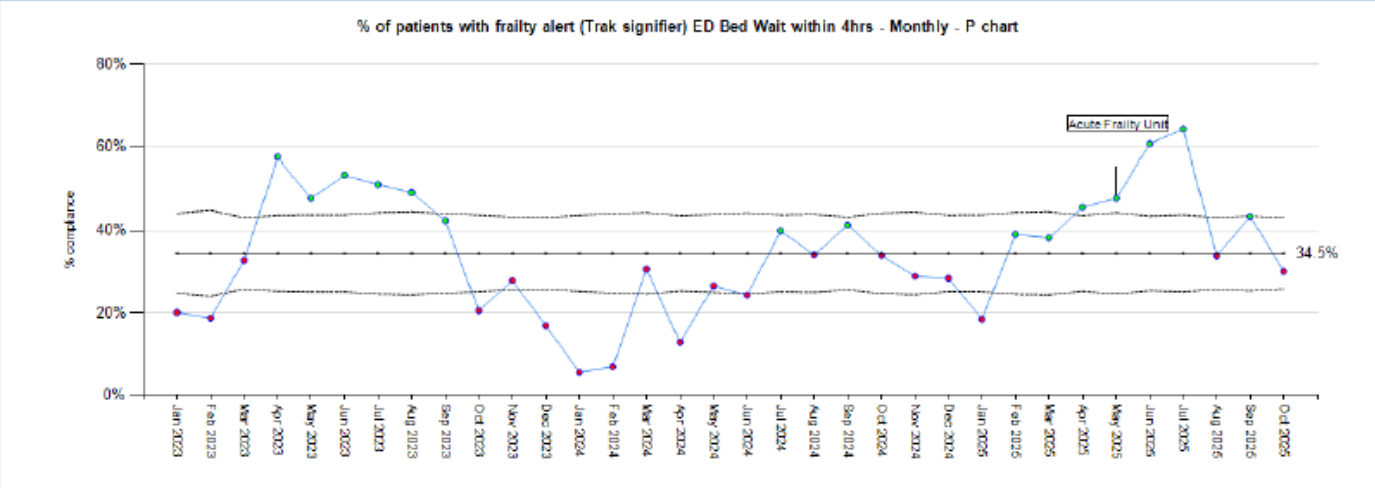
- High number of patients who do not meet Day of Care Survey (DoCS) criteria for an acute hospital stay.
- High number of patients with a length of stay >14 days as this has a statistically significant (negative) correlation with ED performance.
- Our current Integrated Discharge Service model does not support pathway-based discharge teams (ward-based).
- Access to Discharge to Assess pathways and Community Hospital stepdown beds.

Next steps

To accelerate progress on delayed discharges and patient flow, NHS Forth Valley will implement a focused ward-level improvement plan under the Discharge Without Delay (DWD) programme. This plan will strengthen daily discharge planning, embed predicted date of discharge (PDD) setting, and appoint ward-based discharge coordinators. Enhanced use of the Discharge Lounge and targeted dashboards will support timely patient movement and enable wards to monitor key metrics. These actions aim to sustain recent gains, adapt to fluctuating demand, and deliver person-centred care across all acute wards.

6. Frailty at the Front Door Workstream

Graph 6.1: Acute Frailty Unit 4-hour Access

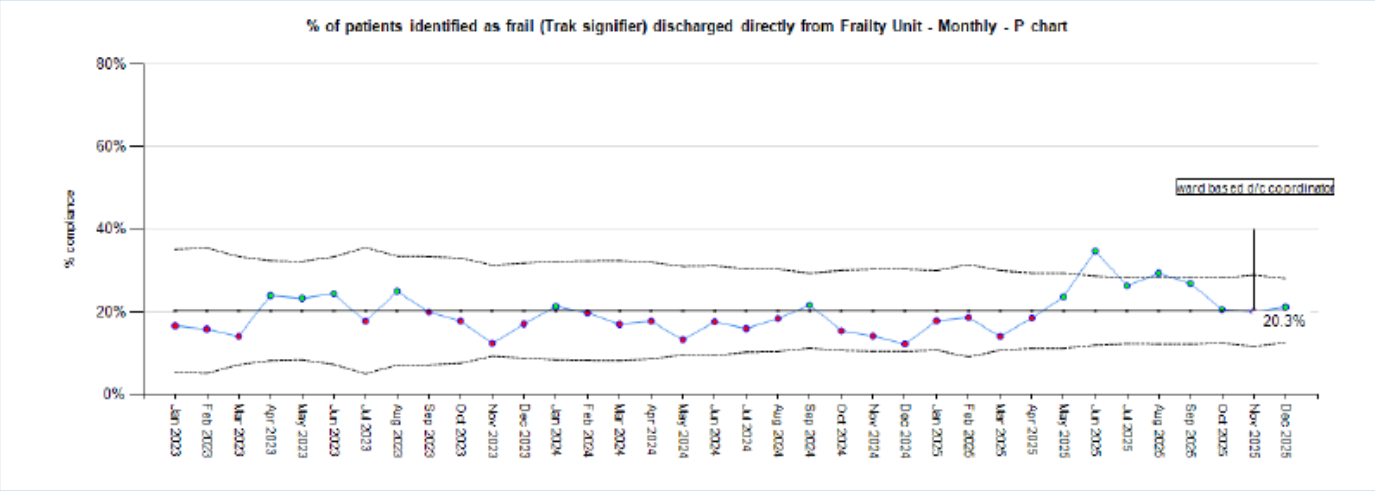


As screening for frailty begins in the ED, the aim is for the frailty team to proactively in reach into the department to support access within the four-hour target.

Compliance with the 4-hour ED bed wait standard for patients with a frailty alert remains variable, with December at **42.8%.**

While performance improved last year, this was not sustained and highlights ongoing challenges in bed availability and frailty pathway flow. Continued focus on discharge reliability and frailty prioritisation will be essential to improve compliance.

Graph 6.2: Acute Frailty Unit Direct Discharges

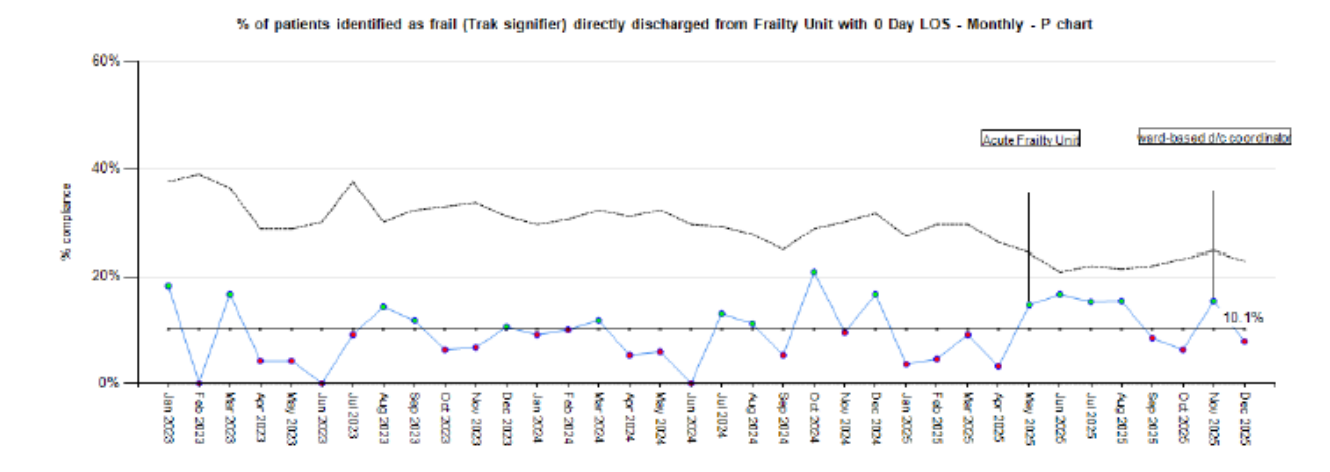


Direct discharge rates from the Acute Frailty Unit remain well below the 50% target, reaching only **21.3% in December.**

The underlying reasons for this shortfall require further investigation to determine whether process inefficiencies, capacity constraints, or patient complexity are contributing factors.

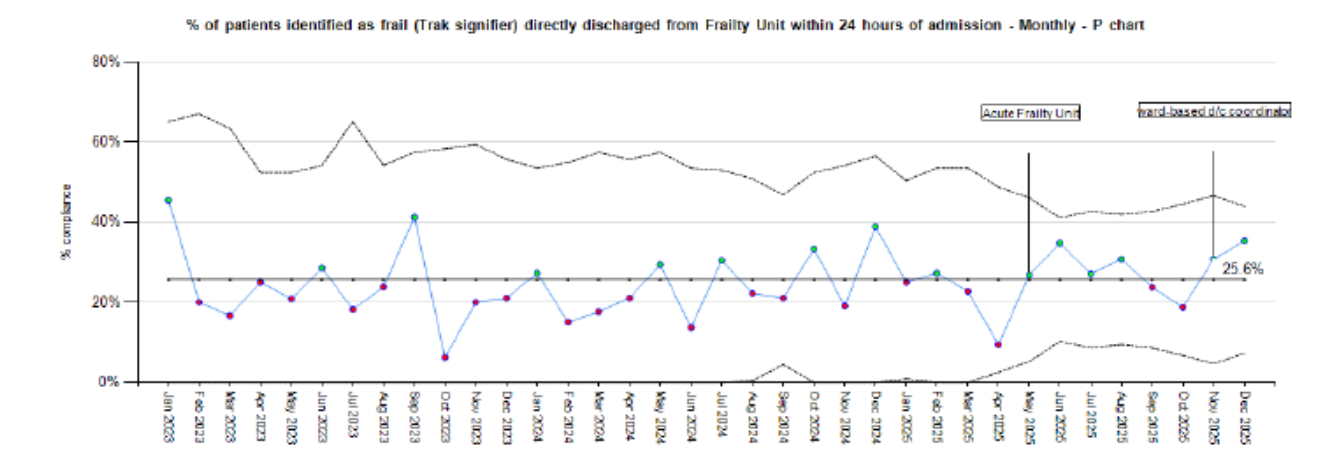
6. Frailty at the Front Door Workstream (continued)

Graph 6.3: Acute Frailty Unit Zero-Day LoS



0-day length of stay rates for frail patients from the Acute Frailty Unit were **10.1%** in December 2025.

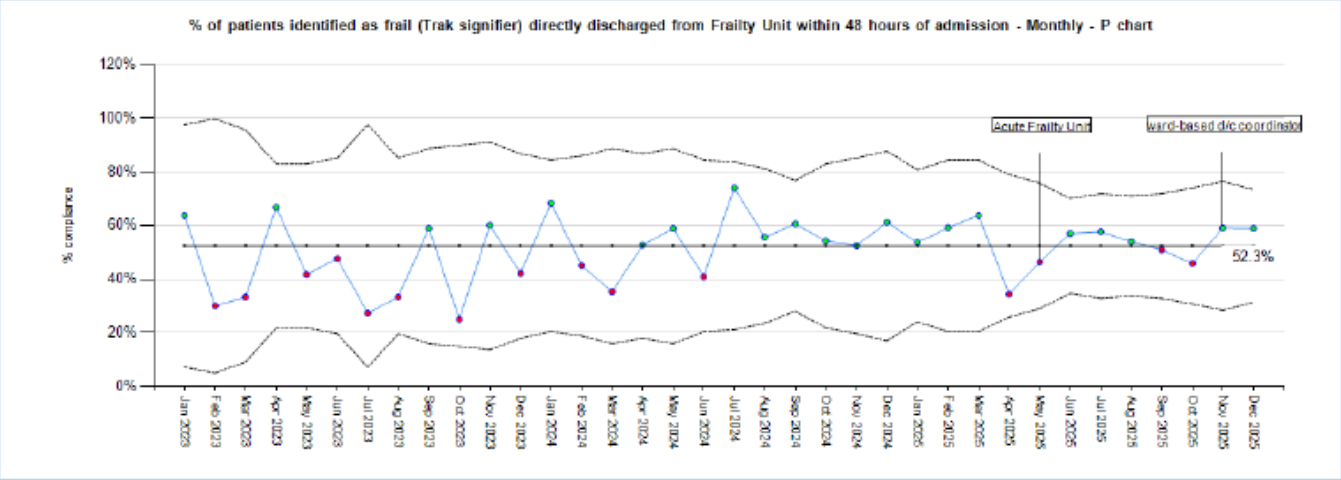
Graph 6.4: Acute Frailty Unit Discharges within 24 hours



Performance for direct discharges within 24 hours has improved slightly since the introduction of the ward-based discharge coordinator and CtR reviews, with the most recent figure at **25.6%** in December 2025.

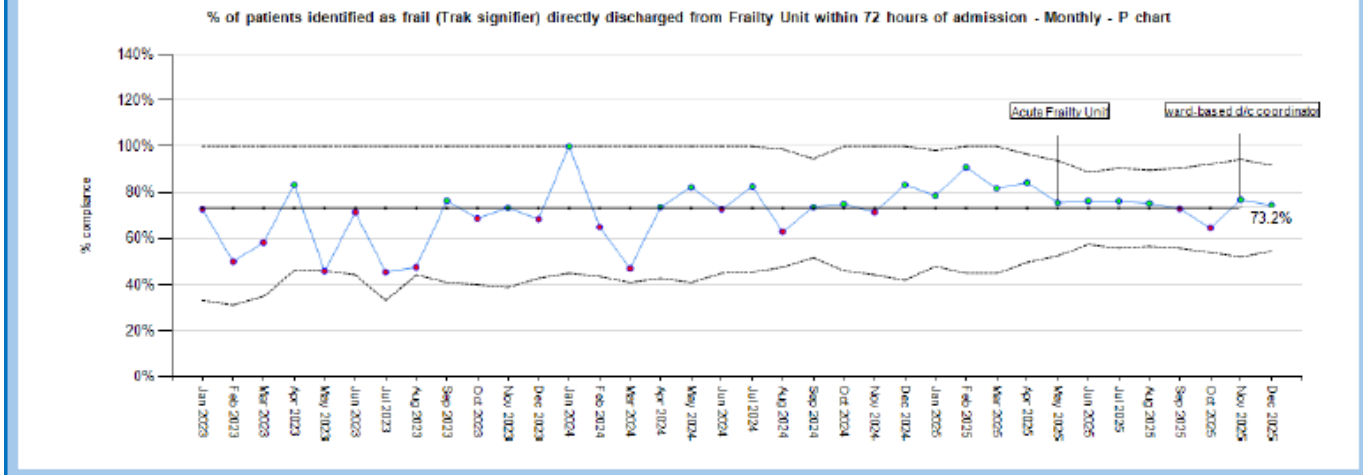
6. Frailty at the Front Door Workstream (continued)

Graph 6.5: Acute Frailty Unit Discharges within 48 hours



Performance for direct discharges within 48 hours has improved slightly since the introduction of the ward-based discharge coordinator and CtR reviews, with the most recent figure at **58.8%** in December 2025.

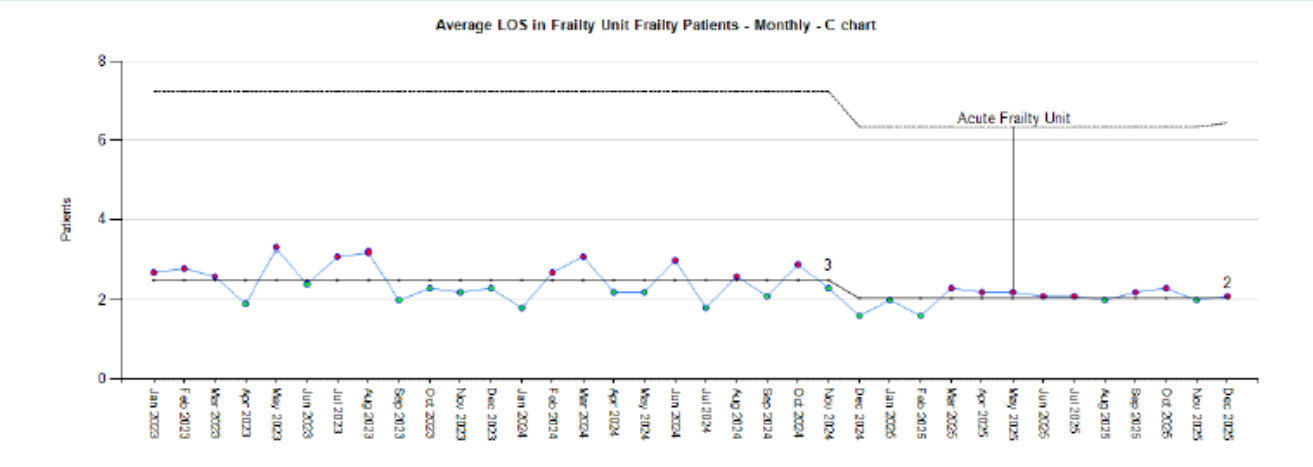
Graph 6.6: Acute Frailty Unit Discharges within 72 hours



Performance for direct discharges within 72 hours has improved slightly since the introduction of the ward-based discharge coordinator and CtR reviews, with the most recent figure at **74.5%** in December 2025.

6. Frailty at the Front Door Workstream (continued)

Graph 6.7: Acute Frailty Unit Average LoS



The National DWD Collaborative is working towards a target of a four-day average LoS in Acute Frailty Units.

Our Acute Frailty Unit currently achieves an average LoS of two days. Timely access to Discharge to Assess pathways and Community Hospital stepdown beds is essential to support patients who require ongoing care. At present, delays in accessing these pathways result in patients being transferred downstream, which lowers our reported length of stay.

Key constraints:

- Maintaining occupancy exclusively for patients who meet the unit's criteria, primarily due to flow issues at the front door of the acute hospital.
- Limited community frailty pathways.
- Access to Discharge to Assess pathways and Community Hospital stepdown beds.
- Access to electronic screening data for all patients over the age of 65.

Next steps:

Frailty at the Front Door

- 7-Day MDT model (workforce plans for clinicians, nursing, AHPs).
- Electronic screening for frailty in ED.
- Specialist clinical advice to GPs and SAS (prof to prof).
- Create weekend discharge protocols and escalation pathways.
- Embedding D2A pathways and use of community hospitals and stepdown rehabilitation units (DWD workstreams).
- Monitor and report on return on investment and patient outcomes.
- Define clear KPIs for 7-day frailty services (develop dashboard).

Community Frailty Pathways

- Frailty identification and assessment (GP LES).
- Test a Rapid Elderly Assessment Care Team (REACT) for frail elderly people.

Section 3: Performance Report - Priority Areas of Performance

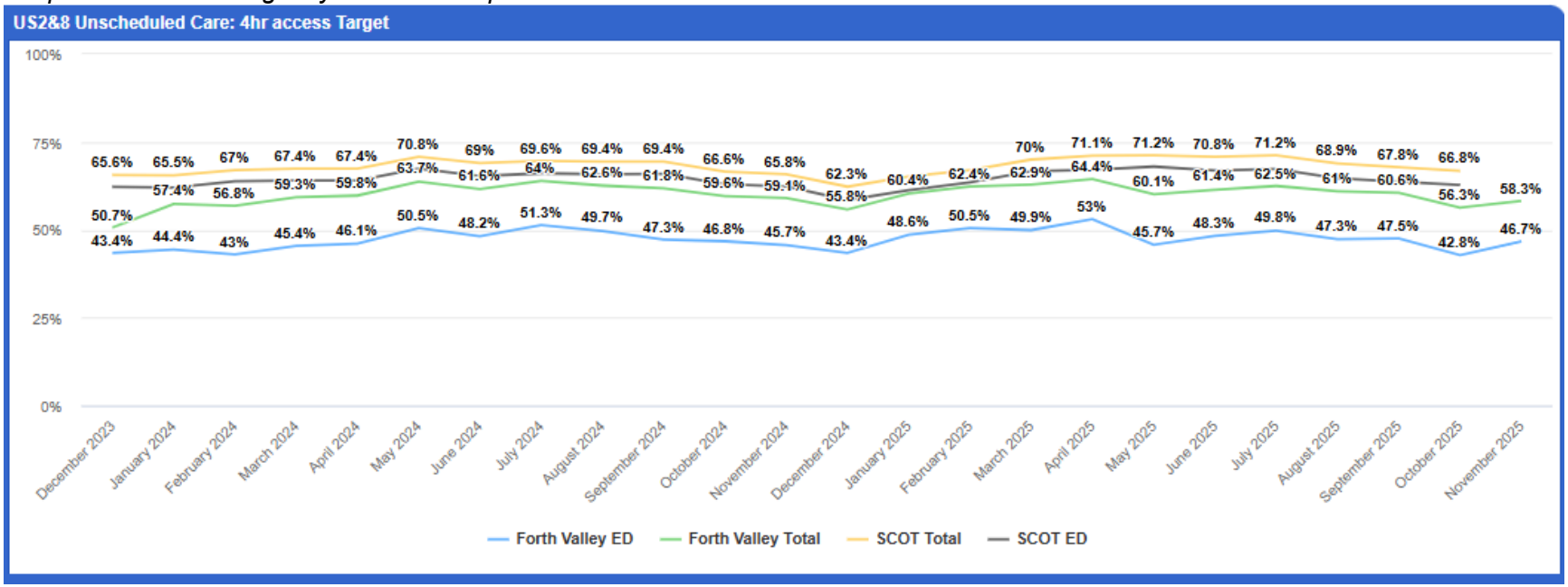
Unscheduled Care

4-hour Access Standard

Percentage of patients waiting less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment - 95% standard.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Emergency Department % compliance against 4 hour access target	30-Nov-25	95%	46.7%	42.8%	43.4%	▲	66.9%	30-Jun-25
Monthly	NHS Forth Valley Overall % compliance against 4 hour target	30-Nov-25	95%	58.3%	56.3%	51.6%	▲	70.8%	30-Jun-25

Graph 7: 4-hour Emergency Access Compliance December 2023 to November 2025

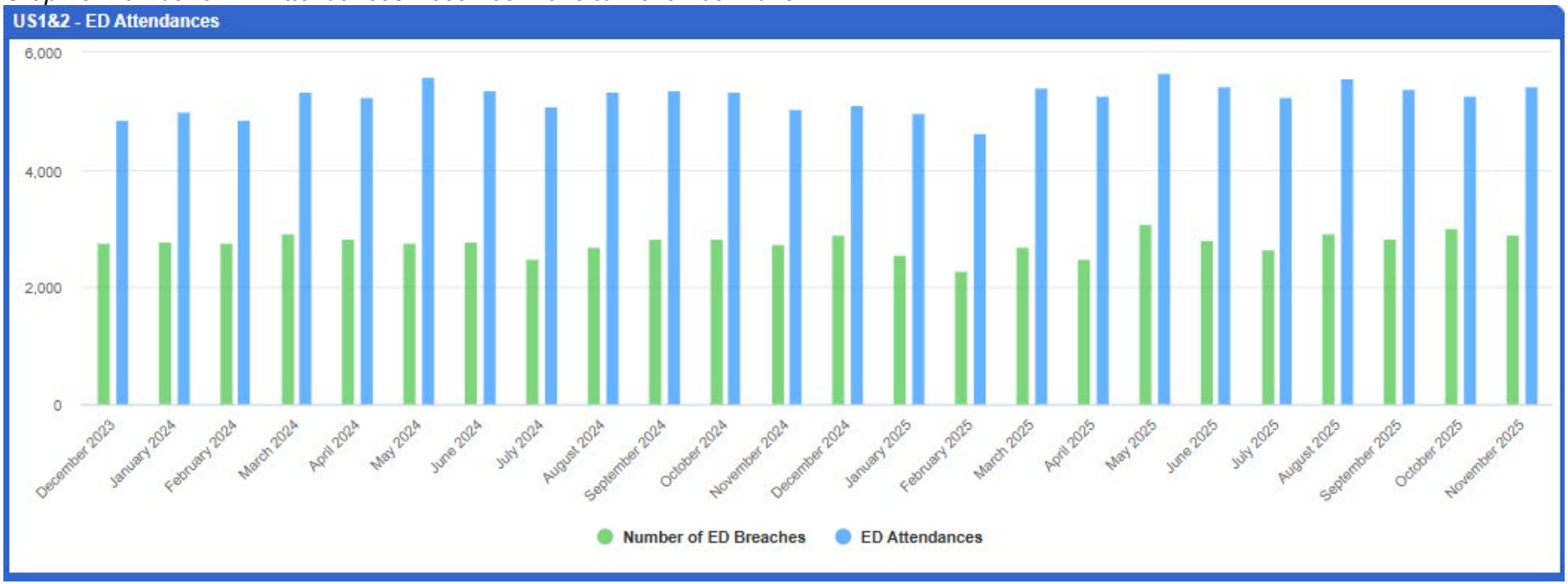


Overall compliance with the 4-hour emergency access standard (EAS) in November 2025 was 58.3%; Minor Injuries Unit 99.7%, Emergency Department 46.7%. A total of 2,891 patients waited longer than the 4-hour target across both the ED and Minor Injuries Unit (MIU); with 1,436 waits longer than eight hours, 701 waits longer than 12 hours and 69 waits longer than 23 hours.

Emergency Department

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total Number of ED Attendances	30-Nov-25	Reduction	5,423	5,272	5,047	▼	-	-
Monthly	Number that waited >4 hours in ED	30-Nov-25	Reduction	2,891	3,013	2,731	▼	-	-

Graph 8: Number of ED Attendances December 2023 to November 2025



The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 1,775 patients, noting this was 1,713 in November 2024. Wait for a bed accounted for 617 patients waiting beyond 4 hours with Clinical reasons accounting for 197 breaches. It is worth noting 999 of patients attending ED in November 2025 did not wait.

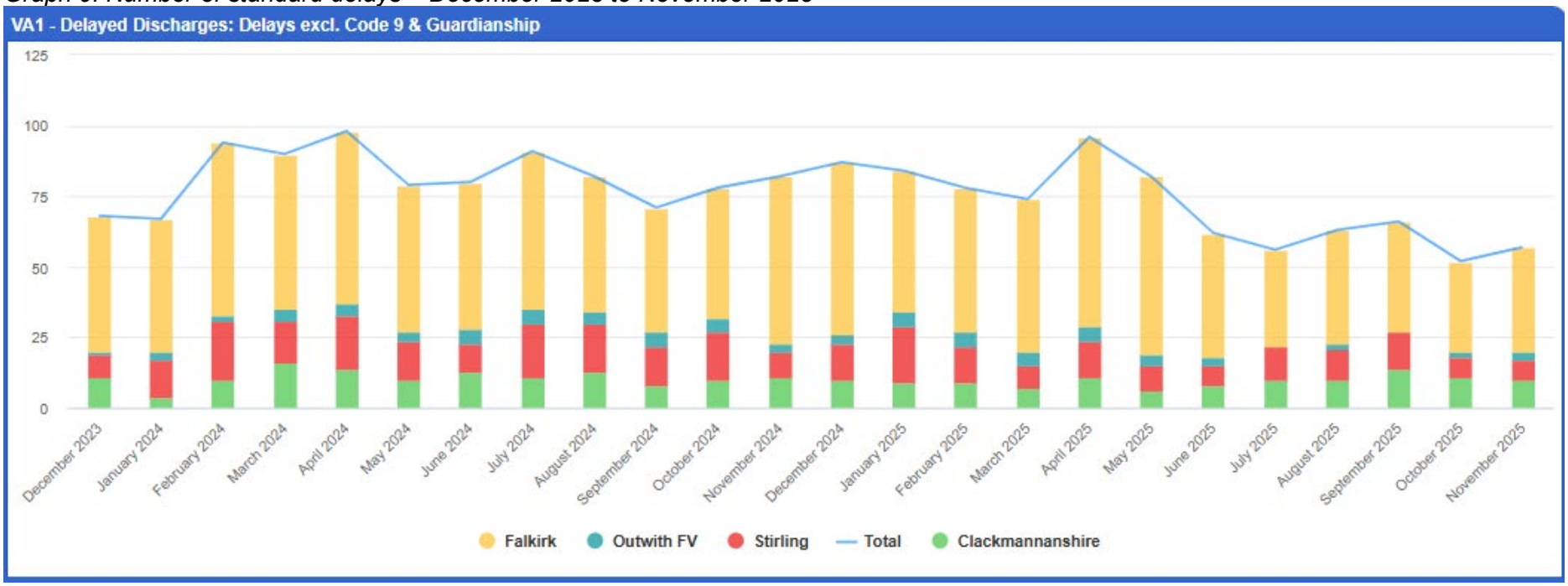
Work continues to support delivery of actions aligned to the various workstreams and projects underway system wide to support ongoing improvements in performance. In addition, NHS Forth Valley has joined the Discharge without Delay Collaborative which will influence the structure of how we align the 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: 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.

Delayed Discharge

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Delayed Discharges - excl. Code 9 & Guardianship (Standard Delays)	30-Nov-25	Reduction	57	52	82	▲	-	-
Monthly	Code 9 & Guardianship Delays	30-Nov-25	Reduction	60	58	52	▼	-	-
Monthly	Total Bed Days Occupied by Delayed Discharges (Standard Delays)	30-Nov-25	Reduction	2,886	1,820	3,276	▲	-	-

Graph 9: Number of standard delays – December 2023 to November 2025



The November 2025 census position in relation to standard delays (excluding Code 9 and guardianship) is 57 delays; this is compared to 82 in November 2024.

The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the November 2025 census was 2,886, this is a reduction from 3,276 in November 2024. Local authority breakdown is noted as Clackmannanshire 284, Falkirk 2,260, Stirling 281. In addition, there were 61 bed days occupied by delayed discharges for local authorities' out with Forth Valley.

Delayed Discharges have become a particular focus of attention at Scottish Government and COSLA due to the unprecedented levels for Scotland as a whole. Weekly meetings have been put in place chaired by the Cabinet Secretary and Councillor Paul Kelly, COSLA Health and Social Care lead, with expected attendance by all 31 Chief Officers or their substitute.

The issue of delayed discharges 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.

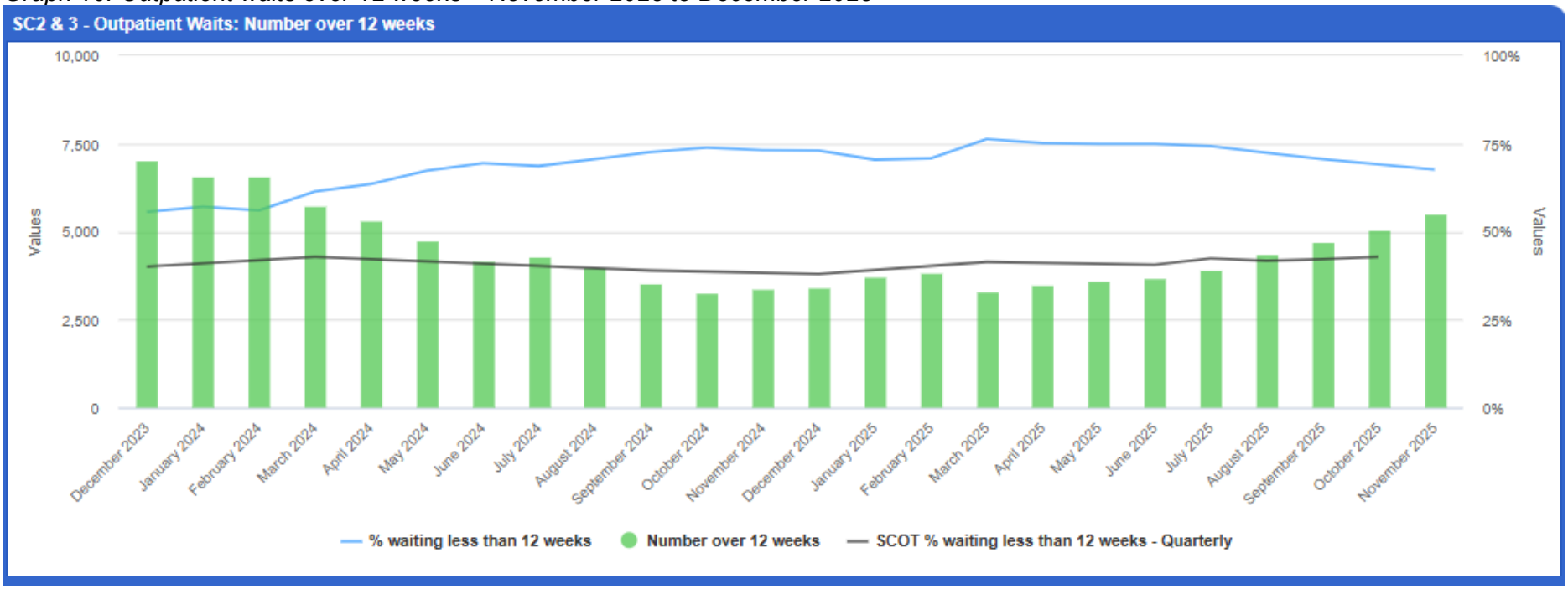
Scheduled Care

Outpatients

The percentage of patients waiting less than 12 weeks from referral to a first outpatient appointment – 95% Target.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total Number of New Outpatients Waiting	30-Nov-25	Reduction	17,046	16,426	12,639	▼	-	-
Monthly	Number of New Outpatients waiting over 12 weeks	30-Nov-25	Reduction	5,517	5,074	3,396	▼	-	-
Monthly	Number of New Outpatients waiting over 52 weeks	30-Nov-25	0	146	215	160	▲	-	-
Monthly	New Outpatients waiting under 12 weeks %	30-Nov-25	95%	67.6%	69.1%	73.1%	▼	42.8%	21-Oct-25

Graph 10: Outpatient waits over 12 weeks – November 2023 to December 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 November 2025, the number of patients on the waiting list for a first outpatient appointment was 17,046 (16,738 excluding mutual aid) compared with 12,639 in November 2024 with the number waiting beyond 12 weeks 5,517 (5,289 excluding mutual aid) compared to 3,396 in November 2024. Note 67.6% (68.4% excluding mutual aid) of patients were waiting less than 12 weeks for a first appointment; a decline in performance from 73.1% the same period the previous year.

The Scottish Government target for 2025/26 that 0 patients waiting over 52 weeks for a New Outpatient appointment. The graph and table below show the numbers and breakdown by specialty. Most specialties have no waits over 52 weeks and those that do are minimal.

The Scottish Government published updated waiting times guidance on 4 December 2023. The guidance aims to ensure consistency in how waiting lists are managed and to this end includes revisions to the ways in which adjustments can be made in relation to clock pauses and resets.

The 2023 Waiting Times Guidance revisions require changes to local patient management systems and the national waiting times data mart which is managed by Public Health Scotland.

Public Health Scotland data publications are now consistent with the 2023 guidance.

As NHS Forth Valley is progressing with implementation of the 2023 guidance in our patient management system, we are currently still accessing waiting times data based on calculations compliant with previous guidance. Resulting in differences in waiting times data provided from local system by NHS Forth Valley in comparison to data provided by Public Health Scotland in the interim period.

Graph 11: Number waiting over 52 weeks for new outpatient appointment - December 2023 to November 2025

Table 1: Number waiting over 52 weeks for New Outpatient appointment by Specialty – November 2025

Planned Care - New outpatient >52 Week waits

LG Service Area	Value	Numerator ▼	Denominator
General Surgery - Plastics	16.5%	51	309
Dermatology	1.4%	47	3,400
Rehabilitation Medicine	100.0%	23	23
Respiratory Medicine	3.0%	20	660
Urology	.3%	2	707

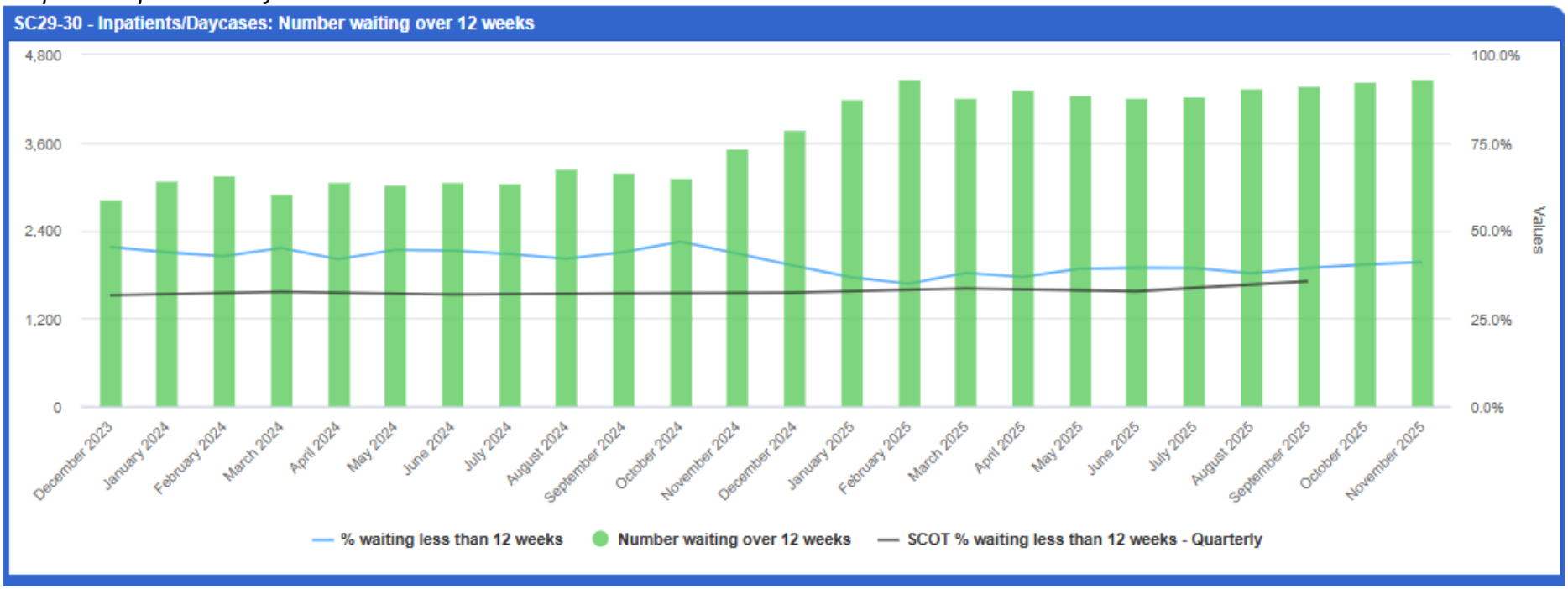
← 1 of 6 →

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.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Quarterly	Number of patients that waited >12 weeks - Completed Wait	30-Sep-25	0	2,054	1,972	1,490	-	-	-
Quarterly	% Compliance with 12 week TTG Standard	30-Sep-25	100%	33.6%	34.8%	44.1%	▼	56.7%	30-Sep-25
Monthly	Total Number of Inpatients/Day cases Waiting	30-Nov-25	Reduction	7,588	7,430	6,223	▼	-	-
Monthly	Number of Inpatients/Day cases waiting over 12 weeks	30-Nov-25	Reduction	4,475	4,434	3,521	▼	-	-
Monthly	Number of Inpatients/Day cases waiting over 52 weeks	30-Nov-25	0%	436	450	554	▲	-	-
Monthly	Percentage of Inpatients/Day cases waiting under 12 weeks	30-Nov-25	100%	41.0%	40.3%	43.4%	▼	35.6%	30-Sep-25

Graph 12: Inpatients/Daycase waits over 12 weeks – December 2023 to November 2025



In November 2025, the number of inpatients/daycases waiting increased to 7,588(7,329 excluding mutual aid and NTC) from 7,430 (7,118 excluding mutual aid and NTC) the previous month. An increase from the previous year in those waiting beyond 12 weeks from 4,434 to 4,475 was also noted.

The Scottish Government target for 2025/26 that 0 patients waiting over 52 weeks for Inpatient / Daycase treatment. Graph 15 and table 2 below show the numbers and breakdown by specialty respectively as at end of May. Weekly monitoring of the specialties with the largest numbers waiting over 12 weeks would suggest, based on progress so far, that we are on track to meet the target for end of March 2026. Details are included in the specialty sections below.

Graph 13: Number waiting over 52 weeks for Inpatient/Daycase – December 2023 to November 2025

Table 2: Number waiting over 52 weeks for Inpatient/Daycase by Specialty – November 2025

Planned Care - TTG >52 Week waits

LG Service Area	Value	Numerator	Denominator
Trauma and Orthopaedic Surgery	6.3%	164	2,622
Ear, Nose and Throat (ENT)	13.5%	116	857
General Surgery	7.2%	66	918
Urology	10.3%	45	438
Gynaecology	6.5%	36	551
Vascular Surgery	7.9%	6	76
Ophthalmology	.1%	2	1,885
Pain Management	2.6%	1	39

1 of 1

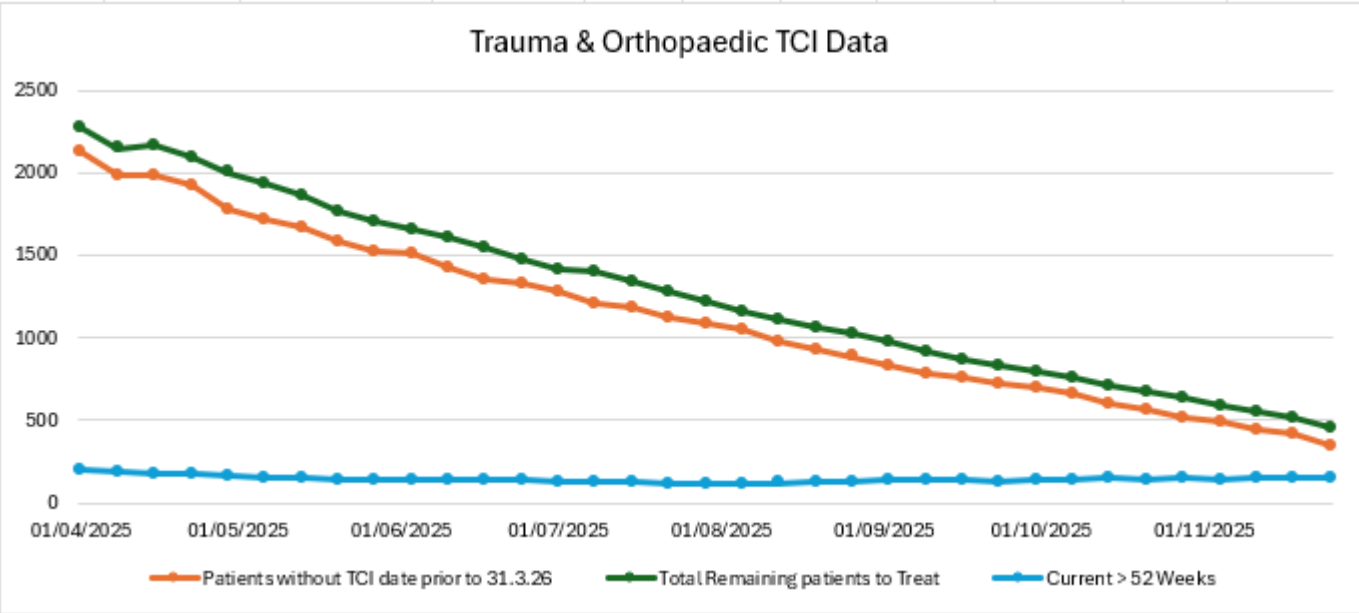
The following specialty level sections detail the weekly position of the waiting lists with the largest numbers waiting over 52 weeks, these show the numbers waiting in total and the numbers dated To Come In (TCI). Further breakdowns show the numbers waiting over 52 weeks and the numbers and percentages of these which are dated to come in and of which are currently unavailable.

Trauma and Orthopaedic Surgery

Table 3: Trauma and Orthopaedic clearance of IPDC >52-week waiters

		Included: Trauma and Orthopaedic Surgery Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Wee	Current > 78 Wee	Longest Wait (week	No > 52 Weeks Dated	No > 52 Weeks Unavailab	% of 52 Weeks Date	% of 52 Weeks Unavailab
01/04/2025	Trauma and Orthopaedic Surger	151	2130	2281	196	24	110	32	33	16	16
08/04/2025	Trauma and Orthopaedic Surger	166	1987	2153	183	23	110	40	35	21	19
15/04/2025	Trauma and Orthopaedic Surger	180	1991	2171	171	21	107	38	30	22	17
22/04/2025	Trauma and Orthopaedic Surger	173	1925	2098	173	24	108	44	28	25	16
29/04/2025	Trauma and Orthopaedic Surger	220	1787	2007	165	25	109	37	26	22	15
06/05/2025	Trauma and Orthopaedic Surger	221	1725	1946	155	24	110	38	21	24	13
13/05/2025	Trauma and Orthopaedic Surger	193	1669	1862	147	25	111	37	21	25	14
20/05/2025	Trauma and Orthopaedic Surger	185	1586	1771	139	24	112	36	23	25	16
27/05/2025	Trauma and Orthopaedic Surger	187	1525	1712	145	23	113	36	26	24	17
03/06/2025	Trauma and Orthopaedic Surger	150	1510	1660	142	22	103	30	25	21	17
10/06/2025	Trauma and Orthopaedic Surger	181	1432	1613	143	21	104	33	26	23	18
17/06/2025	Trauma and Orthopaedic Surger	192	1355	1547	140	23	105	32	31	22	22
24/06/2025	Trauma and Orthopaedic Surger	147	1330	1477	135	19	99	23	31	17	22
01/07/2025	Trauma and Orthopaedic Surger	131	1285	1416	133	17	100	27	32	20	24
08/07/2025	Trauma and Orthopaedic Surger	195	1213	1408	128	18	100	26	31	20	24
15/07/2025	Trauma and Orthopaedic Surger	158	1189	1347	123	17	95	18	28	14	22
22/07/2025	Trauma and Orthopaedic Surger	147	1131	1278	118	11	96	22	27	18	22
29/07/2025	Trauma and Orthopaedic Surger	140	1085	1225	115	10	95	17	22	14	19
05/08/2025	Trauma and Orthopaedic Surger	113	1049	1162	113	10	96	19	23	16	20
12/08/2025	Trauma and Orthopaedic Surger	140	978	1118	122	11	97	25	27	20	22
19/08/2025	Trauma and Orthopaedic Surger	127	933	1060	131	9	98	21	21	16	16
26/08/2025	Trauma and Orthopaedic Surger	135	888	1023	132	7	94	20	23	15	17
02/09/2025	Trauma and Orthopaedic Surger	150	834	984	135	8	95	28	24	20	17
09/09/2025	Trauma and Orthopaedic Surger	138	785	923	141	8	96	39	27	27	19
16/09/2025	Trauma and Orthopaedic Surger	113	758	871	140	7	85	33	21	23	15
23/09/2025	Trauma and Orthopaedic Surger	101	727	828	133	7	96	27	19	20	14
30/09/2025	Trauma and Orthopaedic Surger	95	702	797	139	9	87	29	19	20	13
07/10/2025	Trauma and Orthopaedic Surger	94	662	756	146	7	88	27	18	18	12
14/10/2025	Trauma and Orthopaedic Surger	111	603	714	149	6	89	31	24	20	16
21/10/2025	Trauma and Orthopaedic Surger	117	564	681	146	6	89	28	27	19	18
28/10/2025	Trauma and Orthopaedic Surger	115	521	636	147	7	90	34	21	23	14
04/11/2025	Trauma and Orthopaedic Surger	101	493	594	143	5	89	35	19	24	13
11/11/2025	Trauma and Orthopaedic Surger	106	448	554	149	4	90	45	23	30	15
18/11/2025	Trauma and Orthopaedic Surger	98	415	513	153	2	91	45	22	29	14
25/11/2025	Trauma and Orthopaedic Surger	109	350	459	156	3	92	51	26	32	16

Graph 14: Trauma and Orthopaedic reduction of the target cohort

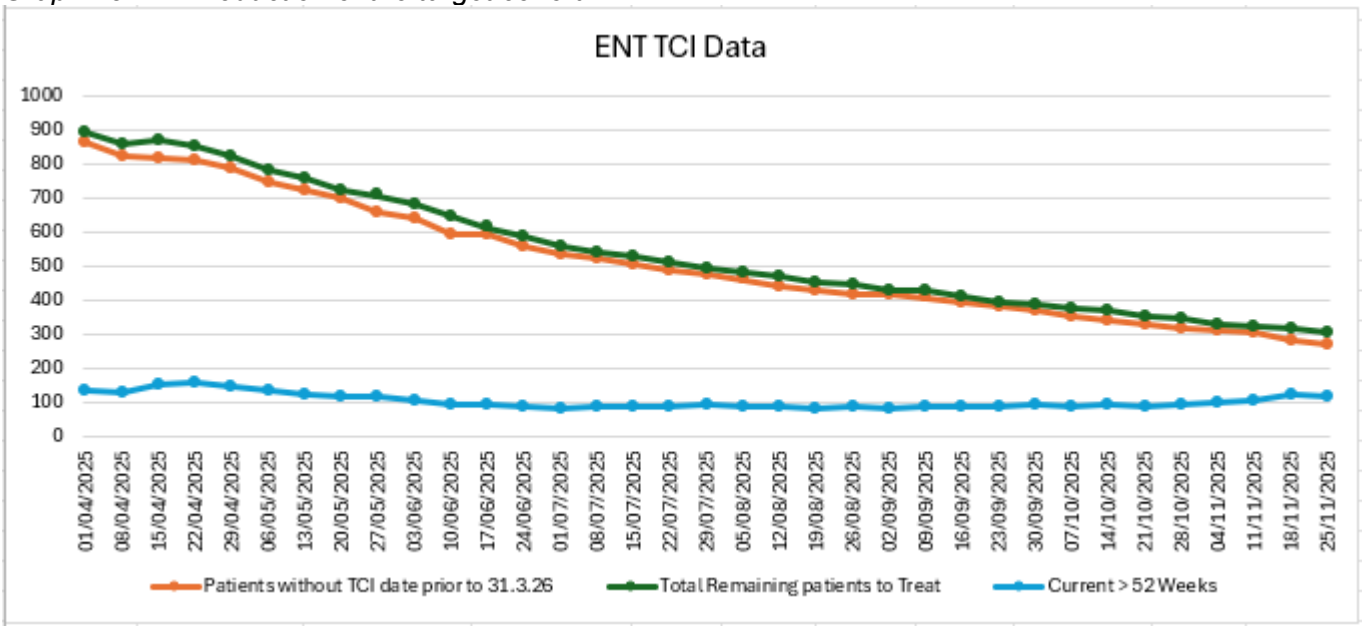


Ear, Nose and Throat

Table 4: ENT clearance of IPDC >52-week waiters

		Included: ENT Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Weeks	Current > 78 Weeks	Longest Wait (weeks)	No > 52 Weeks Dated	No > 52 Weeks Unavailable	% of 52 Weeks Dated	% of 52 Weeks Unavailable
01/04/2025	Ear, Nose and Throat (ENT	30	861	891	132	22	89	0	10	0	7
08/04/2025	Ear, Nose and Throat (ENT	37	822	859	130	21	89	3	11	2	8
15/04/2025	Ear, Nose and Throat (ENT	56	815	871	152	27	91	22	11	14	7
22/04/2025	Ear, Nose and Throat (ENT	45	810	855	157	28	92	21	11	13	7
29/04/2025	Ear, Nose and Throat (ENT	37	788	825	148	27	93	13	9	8	6
06/05/2025	Ear, Nose and Throat (ENT	34	747	781	134	27	94	17	9	12	6
13/05/2025	Ear, Nose and Throat (ENT	34	723	757	122	28	95	15	11	12	9
20/05/2025	Ear, Nose and Throat (ENT	25	700	725	118	30	96	12	8	10	6
27/05/2025	Ear, Nose and Throat (ENT	52	656	708	115	28	97	20	8	17	6
03/06/2025	Ear, Nose and Throat (ENT	36	643	679	104	26	98	13	12	12	11
10/06/2025	Ear, Nose and Throat (ENT	51	595	646	92	21	99	14	13	15	14
17/06/2025	Ear, Nose and Throat (ENT	23	591	614	92	19	97	7	15	7	16
24/06/2025	Ear, Nose and Throat (ENT	27	558	585	86	17	98	9	13	10	15
01/07/2025	Ear, Nose and Throat (ENT	25	532	557	84	15	97	6	16	7	19
08/07/2025	Ear, Nose and Throat (ENT	21	522	543	86	18	94	5	15	5	17
15/07/2025	Ear, Nose and Throat (ENT	19	507	526	87	16	95	3	12	3	13
22/07/2025	Ear, Nose and Throat (ENT	22	488	510	88	16	96	11	11	12	12
29/07/2025	Ear, Nose and Throat (ENT	16	477	493	92	16	91	10	10	10	10
05/08/2025	Ear, Nose and Throat (ENT	18	461	479	87	15	92	9	11	10	12
12/08/2025	Ear, Nose and Throat (ENT	29	441	470	89	13	91	18	6	20	6
19/08/2025	Ear, Nose and Throat (ENT	27	428	455	82	14	92	11	5	13	6
26/08/2025	Ear, Nose and Throat (ENT	27	419	446	85	14	93	11	6	12	7
02/09/2025	Ear, Nose and Throat (ENT	14	417	431	83	13	94	8	5	9	6
09/09/2025	Ear, Nose and Throat (ENT	20	408	428	86	13	95	12	7	13	8
16/09/2025	Ear, Nose and Throat (ENT	19	394	413	86	12	96	9	8	10	9
23/09/2025	Ear, Nose and Throat (ENT	14	382	396	87	10	97	7	10	8	11
30/09/2025	Ear, Nose and Throat (ENT	17	369	386	91	10	98	10	10	10	10
07/10/2025	Ear, Nose and Throat (ENT	25	351	376	90	11	96	16	8	17	8
14/10/2025	Ear, Nose and Throat (ENT	25	342	367	94	9	94	12	11	12	11
21/10/2025	Ear, Nose and Throat (ENT	24	328	352	86	5	95	13	11	15	12
28/10/2025	Ear, Nose and Throat (ENT	25	319	344	96	8	96	17	13	17	13
04/11/2025	Ear, Nose and Throat (ENT	19	311	330	100	6	97	12	10	12	10
11/11/2025	Ear, Nose and Throat (ENT	17	305	322	105	6	98	8	12	7	11
18/11/2025	Ear, Nose and Throat (ENT	33	282	315	121	7	99	27	12	22	9
25/11/2025	Ear, Nose and Throat (ENT	36	269	305	119	6	100	31	10	26	8

Graph 15: ENT reduction of the target cohort

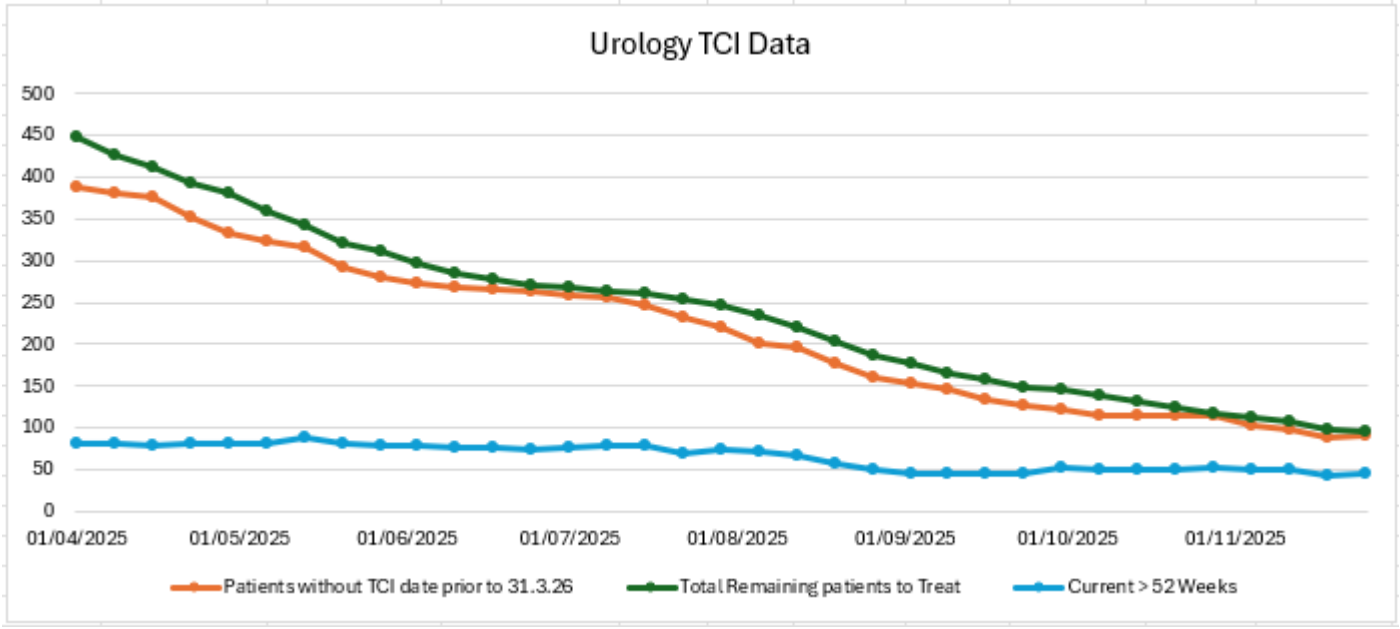


Urology

Table 5: Urology clearance of IPDC >52-week waiters

		Included: Urology Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Wee	Current > 78 Wee	Longest Wait (week	No > 52 Weeks Date	No > 52 Weeks Unavailal	% of 52 Weeks Date	% of 52 Weeks Unavailal
01/04/2025	Urology	59	389	448	80	37	108	1	1	1	1
08/04/2025	Urology	46	381	427	80	37	108	1	1	1	1
15/04/2025	Urology	38	375	413	79	38	110	0	3	0	3
22/04/2025	Urology	40	353	393	80	42	111	1	3	1	3
29/04/2025	Urology	47	333	380	80	45	112	5	2	6	2
06/05/2025	Urology	36	323	359	81	46	113	6	1	7	1
13/05/2025	Urology	26	316	342	89	47	114	7	2	7	2
20/05/2025	Urology	30	292	322	82	42	112	7	2	8	2
27/05/2025	Urology	31	280	311	78	40	109	5	2	6	2
03/06/2025	Urology	25	272	297	79	41	110	5	5	6	6
10/06/2025	Urology	19	267	286	77	39	111	5	6	6	7
17/06/2025	Urology	12	265	277	77	39	112	5	3	6	3
24/06/2025	Urology	6	264	270	75	38	109	2	3	2	4
01/07/2025	Urology	9	258	267	77	37	110	4	4	5	5
08/07/2025	Urology	7	257	264	78	38	111	5	5	6	6
15/07/2025	Urology	16	246	262	78	41	112	7	5	8	6
22/07/2025	Urology	21	233	254	70	38	113	7	6	10	8
29/07/2025	Urology	28	219	247	74	36	114	15	7	20	9
05/08/2025	Urology	33	201	234	72	36	115	24	8	33	11
12/08/2025	Urology	23	196	219	66	30	115	16	5	24	7
19/08/2025	Urology	26	177	203	57	23	116	12	4	21	7
26/08/2025	Urology	27	160	187	51	18	117	10	4	19	7
02/09/2025	Urology	23	154	177	46	17	118	6	4	13	8
09/09/2025	Urology	18	146	164	45	16	119	8	4	17	8
16/09/2025	Urology	23	134	157	46	16	120	8	1	17	2
23/09/2025	Urology	23	126	149	46	12	121	11	0	23	0
30/09/2025	Urology	23	122	145	52	12	122	13	1	25	1
07/10/2025	Urology	23	115	138	51	12	123	10	1	19	1
14/10/2025	Urology	18	114	132	51	12	124	8	2	15	3
21/10/2025	Urology	10	114	124	51	7	125	2	3	3	5
28/10/2025	Urology	4	114	118	53	5	122	1	4	1	7
04/11/2025	Urology	9	103	112	51	4	123	8	4	15	7
11/11/2025	Urology	9	98	107	49	3	87	7	2	14	4
18/11/2025	Urology	8	89	97	42	2	88	2	3	4	7
25/11/2025	Urology	6	90	96	44	2	89	0	4	0	9

Graph 16: Urology reduction of the target cohort

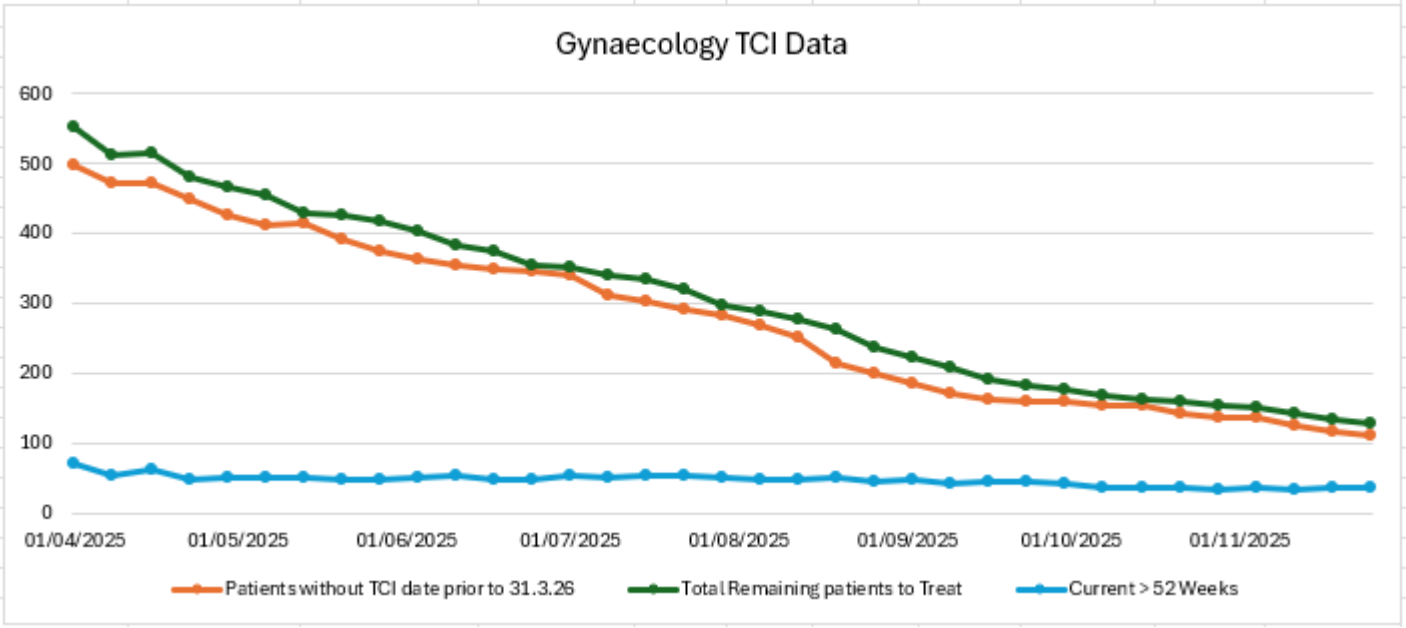


Gynaecology

Table 6: Gynaecology clearance of IPDC >52-week waiters

		Included: Gynaecology Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Wee	Current > 78 Wee	Longest Wait (week	No > 52 Weeks Date	No > 52 Weeks Unavailal	% of 52 Weeks Date	% of 52 Weeks Unavailal
01/04/2025	Gynaecology	54	497	551	70	7	91	21	5	30	7
08/04/2025	Gynaecology	40	473	513	55	7	91	8	8	14	14
15/04/2025	Gynaecology	43	471	514	63	6	93	14	7	22	11
22/04/2025	Gynaecology	32	448	480	48	7	94	12	8	25	16
29/04/2025	Gynaecology	41	425	466	50	7	95	13	7	26	14
06/05/2025	Gynaecology	43	412	455	50	6	96	12	5	24	10
13/05/2025	Gynaecology	15	414	429	51	6	97	9	4	17	7
20/05/2025	Gynaecology	32	393	425	48	5	98	8	6	16	12
27/05/2025	Gynaecology	44	374	418	47	5	99	10	4	21	8
03/06/2025	Gynaecology	39	364	403	51	5	100	9	8	17	15
10/06/2025	Gynaecology	28	354	382	53	6	101	10	8	18	15
17/06/2025	Gynaecology	24	350	374	49	5	102	5	8	10	16
24/06/2025	Gynaecology	10	345	355	49	5	103	1	7	2	14
01/07/2025	Gynaecology	13	339	352	55	4	104	4	4	7	7
08/07/2025	Gynaecology	28	312	340	51	4	105	5	4	9	7
15/07/2025	Gynaecology	32	303	335	55	5	106	6	4	10	7
22/07/2025	Gynaecology	29	292	321	53	5	107	5	3	9	5
29/07/2025	Gynaecology	15	283	298	51	6	108	3	2	5	3
05/08/2025	Gynaecology	20	270	290	49	7	109	7	3	14	6
12/08/2025	Gynaecology	26	252	278	49	6	110	11	5	22	10
19/08/2025	Gynaecology	50	213	263	50	6	111	16	6	32	12
26/08/2025	Gynaecology	37	201	238	46	6	96	14	7	30	15
02/09/2025	Gynaecology	35	187	222	48	5	97	10	5	20	10
09/09/2025	Gynaecology	38	170	208	42	5	98	11	6	26	14
16/09/2025	Gynaecology	29	163	192	44	5	99	11	7	25	15
23/09/2025	Gynaecology	21	161	182	45	5	100	10	4	22	8
30/09/2025	Gynaecology	17	159	176	42	5	101	8	4	19	9
07/10/2025	Gynaecology	14	155	169	36	4	102	5	3	13	8
14/10/2025	Gynaecology	11	153	164	37	4	103	3	2	8	5
21/10/2025	Gynaecology	18	142	160	37	4	104	5	2	13	5
28/10/2025	Gynaecology	17	136	153	35	5	105	4	3	11	8
04/11/2025	Gynaecology	14	136	150	37	6	106	4	4	10	10
11/11/2025	Gynaecology	17	126	143	35	3	107	7	4	20	11
18/11/2025	Gynaecology	18	117	135	37	3	108	12	3	32	8
25/11/2025	Gynaecology	18	111	129	36	4	91	14	3	38	8

Graph 17: Gynaecology reduction of the target cohort

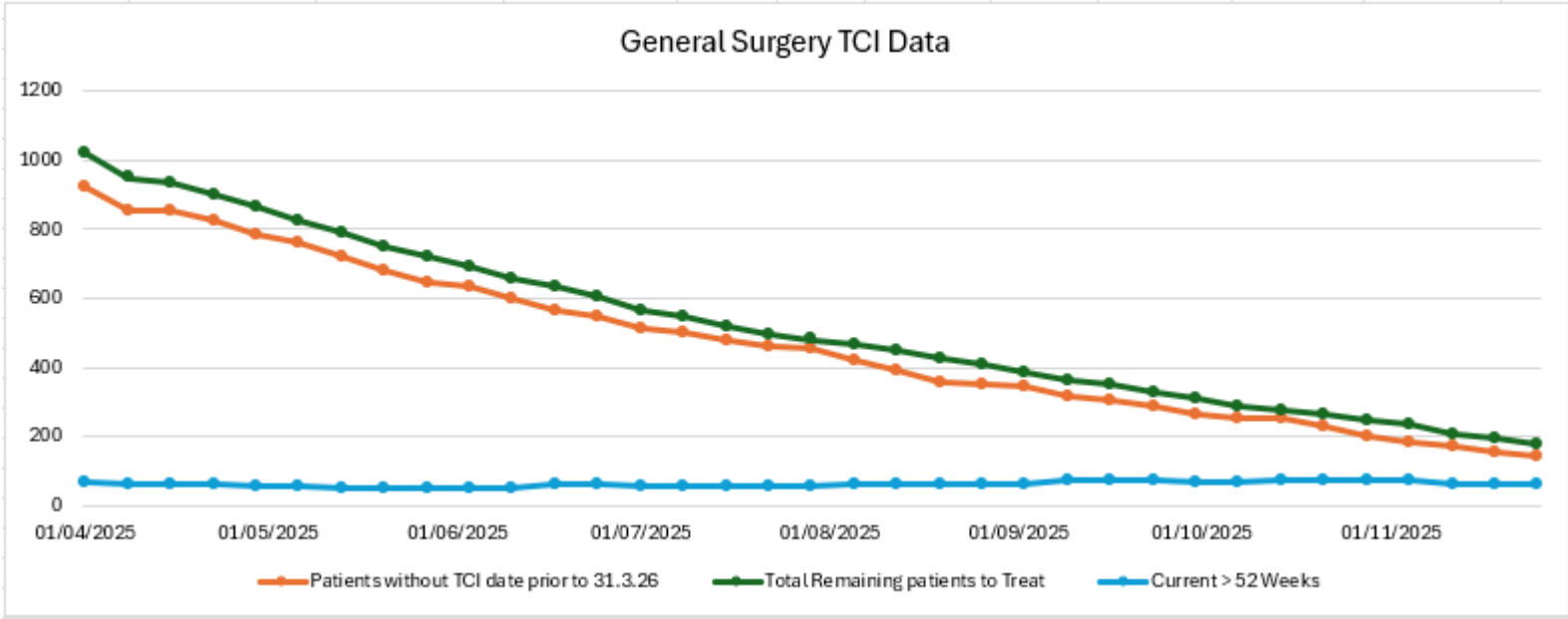


General Surgery

Table 7: General Surgery clearance of IPDC >52-week waiters

		Included: General Surgery Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Wee	Current > 78 Wee	Longest Wait (weeks	No > 52 Weeks Date	No > 52 Weeks Unavaila	% of 52 Weeks Dated	% of 52 Weeks Unavaila
01/04/2025	General Surger	103	921	1024	70	7	93	8	8	11	11
08/04/2025	General Surger	95	854	949	63	7	93	7	9	11	14
15/04/2025	General Surger	79	853	932	62	8	87	11	8	17	12
22/04/2025	General Surger	74	824	898	60	8	88	12	12	20	20
29/04/2025	General Surger	80	783	863	57	8	89	14	12	24	21
06/05/2025	General Surger	61	764	825	57	9	90	13	10	22	17
13/05/2025	General Surger	67	722	789	50	10	91	6	11	12	22
20/05/2025	General Surger	69	678	747	48	10	92	10	11	20	22
27/05/2025	General Surger	72	646	718	49	10	93	7	11	14	22
03/06/2025	General Surger	59	632	691	50	10	94	7	13	14	26
10/06/2025	General Surger	57	602	659	53	8	95	8	16	15	30
17/06/2025	General Surger	69	567	636	60	10	96	13	14	21	23
24/06/2025	General Surger	55	550	605	64	10	97	12	15	18	23
01/07/2025	General Surger	51	515	566	57	5	95	4	15	7	26
08/07/2025	General Surger	43	502	545	56	4	96	3	14	5	25
15/07/2025	General Surger	37	480	517	56	6	97	4	14	7	25
22/07/2025	General Surger	34	463	497	55	6	98	3	9	5	16
29/07/2025	General Surger	28	453	481	57	5	99	4	9	7	15
05/08/2025	General Surger	43	422	465	61	5	95	9	4	14	6
12/08/2025	General Surger	57	391	448	64	5	96	10	8	15	12
19/08/2025	General Surger	71	357	428	62	6	97	8	8	12	12
26/08/2025	General Surger	58	350	408	62	10	98	9	8	14	12
02/09/2025	General Surger	41	343	384	63	7	99	7	8	11	12
09/09/2025	General Surger	47	316	363	74	8	100	10	9	13	12
16/09/2025	General Surger	47	302	349	75	9	101	14	9	18	12
23/09/2025	General Surger	40	285	325	72	8	102	12	9	16	12
30/09/2025	General Surger	46	262	308	69	6	91	12	9	17	13
07/10/2025	General Surger	34	251	285	66	5	92	4	10	6	15
14/10/2025	General Surger	24	253	277	74	6	93	5	12	6	16
21/10/2025	General Surger	35	227	262	74	5	94	11	9	14	12
28/10/2025	General Surger	49	198	247	73	6	95	27	7	36	9
04/11/2025	General Surger	49	185	234	72	5	96	22	11	30	15
11/11/2025	General Surger	35	170	205	62	3	97	14	8	22	12
18/11/2025	General Surger	42	153	195	63	2	98	20	10	31	15
25/11/2025	General Surger	33	143	176	63	1	99	17	9	26	14

Graph 18: General Surgery reduction of the target cohort



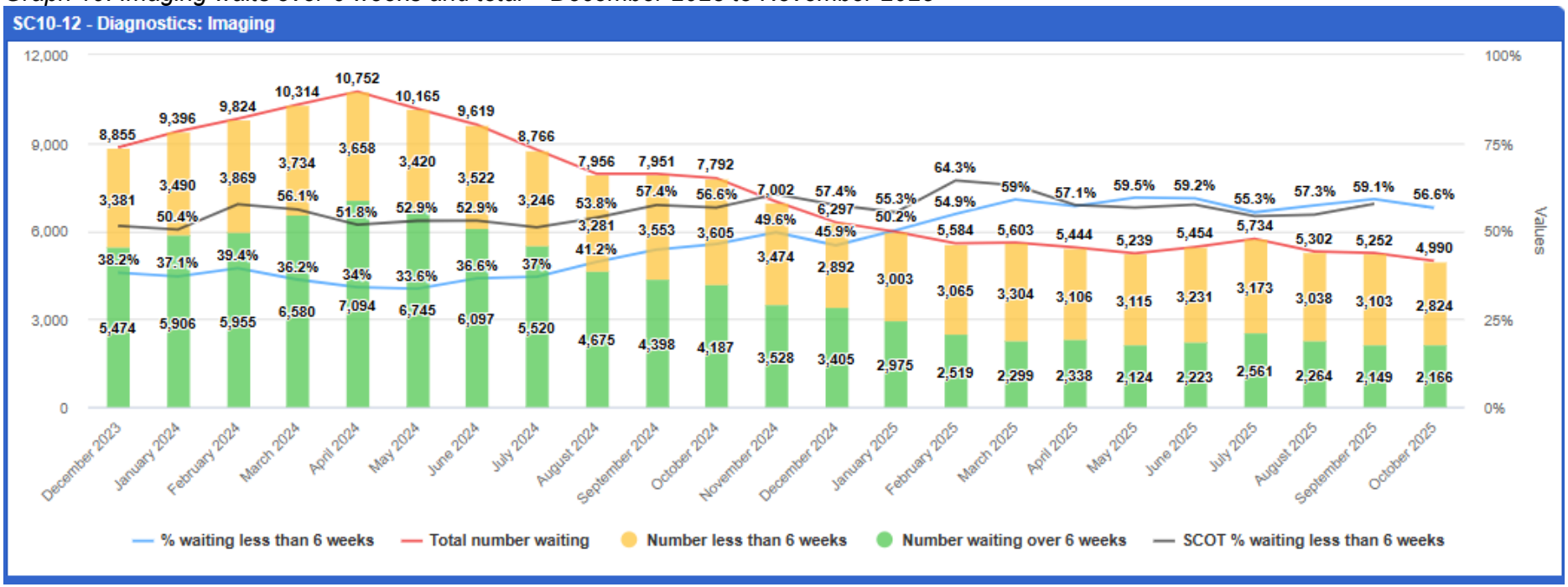
Diagnostics

The Diagnostic Waiting Times Standard states patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations.

Imaging

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total number waiting - Imaging	31-Oct-25	Reduction	4,990	5,252	7,792	▲	-	-
Monthly	Number waiting beyond 42 days - Imaging	31-Oct-25	0%	2,166	2,149	4,187	▲	-	-
Monthly	Percentage waiting less than 42 days - Imaging	31-Oct-25	100%	56.6%	59.1%	46.3%	▲	57.7%	30-Sep-25

Graph 19: Imaging waits over 6 weeks and total – December 2023 to November 2025



At the end of October 2025, 2,166 patients were waiting beyond the 6-week standard for imaging, a reduction from 4,187 in October 2024. At the end of October 2025, the compliance with the 6 weeks standard was 56.6%.

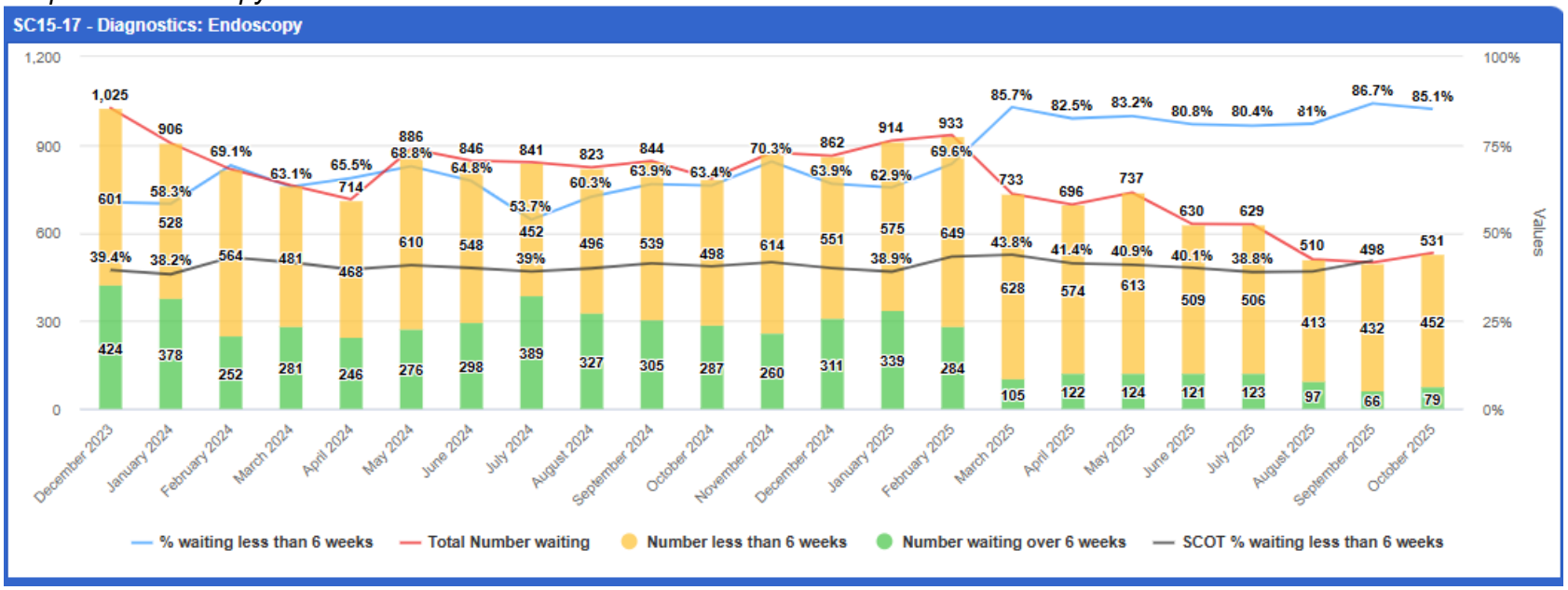
Patients continue to be seen on a priority basis with waiting lists actively monitored and managed on an ongoing basis. The total number of patients waiting for imaging in October 2025 was 4,990; compared with 5,252 in October 2024.

Endoscopy

Waiting times standard is that patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total number waiting - Endoscopy	31-Oct-25	Reduction	531	498	785	▲	-	-
Monthly	Number waiting beyond 42 days - Endoscopy	31-Oct-25	0	79	66	287	▲	-	-
Monthly	Percentage waiting less than 42 days - Endoscopy	31-Oct-25	100%	85.1%	86.7%	63.4%	▲	42.1%	30-Sep-25

Graph 20: Endoscopy waits over 6 weeks and total - December 2023 to November 2025



The current waiting list size for endoscopy (October 2025) is 531, compared to 785 in October 2024. NHS Forth Valley Endoscopy team is moving towards achieving the 6-week diagnostic standard. The size of the waiting list continues to reduce and the number of patients waiting over 6 weeks is also reducing. Performance is now reported with over 80% of patients accessing endoscopy within 6 weeks.

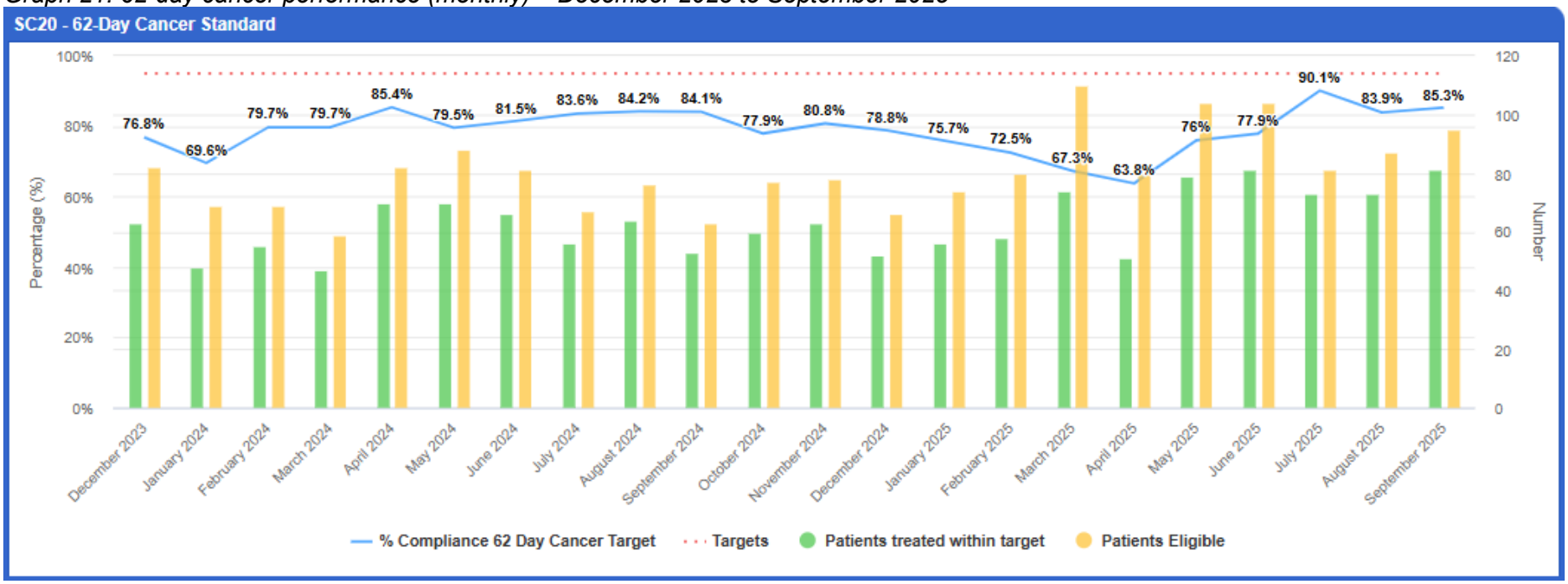
Based on the last published figures the NHS Scotland average performance for Endoscopy is 42.1%.

62-day Cancer Standard

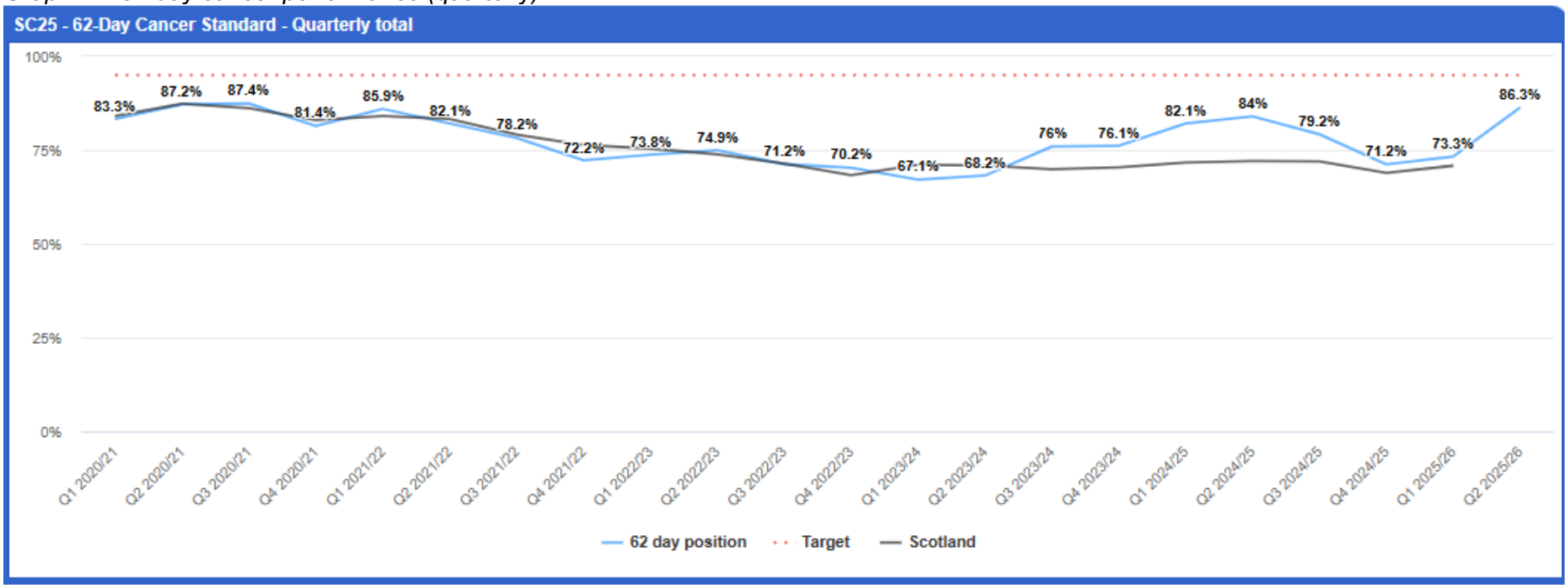
The 62-day standard states that 95% of eligible patients should wait no longer than 62 days from urgent suspicion of cancer referral to first cancer treatment.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	62 Day Cancer Target - Percentage compliance against target	30-Sep-25	95%	85.3%	83.9%	84.1%	▲	69.9%	30-Sep-25
Monthly	62 Day Cancer - Number seen within target against total	30-Sep-25	-	81/95	73/87	53/63	-	-	-
Quarterly	62 Day Cancer Target - Percentage compliance against target	30-Sep-25	95%	86.3%	72.4%	83.5%	▲	70.7%	30-Sep-25

Graph 21: 62-day cancer performance (monthly) – December 2023 to September 2025



Graph 22: 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.

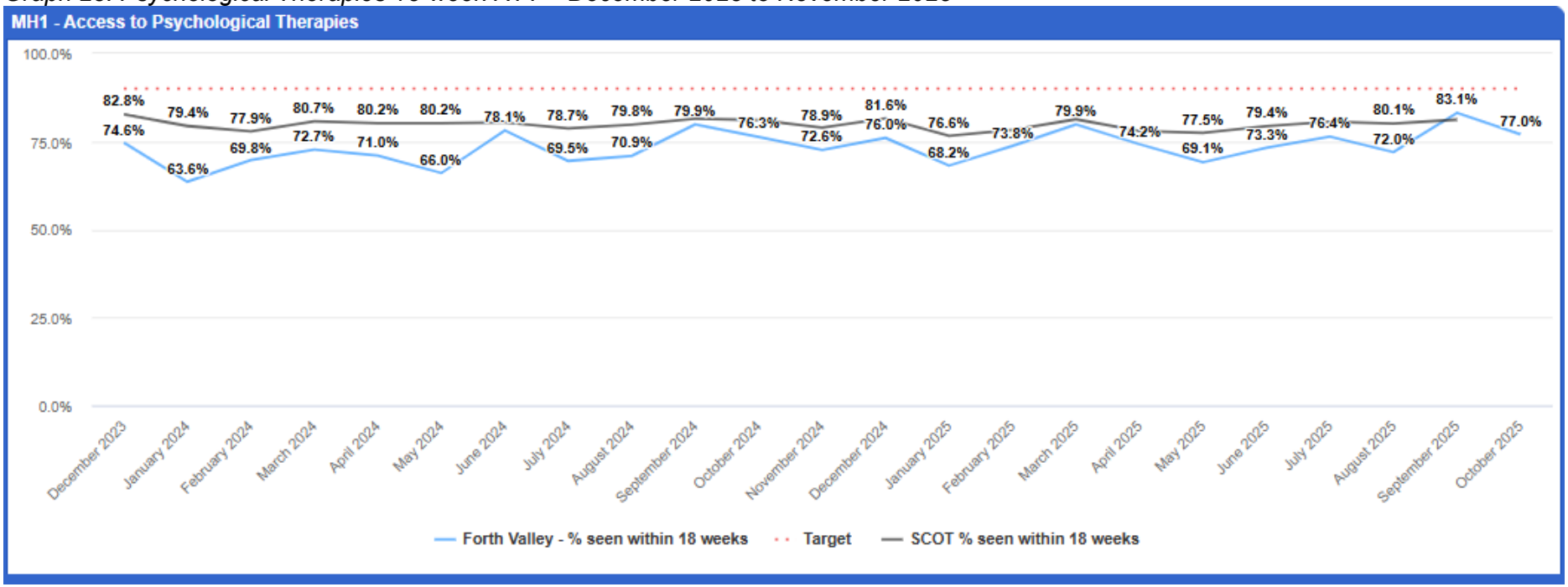
The number of patients being tracked on the 62-day cancer pathway is currently approximately 864 of which 14% are confirmed cancer patients.

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.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Psychological Therapies - 18 week RTT compliance	31-Oct-25	90%	77.0%	83.1%	72.6%	▲	81.2%	30-Sep-25
Monthly	Total Number Waiting for Pyschological Therapies Initial Assessment	31-Oct-25	Reduction	986	936	855	▼	-	-
Quarterly	Psychological Therapies - 18 week RTT compliance	30-Sep-25	90%	77.1%	72.1%	73.2%	▲	80.7%	30-Sep-25

Graph 23: Psychological Therapies 18-week RTT – December 2023 to November 2025



In October 2025, compliance with the RTT was 77.0% continuing a fairly consistent pattern of around 70% compliance or above. The peak in September 2025 was due to several factors: higher numbers of people starting digital therapies; fewer people starting groups due to timings of group programmes; more people being seen for assessments due to clinicians having short term availability in the period between groups; a high number of cases being transferred mid therapy from a departing clinician.

In April 2025 waiting list projections were requested by Scottish Government and conducted by Public Health Scotland on NHS Forth Valley's behalf. These indicated that we are unlikely to meet the RTT without significant investment in additional resource.

There has been a steady increase in the numbers of people awaiting initial assessment from July with 1002 people waiting in October. The October numbers are likely to be inflated by people who have recently been added to the waiting list, but who may not respond to opt-in letters and will subsequently be removed. Nevertheless, the increase in numbers awaiting an assessment may be due to the impact of the implementation of the service's Improvement Plan which focuses on delivering therapy to those people who have been waiting over 104 weeks for treatment. This has required further shifting of assessment capacity to treatment capacity. We will monitor the ongoing impact of the Improvement Plan.

The total waiting list size for treatment had been reducing since the introduction of an Improvement Plan in May 2025 however the reduction was not from those people who have been waiting longest, and we are doing some targeted work to address this. We will monitor the ongoing impact of the Improvement Plan. Numbers waiting have increased in October due to fewer numbers starting treatment in September. The increase in October to 2738 people waiting for treatment reflects (1) the high number of referrals this month and (2) the inclusion of those people who have recently been referred. It is standard for a percentage of those to not opt-in and to be removed from the queue.

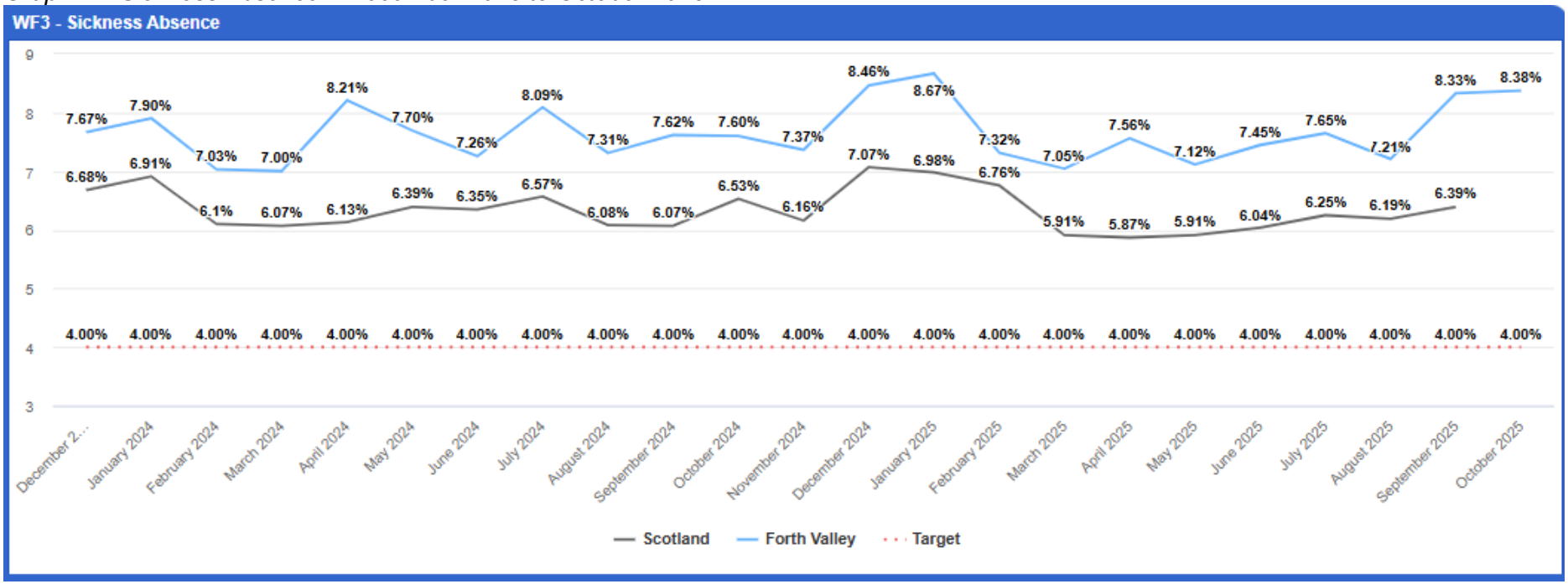
Section 3: Performance Report - Other Areas of Performance

Workforce

To reduce sickness absence to 4%

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Overall Absence	31-Oct-25	4.0%	8.38%	8.33%	7.60%	▼	6.39%	30-Sep-25
Rolling 12 mth	Overall Absence	30-Sep-25	-	7.69%	7.78%	7.62%	▼	6.37%	30-Sep-25

Graph 24: Sickness Absence – December 2023 to October 2025



The sickness absence target is 4.0%. Absence remains above the target at 8.38% in October 2025 noting deterioration from 7.60% in October 2024. The 12-month rolling average October 2024 to September 2025 is noted as, NHS Forth Valley 7.69%; Scotland 6.37%.

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 clinical services are providing staff with pathways to counselling, psychology, physiotherapy, management and self-referrals to align with Once for Scotland Policies. Awareness sessions, aimed at improving managers ability to make more accurate referrals to OH clinical pathways are delivered regularly to educate managers through a Management Referral training package. A proactive Occupational Health consultation advice line is established and increases a person-centred approach to enable individuals with access the right care at the right time.

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.

Unavailability

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Outpatient Unavailability	30-Nov-25	Monitor	0.7%	0.6%	1.3%	▲	0.8%	30-Sep-25
Monthly	Inpatient/Day case Unavailability	30-Nov-25	Monitor	3.6%	3.5%	5.9%	▲	3.8%	30-Sep-25

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 November 2025 was 0.7% of the total waiting list.
- Inpatient/daycase unavailability in November 2025 was 3.6% a reduction from 5.9% in November 2024. The unavailability rate is less than 6% for all specialties except Cardiology (11.11%), Oral and Maxillofacial Surgery (10.34%), Vascular Surgery (8%), General Surgery (6.98%) and Urology (6.16%). The highest in terms of numbers are Orthopaedics with 99 patients unavailable (3.86%) and General

Did Not Attend (DNA)

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	New Acute Services Outpatient % DNA	30-Nov-25	5%	4.3%	4.1%	4.4%	▲	6.3%	30-Sep-25
Monthly	Return Acute Services Outpatient % DNA	30-Nov-25	5%	4.8%	4.8%	5.3%	▲	-	-

The new outpatient DNA rate across acute services in November 2025 is noted as 4.3% which is an improvement from the position in November 2024 of 4.4%. Variation across specialties continues with rates ranging from 12.5% to 0%. The biggest impact in terms of the number of DNAs can be seen in Ophthalmology 5.65% (58 patients).

The return outpatient DNA rate across acute services in November 2025 was 4.8%. There continues to be a high number of DNAs in Ophthalmology with 197 patients (3.29%), Orthopaedics 126 patients (5.26%), Dermatology 111 patients (5.29%) and Diabetes 104 patients (7.86%).

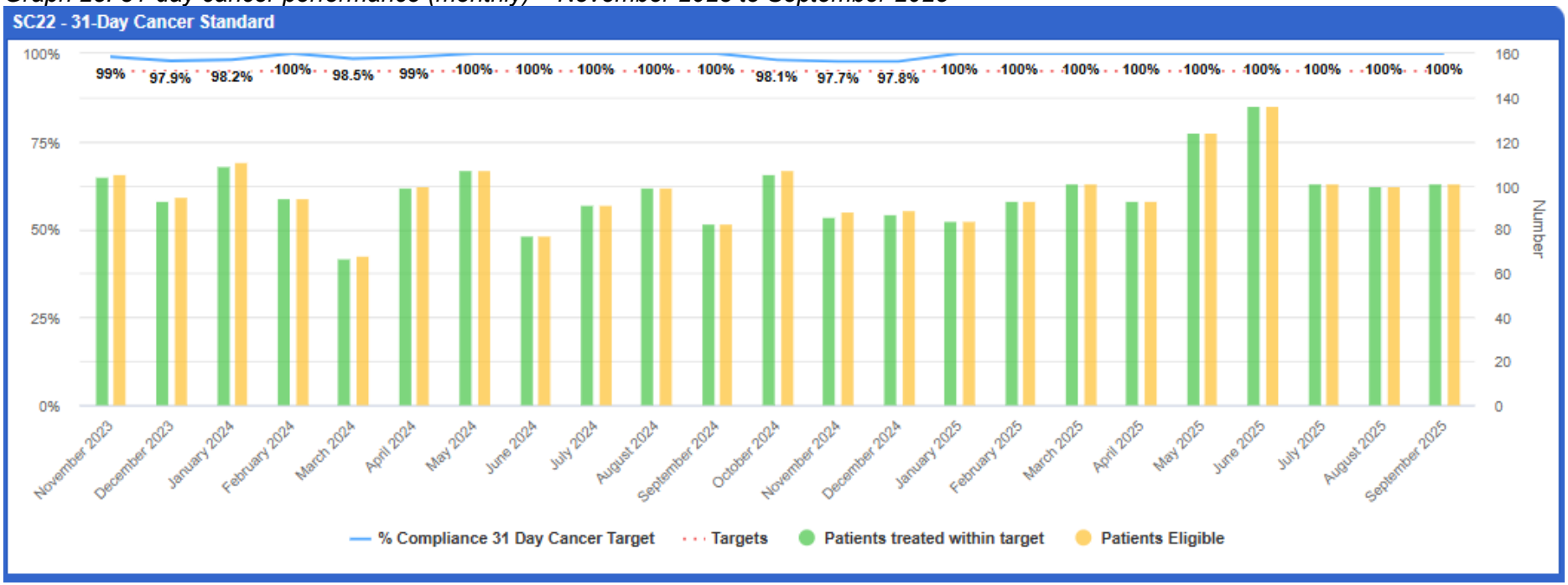
A number of actions are ongoing to support a reduction in the number of DNAs including the roll out of patient focus booking. Application of the Access Policy is actively supported and there is ongoing benchmarking against national DNAs and removal rates. Patient information provides detail on the process to cancel or change an appointment with the relevant contact information.

31- Day Cancer 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.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	31 Day Cancer Target - Percentage compliance against target	30-Sep-25	95%	100.0%	100.0%	100.0%	◄►	95.6%	30-Sep-25
Monthly	31 Day Cancer Target - Number seen within target against total	30-Sep-25	-	101/101	100/100	83/83	-	-	-
Quarterly	31 Day Cancer Target - Percentage compliance against target	30-Sep-25	95%	100.0%	100.0%	100.0%	◄►	95.1%	30-Sep-25

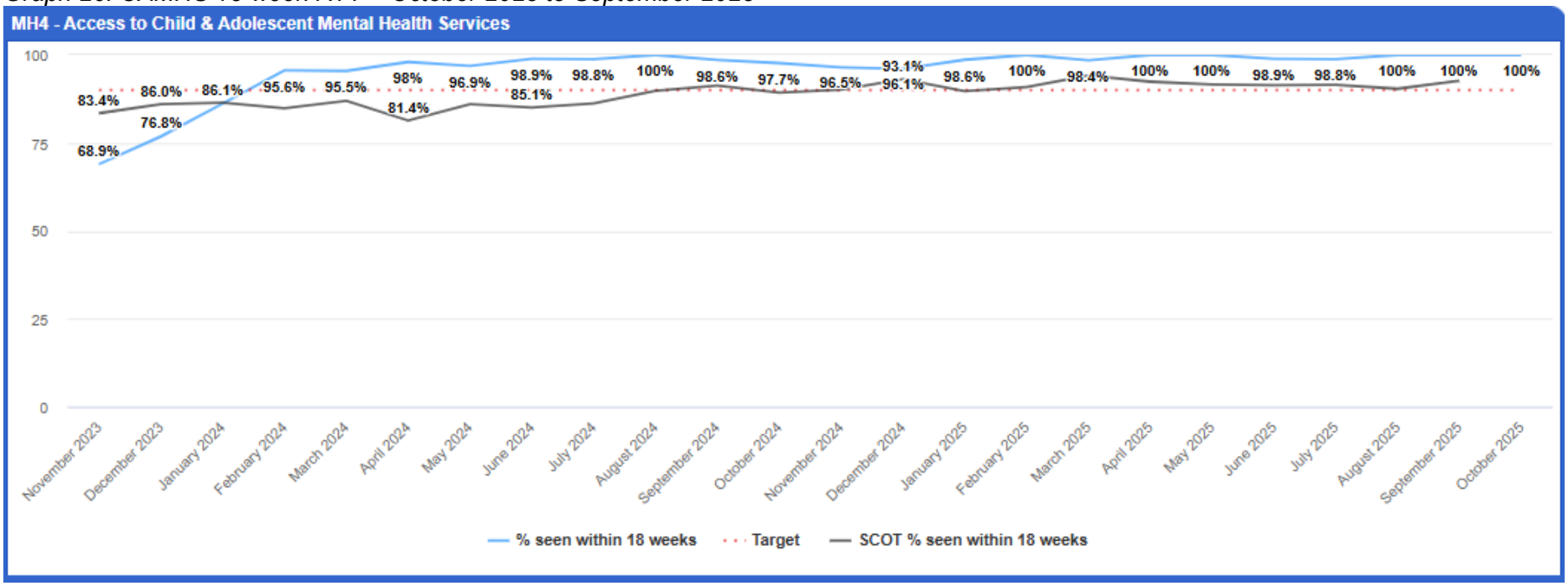
Graph 25: 31-day cancer performance (monthly) – November 2023 to September 2025



Child & Adolescent Mental Health Services (CAMHS)

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Oct-25	90%	100.0%	100.0%	96.5%	▲	92.7%	30-Sep-25
Monthly	Total Number Waiting for CAMHS Initial Assessment	31-Oct-25	Reduction	109	104	50	▼	-	-
Quarterly	Child & Adolescent Mental Health Services - 18 week RTT compliance	30-Sep-25	90%	99.4%	99.6%	99.2%	▲	91.6%	30-Sep-25

Graph 26: CAMHS 18-week RTT – October 2023 to September 2025



October 2025 numbers show we are continuing to perform above target with 100% of patients started treatment within 18 weeks of referral.

Section 4: Performance Scorecard

BETTER CARE													
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	NOTES
HOSPITAL STANDARDISED MORTALITY RATE													
MR1	SG	Rolling 12 mth	Hospital Standardised Mortality Ratio (HSMR)	31-Mar-25	</= 1.00	0.94	0.98	0.96	▲	1.00	31-Mar-25	-	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	30-Nov-25	Reduction	5,423	5,272	5,047	▼	-	-	-	
US1	SG	Monthly	Number of ED Attendances (4 hour access target)	30-Nov-25	Reduction	5,423	5,272	4,821	▼	-	-	-	Number of ED attandances and a target of 'Reduction' is relevant in relation to capacity and flow. National standard for A&E waiting times is that unplanned and new planned 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. 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.
US2	SG	Monthly	Emergency Department % compliance against 4 hour access target	30-Nov-25	95%	46.7%	42.8%	43.4%	▲	66.9%	30-Jun-25	✓	
US3	S5	Monthly	Number that waited >4 hours in ED	30-Nov-25	Reduction	2,891	3,013	2,731	▼	-	-	-	
US4	SG	Monthly	Number that waited >8 hours in ED	30-Nov-25	Reduction	1,436	1,462	1,308	▼	-	-	-	
US5	SG	Monthly	Number that waited >12 hours in ED	30-Nov-25	Reduction	701	674	635	▼	-	-	-	
US6	SG	Monthly	Number that waited >23 hours in ED	30-Nov-25	Reduction	69	48	93	▲	-	-		
	FV	Monthly	Total Number of MIU Attendances	30-Nov-25	Reduction	1,517	1,637	1,656	▲	-	-	-	
US7	SG	Monthly	Number of MIU Attendances (4 hour access target)	30-Nov-25	Reduction	1,517	1,637	824	▲	-	-	-	
US8	SG	Monthly	Minor Injuries Unit % compliance against 4 hour target	30-Nov-25	95%	99.7%	99.8%	100.0%	▼	-	-	-	
US9	SG	Monthly	NHS Forth Valley Overall % compliance against 4 hour target	30-Nov-25	95%	58.3%	56.3%	51.6%	▲	70.8%	30-Jun-25	✓	
US12	FV	Monthly	Number of Rapid Assessment and Care Unit New Attendances	30-Nov-25	-	522	484	537	-	-	-	-	
US13	FV	Monthly	Number of Rapid Assessment and Care Unit Scheduled Return Attendances	30-Nov-25	-	164	162	120	-	-	-	-	
US14	FV	Monthly	Number of Re-directions from ED	30-Nov-25	-	648	575	539	-	-	-	-	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 %	30-Nov-25	-	12.0%	10.9%	10.7%	-	-	-	-	
US16	FV	Monthly	Number of Emergency Admissions	30-Nov-25	Reduction	3,248	3,472	3,189	▼	-	-	-	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	30-Nov-25	Reduction	4,929	4,722	4,767	▼	-	-	-	
	FV	Monthly	Advice	30-Nov-25	-	3,290	3,188	3,204	-	-	-	-	
	FV	Monthly	Attend OOH Appointment	30-Nov-25	-	1,367	1,285	1,307	-	-	-	-	
	FV	Monthly	Home Visit	30-Nov-25	-	239	217	155	-	-	-	-	
	FV	Monthly	Mental Health	30-Nov-25	-	30	32	28	-	-	-	-	
	FV	Monthly	SAS In Attendance	30-Nov-25	-	0	0	60	-	-	-	-	
	FV	Monthly	Remote Consultation	30-Nov-25	-	3	0	13	-	-	-	-	
OH2	FV	Monthly	Out of Hours % Rota Fill	30-Nov-25	-	96%	97%	98%	▼	-	-	-	

REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	NOTES
SCHEDULED CARE													
OUTPATIENTS													
SC1	SG	Monthly	Total Number of New Outpatients Waiting	30-Nov-25	Reduction	17,046	16,426	12,639	▼	-	-	✓	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 now monthly for SOT.
			Forth Valley	30-Nov-25	Reduction	16,738	16,153			-	-	-	
			Mutual Aid	30-Nov-25	Reduction	308	273			-	-	-	
SC2	SG	Monthly	Number of New Outpatients waiting over 12 weeks	30-Nov-25	Reduction	5,517	5,074	3,396	▼	-	-	✓	
			Forth Valley	30-Nov-25	Reduction	5,289	4,824			-	-	-	
			Mutual Aid	30-Nov-25	Reduction	228	250			-	-	-	
		Monthly	Number of New Outpatients waiting over 52 weeks	30-Nov-25	0	146	215	160	▲	-	-	✓	
			Forth Valley	30-Nov-25	0	45	39						
			Mutual Aid	30-Nov-25	0	101	176						
SC3	SG	Monthly	New Outpatients waiting under 12 weeks %	30-Nov-25	95%	67.6%	69.1%	73.1%	▼	42.8%	21-Oct-25	✓	
			Forth Valley	30-Nov-25	95%	68.4%	70.1%			-	-	-	
			Mutual Aid	30-Nov-25	95%	26.0%	8.4%			-	-	-	
SC6	Audit	Monthly	Outpatient Unavailability	30-Nov-25	Monitor	0.7%	0.6%	1.3%	▲	0.8%	30-Sep-25	✓	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	30-Nov-25	5%	4.3%	4.13%	4.4%	▲	6.3%	30-Sep-25	-	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	30-Nov-25	5%	4.8%	4.8%	5.3%	▲	-	-	-	
DIAGNOSTICS - Imaging													
SC10	SG	Monthly	Total number waiting - Imaging	31-Oct-25	Reduction	4,990	5,252	7,792	▲	-	-		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-Oct-25	0	2,166	2,149	4,187	▲	-	-	-	
SC12	SG	Monthly	Percentage waiting less than 42 days - Imaging	31-Oct-25	100%	56.6%	59.1%	46.3%	▲	57.7%	30-Sep-25	✓	
DIAGNOSTICS - Endoscopy													
SC15	SG	Monthly	Total number waiting - Endoscopy	31-Oct-25	Reduction	531	498	785	▲	-	-		
SC16	SG	Monthly	Number waiting beyond 42 days - Endoscopy	31-Oct-25	0	79	66	287	▲	-	-	-	
SC17	SG	Monthly	Percentage waiting less than 42 days - Endoscopy	31-Oct-25	100%	85.1%	86.7%	63.4%	▲	42.1%	30-Sep-25	✓	
CANCER													
SC20	SG	Monthly	62 Day Cancer Target - Percentage compliance against target	30-Sep-25	95%	85.3%	83.9%	84.1%	▲	69.9%	30-Sep-25	✓	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. 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. 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.
SC21	SG	Monthly	62 Day Cancer - Number seen within target against total	30-Sep-25	-	81/95	73/87	53/63	-	-	-	-	
	SG	Monthly	62 Day Cancer - Breast - Percentage compliance against target	30-Sep-25	95%	100.0%	94.7%	100.0%	▲	92.7%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Breast - Number seen within target against total	30-Sep-25	-	23/23	18/19	10/10	-	-	-	-	
	SG	Monthly	62 Day Cancer - Colorectal - Percentage compliance against target	30-Sep-25	95%	87.5%	83.3%	100.0%	▼	75.5%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Colorectal - Number seen within target against total	30-Sep-25	-	7/8	5/6	6/6	-	-	-	-	
	SG	Monthly	62 Day Cancer - Cervical - Percentage compliance against target	30-Sep-25	95%	n/a	n/a	50.0%	▲	50.0%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Cervical - Number seen within target against total	30-Sep-25	-	0/0	0/0	1/2	-	-	-	-	
	SG	Monthly	62 Day Cancer - Head & Neck - Percentage compliance against target	30-Sep-25	95%	57.1%	75.0%	66.7%	▼	66.2%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Head & Neck - Number seen within target against total	30-Sep-25	-	4/7	3/4	2/3	-	-	-	-	
	SG	Monthly	62 Day Cancer - Lung - Percentage compliance against target	30-Sep-25	95%	100.0%	83.3%	100.0%	◄►	81.2%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Lung - Number seen within target against total	30-Sep-25	-	12/12	10/12	5/5	-	-	-	-	
	SG	Monthly	62 Day Cancer - Lymphoma - Percentage compliance against target	30-Sep-25	95%	100.0%	100.0%	100.0%	▲	82.9%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Lymphoma - Number seen within target against total	30-Sep-25	-	3/3	2/2	1/1	-	-	-	-	
	SG	Monthly	62 Day Cancer - Melanoma - Percentage compliance against target	30-Sep-25	95%	100.0%	100.0%	100.0%	▲	80.7%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Melanoma - Number seen within target against total	30-Sep-25	-	7/7	6/6	2/2	-	-	-	-	
	SG	Monthly	62 Day Cancer - Ovarian - Percentage compliance against target	30-Sep-25	95%	100.0%	100.0%	50.0%	▲	84.0%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Ovarian - Number seen within target against total	30-Sep-25	-	3/3	4/4	1/2	-	-	-	-	
	SG	Monthly	62 Day Cancer - Upper GI - Percentage compliance against target	30-Sep-25	95%	84.6%	92.3%	80.0%	▲	84.2%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Upper GI - Number seen within target against total	30-Sep-25	-	11/13	12/13	8/10	-	-	-	-	
	SG	Monthly	62 Day Cancer - Urology - Percentage compliance against target	30-Sep-25	95%	57.9%	61.9%	77.3%	▼	42.8%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Urology - Number seen within target against total	30-Sep-25	-	11/19	13/21	17/22	-	-	-	-	
SC22	SG	Monthly	31 Day Cancer Target - Percentage compliance against target	30-Sep-25	95%	100.0%	100.0%	100.0%	◄►	95.6%	30-Sep-25	✓	
SC23	SG	Monthly	31 Day Cancer Target - Number seen within target against total	30-Sep-25	-	101/101	100/100	83/83	-	-	-	-	
SC24	SG	Quarterly	62 Day Cancer Target - Percentage compliance against target	30-Sep-25	95%	86.3%	72.4%	83.5%	▲	70.7%	30-Sep-25	✓	
SC25	SG	Quarterly	31 Day Cancer Target - Percentage compliance against target	30-Sep-25	95%	100.0%	100.0%	100.0%	◄►	95.1%	30-Sep-25	✓	

REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	NOTES
INPATIENTS & DAYCASES													
SC26	SG	Quarterly	Number of patients that waited >12 weeks - Completed Wait	30-Sep-25	0	2,054	1,972	1,490	-	-	-	-	
SC27	SG	Quarterly	% Compliance with 12 week TTG Standard	30-Sep-25	100%	33.6%	34.8%	44.1%	▼	56.7%	30-Sep-25	-	
SC28	SG	Monthly	Total Number of Inpatients/Day cases Waiting	30-Nov-25	Reduction	7,588	7,430	6,223	▼	-	-	✓	
			Forth Valley	30-Nov-25	Reduction	7,329	7,118		-	-	-	-	
			Mutual Aid	30-Nov-25	Reduction	67	44		-	-	-	-	
			NTC	30-Nov-25	Reduction	192	268		-	-	-	-	
SC29	SG	Monthly	Number of Inpatients/Day cases waiting over 12 weeks	30-Nov-25	Reduction	4,475	4,434	3,521	▼	-	-	✓	
			Forth Valley	30-Nov-25	Reduction	4,305	4,186		-	-	-	-	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
			Mutual Aid	30-Nov-25	Reduction	24	31		-	-	-	-	
			NTC	30-Nov-25	Reduction	146	217		-	-	-	-	
		Monthly	Number of Inpatients/Day cases waiting over 52 weeks	30-Nov-25	0	436	450	554	▲	-	-	✓	
			Forth Valley	30-Nov-25	0	399	399		-	-	-	-	
			Mutual Aid	30-Nov-25	0	2	7		-	-	-	-	
			NTC	30-Nov-25	0	35	44		-	-	-	-	
SC30	SG	Monthly	Percentage of Inpatients/Day cases waiting under 12 weeks	30-Nov-25	100%	41.0%	40.3%	43.4%	▼	35.6%	30-Sep-25	✓	
			Forth Valley	30-Nov-25	100%	41.3%	41.2%		-	-	-	-	
			Mutual Aid	30-Nov-25	100%	64.2%	29.5%		-	-	-	-	
			NTC	30-Nov-25	100%	24.0%	19.0%		-	-	-	-	
SC33	Audit	Monthly	Inpatient/Day case Unavailability	30-Nov-25	Monitor	3.6%	3.5%	5.9%	▲	3.8%	30-Sep-25	✓	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	30-Nov-25	Reduction	2.5%	2.3%	2.2%	▼	-	-	-	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	30-Nov-25	Reduction	5.9%	5.9%	5.6%	▼	-	-	-	
R3	FV	Monthly	Readmissions - Medical 7 day	30-Nov-25	Reduction	1.6%	2.0%	1.9%	▲	-	-	-	
R4	FV	Monthly	Readmissions - Medical 28 day	30-Nov-25	Reduction	4.5%	5.6%	4.7%	▲	-	-	-	
MENTAL HEALTH													
PSYCHOLOGICAL THERAPIES													
MH1	SG	Monthly	Psychological Therapies - 18 week RTT compliance	31-Oct-25	90%	77.0%	83.1%	72.6%	▲	81.2%	30-Sep-25	✓	
MH2	FV	Monthly	Total Number Waiting for Pyschological Therapies Initial Assessment	31-Oct-25	Reduction	986	936	855	▼	-	-	-	
MH3	SG	Quarterly	Psychological Therapies - 18 week RTT compliance	30-Sep-25	90%	77.1%	72.1%	73.2%	▲	80.7%	30-Sep-25	✓	
CHILD & ADOLESCENT MENTAL HEALTH SERVICES													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.
MH4	SG	Monthly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Oct-25	90%	100.0%	100.0%	96.5%	▲	92.7%	30-Sep-25	✓	
MH5	FV	Monthly	Total Number Waiting for CAMHS Initial Assessment	31-Oct-25	Reduction	109	104	50	▼	-	-	-	
MH6	SG	Quarterly	Child & Adolescent Mental Health Services - 18 week RTT compliance	30-Sep-25	90%	99.4%	99.6%	99.2%	▲	91.6%	30-Sep-25	✓	
SUBSTANCE USE													
SM1	SG	Quaterly	% Compliance with the 3 Week target - ADP (excluding Prisons)	30-Jun-25	90%	100.0%	98.5%	94.0%	▲	94.3%	30-Jun-25	✓	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-Jun-25	90%	98.5%	98.9%	98.9%	▼	94.4%	30-Jun-25	✓	
COMPLAINTS													
C1		Monthly	% Compliance Forth Valley (inc. prisons)	31-Oct-25	100%	77.4%	74.9%	68.8%	▲	-	-	✓	Complaints monitoring and feedback is a standing item on the Clinical Governance Committee agenda
C2		Monthly	% Compliance Stage 1 (inc. prisons)	31-Oct-25	100%	86.8%	71.3%	67.4%	▲	-	-	✓	
C3		Monthly	% Compliance Stage 2 (inc. prisons)	31-Oct-25	100%	39.5%	31.3%	25.7%	▲	-	-	✓	

REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	
WF3	SG	Monthly	Overall Absence	31-Oct-25	4.0%	8.38%	8.33%	7.60%	▼	6.39%	30-Sep-25	✓	Hours lost due to sickness absence / total hours available (%). Short Term Absence - a period of sickness absence of 28 days or less Long Term Absence - a period of sickness absence lasting over 28 days Absence Management is a standing item on the Staff Governance Committee agenda.
WF4	FV	Monthly	Short Term Absence	31-Oct-25	-	2.51%	2.65%	2.58%	▲	-	-	-	
WF5	FV	Monthly	Long Term Absence	31-Oct-25	-	5.86%	5.69%	5.01%	▼	-	-	-	
WF6	FV	Rolling 12 mth	Overall Absence	30-Sep-25	-	7.69%	7.78%	7.62%	▼	6.37%	30-Sep-25	-	
							BETTER VALUE						
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	
DELAYED DISCHARGES													
VA1	FV	Monthly	Delayed Discharges - excl. Code 9 & Guardianship (Standard Delays)	30-Nov-25	Reduction	57	52	82	▲	-	-	✓	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	30-Nov-25	Reduction	37	32	59	▲	-	-	✓	
			Clackmannanshire	30-Nov-25	Reduction	10	11	11	▲	-	-	✓	
			Stirling	30-Nov-25	Reduction	7	7	9	▲	-	-	✓	
			Outwith Forth Valley	30-Nov-25	Reduction	3	2	3	◄►	-	-	✓	
VA2	FV		Code 9 & Guardianship Delays	30-Nov-25	Reduction	60	58	52	▼	-	-	✓	
			Falkirk	30-Nov-25	Reduction	29	30	19	▼	-	-	✓	
			Clackmannanshire	30-Nov-25	Reduction	13	10	10	▼	-	-	✓	
			Stirling	30-Nov-25	Reduction	16	16	18	▲	-	-	✓	
			Outwith Forth Valley	30-Nov-25	Reduction	2	2	5	▲	-	-	✓	
VA3	FV		Total Bed Days Occupied by Delayed Discharges (Standard Delays)	30-Nov-25	Reduction	2,886	1,820	3,276	▲	-	-	✓	
			Falkirk	30-Nov-25	Reduction	2,260	1,152	2,005	▼	-	-	✓	
			Clackmannanshire	30-Nov-25	Reduction	284	411	658	▲	-	-	✓	
			Stirling	30-Nov-25	Reduction	281	240	266	▼	-	-	✓	
			Outwith Forth Valley	30-Nov-25	Reduction	61	17	347	▲	-	-	✓	
VA4	FV	Daily	Number waiting for a Community Bed	30-Nov-25	Reduction	33	40	51	▲	-	-	-	
AVERAGE LENGTH OF STAY													
VA4	FV	Monthly	FVRH Acute Wards Average Length of Stay (Days)	30-Nov-25	Reduction	6.18	6.19	6.37	▲	-	-	-	This is the mean length of stay (in days) experienced by inpatients in FVRH Acute wards, does not include MH or W&C.
EFFICIENCY													
E1	FV	Monthly	ED Attendances per 100,000 of the population - Forth Valley	30-Nov-25	Reduction	1,791	1,741	1,593	▼	-	-	-	
E2	FV	Rolling 12 mth	Acute Emergency Bed days per 1,000 population - Forth Valley	30-Nov-25	Reduction	716	779	805	▲	-	-	-	
E3	FV	Monthly	% Bed Occupancy - FVRH	30-Nov-25	Reduction	102.8%	102.4%	106.7%	▲	-	-	-	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	30-Nov-25	Reduction	84.0%	81.2%	107.0%	▲	-	-	-	
E5	FV	Monthly	% Bed Occupancy - ICU	30-Nov-25	Reduction	104.2%	86.8%	93.7%	▼	-	-	-	
EQUITABLE													
EQ1		Rolling 3 year	Scottish Breast Screening Programme	2020/23	70%	76.4%	74.4%	76.4%	◄►	75.9%	2020/23	-	Percentage uptake (three-year rolling periods), females aged 50-70 years
EQ2		Annually	Scottish Cervical Screening Programme	2023/2024	-	66.9%	66.3%	72.5%	▼	63.3%	2023/24	-	The percentage of eligible women who are up-to-date with their screening participation
EQ3		Rolling 2 year	Scottish Bowel Screening Programme	2022/24	60%	66.2%	66.6%	66.6%	▼	65.7%	2022/24	-	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) screening programme	2023/24	75%	73.4%	24.1%	24.1%	▲	77.3%	2023/24	-	Percentage of eligible population who are tested before age 66 and 3 months
		Annually	Surveillance AAA scan (quarterly)	2023/24	90%	100.0%	84.4%	81.0%	▲	94.3%	2023/24	-	Due to attend quarterly surveillance and tested within 4 weeks of due date
		Annually	Surveillance AAA scan (annually)	2023/24	90%	91.8%	84.4%	84.4%	▲	94.4%	2023/24	-	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	31-Mar-25	87	57	51	79	▼	-	-	-	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	31-Mar-25	100%	66.0%	59.0%	91.1%	▼	64.0%	31-Dec-24	-	
FINANCE													
F1	SG	FYTD	Year to date revenue position	31-Oct-25	Breakeven	-£4.56m	-£6.522m	-£18.162m	▲	-	-	-	

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	

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	☑		☑	☑	☑	☑	☑
Directions (as required)	☑		☑	☑	☑	☑	☑
HSCP Annual Performance Reports					☑		
Strategy							
Access Policy			☑				
Annual Delivery Plan 2025/2026 (including Workforce Plan)			☑				
Anti-Racism Strategy						☑	

Communications Priorities – Annual Update							☑
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			☑				
Risk Management Framework							
Risk Appetite & Tolerance							
Whole System Plan – tbc							
Winter Plan					☑		
Performance & Finance							
Annual Accounts		☑					
Draft Financial Plan 2025/2026							☑
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							