

A meeting of the **Forth Valley NHS Board** will be held on **Tuesday 31 March 2026** at **9.15am** in the **Boardroom, Carseview House, Castle Business Park, Stirling FK9 4SW**.

Neena Mahal
Chair

AGENDA

| | | | |
|--|--|---|--------------|
| 1. | Welcome, Apologies and Confirmation of Quorum | | 09.15 |
| 2. | Declaration(s) of Interest(s) | | |
| FOR APPROVAL | | | |
| 3. | <u>Draft Financial Plan</u> (Paper presented by Mr Scott Urquhart, Director of Finance) | For Decision Pages 4 to 32 | |
| 4. | <u>NHS Forth Valley Corporate Objectives</u> (Paper presented by Professor Ross McGuffie, Chief Executive) | For Decision Pages 33 to 38 | 9.30 |
| 5. | <u>Whole System Urgent and Unscheduled Care Plan</u> (Paper presented by Ms Gail Woodcock, Chief Officer – Falkirk IJB) | For Decision Pages 39 to 120 | 9.45 |
| 6. | <u>Governance Report</u> (a) Clackmannanshire & Stirling IJB – Chair Appointment (b) Appointments Report (Papers presented by Mr Jack Frawley, Board Secretary) | For Ratification For Decision Pages 121 to 132 | |
| 7. ANY OTHER COMPETENT BUSINESS | | | |
| 8. RISKS AND REFLECTIONS | | | |
| 9. | Date and Time of Next Meeting Tuesday 28 April, 9.30am | For Noting | |
| | Business Taken in Private Session In terms of section 5.22 of the Code of Corporate Governance, the Board will resolve into private session on the grounds that in respect of the following item of business the Board is still in the process of developing proposals or its position on certain matters and needs time for private deliberation. | For Decision | |
| 10. | Draft Sub-National Plan 2026/27 (Paper presented by Professor Ross McGuffie, Chief Executive) | For Noting | |

| | | | | | | | | |
|--|---|---|---|---|---|---|---|---|
| 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

Executive Sponsor: Ross McGuffie, Chief Executive

Author: Scott Urquhart, Director of Finance / Jillian Thomson, Deputy Director of Finance

Executive Summary

This paper presents the 3-year financial plan covering the period from 2026/27 to 2028/29.

Based on known and anticipated planning assumptions, the financial plan for 2026/27 forecasts a break-even position. This is dependent on the delivery of £38m of savings. Achieving savings on this scale will require sustained organisational focus and the continued application of rigorous financial controls, alongside detailed scrutiny of the in-year financial position. For years two and three of the plan, there is a higher degree of uncertainty on future funding settlements, inflationary pressures, new and emerging cost drivers and the scale and timing of potential savings opportunities (including sub-national planning impact). As a result, the provisional planning parameters for these years are inherently more volatile, and a prudent approach has therefore been applied in developing plans for latter years, recognising the associated financial risks. Further detail is provided in appendix 1.

The plan reflects feedback from the Scottish Government on the earlier draft submitted in February together with a number of changes in funding assumptions and costs which have been confirmed in the last month. The plan also reflects the refreshed 15 box grid and associated actions issued by the Scottish Government on 27 February 2026 (see appendix 2).

Action Required

Forth Valley NHS Board is asked to:

- (1) approve the 3-year financial plan, noting the key financial planning assumptions and estimates applied.
- (2) note the significant level of financial challenge identified and the associated risk to delivery of financial balance during the 3-year period.
- (3) approve the proposed payments to IJBs for financial year 2026/27 which reflect the agreed uplift as advised by the Scottish Government.
- (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.

- The SPP&RC and the NHS Board receive regular updates on the financial position, plans and risk as a standing agenda item.
- 2 dedicated NHS Board seminars were held on 10 February and 3 March 2026 to discuss the development of the financial plan.

Risk Assessment and Mitigation

Financial sustainability continues to be reported as very high risk in the NHS Board's strategic risk register.

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

Capital and Revenue financial implications are considered in appendix 1. There are no immediate infrastructure or digital implications associated with this report. However, it is recognised that digital innovation is a key enabler of transformation and reform of service delivery in terms of enhanced patient experience and improved efficiency and productivity.

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. As such, workforce optimisation continues to be a key feature of our Financial Sustainability Action Plan.

Quality / Patient Care Implications

It is imperative that quality of care and overall service provision is underpinned by a sustainable medium term financial strategy aligned to the principles of Value Based Health and Care.

Population Health & Care Strategy

The medium-term financial strategy outlines the total resources available to meet the NHS Board's strategic priorities over the next 3 years. It is essential that strategic priorities are delivered on a sustainable financial basis. 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 Value Based Health and Care 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 Financial Sustainability Action Plan.

Engagement and Communications

Was statutory engagement with stakeholders required? Yes No

The 3-year financial plan was prepared through engagement with the NHS Board and Senior Leadership Team colleagues.

Appendices

Appendix 1 – 3-year financial plan 2026/27 to 2028/29

Appendix 2 – refreshed 15 box grid 2026/27

**Promoting
Stewardship**

**Maximising
Value**

**Reducing
Waste**

3 YEAR FINANCIAL PLAN 2026/27 TO 2028/29

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1. Executive Summary

This document outlines the NHS Board's 3-year financial plan covering the period from 2026/27 to 2028/29.

The plan sets out the total resources expected to be available to support the NHS Board's strategic priorities over the next 3 years, alongside planned expenditure commitments and associated cost improvement plans. It has been developed through engagement with the NHS Board and Senior Leadership Team colleagues.

A draft Financial Plan was submitted to the Scottish Government in early February 2026, based on the one-year funding settlement announced in January 2026 and incorporating the key planning requirements which were issued to NHS Boards in December 2025. Subsequent feedback was used to inform this final version of the plan.

The financial position over the next three-year period remains very challenging and there are a range of risks associated with key cost drivers which may impact on planned spending assumptions and parameters, particularly across years two and three of the plan where there is less detailed planning information available. These include:

- the underlying financial position and the level of efficiency savings required to deliver breakeven,
- ongoing capacity and workforce pressures (including the service impact of the reduction in the working week and safe staffing legislation),
- the cost impact of advances in new technology and medical treatments (including uptake of expensive new drugs and devices),
- the cumulative burden of a range of unfunded national policy developments together with other mandatory compliance/legislative requirements and
- general price inflation (primarily in relation to IT and premises related contracts).

Based on known and anticipated planning assumptions, the financial plan for 2026/27 forecasts a break-even position. This is dependent on the delivery of £38m of savings. Achieving savings on this scale will require sustained organisational focus and the continued application of rigorous financial controls, alongside detailed scrutiny of the in-year financial position. Progress in delivering savings will continue to be overseen through the Financial Stewardship Programme Board, with regular updates provided to the NHS Board and the Strategic Planning, Performance and Resources Committee meetings.

For years two and three of the plan, (2027/28 and 2028/29) there is a higher degree of uncertainty reflecting all key assumptions including future funding settlements, inflationary pressures, the impact of key cost drivers, and the scale and timing of potential savings opportunities including sub-national planning impact. As a result, the provisional planning parameters for these years are inherently more volatile, and a prudent approach has therefore been applied in developing plans, recognising the associated financial risks. For planning purposes, deficit positions of approximately 2.1% and 2.8% of core budgets are currently forecast for 2027/28 and 2028/29 respectively. These assumptions will be kept under active review and the position is expected to improve as greater clarity emerges on the underlying assumptions.

2. Local financial context

Financial sustainability remains one of the highest strategic risks for NHS Forth Valley and mitigating actions continue to be prioritised and delivered through the Financial Stewardship Programme Board.

Whilst breakeven is currently forecast for the current financial year 2025/26, this masks a number of material budget pressures and there remains a significant underlying recurring financial gap carried forward to 2026/27. This reflects pressures in medical pay costs, unfunded service areas, delays in achieving recurring efficiency savings, the cost impact of new drugs and devices (particularly in relation to the uptake of new oncology drugs and diabetes technology such as insulin pumps and continuous glucose monitors) and unavoidable inflationary costs in diagnostic supplies budgets and IT contracts.

In recent years, achievement of financial targets has been reliant on non-recurring measures including identification of one-off efficiency savings, receipt of additional unplanned funding from the Scottish Government and fortuitous benefits arising from various changes in financial planning assumptions. Whilst these measures have enabled financial targets to be delivered in year, it is recognised that they do not address recurring budget shortfalls and longer-term financial sustainability. It is clear that service redesign and reform of our services, alongside a shift in resources towards prevention and early intervention during 2026/27 and beyond, is essential. This will be taken forward under a Value Based Health and Care approach and will require challenging decisions to be taken on priorities and disinvestment to deliver cost savings, improve value for money and maximise outcomes for patients and service users.

3. Sub-national planning

[DL\(2025\)25](#) sets out the implementation arrangements for the Sub-National Planning: Co-operation and Planning Directions which came into force on 13 November 2025. The Directions support a move from organisation level planning to population-based planning and supersede HDL(2004)46 on Regional Planning.

Under the Directions, Health Boards are to organise into two sub-national structures: **Scotland East** and **Scotland West** and should work collaboratively to ensure equitable access to services based on population need under a “Once for Scotland” model. A consolidated financial plan for each of these two new structures must be produced for 2026-27 and submitted to the Scottish Government by 31 March 2026. As a member of Scotland West, a copy of the Scotland West sub-national strategic plan will be presented to the NHS Board for approval.

4. Financial planning assumptions

The 3-year financial plan is predicated on a number of financial planning assumptions and estimates. All assumptions have been benchmarked nationally through the Peer Review sub-group of the Corporate Finance Network and amended to reflect local circumstances and risk where appropriate.

4.1. Funding

The plan incorporates the indicative one-year funding settlement for 2026/27 advised by the Scottish Government on 13 January 2026. This confirmed a 2% baseline budget uplift, together with other recurring pay-related allocations for Agenda for Change (AfC) staff, increasing our initial Revenue Resource Limit (RRL) by £32.1m to £818.7m as summarised in exhibit 1 overleaf.

In line with previous years, a range of further separate non-recurring allocations are expected to be added to the 2026/27 RRL during the course of the year in relation to a number of specific policy areas including the Operational Improvement Plan (£100m nationally), the New Medicines Fund (£250m nationally) and Sustainability Funding (£150m nationally). When all separate anticipated allocations are added to the baseline budget, our total overall RRL is expected to equal £919.9m for 2026/27. In terms of future years, a 2% uplift to the baseline RRL is assumed in 2027/28 and 2028/29 for planning purposes.

| Exhibit 1: NHS Board Initial Revenue Allocation 2026/27 | |
|--|----------------|
| | £ million |
| Baseline budget: 2025/26 Revenue Allocation | 786.599 |
| 2.0% Core uplift | 15.732 |
| NRAC Funding | 0.000 |
| 26-27 Agenda for Change Reform | 8.200 |
| 26-27 Additional Pay Inflation (above baseline 2%) | 8.135 |
| 26-27 Uplifts | 32.067 |
| Total Initial Budget 2026/27 | 818.666 |

4.2. Inflation estimates

The 3-year plan is based on a number of cost inflation assumptions as summarised in exhibit 2 below. For context, and as part of scenario planning, exhibit 2 overleaf also illustrates the financial impact of a 1% change in inflationary assumptions (for example every 1% change in overall total pay cost assumptions equates to £3.5m).

The 2026/27 pay award for AfC has been agreed at 3.75% (but remains subject to review to ensure the final pay award remains 1% above inflation), pay awards for all other staff groups is assumed at 3% in line with the public sector pay policy. We continue to plan on the basis that the cost impact of pay awards will be fully funded as advised by the Scottish Government. Similarly, we continue to assume that the cost impact associated with the ongoing reform of AfC terms and conditions (i.e. the further 1-hour reduction in the working week from 1 April 2026 and the ongoing impact band 5 to 6 nurse grading reviews) will also be fully funded.

| Exhibit 2: Cost inflation estimates 2026/27 | Funding uplift/ Inflation Projections % | Funding uplift/ Inflation Projections £ | £m impact per 1% variance |
|---|--|--|--|
| Analysis of NHS Core & Set Aside Inflation | | | |
| Pay Inflation - Agenda for Change | 3.75% | 9.380 | 2.501 |
| Pay Inflation - Medical | 3.00% | 2.812 | 0.937 |
| Pay Inflation - Senior Managers | 3.00% | 0.066 | 0.022 |
| Pay Inflation - Other | 3.00% | 0.079 | 0.026 |
| External CBF Outflow | 3.50% | 2.467 | 0.705 |
| Unitary Charge Inflation | 4.25% | 2.374 | 0.559 |
| Hospital Drugs | 8.00% | 2.995 | 0.374 |
| Capital Charges | 2.00% | 0.393 | 0.196 |
| Energy | 0.00% | 0.000 | 0.121 |
| Rates | 12.51% | 0.934 | 0.075 |
| Voluntary Bodies / other providers | 2.00% | 0.008 | 0.004 |
| General Price Inflation | 2.00% | 0.868 | 0.434 |
| Other | 3.62% | 0.859 | 0.238 |
| External CBF Inflow | 3.50% | (0.566) | (0.162) |
| General Income Inflation | 0.00% | 0.000 | (0.216) |
| Total for NHS Core & Set Aside | 3.90% | 22.669 | 5.815 |

Inflationary pressures on a range of contracts which are linked to RPI (most notably our 3 PFI/PPP contracts) are included in the plan. Our current estimate of the likely RPI is 4.25% which equates to a £2.4m increase in estimated unitary charge payments during 2026/27. 5% is assumed for years 2 and 3. A 3.5% uplift is budgeted for national IT contracts in 2026/27, this emphasises the need to maximise the potential of these systems to ensure that we avoid paying for functionality that is not used.

For other premises costs, no uplift is assumed in relation to energy costs for 2026/27. Note that the national planning assumption for energy costs suggested a potential 8.87% reduction (based on raw commodity costs¹ with 67% of electricity and 55% of gas already purchased in advance for 2026/27 under national contracts), this will be kept under review. A 5% uplift is assumed for future years. In terms of non-domestic rates, new rateable values will come into effect from 1 April 2026, with draft figures from the Scottish Assessor suggesting an overall average increase of 12.23%. This will be offset by a c3.4% reduction in the basic, intermediate and higher poundage multipliers. This has been reflected in the plan for 2026/27, with a 5% uplift applied in future years.

Hospital prescribed drugs are expected to rise by 8% annually over the term of the plan. Further horizon scanning work is underway to refine this estimate (local expenditure growth has been closer to 11% in recent years, however due to the anticipated positive impact of the Acute medicines efficiency savings plan, coupled with the new medicines fund allocation and rebates, 8% is considered a reasonable planning assumption at this stage).

¹ Raw commodity costs account for c60% of our energy bill.

4.3. Proposed IJB payments

The Scottish Government has advised that payments to Integration Joint Boards (IJBs) in respect of delegated health functions in 2026/27 should be additional and not substitutional to 2025-26 budgets. It is therefore assumed that the 2% RRL uplift (equivalent to £5.8m) will be passed over to IJBs in full. Exhibit 3 overleaf sets out the proposed initial payment to both IJBs.

Note that further payments are expected to be made to the IJBs during 2026/27 once funding is confirmed for various delegated Health and Social Care policy developments and other relevant ring-fenced areas which are not part of the baseline RRL. A number of these allocations remain subject to national negotiation and/or Scottish Government approval (for example agreed uplifts for Family Health Service contractors such as GP Practices) and are allocated later in the year.

At present the budget for Prison Healthcare Services is not delegated to IJBs. This is expected to be formally delegated to Falkirk IJB during 2026/27 pending Ministerial approval of the revised Integration Scheme.

| Exhibit 3: IJB Initial Payments | | |
|--|----------------|-----------------------------|
| Category | Falkirk | Clacks/ Stirling |
| | £ million | £ million |
| <u>Baseline budget: 2025/26 Revenue Allocation</u> | | |
| Set Aside | 47.159 | 37.585 |
| Operational budgets | 74.209 | 60.215 |
| Universal budgets (Prescribing / Family Health Services) | 33.688 | 32.833 |
| Transformation Funding | 0.765 | 3.405 |
| | <hr/> | <hr/> |
| | 155.821 | 134.038 |
| 2% Core Uplift | 3.116 | 2.681 |
| Universal Funding outwith recurrent baseline | 58.308 | 61.175 |
| | <hr/> | <hr/> |
| Total Initial Budget 2026/27 | 217.246 | 197.893 |

In line with previous years, further funding will also be transferred from the health portfolio to Local Government to support Health and Social Care Integration, specifically in relation to the recurring pay commitments associated with the real living wage (£160.0m nationally) and increases to free personal nursing care rates (£7.0m nationally).

Additional investment to support improvements to wider terms and conditions for Adult Social Care workers and support for advocacy within social care, as well as investment to support a digital telecare pilot as part of commitment to remove non-residential charges will also be allocated in 2026/27. The Scottish Government has advised that further information on this will be provided on this in due course.

The funding position presented in exhibit 3 is consistent with the funding assumptions applied by the IJBs as part of their financial planning processes. Note that both IJBs have identified significant financial gaps for 2026/27 and beyond. Whilst the HSCPs have

developed savings plans to reduce projected budget deficits as far as possible (recognising that whole system reform and transformation is required to deliver longer term financial balance on a sustainable footing), both IJBs have indicated that the lead in time required to deliver the necessary transformation programme may require recovery plans and potential risk sharing arrangements to be enacted during 2026/27. No risk share assumptions have been included in the 3-year financial plan at this stage. The position will be kept under review in conjunction with IJB Chief Finance Officers.

4.4. Savings plans

In line with previous years, the Scottish Government has set a 3% recurring savings target on baseline budgets (including those budgets delegated to IJBs) which equates to £24.6m in 2026/27. The Board's share of the target is £18.4m with the balance of £6.2m relating directly to IJBs.

Table 2 below, summarises the programme of work and supporting actions to deliver £38.0m of savings in respect of Set Aside and non-delegated functions during 2026/27. This is aligned to the refreshed 15 box grid. Implementation and progress will continue to be overseen by the Financial Stewardship Programme Board.

Of the £38.0m total targeted saving, c£23.0m (60%) is expected to be delivered on a recurring basis (which exceeds the £18.4m Board share of the 3% Scottish Government target), with the balance of £15.0m relating to various non-recurring measures and one-off funding sources.

Note that c£4.2m of savings have still to be fully identified and risk assessed at this stage, this will be closely monitored as the plan is implemented.

A high-level summary of each workstream is provided below (see further detail in appendix A):

- **Service Sustainability (Operational Improvement Plan)** – savings reported under this workstream are linked to **Theatres Optimisation**, including implementation of the CfSD [Framework](#) for Perioperative Services in Scotland, reducing unproductive theatre hours and the roll out of digital theatre scheduling tools. Reducing **Length of Stay** and applying discharge without delay principles to improve productivity are also included in this workstream, as is **Prescribing Optimisation** in terms of technical switches and reducing waste.
- **Reform Priorities (Service Renewal Framework)** – various efficiencies are reported under this workstream relating to **Shifting the Balance of Care**, including the expansion of Hospital at Home and closure of ward A11. Use of **Digital First** options to deliver care is also included with an emphasis on enhancing productivity and reducing costs (eg increasing uptake of Near Me/remote outpatient appointments, implementation of Digital Front Door and reducing printing and stationery costs).
- **Prevention (Population Health Framework)** – savings reported under this workstream are linked to improvement actions to reduce unwarranted variation, ongoing rollout of the **Value Based Health and Care** programme and implementation of tests of change in relation to **prevention** and early intervention.

| TABLE 2: 2026/27 Financial Sustainability Action Plan | Annual plan £000s |
|---|------------------------------|
| 15 Box Grid: Service Sustainability (Operational Improvement Plan) | |
| Theatres Optimisation | 90 |
| Length of Stay | 125 |
| Prescribing Optimisation | 4,847 |
| Sub total: Service sustainability (OIP) | 5,062 |
| | |
| 15 Box Grid: Reform Priorities (Service Renewal Framework) | |
| Shifting the Balance of Care | 2,274 |
| Digital Programmes | 608 |
| Patient Level Information & Costing System (PLICS) | 875 |
| Sub total: Reform Priorities (SRF) | 3,757 |
| | |
| 15 Box Grid: Prevention (Population Health Framework) | |
| Value Based Health & Care | 1,562 |
| Sub total: Prevention (PHF) | 1,562 |
| | |
| 15 Box Grid: Workforce | |
| Supplementary Staffing | 4,731 |
| Business Services | 4 |
| Attendance Promotion | 500 |
| Sub total: Workforce | 5,235 |
| | |
| 15 Box Grid: Financial Management | |
| Contract Management | 618 |
| Transport | 1,287 |
| Estates & Facilities | 2,100 |
| Sub total: Financial Management | 4,005 |
| | |
| Other local savings plans | |
| Facilities | 12 |
| Digital | 901 |
| Service reform & redesign | 2,457 |
| Procurement | 101 |
| Workforce | 1,835 |
| Non-pay | 8,870 |
| Savings still to be identified | 4,239 |
| sub total: Other local savings plans | 18,415 |
| | |
| TOTAL | 38,036 |
| | |
| Recurring | 22,954 |
| Non-recurring | 15,082 |
| TOTAL | 38,036 |

- **Workforce** – the majority of the savings reported under this workstream have been carried forward from the previous year in relation to reducing costs associated with **supplementary staffing** and sickness absence. An invest to save scheme is currently being implemented to provide dedicated HR resource to support staff to return to work and **promote attendance**. Savings under this workstream also include efficiencies linked to the **Business Systems** Transformation Project.
- **Financial Management** – a range of savings plans linked to **contract management** (in terms of reducing contract leakage and improving contract monitoring) and a review of **transport** costs (including non-emergency patient transport, fleet, car leasing and logistics) are included in this workstream. **Estates** savings to cut clinical waste, improve energy efficiency and reduce our premises footprint are also reported here.
- **Other Local Savings Plans** – this workstream is comprised of a number of other local schemes that are not part of the 15 box grid, including schemes carried forward from 2025/26 due to delays in implementation and new initiatives relating to service redesign and anticipated changes in financial planning assumptions.
- **Savings under development** – these savings have still to be fully identified at this stage.

5. Three-year revenue projection

Based on the financial planning assumptions set out in this document, together with our assessment of the impact of recurring pressures and unachieved recurring savings carried forward from prior years, an underlying recurring deficit of £42.7m has been identified for 2026/27 (5.2% of our core RRL) as set out in table 3 below (see further details in appendix B):

| Table 3: 3 year revenue projection | 2026/27 | | | 2027/28 | | | 2028/29 | | |
|------------------------------------|-----------------|---------------|--------------|-----------------|---------------|-----------------|-----------------|---------------|-----------------|
| | Rec £m | Non-Rec £m | Total £m | Rec £m | Non-Rec £m | Total £m | Rec £m | Non-Rec £m | Total £m |
| Financial gap before savings | (42.654) | 4.618 | (38.036) | (34.056) | (3.534) | (37.590) | (40.836) | (2.050) | (42.886) |
| Savings plans/targets | 22.954 | 15.082 | 38.036 | 10.000 | 8.365 | 18.365 | 11.000 | 5.432 | 16.432 |
| Residual deficit | (19.700) | 19.700 | 0.000 | (24.056) | 4.831 | (19.225) | (29.836) | 3.382 | (26.454) |

Achieving breakeven in 2026/27 is dependent on the delivery of £38m of savings. Achievement of savings on this scale will require sustained organisational focus and the continued application of rigorous financial controls, alongside detailed scrutiny of the in-year financial position.

With respect to estimates for 2027/28 and 2028/29 a range of scenarios relating to funding settlements, inflationary uplifts and the pace of service reform/likely savings achievement have been modelled reflecting the level of uncertainty in key planning parameters for future years. Net deficits of £19m in 2027/28 and £26m in 2028/29 are currently projected (equivalent to 2.1% and 2.8% of core budgets respectively). The scale of the financial pressure we are facing over the next 3 years is significant and it is recognised that it will be extremely challenging to deliver recurring financial balance by the end of the 3-year term of the plan without fundamental service redesign and reform. The projections for latter years will be kept under active review as greater clarity emerges on the underlying assumptions and associated financial risks.

6. Three-year capital projection

The core Capital formula allocation has been confirmed at £6.7m pa for the for the duration of the 3-year plan. The formula allocation is expected to be supplemented by additional anticipated allocations relating to property sales and the return of banked monies linked to slippage on various projects from prior years (eg delays in implementing the national Laboratory Information Management System and previously approved “Business Continuity Plan” or BCP schemes). Note that no additional funding is assumed from the National Infrastructure Board at this stage.

Key investments been prioritised in the following areas:

- Information Management and Technology to support software replacement and upgrades, introduction/replacement of new national and local systems and various digital innovation developments (including electronic patient records).
- Medical Equipment: on new and replacement key medical equipment items as advised by the Medical Devices Group and prioritised in line with the agreed rolling replacement programme.
- Facilities and Infrastructure: to support a range of projects aimed at statutory compliance, backlog maintenance, energy efficiency and a limited range of premises improvements.
- Board wide/corporate projects: a small contingency balance is being held across all years.

A summary of the 3-year projection is outlined in table 4 below (see further detail in appendix C):

| Table 4: NHS Forth Valley 3-year capital projection | 2026/27 £m | 2027/28 £m | 2028/29 £m |
|--|-----------------------|-----------------------|-----------------------|
| Capital Resource Limit (CRL) | 6.708 | 6.708 | 6.708 |
| Anticipated CRL allocations | 4.265 | 0.400 | |
| Sale of property proceeds | 3.000 | | |
| Total estimated Capital funding | 13.973 | 7.108 | 6.708 |
| <u>Planned expenditure</u> | | | |
| IM&T | 5.643 | 2.355 | 1.844 |
| Medical Devices | 2.804 | 3.225 | 1.965 |
| Estates & Facilities | 5.052 | 1.259 | 1.177 |
| Board/Corporate projects & contingency | 0.474 | 0.269 | 1.722 |
| Total estimated capital expenditure | 13.973 | 7.108 | 6.708 |
| Projected surplus/(deficit) | 0.000 | 0.000 | 0.000 |

In addition to the above, an update to the BCP return originally submitted in November 2025 to the Scottish Government in line with the new NHS Scotland strategic infrastructure planning and investment process has been completed which indicates that £3.550m is required for 2026/27 (this compares to the original estimate of £2.188m).

The BCP submission is primarily a maintenance-only plan based on a risk-based assessment of the Board’s existing infrastructure and covers 24 key projects (including the technical accounting treatment relating to right of use assets). A new BCP sub mission will be due to the submitted in November 2026, updated estimates are highlighted in table 5 below.

| Table 5: Updated NHS Forth Valley BCP submission | 2026/27 £m | 2027/28 £m | 2028/29 £m |
|---|-----------------------|-----------------------|-----------------------|
| <u>Funding requested:</u> | | | |
| Information Management & Technology | | | |
| Medical Equipment | | | |
| Facilities & Infrastructure | 2.420 | | |
| Board wide /corporate | 1.130 | 1.318 | 1.427 |
| Total current BCP estimate | 3.550 | 1.318 | 1.427 |

7. Key risks

In light of the scale of the financial challenge described in this document, together with ongoing uncertainty linked to the current economic climate, financial sustainability continues to be reported as very high risk in our strategic risk register.

Specific risks associated with the 3-year financial plan include:

- Our ability to deliver the level of recurring savings required in 2026/27 and beyond to address the underlying deficit and return to recurring financial balance by the end of 2028/29
- Potential delays in delivering efficiency savings due to the lead in time necessary to develop and implement the associated project plans, coupled with the limited availability of key staff to drive progress if they continue to be required to focus on immediate front-line service and capacity pressures.
- Workforce pressures, including the uncertainty regarding the financial impact of safe staffing legislation, ongoing AfC reform (particularly in relation to band 5 to 6 grading reviews) and pay awards. The reduction in the working week together with wider recruitment and retention challenges may also impact on our ability to successfully implement our workforce plan, resulting in continued use of temporary bank and agency staffing solutions.
- Ongoing delays in implementing exit strategies in respect of unfunded service areas (including Covid legacy costs, historic unfunded posts alongside the cumulative burden of a number of unfunded national policy commitments).

- Ongoing whole-system capacity and workforce pressures across the entire health and social care sector is likely to continue which may impact on our ability to close remaining contingency beds.
- Ongoing uncertainty regarding the geopolitical landscape and price inflation which has a direct impact on the cost of goods and services (particularly in relation to contracts which are linked to the Retail Price Index). A number of national contracts in respect of IT and other managed service contracts are also expected to incur significant cost increases over the term of the plan.
- Affordability challenges regarding the introduction of new drugs and therapies leading to increased treatment costs and demand over and above initial planning assumptions (particularly in relation to GLP1 medicines for the treatment of obesity and ongoing uptake of diabetes technologies).
- Financial pressures associated with the disproportionately high prison population in Forth Valley and the impact of decisions taken outwith our control by the Scottish Prison Service as part of measures to alleviate overcrowding across other parts of the Scottish prison estate (we are not staffed or funded to accommodate this change).
- IJB risk sharing arrangements in terms of overall affordability to the NHS Board and Local Authority partners of any potential additional non-recurring payments to IJBs in 2026/27 and beyond.
- Lack of funding to progress major capital investment priorities including the redevelopment and modernisation of our Primary Care estate and Falkirk Community Hospital, combined with uncertainty regarding approval of funding requested through the BCP process. Sub-national plans may also impact on the overall capital position and this will be considered by the Scotland West executive team.

Appendix A: 2026/27 savings plan

| Financial Sustainability Action Plan (Set Aside & NHS Core only) | 2026/27 TARGET | | | RAG status |
|---|----------------|---------------|-------------|------------|
| | Rec £000s | Non-Rec £000s | Total £000s | |
| <u>15 Box Grid: Service Sustainability (Operational Improvement Plan)</u> | | | | |
| Theatres Optimisation: implement CfSD Framework for Perioperative Services in NHS Scotland. | | | 0 | |
| Theatres Optimisation: action plan for specialties with highest unproductive theatre hours | | | 0 | |
| Theatres Optimisation: implement digital theatre scheduling tool. | 90 | | 90 | GREEN |
| Length of Stay: action plan for specialties with highest LoS | 125 | | 125 | GREEN |
| Length of Stay: Implement and expand Discharge without Delay | | | 0 | |
| Prescribing Optimisation: reducing medicines waste | 100 | | 100 | AMBER |
| Prescribing Optimisation: new technical switches | 2,187 | | 2,187 | AMBER |
| Prescribing optimisation: sock management, order process & off-contract spend FYE | 560 | | 560 | GREEN |
| Prescribing Optimisation: technical switches FYE | 2,000 | | 2,000 | GREEN |
| <i>Sub total: Service Sustainability (OIP)</i> | 5,062 | 0 | 5,062 | |
| <u>15 Box Grid: Reform Priorities (Service Renewal Framework)</u> | | | | |
| Shifting the Balance of Care: increase Hospital at Home capacity | | | 0 | GREEN |
| Shifting the Balance of Care: uptake of Near Me | 50 | | 50 | GREEN |
| Shifting the Balance of Care: Acute ward closure/transfer to HSCP | 197 | 2,027 | 2,224 | GREEN |
| Digital Programmes: implementation of Digital Front Door | | | 0 | RED |
| Digital Programmes: reduce postage, paper & printing costs | 608 | | 608 | AMBER |
| Patient Level Information & Costing System (PLICS) | 875 | | 875 | GREEN |
| <i>Sub total: Reform Priorities (SRF)</i> | 1,730 | 2,027 | 3,757 | |
| <u>15 Box Grid: Prevention (Population Health Framework)</u> | | | | |
| Budget Tagging: preventative spend | | | 0 | AMBER |
| Tests of Change: prevention opportunities | | | 0 | AMBER |
| Value Based Health & Care FYE Hyperhidrosis | 11 | | 11 | GREEN |
| VBHC - orthopaedics & general surgery | 500 | | 500 | AMBER |
| VBHC - paediatric continence service | 100 | | 100 | AMBER |
| VBHC - vascular pathway | 596 | | 596 | AMBER |
| VBHC - Labs (microbiology) | 205 | | 205 | AMBER |
| VBHC - Cardiology/Heart Failure Pathway | 150 | | 150 | GREEN |
| <i>Sub total: Prevention (PHF)</i> | 1,562 | 0 | 1,562 | |
| <u>15 Box Grid: Workforce</u> | | | | |
| Supplementary Staffing: nurse bank (untrained) | 1,574 | | 1,574 | AMBER |
| Supplementary Staffing: nurse agency | 1,141 | | 1,141 | AMBER |
| Supplementary Staffing: nurse bank (trained) | 17 | | 17 | AMBER |
| Supplementary Staffing: medical agency | 999 | 1,000 | 1,999 | GREEN |
| Business Services: review of Finance, HR & Procurement WTEs | 4 | 0 | 4 | RED |
| Attendance Promotion: improvement plan | 500 | | 500 | AMBER |

| | | | | |
|--|---------------|---------------|---------------|-------|
| <i>Sub total: Workforce</i> | 4,235 | 1,000 | 5,235 | |
| <u>15 Box Grid: Financial Management</u> | | | | |
| Contract Management: review of contract leakage | | | 0 | GREEN |
| Contract Management: contract renewals (Rx) | 618 | | 618 | GREEN |
| Transport: Fleet (Telematics) | 176 | | 176 | GREEN |
| Transport: reduce patient transport costs | 1,000 | | 1,000 | RED |
| Transport: review lease car arrangements | 111 | | 111 | AMBER |
| Estates: rationalise estates footprint | | | 0 | GREEN |
| Estates: PFI finance arrangements | | | 0 | GREEN |
| Estates: energy efficiency (PFI contracts) | 1,300 | | 1,300 | GREEN |
| Estates: energy efficiency (PV panels & LED lighting @ FVRH) | 655 | | 655 | GREEN |
| Estates: energy efficiency (ongoing Green Theatres implementation) | 135 | | 135 | GREEN |
| Estates: synthetic air plant | 10 | | 10 | AMBER |
| Estates: reduction in clinical waste | | | 0 | AMBER |
| <i>Sub total: Financial Management</i> | 4,005 | 0 | 4,005 | |
| <u>Other local savings plans</u> | | | | |
| Facilities: water rates | 12 | | 12 | GREEN |
| Digital: offsite storage (Burnbank) | 151 | | 151 | RED |
| Digital: redesign of Health Records | 500 | | 500 | GREEN |
| Digital: voice | 250 | | 250 | AMBER |
| Reform: Flow Navigation Centre & SRU | 2,457 | | 2,457 | AMBER |
| Procurement: Cardiology implantable devices | 101 | | 101 | GREEN |
| Workforce: medical locum VAT | | 900 | 900 | AMBER |
| Workforce: Rota Compliance | 935 | | 935 | RED |
| Non-Pay: Review of financial planning assumptions | 1,150 | 5,000 | 6,150 | GREEN |
| Non-Pay: Externals | 220 | | 220 | AMBER |
| Non-Pay: slippage on recruitment/investment | | 2,000 | 2,000 | GREEN |
| Non-Pay: POP accruals | | 500 | 500 | GREEN |
| Savings under development | 584 | 3,655 | 4,239 | RED |
| <i>sub total: Other local savings plans</i> | 6,360 | 12,055 | 18,415 | |
| GRAND TOTAL | 22,954 | 15,082 | 38,036 | |

Appendix B: 3-year revenue projection

3 Year Revenue Financial Plan

Mar-26

| | Year 1 (2026/27) | | Year 2 (2027/28) | | Year 3 (2028/29) | |
|---|------------------|-----------------|------------------|-----------------|------------------|-----------------|
| | % | Total £m | % | Total £m | % | Total £m |
| Summary of Costs | | | | | | |
| Funding | | | | | | |
| Base Uplift | 2.00% | 15.732 | 2.00% | 16.373 | 2.00% | 16.701 |
| NRAC | 0.00% | 0.000 | 0.00% | 0.000 | 0.00% | 0.000 |
| Pay Inflation beyond baseline uplift | | 8.135 | | 0.000 | | 0.000 |
| 26-27 Agenda for Change Reform | | 8.200 | | 0.000 | | 0.000 |
| Sustainability Payment share of £150m | | 8.205 | | 0.000 | | 0.000 |
| Elective Capacity Development SEU-FV | | 13.457 | | 13.457 | | 13.457 |
| New Medicines Fund (NRAC share of £250m) | | 13.675 | | 13.675 | | 13.675 |
| | | | | | | |
| Total Resource Increase | | 67.404 | | 43.505 | | 43.833 |
| Costs | | | | | | |
| Brought forward pressures | | 29.897 | | 19.996 | | 24.056 |
| Pay & Prices Inflation | | | | | | |
| Pay Inflation - Agenda for Change | 3.75% | 7.189 | 2.00% | 3.978 | 2.00% | 4.058 |
| Pay Inflation - Medical | 3.00% | 2.281 | 2.00% | 1.566 | 2.00% | 1.597 |
| Pay Inflation - Senior Managers | 3.00% | 0.066 | 2.00% | 0.045 | 2.00% | 0.046 |
| Pay Inflation - Other | 3.00% | 0.078 | 2.00% | 0.054 | 2.00% | 0.055 |
| General Price Inflation | 2.00% | 0.826 | 2.00% | 0.842 | 2.00% | 0.859 |
| General Income Inflation | 0.00% | 0.000 | 0.00% | 0.000 | 0.00% | 0.000 |
| Unitary Charge Inflation | 4.25% | 2.511 | 5.00% | 3.099 | 5.00% | 3.250 |
| Energy | 0.00% | 0.000 | 5.00% | 0.603 | 5.00% | 0.633 |
| Rates | 12.51% | 0.934 | 5.00% | 0.420 | 5.00% | 0.441 |
| Capital Charges | 2.00% | 0.393 | 2.00% | 0.401 | 2.00% | 0.409 |
| Resource Transfer | 2.00% | 0.000 | 2.00% | 0.000 | 2.00% | 0.000 |
| Voluntary Bodies / other providers | 2.00% | 0.008 | 2.00% | 0.009 | 2.00% | 0.009 |
| External CBF Outflow | 3.50% | 2.933 | 2.00% | 2.163 | 2.00% | 2.241 |
| External CBF Inflow | 3.50% | (0.566) | 2.00% | (0.335) | 2.00% | (0.341) |
| Hospital Drugs | 8.00% | 2.747 | 8.00% | 2.966 | 8.00% | 3.204 |
| HSCP Set Aside Inflation | 2.00% | 1.698 | 2.00% | 1.732 | 2.00% | 1.767 |
| Clacks/Stirling HSCP baseline inflation - Operational & Universal | 2.00% | 1.861 | 2.00% | 1.898 | 2.00% | 1.936 |
| Falkirk HSCP baseline Inflation - Operational & Universal | 2.00% | 2.158 | 2.00% | 2.201 | 2.00% | 2.245 |
| HSCP baseline funding still to be allocated | 2.00% | 0.332 | 2.00% | 0.339 | 2.00% | 0.345 |
| Other Inflation | | 5.517 | | 1.016 | | 1.052 |
| | | | | | | |
| Other Pay & Prices | | 1.246 | | 0.636 | | 0.648 |
| Agenda for Change Pay Reform | | 8.200 | | 0.164 | | 0.167 |
| Drugs and Medicines | | 13.675 | | 13.675 | | 13.675 |
| eHealth | | 0.758 | | 0.160 | | 0.032 |
| Property | | 0.107 | | 0.000 | | 0.000 |
| Capacity & Flow (SEU-FV) | | 13.457 | | 13.457 | | 13.457 |
| Regional Issues | | 0.563 | | 0.110 | | 0.010 |
| National Strategy / Policy Impact | | 1.807 | | 2.762 | | 1.904 |
| Demographic Change | | 0.000 | | 3.500 | | 5.000 |
| Non Demographic Growth | | 0.000 | | 2.500 | | 3.750 |
| Local Developments/ Investments/ Initiatives | | 4.264 | | 1.137 | | 0.214 |
| New & Emerging Pressures | | 0.500 | | 0.000 | | 0.000 |
| Partnership Risk Share | | 0.000 | | 0.000 | | 0.000 |
| | | | | | | |
| Total cost increase | | 105.440 | | 81.095 | | 86.719 |
| | | | | | | |
| Net Savings Requirement | | (38.036) | | (37.590) | | (42.886) |
| | | | | | | |
| Estimated Savings Delivery | | 38.036 | | 18.365 | | 16.432 |
| | | | | | | |
| Net Gap | | 0.000 | | (19.225) | | (26.454) |

Appendix C: 3-year capital projection

**NHS Forth Valley
5 Year Capital Plan
2026/27 to 2028/29**

| | 2026/27 | 2027/28 | 2028/29 |
|--|---------------|--------------|--------------|
| SOURCES OF GENERAL FUNDING | £'m | £'m | £'m |
| Scottish Government General Allocation | 6.708 | 6.708 | 6.708 |
| SGHD - Improving Access to Elective Care | | | |
| SGHD - LIMS Implementation | 0.260 | | |
| SGHD - Projects C/Fwd From 2025/26 | 2.505 | | |
| SGHD - BCP Approved | 1.500 | 0.400 | |
| SGHD - Right of Use Assets IFRS16 | 1.130 | 1.318 | 1.427 |
| SGHD - Asset Sales Retained | 3.000 | 0.000 | 0.000 |
| Total Gross Capital Resource Limit | 15.103 | 8.426 | 8.135 |
| SGHD - Indirect Capital Exp. Charged to Revenue | -1.600 | -1.600 | -1.600 |
| Total Net Core Capital Resource Limit | 13.503 | 6.826 | 6.535 |
| | | | |
| PLANNED CAPITAL EXPENDITURE | £'m | £'m | £'m |
| Elective Care | | | |
| Information Management & Technology | 5.643 | 2.355 | 1.844 |
| Medical Equipment | 2.804 | 3.225 | 1.965 |
| Facilities & Infrastructure | 5.064 | 1.259 | 1.177 |
| Energy Efficiency Capital Grants | | | |
| NHS Board | 1.130 | 1.318 | 1.427 |
| Unallocated Funds Available (Required) | 0.462 | 0.269 | 1.722 |
| Total Gross Capital Expenditure | 15.103 | 8.426 | 8.135 |
| Capital Grants & Capital to Revenue | -1.600 | -1.600 | -1.600 |
| Total Net Capital Expenditure Charged to CI | 13.503 | 6.826 | 6.535 |
| | | | |
| Balance Available / (Required) | 0.000 | 0.000 | 0.000 |

| Memorandum - Forecast Property Sales | 2026/27 | 2027/28 | 2028/29 |
|---|--------------|--------------|--------------|
| Bellsdyke Land | | | |
| Surplus Stirling Royal Infirmary Site Land | 3.000 | 0.000 | 0.000 |
| Total Forecast property Sales | 3.000 | 0.000 | 0.000 |

E: Caroline.lamb@gov.scot

NHS Board Chief Executives
NHS Board Chairs
HSCP Chief Officers

Cc. Directors of Finance
HSCP Chief Finance Officers

By email only

27 February 2026

NHS Scotland Financial Improvement – Refreshed 2026-27 15 Box Grid

Dear all,

I am writing to set out our refreshed 15 Box Grid (the ‘Grid’) for 2026-27 together with the underlying actions I expect each Board to take forward to help improve financial and service sustainability across NHS Scotland.

NHS Scotland’s financial challenge remains significant. Despite ambitious savings targets, NHS Boards are forecasting an increased net deficit in 2026-27 compared to prior year, and we must continue our focus to increase the delivery of recurring savings. Through your collective efforts, NHS Scotland is on course to deliver record recurring savings in 2025-26 and it is important we continue this momentum to improve financial sustainability.

The recurring savings target set by Scottish Government of 3% against baseline funding will continue into 2026-27. The Grid has become a well-established financial improvement tool and will remain central to helping Boards achieve recurring savings through collaboration and sharing best practice. The Grid collates savings opportunities and provides robust benchmarking data to allow NHS Boards to assess their performance and highlight areas of opportunity.

The Grid has been refreshed for 2026-27 to align with national priorities on reform and to continue to provide targeted opportunities in 2026-27. The 2026-27 Grid is provided below, and a detailed list of requirements is provided in the Annex.

| 15 Box Grid | | | | |
|-----------------------------|---------------------------------|--------------------------------|----------------------------|----------------------------|
| Service Sustainability | Reform Priorities | Prevention | Workforce | Financial Management |
| 1. Theatre optimisation | 4. Shifting the balance of care | 7. Budget tagging | 10. Supplementary staffing | 13. Contract Management |
| 2. Length of Stay | 5. Digital programmes | 8. Tests of change | 11. Business Services | 14. Transport |
| 3. Prescribing optimisation | 6. PLICS | 9. Value Based Health and Care | 12. Attendance Promotion | 15. Estates and facilities |

Format

A refreshed format enables alignment between financial improvement and the Population Health Framework, Service Renewal Framework, and the Operational Improvement Plan. Digital innovation is also a key focus of the Grid in 2026-27, and features throughout the requirements included in the Annex.

Sub-national planning

Improved financial sustainability is a key requirement of [DL\(2025\)25](#) requiring NHS Boards to collaborate through sub-national structures. The 2026-27 Grid should be considered within sub-national planning, targeting unwarranted variation within sub-national structures to achieve financial savings. The NHS Scotland Finance Delivery Unit (FDU) will continue to provide national benchmarking on the Grid which can be factored into sub-national planning.

Capacity building

the FDU use PowerBI software to provide significant insight into each Board's performance across key areas. It is important local teams have the skillset to interact with the software and can identify opportunities for improvement. The FDU will provide teach-in sessions on using the Grid benchmarking pack; please ensure these are attended by teams if required.

Benchmarking

The Grid is intended to supplement, not replace, local cost improvement programmes, which should also continue to deliver against savings targets. The FDU will continue to provide benchmarking in 2026-27 supplemented by self-assessments which will identify areas of opportunity within your own NHS Board. This will be shared quarterly with finance teams over the course of the financial year.

The Grid will remain a key focus of quarterly finance reviews and a recurring agenda item at key forums including Directors of Finance, and Corporate Finance Network.

Yours sincerely,



Caroline Lamb
Chief Executive of NHS Scotland and Director General Health and Social Care

Annex – 15 Box Grid Requirements in 2026-27

| Service sustainability | | |
|------------------------|--|--|
| | Action required | More information |
| 1 | <p>Theatre optimisation</p> <p>1. Ensure all aspects of the CfSD Framework for Perioperative Services in NHS Scotland have been fully implemented, including guidance on High-Flow surgery to maximise theatre time, Scheduling and Pre-Op assessment.</p> <p>2. Review specialties with highest theatre unproductive hours at appropriate local meetings and set an action plan to improve.</p> <p>3. Continue with implementation of the theatre digital scheduling tool (and where available digital pre-op assessment), with a focus on realising benefits through regular review of the data with operational teams.</p> | <p>The Framework for Perioperative Services is available here: a-framework-for-perioperative-services-in-scotland.pdf and there is an accompanying self-assessment to support implementation.</p> <p>National Theatre Information Group (NTIG) data is available via NHS Discovery and should be reviewed regularly including scrutiny of the 'productive theatre time' metric, along with measures of throughput (e.g. numbers of operations per list).</p> |
| 2 | <p>Length of stay</p> <p>1. Review specialties with the highest lengths of stay and understand from service managers what action can be taken to reduce length of stay and release financial efficiencies and productive opportunities.</p> <p>2. Implement and expand Discharge without Delay principles to minimise avoidable delays, reduce cost pressures associated with extended admissions, and maximise the efficient use of hospital beds.</p> | <p>More information can be found on Discovery and will be shared via 15 Box Grid benchmarking packs.</p> <p>As well as the financial benefits, these activities align with the priorities set out in the OIP around improving access and flow through our health and social care systems. Boards should report progress against local targets and improvement goals.</p> |
| 3 | <p>Prescribing optimisation</p> <p>1. Implement pathway development to increase and mainstream polypharmacy reviews (including care homes) in line with findings from iSIMPATY and revised polypharmacy guidance published in February 2026.</p> <p><u>Primary Care Prescribing</u></p> <p>2. Optimisation of asthma care through implementation of BTS/NICE/SIGN asthma guidance (SIGN 245, Nov 24). Demonstrated</p> | <p>Polypharmacy reviews must be consistently coded in line with guidance. Pre and review polypharmacy proformas will be provided to clinicians through a common toolbar in 2026-27.</p> <p>Boards should continue to implement Medicines of Low & Limited Clinical Value guidance, spend on Medicines of Low and Limited Clinical Value will be tracked on a quarterly basis.</p> <p>Available switches are outlined in the quarterly NSS Medicines procurement</p> |

| | | |
|--|--|--|
| | <p>by adoption of AIR/MART therapy and reduction in SABA use.</p> <p><u>Secondary Care Prescribing</u></p> <p>3. To review medicines wastage metrics within your Board and share best practice proactively across NHS Scotland.</p> <p>4. Ensure medicine switches are implemented as soon as possible once the originator medicine has lost exclusivity and a generic/biosimilar alternative is clinically appropriate and provides more value for money.</p> | <p>Newsletter and National update of medicines switches are monitored by National Procurement.</p> <p>Data on non-medicine spend and volume will be available in 2026/27, this will cover products including diabetes sundries, stoma, and wound care.</p> |
|--|--|--|

Reform priorities

| | Action required | More information |
|---|--|---|
| 4 | <p>Shifting the balance of care</p> <p>1. Increase Hospital at Home capacity to allow more patients to be treated through a lower cost model of care compared with inpatient admissions.</p> <p>2. Continue adopting digital first options to deliver care, with an emphasis on enhancing productivity and reducing costs. E.g. increasing uptake of national services such as video consulting systems and Near Me to reduce unnecessary and/or lengthy travel, working with social care services and primary care to utilise remote monitoring services, and supporting roll out and enhanced functionality of MyCare.scot.</p> <p>3. Share areas of success with shifting the balance of care through self-assessments which can be cascaded across other NHS Scotland Boards.</p> | <p>More information is due to be published on Discovery and will be shared via the 15 Box Grid Benchmarking packs when available.</p> <p>National strategy aims to expand Hospital at Home to 2,000 beds by December 2026, backed by OIP investment, establishing it as Scotland's largest "hospital." To standardise and strengthen clinical pathways, please consult the Hospital at Home guiding principles.</p> <p>In alignment with other areas of the 15 Box Grid, the expansion of Hospital at Home can be supported by digital-first and remote-monitoring approaches. Hospital at Home also aligns with Realistic Medicine, the Operational Improvement Plan, and the Health & Social Care Service Renewal Framework.</p> <p>Services for Older Adults have demonstrated lower cost per episode and reduced subsequent healthcare usage, creating sustainable long term financial and system benefits.</p> |
| 5 | <p>Digital programmes</p> <p>1. Adhere to all national timelines for implementation of Digital Front Door, to</p> | <p>The FDU will liaise with Digital colleagues to share information and benchmarking, where appropriate, on uptake of Digital Front Door.</p> |

| | | |
|-------------------|--|--|
| | <p>ensure cash releasing benefits are realised as per the business case.</p> <p>2. Review options to continue to reduce postage, paper, and printing costs through, for example, increasing take up of e-payslips, sending letters digitally and using automation to reduce manual time.</p> | <p>Benchmarking on e-payslips will be available in the 15 Box Grid benchmarking pack.</p> |
| 6 | <p>Patient Level Information and Costing System (PLICS)</p> <p>1. Adhere to all national timelines set by the FDU.</p> <p>2. Boards with PLICS implemented must use the PLICS system for Costs Book submissions from 2026–27 onwards.</p> <p>3. Boards should use PLICS data to identify and prioritise efficiency opportunities by analysing patient-level costs, highlighting variation, and informing improvement plans.</p> | <p>Guidance and information can be provided by the FDU.</p> <p>Boards should ensure active participation and appropriate representation at all national working group meetings and actively contribute to the development and refinement of national standards.</p> |
| Prevention | | |
| | Action required | More information |
| 7 | <p>Budget tagging</p> <p>1. Boards participating in the preventative spend budget-tagging pilot are expected to adhere to the established timelines (April 2026). Continued engagement will be required with subsequent plans to develop this approach into a system of ongoing measurement of preventative spend across the full Scottish Budget.</p> | <p>A series of pilots are ongoing to test a consistent approach to tracking preventative spend across the Scottish Government and the wider public sector. Using jointly agreed financial guidance in selected Health Board service areas, the pilots will improve understanding of current preventative spend, inform future budget guidance, and support wider discussions on prioritising prevention.</p> <p>Guidance and information can be provided by the FDU.</p> |
| 8 | <p>Tests of change</p> <p>1. Actively seek out prevention opportunities and share best practice across finance communities, ensuring prevention spend is not targeted for savings schemes without consideration of the wider public sector budget benefits.</p> | <p>Boards should share tests of change through FIN or other relevant forums.</p> <p>Examples of good practice include NHS Forth Valley – Population Health & Care Strategy 2025 – 2035.</p> |

| | | |
|---|--|--|
| | 2. Develop and implement targeted improvement actions to reduce unwarranted variation and monitor their impact over time. | |
| 9 | <p>Value Based Health and Care (VBHC)</p> <p>1. Continue to embed person-centred care within services, through implementation of Value Based Health and Care action plan, to ensure we deliver the outcomes that matter to the people we care for.</p> <p>2. Optimise the use of resources through evidence-based practice, by implementing the National Referral Protocol, ACRT, PIR, CfSD best practice pathways and resources, Demand Optimisation Atlas, and best practice case studies set out the Realistic Medicine Casebook to drive efficiencies and release savings.</p> <p>3. Ensure the adoption of Patient Focused Booking (PFB) wherever possible to establish patient centred approaches to outpatient care and reduce did-not-attends.</p> <p>4. Use available data, including Discovery, PHS publications and PLICS (where available), to identify areas of significant variation across priority clinical pathways, working with clinical and costing teams to understand whether observed variation is warranted or unwarranted.</p> | <p>A full list of CfSD pathways and resources are available from the Centre for Sustainable Delivery and Right Decision Service.</p> <p>Although there will be some appropriate exceptions and exclusions, Patient Focused Booking should be considered the default for new outpatients and may also be appropriate for some groups of urgent patients. Wherever systems allow, Boards should explore the use of PFB to support return patient pathways too. Further information and support available from: cfdmppp@nhs.scot</p> <p>Realistic Medicine Casebook</p> <p>Resources to identify areas of significant variation across priority clinical pathways:</p> <p>Discovery - Discovery Home Page PHS - Health intelligence and data management - Resources and tools - Public Health Scotland</p> |

Workforce

| | Action required | More information |
|----|--|--|
| 10 | <p>Supplementary staffing</p> <p>1. Ensure availability of bank facilities and optimise staff bank attraction, ensuring best practice checklists are used.</p> <p>2. Boards should closely monitor agency usage (including off-framework) and ensure control frameworks are observed.</p> | <p>Benchmarking will be provided by FDU.</p> <p>Bank and agency usage will be regularly monitored and will form part of quarterly finance reviews.</p> <p>Staff bank practice checklists can be shared by the FDU. Staff Bank National Marketing Materials are available on TURAS.</p> |

| | | |
|----|--|--|
| | <p>3. Boards should engage in effective workforce planning in line with SG guidance and share success across NHS Scotland.</p> <p>4. Boards should ensure they are using direct engagement.</p> <p>5. Boards must monitor the impact of the reduced working week requirement to reduce the working week by 1 hour. The impact on supplementary staffing should be minimised where possible, and timely feedback given to Scottish Government on the impact.</p> | |
| 11 | <p>Business services</p> <p>1. Adhere to national timelines in relation to the Business Systems Transformation Project.</p> <p>2. Implement a plan to review and rationalise where appropriate WTE in job families relating to business systems. The plan must work within NHS Scotland's employment terms and conditions and consider:</p> <ul style="list-style-type: none"> • Effective vacancy panels; • Skills mix and grade profile; • Opportunities to increase standardisation, reduce duplication, automate tasks and increased use of AI tools; and • Sharing of services between Boards. | <p>The Public Sector Reform Strategy sets out an overarching commitment to reduce the annualised Scottish Government and public body corporate costs by £1 billion, representing around 20% of the identified public body corporate and core government operating costs.</p> <p>The FDU will provide frequent updates through the 15 Box Grid benchmarking pack.</p> <p>Central functions should align with the definition found on TURAS.</p> |
| 12 | <p>Attendance promotion</p> <p>1. Continue compliance with the Once for Scotland absence management policies by employers. Boards must ensure adherence to policies and compliance with the Staff Governance Standard.</p> <p>2. Ensure regular reporting on areas of concern on sickness absence are discussed at Board meetings with improvement plans agreed and set into action.</p> <p>3. Share best practice in any sustained reduction in sickness absence achieved locally.</p> | <p>SSTS Absence Analysis Report is available on TURAS.</p> <p>The FDU will share benchmarking on sickness absence to allow regular review and monitoring.</p> |

Financial management

| | Action required | More information |
|----|--|---|
| 13 | <p>Contract management</p> <p>1. Perform reviews of high value contracts in quarter 1 with a view to:</p> <ul style="list-style-type: none"> • Reduce contract leakage, for example, identifying supplier overcharges against contractual rates, and agreeing credits for services not provided in line with the contract terms and conditions. • Review contract end dates and engage with NSS for contract renewal support. | <p>Guidance and support can be provided by the FDU and NSS.</p> |
| 14 | <p>Transport</p> <p>1. Review current patient transport costs within your NHS Board and understand any opportunities for reduced spend. For example, through a transport hub, working with the Scottish Ambulance Service and third sector organisations differently, aiming to achieve more co-ordinated transport routes.</p> <p>2. Review lease car arrangements and fleet utilisation to ensure value for money.</p> <p>3. Share examples of successfully reducing transport expenditure across NHS Scotland, including taxi, logistical movements, and expenses.</p> | <p>The Scottish Government Transport to health: delivery plan was published in October 2024, setting out 20 commitments across health and transport in Scotland, to improve transport to health and social care through cross-portfolio action.</p> <p>Guidance and support can be provided by the FDU.</p> |
| 15 | <p>Estates</p> <p>1. Work closely with estates teams for options to rationalise estates footprint both within local Boards but also on a sub-national and national basis, including clinical and non-clinical sites. Boards should report against their local plans for asset management/reduction.</p> <p>2. Continue to work closely with NHS Assure on PFI financial arrangements and refinancing where relevant.</p> <p>3. Consider energy efficiency opportunities, contributing to net zero objectives and potential financial efficiencies.</p> | <p>Review the National Green Theatres programme Actions for Implementation for ideas to consider regarding energy efficiency opportunities.</p> <p>Guidance and support should be sought from local estates teams and NHS Assure.</p> |

| | | |
|--|---|--|
| | <p>4. Set multi-year targets and progress work to deliver sustained and meaningful reduction in the total weight of clinical waste (yellow and orange). NHS Boards should be actively reviewing waste data for opportunities.</p> | |
|--|---|--|

NHS Forth Valley

Forth Valley NHS Board

4 NHS Forth Valley Corporate Objectives

Purpose: This report is for Decision

Executive Sponsor: Ross McGuffie, Chief Executive

Author: Kevin Reith, Director of People

Executive Summary

The NHS Forth Valley Corporate Objectives reaffirm our ambition and purpose as an organisation, aligned with Scottish Government Guidance and provides a link between national and local context. The Health Board annually revisits its corporate objectives (in line with national policy) to provide direction for staff whilst promoting action towards goal-related activities and behaviours that align with our values.

This paper provides the Board with an updated proposal for the Corporate Objectives which will direct the agreement of specific 2026/27 organisational objectives which will be captured in our Delivery Plan and will support the next year's progress against our Population Health & Care Strategy. The proposal has been developed through engagement with Board and Executive colleagues.

Staff will be supported when developing and agreeing their objectives and personal development plans to which they will be held to account for. Taking cognisance of the Corporate Objectives, the Senior Leadership Team in setting team and personal objectives is asked to consider SMART objectives (Specific, Measurable, Achievable, Relevant, and Time-Bound) supporting the creation and delivery of goals in line with NHS Forth Valley's priorities.

Action Required

The Forth Valley NHS Board is asked to:

- (1) approve the proposed Corporate Objective refresh as a frame for our delivery aims during 2026/27, and
 - (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

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.

- During February and March 2026, the current Corporate Objectives were reviewed by the Executive Group with amendments made to develop a draft proposal to present to the Board
 - Board Development Seminar 10 February 2026. The proposed draft objectives were discussed, and feedback was sought from Board members to finalise for board approval. Feedback provided post seminar has been incorporated into the revised draft presented.
-

Risk Assessment and Mitigation

Objective setting contributes to improved alignment of Board strategic direction and staff engagement in supporting overall improved performance - helps minimise risks at operational and strategic levels.

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 no Financial, Digital or Infrastructure implications associated with this proposal.

Workforce Implications

The paper supports the outcome of championing a culture where staff feel valued, safe and have a voice, which sits under the 'Collaborative' corporate objective – 'We will collaborate locally, sub-nationally and nationally to deliver shared priorities at pace, with clear accountability, aligned governance and demonstrable benefits for population health, service sustainability and workforce wellbeing.'

Quality / Patient Care Implications

This paper supports the outcome of ensuring safe, high quality and sustainable patient care, which is reflected across all of the objectives and is consistent with our aspirations to deliver Value Based Healthcare.

Engagement and Communications

Was statutory engagement with stakeholders required? Yes No

Appendix

Appendix 1: NHS Forth Valley Corporate Objectives 2026/27

1. Our Purpose and Priorities

Effective NHS boards drive high-quality care through strong, value-driven leadership, fostering a positive, patient-centered culture while ensuring robust, accountable, governance. They balance performance and financial pressures with strategic, long-term goals, utilising a mix of executive and non-executive skills for constructive challenge. Key functions of the NHS Board are – Setting direction; Holding the Executive Leadership Team to account; Managing risk; Engaging with key stakeholders; Influencing organisational culture.

As we work to achieve our aims we will be informed by:

- the external context within which we operate
- the intelligence which provides trend and comparative information on how our Board is performing.
- dialogue and engagement with our patients, staff, partners, and the people of Forth Valley, using a whole-system approach.

The Corporate Plan is our road map for 2026/2027. It sets out our key objectives and deliverables for the year as we work together to deliver our Population Health and Care Strategy 2025/2035 alongside our day-to-day activities, ongoing projects and with support from our key partners.

Our Population Health and Care Strategy sets out our plans and priorities for the next decade to achieve a healthier population, taking account of an ageing population, a growing gap in life expectancy between the poorest and the wealthiest, and that people are spending more of their life in ill health. With these growing challenges, innovation and different approaches to how we deliver health and care services will be essential and understood by all, with a key focus on increasing and embedding prevention activities which are proven to be effective across health and care. The high cost of living and the focus on climate change has informed the Board's continued commitment to sustainability and to reforming the services we provide, to improve the health and wellbeing of the people who live and work in Forth Valley.

The two local Integration Joint Boards will continue to play a key role in commissioning services in ways that support people to stay and keep well in their own homes and/or communities, and we remain committed to working with a range of partners to deliver improved outcomes for the people of Forth Valley. We will continue to seek opportunities for broader collaborative delivery, recognising the new Sub-National infrastructure and our contribution to national improvement aims.

2. Our Corporate Objectives

The NHS Forth Valley Board reviews and approves the Corporate Objectives annually., Corporate Objectives guide the development of team and individual objectives for the year ahead. Table 1 outlines the Corporate Objectives for 2026/2027, demonstrating how they underpin NHS Forth Valley’s overall vision and aim, and how they align with the core values of NHS Scotland. Each objective will be supported by clear ownership, milestones, measures and Board-level assurance. Progress will focus on impact and learning as well as activity.

Table 1. Corporate Objectives 2026/2027

| | | | | |
|-----------------------------|--|--|---|---|
| Vision | Life Changing Transformation for Better Health, Care and Wellbeing. | | | |
| NHS Scotland Values | Care and compassion; dignity and respect; openness, honesty and responsibility; quality and teamwork. | | | |
| NHS Forth Valley | To improve the health and wellbeing of everyone living in Forth Valley by preventing people from becoming unwell, reducing inequalities and making the best use of the resources available to achieve better outcomes. | | | |
| Corporate Objectives | <p>Collaboration</p> <p>We will collaborate locally, sub-nationally and nationally to deliver shared priorities at pace, with clear accountability, aligned governance and demonstrable benefits for population health, service sustainability and workforce wellbeing.</p> | <p>Transformation</p> <p>We will reform and redesign the way we deliver health and care services to meet current and future challenges, including demographic change, widening inequalities and improving the quality and safety of services.</p> | <p>Stewardship</p> <p>We will strengthen stewardship capability and accountability at all levels to ensure that we have a positive and proactive approach to clinical, staff and financial governance across the organization.</p> | <p>Outcomes</p> <p>Focus our services, funding and efforts on the areas which will achieve the greatest impact, benefits and outcomes to improve the health and wellbeing of our whole population.</p> |
| Deliverables | Greater collaboration with partners and communities including carers across Forth | Reduced reliance on hospital-based care, through greater investment in preventative and proactive community | Greater financial sustainability and reduced waste through programmes to increase efficiency and innovation. | Embed a preventative, value-based approach by disinvesting from low-value activity and delivering measurable |

| | | | | |
|--|---|--|---|---|
| | <p>Valley.</p> <p>Greater sub-national collaboration to jointly plan and prioritise services at a sub-national scale in order to reduce duplication, strengthen sustainability, improve equity of access, and enhance accountability across NHS Scotland.</p> <p>Integrated and aligned goals and streamlined governance arrangements with explicit ownership and decision rights.</p> <p>More integrated services locally, and sub-nationally and nationally with evidence of reduced duplication and improved access or outcomes.</p> <p>Create an environment where diversity is valued, and people are treated with respect.</p> <p>Improved health and wellbeing of staff, patients and the wider community.</p> | <p>care services supported by a skilled workforce.</p> <p>Ongoing investment in digital technology and innovation to support improvements across our health and care system.</p> <p>Further improvements in the delivery of safe, high quality, and sustainable patient care through an effective Quality Management System.</p> <p>Reduce the levels of disease and premature death through targeted action and investment to address health inequalities, increase prevention programmes, and improve uptake across local communities.</p> <p>Develop a wider understanding of the health needs of our population and communities.</p> <p>Embed a Human Learning System culture across the organization as a whole as a key foundation of organisational transformation.</p> <p>Continue to build a culture with associated behaviours which is a delivery lever for transformation, productivity and change across our health and care system.</p> <p>Improved staff recruitment and retention through staff feeling valued, involved and empowered to make positive change</p> | <p>Achieving the best value for our available resources, including reducing variation and treatments of low clinical value.</p> <p>Transparent monitoring of savings delivery and reinvestment.</p> <p>Development of key workforce plans and policies including staff development and PDPR activity to support improved compliance with standards and stronger grip on costs.</p> <p>Financial Stewardship development for budget holders.</p> <p>Development and delivery of capital priorities.</p> <p>Continued improvement of corporate governance and processes embracing digital solutions which enhance our delivery.</p> | <p>improvements in population health as we implement our Population Health and Care Strategy.</p> <p>Improve health and wellbeing outcomes to ensure the best start for children and young people.</p> <p>Improve mental health and wellbeing for everyone .</p> <p>Improve patient safety outcomes by more comprehensively integrating our Quality Management System into patient care and clinical governance processes.</p> <p>Ongoing progress against the targets in our Climate Emergency & Sustainability Action Plan.</p> <p>Staff feel valued, respected and safe at work in an environment where every individual can flourish and we monitor culture outcomes to ensure that there is consistently positive staff experience across the organisation.</p> <p>Diversity is valued, fostered and celebrated with the organization, appreciating the richness of skills and experiences a diverse workforce brings.</p> |
|--|---|--|---|---|

5. Whole System Urgent and Unscheduled Care Plan

Purpose: This report is for Decision

Executive Sponsor: Ross McGuffie, Chief Executive

Authors: Caroline Doherty, Head of Community Services, Gail Woodcock, Chief Officer, Falkirk IJB, Jennifer Borthwick, Interim Chief Officer, Clackmannanshire and Stirling IJB, Garry Fraser, Director of Acute

Executive Summary

This report brings forward an overview of the developing Forth Valley Whole System Urgent and Unscheduled Care Plan for noting.

Some elements of the plan are now well embedded, some are in the process of being implemented and others at development stage. The report notes the changes that are anticipated through the implementation of the plan and highlights some system metrics which are already showing improvement.

The report highlights the impact of the “Shifting the Balance of Care – Delayed Discharges” project during 2025/26 and seeks approval for funding for this element of the plan for 2026/27. The report notes the intention to build the STBC approach into a business as usual element of whole system working across both health and social care partnerships during the course of 2026/27, with ongoing financial implications being brought forward to NHS Board in due course as part of the overall urgent and unscheduled care programme of investment.

Included within the report is a summary of the business case, which has been developed to consider how the benefits already demonstrated, including supporting timely hospital discharge, enhancing hospital capacity, and strengthening whole-system performance can be maintained. The 2025 test of change, Shifting the Balance of Care through Discharge to Assess, contributed to significant improvements, including sustained reductions in delayed discharges, improved patient flow, fewer bed days lost for older people, and a meaningful shift toward enabling people to remain at home rather than move directly into long-term care. The model aligns with national and local priorities to deliver care closer to home and reduce harm associated with prolonged hospital stays.

Building on the positive patient centred outcomes from the initial phase of STBC, this report sets out a future model for urgent and unscheduled care in Forth Valley. The proposal is evaluated to be a credible and innovative approach to service delivery which supports improved outcomes and experiences for patients, staff and the wider health and care system.

Action Required

The Forth Valley NHS Board is asked to:

- (1) note the developing Forth Valley Whole System Urgent and Unscheduled Care Plan, including seeking the fully developed and costed plan to come to a future board meeting.
- (2) approve initial non-recurring transfer of £2,027,180 in 2026/27 from NHS Forth Valley to Falkirk Health and Social Care Partnership (HSCP) to maintain and embed the Discharge to Assess (D2A) / Shifting the Balance of Care model as a business-as-usual approach during 2026/27, noting that a further request to make the funding recurring from 2027/28 financial year onwards will come forward as part of the fully developed and costed UUSC plan as indicated in recommendation 1.
- (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.

- Falkirk Senior Leadership Team - 13/2/26
- NHS SLT – 16/02/26
- NHS Executive Team – 23/2/26
- The initial Shifting the Balance of Care proposal was considered by NHS Board on 27 May 2025.
- The associated evaluation of Shifting the Balance of Care was considered by the NHS Board SPRRC Committee on 16 December 2025

Risk Assessment and Mitigation

The overall whole system Urgent and Unscheduled Care Plan seeks to mitigate the following strategic risks:

- **System Capacity and Demand Pressures** – demand for health and care continues to rise faster than capacity, particularly impacting on unscheduled care, whole system flow, delayed discharge and community services. The UUSC plan seeks to minimise delays and higher costs associated with bedded care provision, minimise the requirement for patients to be “boarded” elsewhere in the hospital, improve flow through the reduction of length of stay, reduce hospital occupancy and improve performance at the front door.
- **Reduce Risk of Harm to People** - a whole system approach to managing urgent and unscheduled care, including shifting the balance of care to home and community will help to mitigate risks of harm to people resulting from prolonged hospital stays and delays in providing clinical and social care. A reduced hospital occupancy creates capacity which can be used to respond to surge demand and also support ongoing required maintenance and refurbishment within the hospital. The reablement approach undertaken in community will maximise the potential of people to stay as independent as possible, in their own homes for as long as possible.

- **Financial Sustainability** – the UUSC plan seeks to maximise the opportunity for whole system financial sustainability, by providing the right care, at the right time and in the right place to reduce deconditioning and other potential harms as a result of longer hospital stays than required, therefore reducing the level of longer term health and social care requirements, thus maximising the available whole system resource to meet increasing demand. The whole system approach will also support market facilitation in the community, helping with our financial stewardship as well as protecting valuable community resource for those with greatest need.
- Should the transfer of resources not be approved to continue the STBC approach during 2026/27, Falkirk HSCP will require to manage down the number of community packages funded and discontinue current additional staffing, in order to manage within its agreed budget. It is anticipated that this could result in more people delayed in their discharge, and a need to revert to previous pathways including reopening the FVRH surge ward, which would result in higher overall costs to the whole system, reduced opportunities for ongoing improvement and poorer outcomes for people.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? Yes

If yes, please confirm this is attached. Attached Not required

An EPIA has been completed for the Shifting the Balance of Care – Delayed Discharges part of the UUSC plan and is attached as an appendix to this paper. An EQIA for the full UUSC plan will be developed and brought back to the board along with the fully developed plan.

The EPIA identifies that the model delivers positive impacts for older people and people with disabilities by reducing unnecessary hospital stays and supporting assessment at home, improving outcomes and reducing hospital-related harm. Recognised risks for people with dementia or complex needs include distress, care package breakdown and increased carer burden; these are mitigated through robust multidisciplinary oversight, carer involvement, contingency planning, use of telecare, and close monitoring of outcomes and readmissions.

Financial and Infrastructure Implications

The UUSC Plan is currently being supported through fixed term ring fenced Scottish Government Funding. In respect of the Shifting the Balance of Care – Delayed Discharge part of the plan, a non-recurring transfer of **£2,027,180** from NHS Forth Valley to Falkirk HSCP will be required for 2026/27 and is this is planned by NHS FV. The ongoing spend within the partnership will be as follows funded by the transfer of resources from NHS Forth Valley and existing budget within the HSCP:-

A paper setting out the full recurring requirements of the ongoing UUSC plan, including the STBC element, will be brought forward to the board during 2026/27.

It is noted that while there has been national UUSC funding during 2025/26 which has enabled the Forth Valley whole system UUSC plan it is not yet clear if the national funding for 2026/27 will be targeted at specific interventions or will give flexibility for local prioritisation. However urgent and unscheduled care is one of NHS Forth Valley’s overall priorities to be delivered within its overall available budget.

Clackmannanshire & Stirling Implications

Clackmannanshire and Stirling HSCP is currently developing its approach to implementing Shifting the Balance of Care, building directly on the learning and evidenced outcomes from the Falkirk test of change. This work is fully aligned with national priorities to deliver Discharge to Assess and Home First principles, ensuring people receive the right care, in the right place, at the right time, and are supported to return home wherever clinically appropriate.

The emerging model within Clackmannanshire and Stirling will focus on a ‘home to assess’ approach that delivers person-centred, holistic assessment and time-specific support in individuals’ homes, including access to 24-hour support where required. This will strengthen community capacity, reduce time spent in hospital unnecessarily, and improve outcomes through assessment in a more natural, familiar environment. This work forms part of the wider Forth Valley Urgent and Unscheduled Care (UUSC) Programme. A fully developed plan, including timelines and any recurring funding implications, will be incorporated into the overall UUSC plan scheduled for reporting to the NHS Board during 2026/27, ensuring a consistent and sustainable whole-system model across Forth Valley.

Workforce Implications

While there were initial challenges in implementing the STBC – Delayed Discharges part of the UUSC plan over Summer 2025, the ambitions of the plan have been fairly widely supported by all stakeholders including staff.

The STBC - Delayed Discharges evaluation report, which covered the period June – October 2025, found that for overall staff experience, staff broadly viewed the model positively, particularly in terms of improved collaboration, problem-solving and

| Recurring costs | £000s |
|---|--------------|
| Ongoing costs for 32 initial additional discharges | 916 |
| Ongoing staffing costs (OT/Physio/Therapy Asst Prac/Social Worker) | 252 |
| Overnight and MECS support additional staffing (2 co-ord/18 MECS staff) | 805 |
| Outsource care at home hours to free up additional in house capacity | 260 |
| GP assessment enhanced service | 32 |
| Equipment/other costs | 30 |
| Total costs | 2,295 |
| | |
| Funding available | £000s |
| NHS Forth Valley transfer of budget | 2,027 |
| HSCP internal budget | 268 |
| Total Funding | 2,295 |
| Shortfall to be funded from within IJB existing budget | 0 |

shared ownership of discharge decisions across hospital and community teams. However, it did find that while staff are supportive, the model can increase workload intensity and requires realistic workforce modelling in community teams, including assessors, Home First, ReACH and care providers. These considerations are being taken forward through the ongoing Care at Home redesign within Falkirk Health and Social Care Partnership.

Learning from the implementation of this model has supported roll-out of the other UUSC programmes. An evaluation of the workforce implications for the other elements of the UUSC plan has not yet taken place and will form part of the proposed follow-on report.

Quality / Patient Care Implications

Supporting national and local strategy implementing a Home First approach. This reduces risks on site such as falls, hospital acquired infection, deconditioning and institutionalisation.

The STBC and wider UUSC programme reduces length of stay in hospital and supports patients to receive the right care, at the right place, at the right time. It is important to highlight that every unnecessary day in hospital increases the risk of an adverse outcome for the individual, drives up the demand for institutional care and reduces the level of investment that is available for community support.

Population Health & Care Strategy

This approach and discharge to assess links to several key priorities within the NHS Forth Valley's Population Health & Care Strategy 2025 – 2035:

- **Reducing Inequalities:** Address social and economic factors, physical environment, health behaviours, and access to care.
All patients who are clinically well will be considered for a reablement and/or discharge to assess approach.
- **Delivering Care Closer to Home:** Expand community-based services and support and reduce hospital stays.
This approach supports patients to receive assessment, care and rehabilitation within their home environment. This reduces patients going straight from an acute hospital site to a care home as their trajectory, increasing opportunity for cultural change (within the population and staffing group).
- **Value Based Health and Care:** Use resources effectively to improve health outcomes, reduce waste and ensure sustainability.
Discharge to assess creates a flexible, resilient and dynamic approach to assessment at home. We can efficiently utilise a multidisciplinary approach throughout a time limited assessment period, establishing goals and outcomes at home (where patients tend to recovery more quickly in their home environment).
- **Developing our Workforce:** Attract and retain a diverse workforce and provide opportunities for ongoing training and development.
Discharge to assess provides a dynamic approach in supporting patient discharge and outcomes – supporting a transition from a hospital site to home, utilising different skills, information sharing and reablement approach to discharge.

- **Working Collaboratively:** Work with local councils, community organisations, and other key partners to tackle health inequalities and support wellbeing
This is an integrated approach between health and social care professionals within Forth Valley.

Climate Change / Sustainability Implications

There are no identified climate change/ environmental sustainability implications identified as linked to the recommendations in this report.

Engagement and Communications

Was statutory engagement with stakeholders required? Yes No

While statutory engagement is not required, there has been wide engagement with key stakeholders including:

- People in hospital, residents of Falkirk HSCP
- Care at home staff – internal and external provision
- AHP staff
- Elected members
- Advocacy
- Primary Care
- District Nurses
- Hospital at home
- Reach services
- Acute hospital services and areas
- Intermediate Care Settings & staff
- Home First
- MECS
- Locality Adult Social Work Services
- Carers Centre and Carers
- Service user representative

Appendices

Appendix 1 – Main report

Appendix 2 – Shifting the Balance of Care Evaluation Report

Appendix 3 - EPIA

Appendix 1: Main Report

1. Introduction

There are a number of pillars to the overall Forth Valley UUSC Plan, each at different stages of delivery. This report sets out the various elements of the plan, and what impact (metrics) we expect to see changing in the UUSC system as they become operational and optimised:

1. 12 Week ED improved Flow Programme
2. Embed Criteria to Reside as Business as Usual
3. Implement Integrated Discharge Service
4. Shifting the Balance of Care – Delayed Discharges
5. Expand Hospital at Home
6. Develop Discharge to Assess Pathway
7. Improve Digital Visibility and Real Time Flow Data
8. Implement Frailty at the Front Door 7 days a week

It is highlighted that there are a range of variables out with our control, and also multiple improvement actions may contribute to changes in measurable indicators.

Centre for Sustainable Delivery (CfSD) has provided evidence to support the development of our plan and at the national Winter Pressures meeting held on 26 February, CfSD confirmed that our Forth Valley system is focussing on the right areas and there is clear evidence of progress being made. This is displayed in the charts further on in this paper.

It is highlighted that a positive culture and whole system working is critical for both changes to be implemented, and improvements to be realised and sustained. We continue to nurture a positive culture across all levels in our Forth Valley system.

2. Summary of UUSC Plan pillars

| 1. 12 Week ED Flow Programme | |
|---|---|
| Brief Description | Current Status |
| <p>This rapid improvement programme commenced 1 March 2026 and includes a number of front door and immediate actions including:</p> <ul style="list-style-type: none"> • Breach Analysis – driving targeted improvement and real-time escalation • Internal professional standards – strengthening consistency and clinical responsiveness • Strengthened redirection pathways with increased use of community alternatives and Hospital at Home | <p>This work was paused due to whole system peak pressures during January and February 2026. Full implementation recommenced on 1 March 2026.</p> |

| 1. 12 Week ED Flow Programme | |
|--|---|
| Brief Description | Current Status |
| Expected Impact | Impact seen to date |
| <p>Target greater or equal to 5% improvement in A&E performance by end of March 2026.</p> <ul style="list-style-type: none"> • Daily operational standards: triage within 15 minutes; first assessment within 60 mins • Reduction in ED occupancy • Zero tolerance of 8 & 12 hour breaches • Reduction in hospital occupancy | <p>The performance has largely remained stable through the highest peak period of the year.</p> |

| 2. Embed Criteria to Reside as Business as Usual | |
|---|--|
| Brief Description | Current Status |
| <p>Criteria to Reside involves the review of all patients in the hospital on a daily basis to consider whether they can be supported somewhere other than in the acute hospital, by considering ten different criteria to reside including whether the patient:</p> <ul style="list-style-type: none"> • is clinically fit for discharge • has ongoing oxygen requirement • is receiving IV therapy • is receiving IV antibiotics • is awaiting a diagnostic test • is awaiting speciality input/ review • is receiving ongoing acute intervention/ treatment • is awaiting initial assessment by AHP to inform discharge plans • is receiving rehabilitation which can only be delivered by acute AHP or in an acute setting • is receiving end of life care that requires to be delivered in an acute setting or if it is the patient's wish to remain in hospital <p>For each of these criteria, the team considers what other options could be put in place to safely deliver the care required at home or in a more homely setting and/ or as an outpatient.</p> | <p>Commenced December 2025. Currently being utilised 3 x days per week supporting identification of people who no longer required acute care and enabling earlier escalation of barriers at daily feedback sessions.</p> <p>Ward level discharge coordination is key to supporting Criteria to Reside in advance of the Integrated Discharge Service (IDS) being established, the temporary ward based Discharge Coordinator roles have been extended for a six month period to coincide with the IDS development.</p> |

| 2. Embed Criteria to Reside as Business as Usual | |
|---|--|
| Brief Description | Current Status |
| Expected Impact | Impact seen to date |
| <p>This process will enable more efficient discharge and progress of each patient journey. Will help to reduce FVRH occupancy level.</p> <p>Once established will support overall discharge without delay programme. Ward level discharge reliability will be strengthened.</p> | <p>Criteria to reside was initially implemented during December, and aligned with a range of improved performance indicators.</p> <p>During January and into February following an initial deterioration in performance, ED performance has remained stable to improving with reductions seen in both 8 hour and 12 hour waits.</p> <p>It is noted that improvements coinciding with Criteria to Reside have also coincided with additional resource being made available for community capacity through slippage funding, reflecting the interdependency of a range of improvement actions.</p> |

| 3. Implement Integrated Discharge Service | |
|---|--|
| Brief Description | Current Status |
| Expected Impact | Impact seen to date |
| <p>An Integrated Discharge Service (IDS) is one of the key recommended actions within Discharge without Delay. The Forth Valley proposal would see the individual discharge teams, connected to each Partnership and the Acute team, come together into a single integrated discharge service, structured around patient pathways.</p> <p>This will support clearer roles, a single point of coordination, and pathway based discharge teams.</p> | <p>Proposals for this service are currently going through governance approval (at time of report, has been approved by Falkirk SLT, NHS FV SLT), with engagement/ consultation with staff and trade unions anticipated to be concluded by April 2026, to support an implementation period during May to September 2026, allowing the refined team to be fully operational by Winter 2026/27.</p> |
| <p>It is expected that the Integrated Discharge Service will impact positively on a number of indicators including:</p> <ul style="list-style-type: none"> • Admission rates • Community waiting list • Current discharge team activity levels <p>Note – some of the current mitigating activities such as ward based coordinators and the criteria to reside work will currently be impacting on these indicators, so the implementation of this service will help to stabilise</p> | <p>Not yet commenced.</p> |

| 3. Implement Integrated Discharge Service | |
|--|----------------|
| Brief Description | Current Status |
| where there are improvements already being achieved. | |

| 4. Shifting the Balance of Care – Delayed Discharges | |
|---|--|
| Brief Description | Current Status |
| <p>Shifting the Balance of Care (STBC) is a focussed intervention to support discharge of people already delayed in hospital and to shift care closer to home, supported by community capacity and Discharge to Assess (D2A) principles.</p> <p>In May 2025, NHS Forth Valley Board approved a <i>nonrecurring</i> transfer of £2.027m to Falkirk Integration Joint Board (IJB) reserves to support the development and capacity within a D2A model during 2025/26.</p> <p>This funding enabled rapid discharge of patients, shifting resource and operational focus from acute hospital care towards community-based pathways.</p> <p>The cohort of patients supported through this approach were patients who under the previous model would have waited in hospital prior to going into a long term care home.</p> | <p>Test of change still ongoing. Work underway to redesign the care at home model of care in Falkirk to improve efficiency and sustainability. Funding sought from NHS Forth Valley to continue model during 2026/27 while work on the overall UUSC plan continues.</p> <p>Clackmannanshire and Stirling HSCP seeking to adopt learning from the Falkirk test of change to support the redesign of the discharge to assess approach for their patients.</p> <p>Objectives Going Forward:</p> <ol style="list-style-type: none"> Maintain and Improve Delayed Discharge Performance - Ensuring Falkirk HSCP remains aligned with national performance levels per 100,000 population. Strengthen Community Pathways - Further development of care at home and assessment at home approaches to reduce pressure on acute hospital services. Maximise Whole-System Use of Public Resources - Ensure funding is deployed in the right parts of the system to deliver best value and better outcomes. Support Timely Return Home from Hospital - Reducing harms associated with prolonged hospital stays and improving patient and primary care outcomes. Stimulate Further Innovation - Support ongoing culture change, reablement, and embedding D2A principles across services. Demonstrate Affordability and Efficiency - Demonstrate that the |

| 4. Shifting the Balance of Care – Delayed Discharges | |
|--|--|
| Brief Description | Current Status |
| | recurring transfer of resource to the IJB budget delivers ongoing system efficiencies and sustainability. |
| Expected Impact | Impact seen to date |
| <ul style="list-style-type: none"> • Reduced delayed discharges for Falkirk patients • Reduced length of stay for Falkirk patients | <p>An evaluation was conducted for the period of the test of changes from June 2025 – October 2025. It found the following benefits:</p> <p>Improved Patient Flow</p> <ul style="list-style-type: none"> • Reduced length of stay for Falkirk patients • Sustained reduction in delayed discharges • Fewer patients boarding in acute hospital areas <p>Better Outcomes for People</p> <ul style="list-style-type: none"> • About 60% of individuals previously discharged to care homes were instead supported to return home with care at home • This has protected care home capacity for those most in need • More people able to retain independence and achieve personal outcomes <p>System-Level Benefits</p> <ul style="list-style-type: none"> • Improved whole-system flow • Optimised resource use across acute and community sectors • Enhanced capacity for planned care <p>While there have been a range of improvements ongoing, the graphs below show the difference in delayed discharge performance and length of stay across both partnerships: Falkirk has implemented the STBC test of change and Clackmannanshire and Stirling have not yet implemented.</p> |

| 5. Expand Hospital at Home Capacity | |
|--|--|
| Brief Description | Current Status |
| Hospital at home allows patients to receive treatment in a safe way without having to be admitted to hospital. | <ul style="list-style-type: none"> Hospital at Home: Utilisation remained strong at 82.9%–92.4%, slightly below the optimal 90–95% range. |
| Expected Impact | Impact seen to date |
| Better patient experience Reduced LOS | <ul style="list-style-type: none"> Work continues toward expanding capacity to 112 beds by December 2026. |

| 6. Develop Discharge to Assess Pathway | |
|--|--|
| Brief Description | Current Status |
| This workstream expects to develop consistent discharge to assess pathways across Forth Valley. Building on existing pathways and reducing variation. | Project is in early stages, setting out terms of reference and reviewing current D2A pathways in Forth Valley and elsewhere. |
| Expected Impact | Impact seen to date |
| Greater consistency and awareness across the Forth Valley system of discharge to assess. It is expected that this will support more people to leave hospital, once clinically ready, to receive their assessment at home or in a more homely environment. This may reduce longer term social care demand as a result of assessments being carried out in a more appropriate place. | Not yet implemented. |

| 7. Improve Digital Visibility and Real Time Flow Data | |
|--|--|
| Brief Description | Current Status |
| Ensuring that the teams have a single source of data for the improvement work underway | A data group has been formulated with the Head of Information Services chairing the group. |
| Expected Impact | Impact seen to date |
| Clear concise meaningful data that is used and owned by the operational teams | Group has started to formulate the data it requires to measure their improvement journeys. |

| 8. Implement Frailty at the Front Door 7 days a week | |
|--|---|
| Brief Description | Current Status |
| Frail patients are identified through a protocol and are admitted to the frailty unit to ensure the patient receives the | Frailty at front door is currently running 5 days per week. |

| 8. Implement Frailty at the Front Door 7 days a week | |
|---|--|
| Brief Description | Current Status |
| right care at the right place, first time. Our current target for direct discharges from the unit is 50%, we achieved 25% in the month of February. | |
| Expected Impact | Impact seen to date |
| This will reduce the LOS of stay for this cohort of patients and overall reduce the LOS for medical beds. | Frailty at the front door is identifying and managing the right patients but is reliant on D2A and stepdown capacity to see full benefits going forward. |

3. Evidence of Performance Impact to Date:

The following section shows evidence of impact of the UUSC plan to date.

3.1. Medical bed occupancy with FVRH:

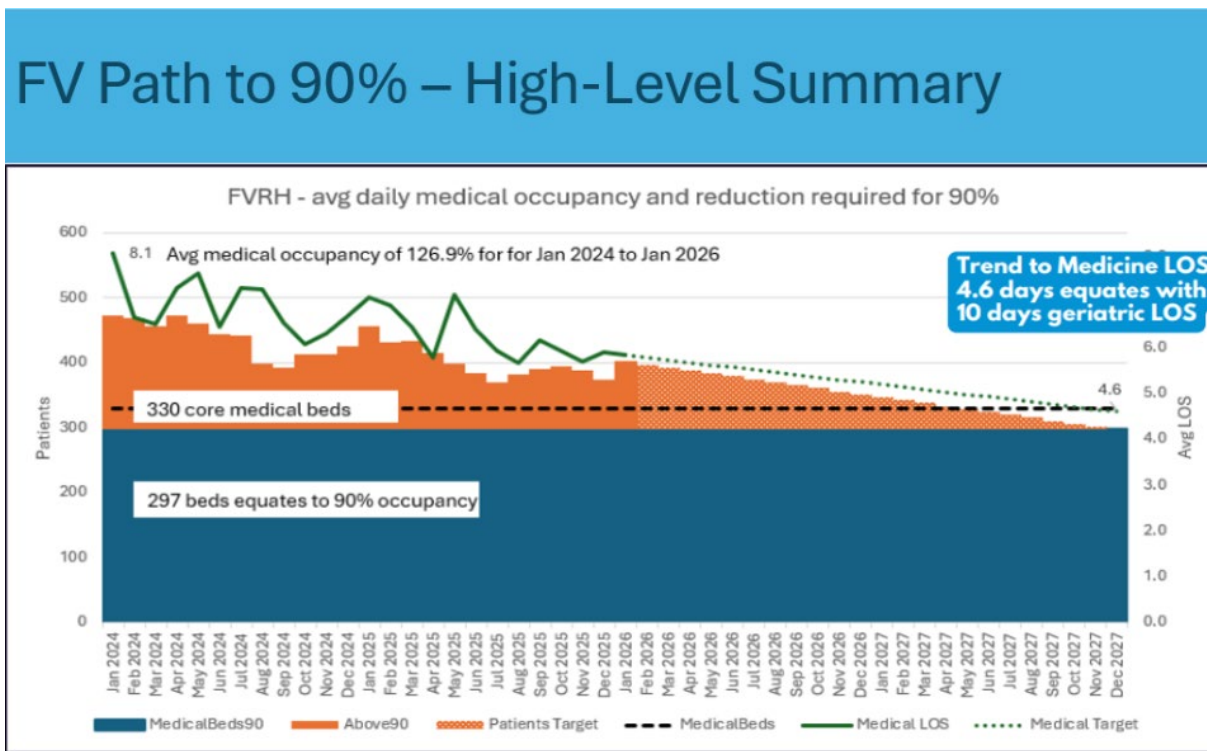


Chart 1.

The chart displays the progress made over the last two years to reduce the occupancy level on the FVRH site towards 90%. This is a key aim which would allow the acute site to function more efficiently and in turn increase the performance of the 4 EAS as well as other metrics. There are a range of our UUSC planned actions that are contributing to this including STBC and Frailty at the Front door, both of which went live early Summer 2025.

3.2. Forth Valley Royal Hospital Length of Stay

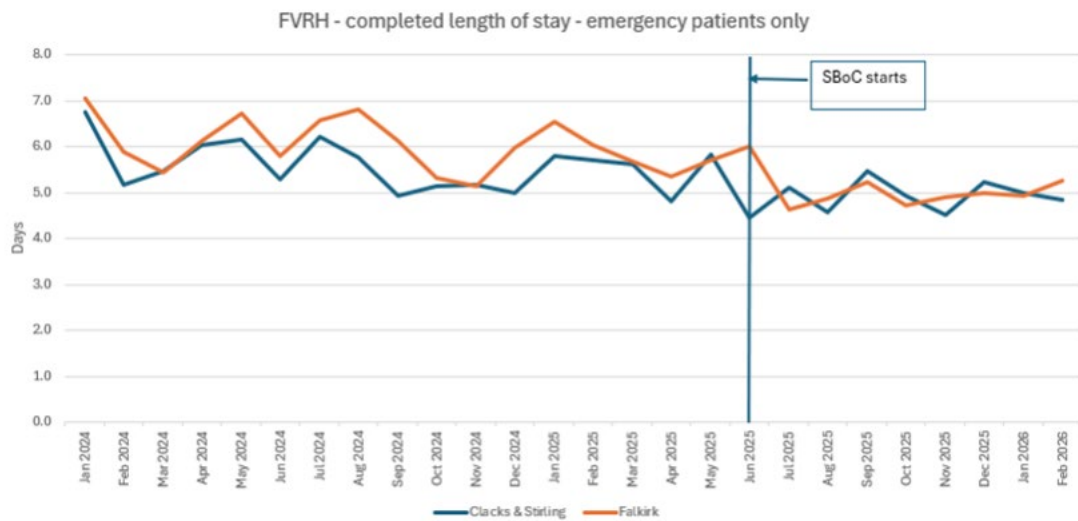


Chart 2:

The above charts illustrates the length of stay at Forth Valley Royal Hospital for patients across both Forth Valley HSCPs. The chart shows a similar trend direction for both areas. The data behind gives an average LoS across June 25 to February 26 as 5.1 days for Falkirk and 4.9 for Clackmannanshire and Stirling. For the equivalent period the year before, the figures were 6 days for Falkirk and 5.4 days for Clackmannanshire & Stirling. While both areas have seen a reduction since the introduction of Shifting the Balance of Care, Falkirk's reduction has been greater and brings its length of stay closer to the Clackmannanshire and Stirling HSCP average.

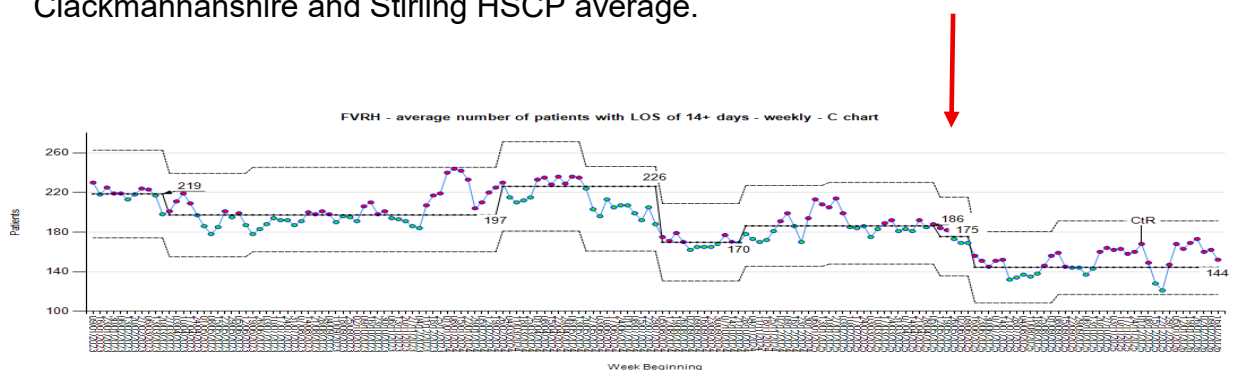


Chart 3:

The above chart shows the number of patients with a Length of Stay (LOS) over 14 days in duration. The red arrow shows the commencement of shifting the balance of care, the commencement of Criteria to Reside is also shown which coincided with additional community capacity being made available through slippage funding. Following each intervention there was a notable drop in the number of patients with an average LOS of over 14 days.

3.3. Delayed Discharges

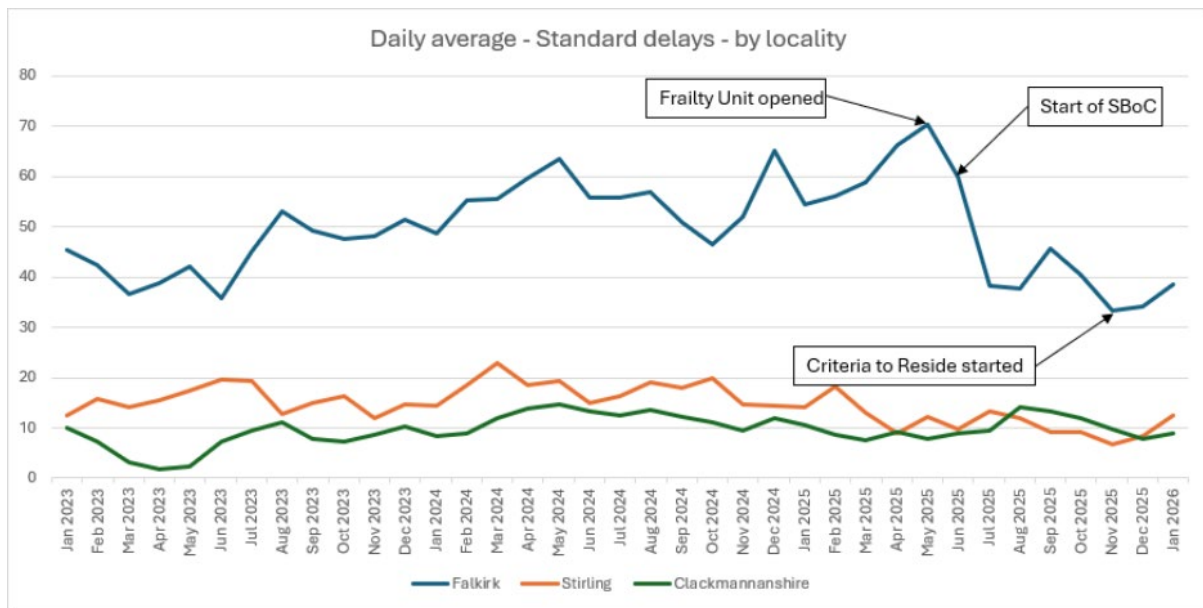


Chart 4:

The chart above shows Falkirk’s standard delays as of 26 February 2026. The data indicates a steady decline from previously high standard delay levels to around 35. This suggests a significant process shift coinciding with the launch of Shifting the Balance of Care in June 2025. Since that point, there has been a consistent, maintained, and sustained reduction in standard patient delays. Notably, these low levels have not been seen since Summer 2023. On review of Stirling and Clackmannanshire HSCP data, where the STBC was not implemented the same significant reduction which is then sustained is not observed. In Falkirk there is a clear and continued shift of around 20 – 30 people who are delayed in their discharge. At a national level this has seen Falkirk shifting from being one of the lowest performing HSCPs to being constantly around the Scottish national average for the last eight months.

4. Shifting the Balance of Care – Business Case

A detailed business case has been developed to consider how the benefits of the Shifting the Balance of Care may be sustained. A summary of this business case is set out below:

4.1. Purpose and Context

The Shifting the Balance of Care programme is a community-based 24/7 Discharge to Assess (D2A) model designed to support people to leave hospital earlier and be assessed at home rather than in hospital or moving directly into long-term care. The model was introduced as a test of change from June 2025, aligned to the national Discharge without Delay programme and wider integrated discharge service development across Forth Valley.

4.2. Model of Care

The approach enables patients who would otherwise be delayed in hospital—often those on a trajectory towards care home admission—to return home promptly with time-limited support. This includes:

- Daytime care provided by external care at home providers
- Overnight support delivered by MECS
- Multidisciplinary assessment and rehabilitation in the person's own home
- An assessment period of up to **21 days**, with care reducing as independence is maximised

The model is explicitly grounded in Home First principles, ensuring people receive the right care, in the right place, at the right time.

4.3. Outcomes and Benefits

Early evaluation evidence demonstrates positive system-wide and individual outcomes, including:

- **Reduced delayed discharges** and improved patient flow across Forth Valley Royal Hospital
- **Shorter hospital length of stay**, particularly for older people
- Approximately **60% of people initially expected to require long-term care remaining at home with support**, improving outcomes and reducing reliance on institutional care
- Improved multidisciplinary working and more timely identification of patients suitable for discharge
- Reduced risks associated with prolonged hospital stays, including deconditioning and hospital-acquired infection.

As the model matured, assessment periods at home reduced, indicating improved efficiency and embedding into routine practice.

4.4. Options Appraisal and Recommendation

The business case considered two core options:

- **Option 3A:** Revert to the previous discharge model from April 2026
- **Option 3B:** Continue the Shifting the Balance of Care / Discharge to Assess model

Option 3B scored more strongly against agreed objectives, delivering better outcomes for people, improved system flow, and more effective use of resources. The recommended option is therefore to **continue the Shifting the Balance of Care model on a recurring basis**, subject to agreed funding and governance arrangements.

4.5. Strategic Fit

The programme supports national and local priorities, including:

- Discharge without Delay
- Reducing avoidable hospital stays
- Shifting care from acute to community settings
- Preventing unnecessary admissions to long-term care
- Maximising independence and outcomes for people

It also complements other system improvements, such as criteria-to-reside, frailty pathways and integrated discharge services, contributing to whole-system resilience rather than acting in isolation.

4.6. Conclusion

Overall, SBTC is a necessary and effective intervention for a defined downstream problem (reducing coded delays and improving discharge outcomes for a targeted cohort), and as a key part of the whole system improvement underway. The charts support that progress has been made, and sustaining improvement will depend on the broader U&UC programme, particularly strengthening reliable discharge planning through DWD and completing IDS development to support consistent pathway-based discharge coordination and access to community capacity.

Shifting the Balance of Care Evaluation Report

Evaluation report, 2025

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Document information

| | |
|-----------------------------|--------------|
| Date of issue: | October 2025 |
| Approval status: | |
| Available from: | |
| Alternative formats: | |
| Key contact: | |

Executive Summary

This report presents the findings of an evaluation of the *Shifting the Balance of Care* (SBoC) model, a discharge to assess approach implemented in Falkirk during 2025/26. The model aimed to reduce delayed discharges, improve patient flow, and shift assessment and care planning from hospital to community settings. It was introduced as a test of change, supported by a non-recurring transfer of £2.021 million, with the goal of discharging at least 32 additional patients and enabling the reprovision of a 32-bedded acute ward.

The evaluation explored how the model was implemented, what outcomes it achieved, and how it was experienced by patients, carers, and staff. It drew on qualitative data from implementation meetings, staff reflections, and patient surveys, alongside quantitative analysis of hospital and social care metrics.

Key findings include:

- **Discharge efficiency:** The model coincided with a reduction in delayed discharges and hospital length of stay for older adults. Ward A11 was successfully transitioned, and acute occupancy temporarily declined.
- **Patient experience:** Survey responses indicated high levels of satisfaction with the discharge process, care quality, and communication. Patients appreciated being assessed at home and felt safer and more supported.
- **Staff perspectives:** Staff reported improved collaboration and problem-solving, but also highlighted challenges with information sharing, documentation quality, and provider capacity.
- **System learning:** Operational adaptations were made during implementation, including changes to MDT structures, commissioning processes, and contingency planning. These reflect a responsive approach but also point to areas requiring further development.

The evaluation found that the model broadly aligned with its original objectives and the assumptions underpinning its theory of change. Community-based assessment supported person-centred care and discharge efficiency, and the model showed potential to reduce hospital-associated deconditioning. However, the evaluation also identified limitations, including data quality issues, short evaluation duration, and the need for ongoing investment and system integration to sustain and scale the approach.

Overall, the SBoC model has demonstrated promise as a more responsive and person-centred discharge pathway. The findings will inform future planning, including decisions about mainstreaming the model and strengthening infrastructure to support its delivery.

Context / Background to the Shifting the Balance of Care Approach

Background and Rationale for Implementing the Discharge to Assess Model

The implementation of the discharge to assess model in Falkirk forms part of a broader strategic initiative to shift the balance of care from acute hospital settings to community-based services. This approach responds to a range of system-wide challenges, including increasing demand for hospital care, persistent delayed discharges, and the need to improve patient flow and system efficiency.

The model was introduced as a test of change during the 2025/26 financial year, supported by a non-recurring transfer of £2.021 million from NHS Forth Valley to Falkirk Health and Social Care Partnership. The funding aimed to support the discharge of at least 32 additional patients from hospital, thereby enabling the reprovisioning of a 32-bedded acute ward (Ward A11 or equivalent).

The rationale for this shift was underpinned by several key objectives:

- Reducing delayed discharges by enabling timely transitions from hospital to home or homely settings.
- Creating hospital capacity for planned care and reducing pressure on acute services.
- Improving patient outcomes by minimising the harms associated with prolonged hospital stays.
- Enhancing system efficiency through better use of community resources and a “spend to save” approach.
- Supporting integration and transformation across health and social care services.

The discharge to assess model prioritises the principle of providing the right care, at the right time, in the right place. It enables individuals who no longer require acute care to be discharged promptly, with assessments and care planning taking place in the community. This approach aligns with the Partnership’s Strategic Plan and national policy objectives around integrated, person-centred care.

The model builds on existing resources and practices, refocusing assessment into the individual’s own familiar environment over a 21-day period. This setting allows for more accurate and less stressful evaluations of care needs, supporting independence and recovery. It also enables social work and ReACH staff to gather a clearer picture of what support is required, avoiding both over- and under-provision of care.

The test of change was designed to be evaluated throughout its implementation, with the aim of informing a longer-term business case and potential mainstreaming of the model. The evaluation focuses on understanding how the model was implemented, the outcomes it achieved, and the experiences of those involved.

Summary of Existing Research on Discharge to Assess Models

Across the reviewed literature, there is broad consensus that the Discharge to Assess model offers potential benefits for both patients and health systems, particularly in reducing delayed

discharges and improving patient flow. However, the effectiveness of Discharge to Assess in practice is shaped by a range of interdependent factors, and outcomes vary depending on how well these are addressed.

Implementation factors

Several studies emphasise that successful implementation of Discharge to Assess depends on clear operational policies, adequate resourcing, and effective multidisciplinary collaboration. Jeffery et al. (2023) and Gadsby et al. (2022) both highlight the importance of having a shared understanding of the pathway's purpose among stakeholders. Where Discharge to Assess was framed primarily as a mechanism to free up hospital beds, its person-centred potential was often compromised. Horton and Wood (2022) similarly emphasise that improvements in discharge are most successful when driven by front-line staff seeking to improve patient care, rather than simply reduce length of stay.

Communication emerged as a critical enabler or barrier across all studies. Meehan et al. (2018) found that poor communication with patients and carers, particularly around discharge planning and follow-up care, was a common source of dissatisfaction. Similarly, Gadsby et al. identified that patients often felt excluded from decisions, and that professional boundaries between hospital and community teams hindered co-ordination. The absence of shared digital records and inconsistent information flows were also noted as obstacles to continuity of care.

Capacity within community services was another recurring theme. The studies consistently reported that the success of Discharge to Assess was contingent on the availability of timely assessments and support in the community. Where services were overstretched or under-resourced, patients experienced delays, unmet needs, or were discharged into environments ill-equipped to support recovery. Horton and Wood warn that without adequate resourcing, Discharge to Assess risks discharging patients without the necessary support, particularly as ringfenced discharge funding has ended. Edwards and Anwer (2019) demonstrated that Discharge to Assess could improve unscheduled care performance but also showed that these gains were not sustained once the pilot ended, underscoring the need for long-term investment.

Outcomes for patients

In terms of patient outcomes, the evidence presents a mixed picture. Meehan et al. found that most patients appreciated being discharged earlier and assessed in their own homes, with satisfaction increasing as the scheme matured. However, the same study revealed that patients with more complex needs, such as those requiring physiotherapy or district nursing, were more likely to report negative experiences. This suggests that Discharge to Assess may be more effective for patients with lower levels of need, and that additional safeguards are required for those with higher dependency.

Gadsby et al. also noted that some patients felt “pushed” out of hospital before they were ready, and that the emotional and relational aspects of care were often overlooked. The lack of support for carers and the assumption that informal networks would fill gaps in provision were identified as ethical concerns. These findings point to the need for a more nuanced approach to

discharge planning, one that considers not only clinical readiness but also social and psychological preparedness.

System-level impacts

At the system level, Discharge to Assess has been shown to improve hospital flow and reduce escalation status, as evidenced by Edwards and Anwer. However, these improvements are fragile and dependent on sustained implementation. Jeffery et al. argue that without robust oversight and outcome monitoring, it is difficult to assess whether Discharge to Assess is delivering its intended benefits beyond throughput metrics.

Horton and Wood caution that the withdrawal of discharge funding could exacerbate pressures on bed capacity. They also highlight the potential of virtual wards and hospital-at-home models to support discharge, though they note that these cannot fully replace the need for dedicated Discharge to Assess infrastructure.

Conclusion

Taken together, the research suggests that Discharge to Assess can be a valuable approach to discharge planning, but its success is not guaranteed. It requires more than a procedural shift, it demands cultural change, investment in community capacity, and a commitment to person-centred care. The model works best when patients and carers are actively involved, when services are well-coordinated, and when outcomes are monitored and used to drive improvement. Without these conditions, Discharge to Assess risks becoming a short-term fix rather than a sustainable solution.

Description of the Model in Falkirk

The discharge to assess model implemented in Falkirk is designed to facilitate timely discharge from hospital by shifting rehabilitation, assessment and care planning into the community. The model enables individuals who no longer require acute medical care to leave hospital promptly, with their ongoing needs assessed and addressed in a more appropriate setting.

This approach is centred on the principle of delivering the right care, at the right time, in the right place, and is supported by a flexible, multidisciplinary response. The model includes:

- Community-based assessment and support, led by teams from Home First and ReACH services, including occupational therapists, physiotherapists, therapy assistants, and social workers.
- 24-hour care at home capability, achieved through MECS, with additional staffing introduced to support the initial phase of implementation.
- A 21-day home assessment period, during which individuals' needs are reviewed daily by a multidisciplinary team, allowing care packages to be adjusted as required.
- Rapid discharge planning, particularly during the initial test of change period, with a focus on discharging 32 patients to free up a full acute ward.
- Flexible care packages, including both long-term care placements and care at home arrangements, tailored to individual needs and circumstances.

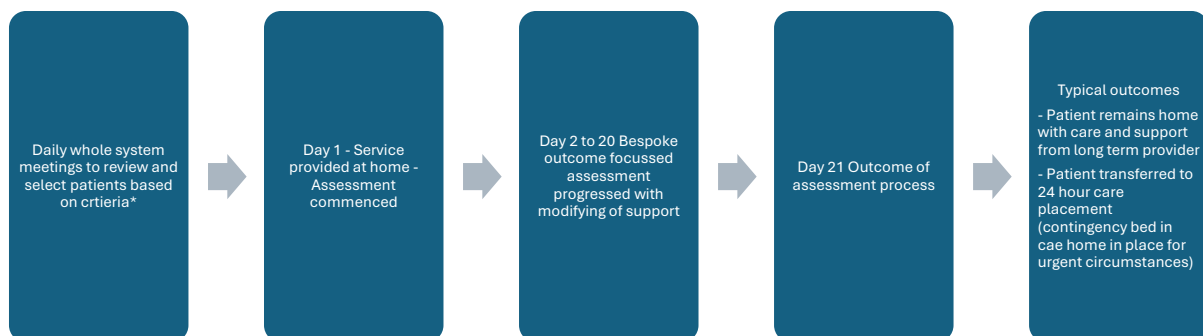
- Operational adjustments, such as the use of the care and support at home framework and scaling up overnight support to ensure continuity of care.

While the preferred pathway involves discharge followed by assessment in the community, the model also allows for direct discharge to long-term care or care at home where appropriate, particularly in cases where assessments have already been completed or urgent discharge is required. The service operates seven days a week.

Implementation of the model required coordinated planning across hospital and community services, with a six-week lead-in period to establish staffing, processes, and stakeholder engagement. Daily hospital meetings identify suitable patients for transfer, guided by clear criteria. Falkirk residents are eligible for discharge under this model, and housing colleagues are engaged to support individuals delayed due to housing issues.

The model reflects a shift in practice and culture, requiring clinical and operational staff to adopt a more proactive and risk-tolerant approach to discharge. It also depends on strong communication and collaboration across the system to ensure safe and effective transitions of care.

Overview of the model:



Theory of Change

| Inputs | Activities | Outputs | Short / medium term outcomes | Long term outcomes |
|---|---|--|---|---|
| <p>Funding transfer from NHS Forth Valley to Falkirk HSCP</p> <p>Staff time and expertise (Home First, Reach, AHPs, social care, MECS, acute staff)</p> <p>External providers offering short-term interim care packages</p> <p>Existing care infrastructure and digital systems (TrakCare, Edison, LAS, MORSE)</p> <p>Governance and project management structures (Whole Systems Board, PMO)</p> <p>District Nursing</p> <p>Technology and equipment</p> | <p>Rapid discharge of 32 patients from acute hospital</p> <p>Provision of interim care packages by external providers</p> <p>Daily MDT meetings to plan and monitor care</p> <p>Weekly PDSA sessions to capture learning</p> <p>Community-based assessment and care planning</p> <p>Engagement with patients, carers, and providers</p> <p>Data collection and performance monitoring</p> | <p>Number of patients discharged through the model</p> <p>Number of assessments completed in the community</p> <p>Number of care packages initiated</p> <p>Weekly meeting logs and action plans</p> <p>Staff feedback and case reviews</p> | <p>Re-provisioning of Ward A11</p> <p>Reduction in delayed discharges</p> <p>Improved patient flow and hospital capacity</p> <p>Reduction in people leaving the acute hospital to long term care</p> <p>Increased staff collaboration and integration</p> <p>Enhanced patient experience</p> <p>Reduced length of stay and hospital-related harm</p> <p>More accurate and person-centred assessments</p> <p>Improved continuity of care</p> <p>Reduced readmissions</p> <p>Strengthened community care pathways</p> | <p>Sustainable shift in balance of care from hospital to community</p> <p>Improved system efficiency and reduced whole system costs</p> <p>Better health and wellbeing outcomes for service users</p> <p>Cultural change in discharge planning and risk tolerance</p> |

Methodology

Approach to Evaluation

The purpose of the evaluation is to understand how the discharge to assess model was implemented, what outcomes it achieved, and how it was experienced by patients, carers, and staff.

The evaluation is organised around:

- Process – examining whether the model was delivered as intended.
- Outcomes – assessing the impact on system performance and patient outcomes.

Data sources and Methods:

- Qualitative methods include interviews and focus groups with staff, patients, and carers.
- Quantitative methods include analysis of hospital and community care data (e.g. length of stay, readmissions).

Qualitative Data Collection

Several meetings have been established to support the implementation and evaluation of the discharge to assess model. These meetings serve as key sources of qualitative data, offering insight into operational delivery, staff experience, system challenges, and opportunities for improvement. Each meeting contributes a distinct perspective, helping to build a comprehensive understanding of how the model is functioning in practice.

Weekly PDSA Meetings

Weekly Plan-Do-Study-Act (PDSA) sessions have been a central source of qualitative data. These meetings, attended by staff involved in delivering the discharge to assess process, focus on identifying what is working well, what is not working well, and what needs to change. Some sessions have included case reviews to learn from situations where the process did not go as intended. Insights from these discussions will inform analysis of both implementation fidelity and user experience.

Daily MDT Meetings

Daily multidisciplinary team (MDT) meetings are held to discuss patients currently supported through the discharge to assess pathway. These meetings provide real-time feedback on patient progress, risks, care adjustments, and discharge planning. They offer valuable insight into how the model is functioning on a day-to-day basis and how decisions are made collaboratively across services.

Daily Risk and Feedback Drop-In Sessions

Open to all involved in the process, these sessions provide a space for staff to raise concerns, share feedback, and identify risks. They support continuous learning and system responsiveness and will be used to capture themes around operational challenges and staff experience.

Weekly Internal and External Progress Meetings

These meetings focus on reviewing progress, updating actions, and coordinating across internal teams and external partners. They offer insight into strategic alignment, inter-agency collaboration, and the broader system context in which the model is being delivered.

Notes, action logs, and reflections captured through these forums will be analysed to understand how the model was implemented, how it evolved, and how it was experienced by those involved in its delivery.

Quantitative data

Quantitative data will be used to assess the impact of the discharge to assess model on system performance, patient flow, and care outcomes. The evaluation will draw on routinely collected health and social care data, supplemented by project-specific metrics.

The following indicators will be collected and analysed:

- Total number of delayed discharges
- Number of hospital discharges following a period of delay
- Average length of delay, disaggregated by delay type
- Hospital length of stay for patients aged 65 and over admitted as emergencies
- Number of hospital beds closed as a result of the initiative
- Number of beds that remained closed following implementation
- Overall hospital capacity, measured in terms of bed numbers and occupancy rates
- Hospital readmission rates
- Number of patients supported through the discharge to assess model
- Length of time each patient was supported under the model
- Service user outcomes, where available through linked data or follow-up assessments

These measures will be analysed over the course of the test of change period and compared to baseline data from the preceding months. Where possible, trends will be examined over time to assess the sustainability of any observed improvements.

Data is taken from NHS Forth Valley systems (e.g. TrakCare, Edison), social care records, and internal performance monitoring tools. The analysis will focus on identifying changes in performance, understanding variation, and assessing the extent to which the model has contributed to improved outcomes and system efficiency.

Research Questions

Processes

- Was the discharge to assess model implemented as intended across sites and teams?
- What were the key barriers and enablers to implementation?
- How did staff experience the transition to discharge to assess?

Outcomes

- Has the discharge to assess model reduced hospital length of stay and delayed discharges?
- What impact has discharge to assess had on readmission rates and care continuity?
- Has the model led to more efficient use of health and social care resources?
- Are there differences in outcomes or experiences for different patient groups?
- How do patients and carers perceive the quality and continuity of care under the discharge to assess model?

Limitations of the Evaluation

While this evaluation aims to provide a comprehensive understanding of the implementation and impact of the discharge to assess model, several limitations should be acknowledged:

Data availability and data quality

Some quantitative indicators rely on routinely collected data from multiple systems (e.g. TrakCare, Edison, Liquid Logic), which may vary in completeness, consistency, and timeliness. In particular, linking data across health and social care systems to track individual outcomes may be constrained by technical or governance barriers.

Attribution of outcomes

The evaluation takes place within a dynamic and complex system, where multiple initiatives and external factors may influence outcomes such as delayed discharges or readmission rates. As a result, it may be difficult to isolate the specific impact of the discharge to assess model from other concurrent changes.

Duration of evaluation period

The test of change is being implemented over a relatively short period, which may limit the ability to assess longer-term outcomes, sustainability, and seasonal variation in system pressures.

Range of qualitative evidence

Much of the qualitative data is drawn from weekly implementation meetings involving staff directly engaged in the process. While these provide rich insights into operational experience, they may not fully capture the perspectives of patients, carers, or staff in other parts of the system. Additional engagement with these groups would strengthen the evaluation.

Rapid implementation

The initial phase of the model involved a rapid discharge of 32 patients, which may have required deviations from the intended discharge to assess pathway (e.g. direct discharge to long-term care). These adaptations, while necessary, may affect the fidelity of implementation and complicate interpretation of outcomes.

Process Evaluation

This section considers the implementation of the Shifting the Balance of Care model from a process evaluation perspective, focusing on how the approach was delivered in practice and the factors that shaped its development. It explores implementation fidelity, drawing on staff perspectives and case reviews to assess how closely the model aligned with its intended design. The analysis highlights key barriers and enablers encountered during delivery, including operational constraints, inter-agency coordination, and workforce capacity. It also reflects on the learning generated through implementation meetings and case discussions, which informed several adaptations to the model over time.

Staff Feedback

The following findings are drawn from Plan-Do-Study-Act (PDSA) weekly meeting notes and staff reflection sessions held on 24 and 28 July 2025. These sources provide insight into how the Shifting the Balance of Care model was experienced by frontline staff, highlighting practical challenges, adaptations, and areas of learning that emerged during implementation.

Collaborative working:

Staff and providers have worked together to deliver the discharge to assess model, with evidence of joint visits, shared problem-solving, and improved understanding of pathways. Daily MDT meetings have supported coordination and problem-solving, and external providers have reported positive experiences of collaboration. However, as noted by Meehan et al. (2018), communication breakdowns are common, and similar issues were observed in Falkirk. Inconsistent attendance at MDTs by some external providers, limited clinical input, and unclear handover points have affected continuity.

Recent meetings highlighted the need to review MDT structure and attendance, especially as the model evolves. There is interest in integrating MDTs into the broader discharge service to reduce duplication and improve coordination. Acute staff have expressed a desire to be more involved in discharge planning and risk assessment.

Earlier engagement with acute staff, community mental health teams, and Trade Unions remains essential to support cultural change and internal staffing options. Some teams continue to express a need for greater support in adapting to changes in their roles.

Information sharing and communication:

Information sharing has been a recurring challenge across the Shifting the Balance of Care (SBoC) process. Delays in receiving discharge letters and incomplete medication information have affected continuity of care. Fragmented data systems and inconsistent referral documentation have created inefficiencies. Staff have noted that multiple SSA forms are in use across sites, and that outdated assessments complicate care package procurement. There is a need for a standardised SSA form and improved coordination of data flow across the system.

Appendix A maps the information flow in greater detail, highlighting the following risks and opportunities:

- System fragmentation: Key systems such as TrakCare, Liquid Logic, and Live Dashboard are not interoperable. Manual data entry is required across platforms, increasing administrative burden and risk of error.
- Limited access: Non-NHS teams (e.g. Home First, MECS, Intermediate Care) have restricted access to TrakCare and the OPEL dashboard, limiting visibility of patient status and acute capacity.
- Delayed and inconsistent SSAs: SSAs are not consistently uploaded to TrakCare and vary in quality, leading to delays in discharge planning and additional screening by receiving teams.
- Communication channels: Reliance on email, Teams chat, phone calls, and face-to-face updates has led to duplication, confusion, and inconsistent information sharing. Providers report difficulty managing the volume of information and lack of clarity around discharge timing and care arrangements.
- Technical barriers: Sharing documents across organisational systems (e.g. between NHS and Falkirk Council M365 tenancies) has proven difficult, limiting collaboration and access to key planning tools.
- Terminology and acronyms: Inconsistent use of terminology and acronyms has caused confusion, particularly among external providers and families.
- Real-time data gaps: Systems do not sync in real time, which delays decision-making and service mobilisation. For example, Live Dashboard updates are manual and not universally accessible.
- Over-reliance on individuals: Some information sharing depends heavily on individual liaison roles, which creates vulnerability in the event of absence or workload pressures.

Despite these challenges, some improvements have been noted, such as advance updates from teams prior to MDT meetings. However, there remains a clear need to streamline communication, standardise documentation, and improve system integration to ensure that all relevant information is available in a timely and accessible format.

Assessment and discharge planning:

Variation in the quality and completeness of Single Shared Assessments (SSAs) has been identified, with multiple versions of the form in use and many submitted with missing or outdated information. There has also been uncertainty around who is responsible for conducting environmental visits and ordering equipment, which has led to delays and duplication. In some cases, patients have been assessed in hospital prior to discharge, before being assessed again in the community.

Reflection sessions highlighted delays in transitioning to long-term care packages and a lack of clarity around service requirements. There is a need to streamline referral documentation and ensure that assessments are up to date. Staff also noted that some patients discharged under the model may have been suitable for standard care pathways, suggesting a need to review criteria.

Capacity and resource use:

Staffing pressures have affected the pace of care package reviews and raise concerns about the sustainability of the current approach. Provider capacity has varied, with some providers unable to fulfil care packages and others adapting more readily. There is a need to assess how existing capacity is being utilised and whether the model can be sustained beyond the initial test of change. Feedback from assessors has indicated that the current approach may not be sustainable, particularly during periods of high staff absence.

Providers reported challenges in managing fluctuating care hours and sourcing two-carer packages. Staff raised concerns about increased demand without additional resources, and the impact of annual leave and sickness on service delivery. There is a need to model how many patients can realistically be supported each week and to assess the sustainability of the current approach.

Concerns about sustainability were reinforced, with staff noting the need for realistic planning, mobilisation of new frameworks, and clear financial modelling. Trade Union engagement and internal staffing implications require further attention. Posts funded through the project have not always increased capacity due to internal secondments or unfilled roles. Staff have raised concerns about increased demand without additional resources, and the impact of annual leave and sickness on service delivery.

Financial sustainability is also a concern, with long-term care costs currently absorbed within the project budget. Discussions have begun around integrating these costs into existing service budgets.

Commissioning and procurement:

The Care and Support at Home Framework has been described as lacking flexibility, which has made it difficult to commission care quickly or retain providers who have delivered successful packages. Discussions have taken place about using urgent awards and direct commissioning to improve responsiveness. There is also interest in working with providers on workforce development and identifying what enables some to be more flexible and responsive than others.

Difficulties with SDS paperwork and transitioning from the test of change to standard packages were noted. Staff and providers have called for a streamlined SDS process, particularly for Option 2, and for clearer commissioning pathways. There is interest in developing trusted relationships with a small number of providers and using feedback to inform future service design.

Contingency planning and risk management:

Contingency planning has been necessary in cases where care packages have broken down or individuals have reached crisis. While some situations have been managed effectively, others have highlighted gaps in escalation procedures and admission criteria for intermediate care. There have also been concerns about how high-risk individuals are managed, and whether current legal and risk frameworks are sufficient to support safe discharge planning.

Staff have emphasised the need for clearer contingency planning, especially when care packages break down or when high-risk individuals are discharged. Earlier involvement of the Integrated Mental Health Team and better support for managing stress and distress behaviours were identified as priorities.

Case reviews highlighted the need for better support for managing stress and distress behaviours, especially for individuals with cognitive or mental health needs. Matching carers to clients' needs and learning from care home practices were also suggested. There is a need to develop alternative pathways for urgent support or readmission that do not involve the Emergency Department.

Acting earlier in the patient journey:

There is a growing emphasis on identifying patient needs earlier in the discharge process. Earlier conversations about care needs and better identification of patients before delays occur were highlighted as areas for improvement. Staff have suggested that upstream planning could prevent hospital admissions and improve outcomes, but this requires new tools and processes tailored to the discharge to assess model. Alternatives to SSAs may be needed to support this shift in practice. However, early discharges may not be reflected in traditional performance metrics, which presents a challenge for how success is measured.

Understanding of the model

There is not yet a fully shared understanding across teams regarding the intended outcomes of the model. The discharge to assess approach is sometimes interpreted as aiming to keep individuals at home permanently, leading to concerns when readmissions occur.

Clearer communication around the purpose and scope of the model is needed to ensure expectations are aligned. Acute staff need regular training and awareness sessions to understand their role and feel confident initiating and contributing to the process.

Case Studies

This section presents two case studies (Figure 1 and Figure 2) that demonstrate how the Shifting the Balance of Care approach was implemented in practice. Each case outlines the individual's background, including the reason for hospital admission and their care requirements, followed by a timeline of key actions taken to support their discharge and recovery. These examples offer insight into the practical application of the model, highlighting how coordinated interventions enabled more timely discharge, continuity of care, and improved outcomes for people with complex needs.

Figure 1: Case study for Patient A

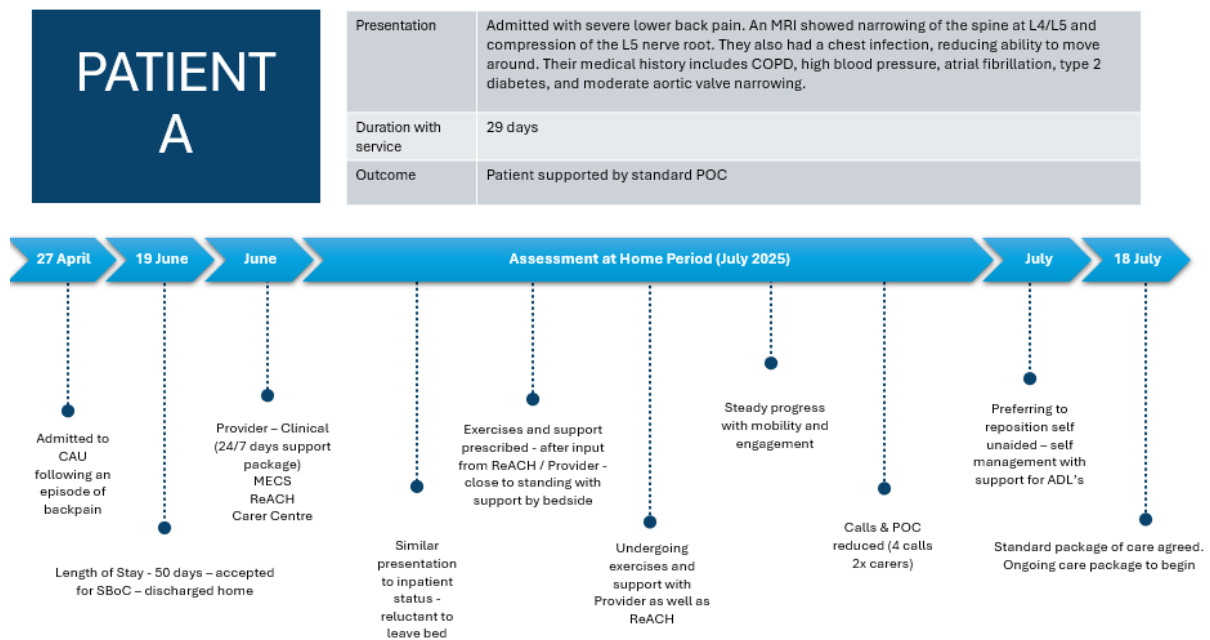
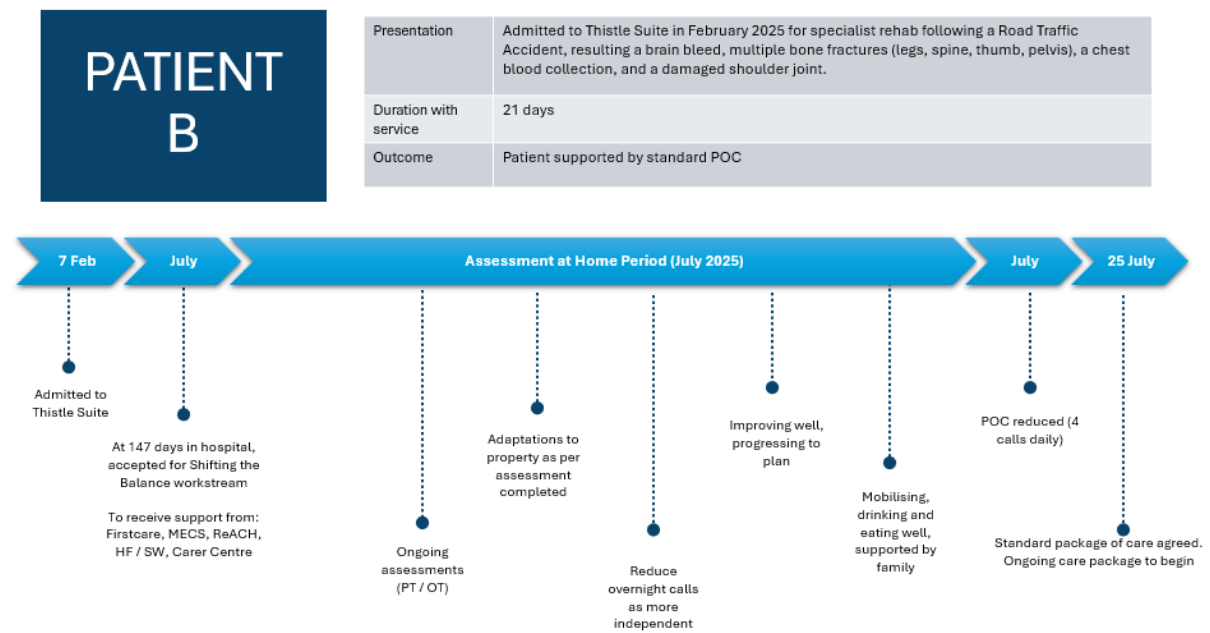


Figure 2: Case study for Patient B



Outcome Evaluation

The outcome evaluation section assesses the extent to which the Shifting the Balance of Care model has achieved its intended impacts. Drawing on both quantitative and qualitative data, this section examines changes in hospital discharge patterns, system efficiency, patient outcomes, and resource use. In doing so, it explicitly revisits the original objectives outlined in the rationale for implementation, such as reducing delayed discharges, freeing up acute capacity, and improving patient flow, to determine whether these goals have been met.

Has the discharge to assess model reduced hospital length of stay and delayed discharges?

The initial implementation of Shifting the Balance of Care coincided with a marked decline in delayed discharges, particularly those related to assessment, suggesting early improvements in discharge processes. While delays subsequently began to rise again, the most recent data shows 66 total delays, which is below the long-term average. More notably, the number of standard delays has reduced and remains below the average, especially in relation to care home and package of care delays. Assessment delays, while still present, have reduced from their earlier peak. Alongside this, average hospital length of stay for people aged 65 and over has fallen for both completed and ongoing stays, remaining lower than for the same period in 2024. These trends suggest that the model may be contributing to improved discharge efficiency, though its impact is likely to be one of several factors influencing current performance.

At the beginning of the Shifting the Balance of Care project, 80 patients were delayed in hospital for all reasons (Figure 3). This figure fell to 63 by the time Ward A11 was re-provisioned. By 28 August, the number of delays had increased slightly to 67, although this remains below the long-term average.

Figure 3: All Delays by date

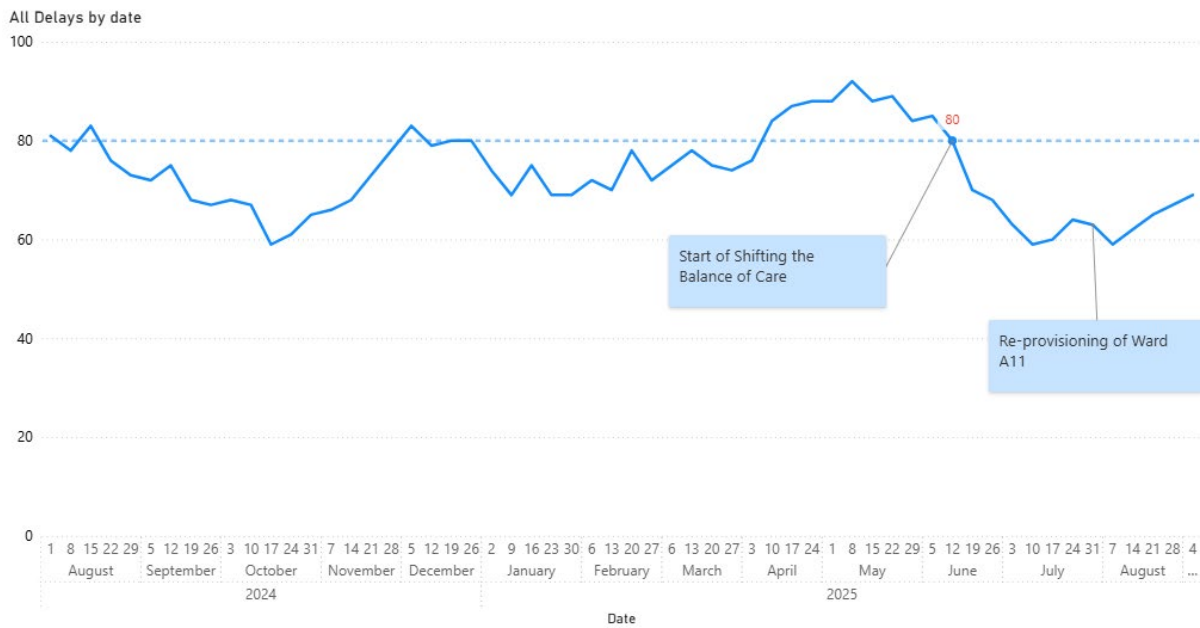


Figure 4 shows the trend in the number of Standard Delays (i.e. delays related to health & social care reasons and patient & family related reasons) over the past year along with the number of patients discharged via Shifting the Balance of Care. The first few weeks of the Shifting the Balance of Care initiative coincided with a steep decline in the number of delays from 59 at the outset of the project on the 10th June 2025 to 30 on the 7th August 2025. Delays subsequently, however, began to rise again, reaching 39 at the end of August, despite a steady rise in the number of patients being discharged.

Figure 4: Standard Delays by date

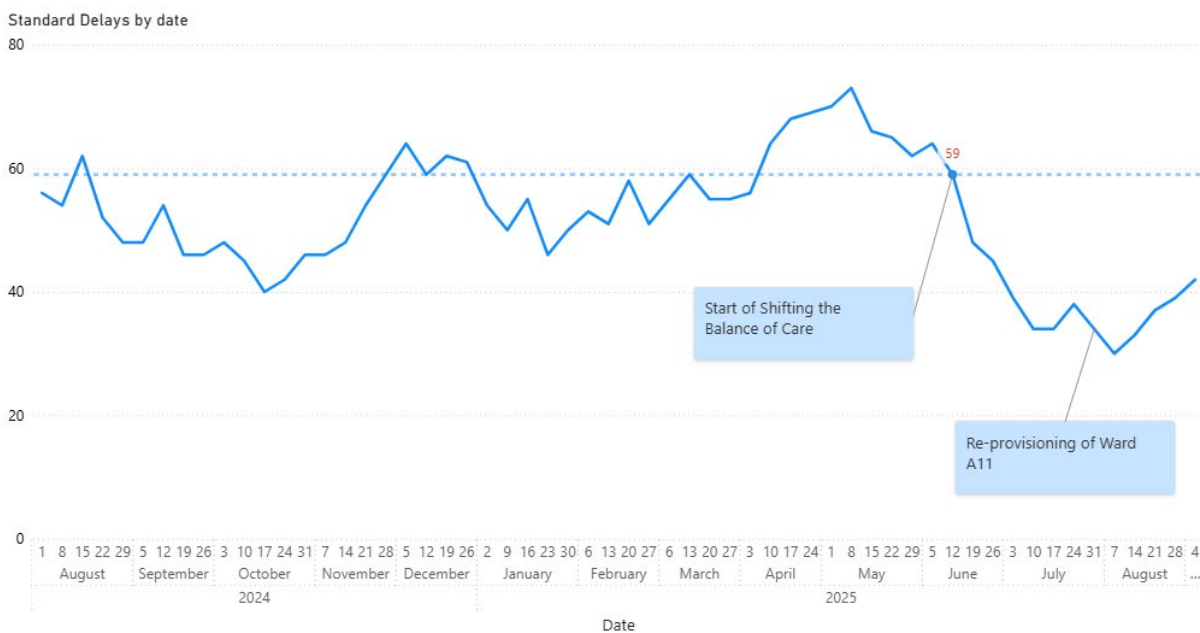
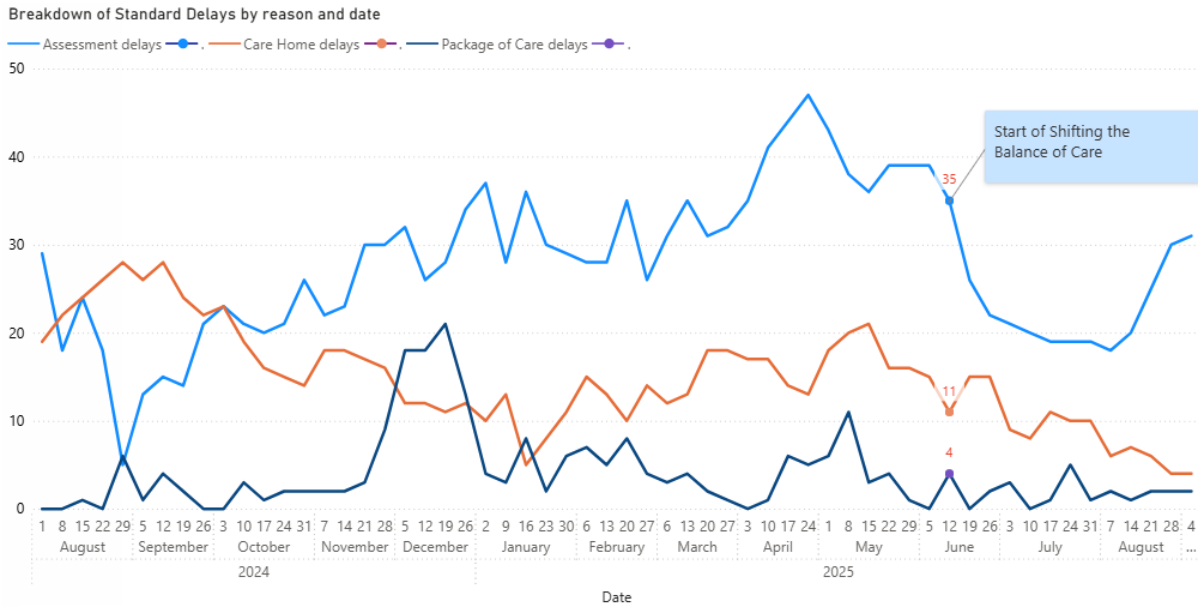


Figure 5 demonstrates that an increase in Assessment Delays has been the primary factor in the overall increase in Standard Delays. These initially dropped significantly, from 35 to 18, but have since climbed back up to 30 by the end of August.

Figure 5: Standard Delays by reason



Average completed length of stay in hospital for people aged 65+ that were admitted to the Emergency Department has reduced since the start of Shifting the Balance of Care. The average fluctuates although it is notably lower than for the corresponding period for 2024 (Figure 6). The ongoing length of stay for people aged 65+ admitted to the Emergency Department has also fallen considerably since the beginning of Shifting the Balance of Care (Figure 7).

Figure 6: Average length of stay, completed stays, people aged 65+ admitted to the Emergency Department

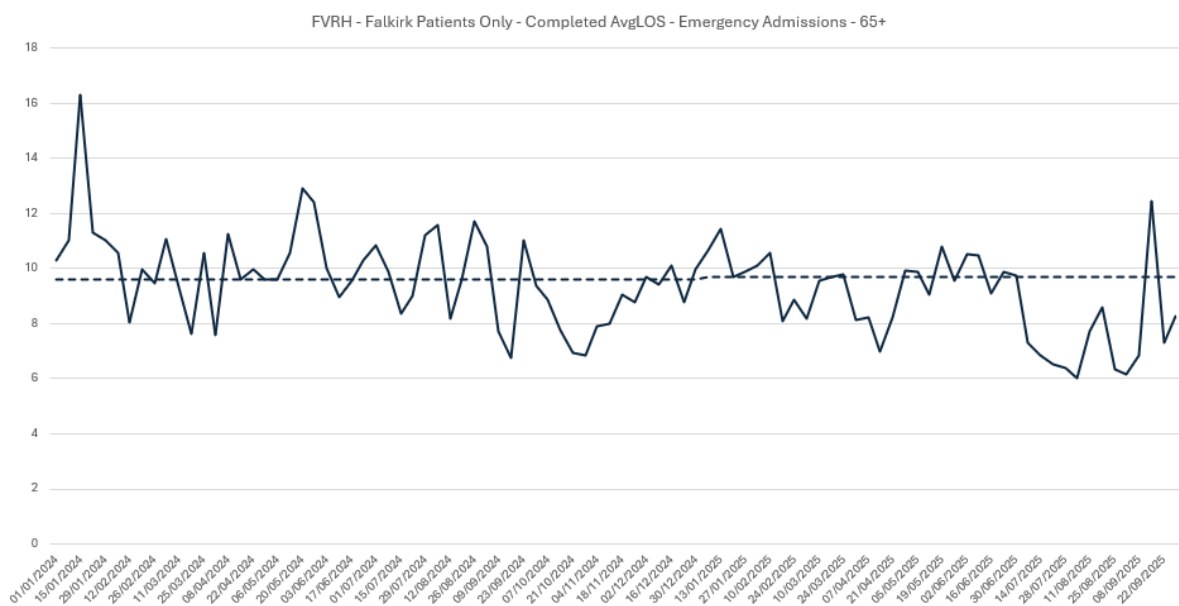
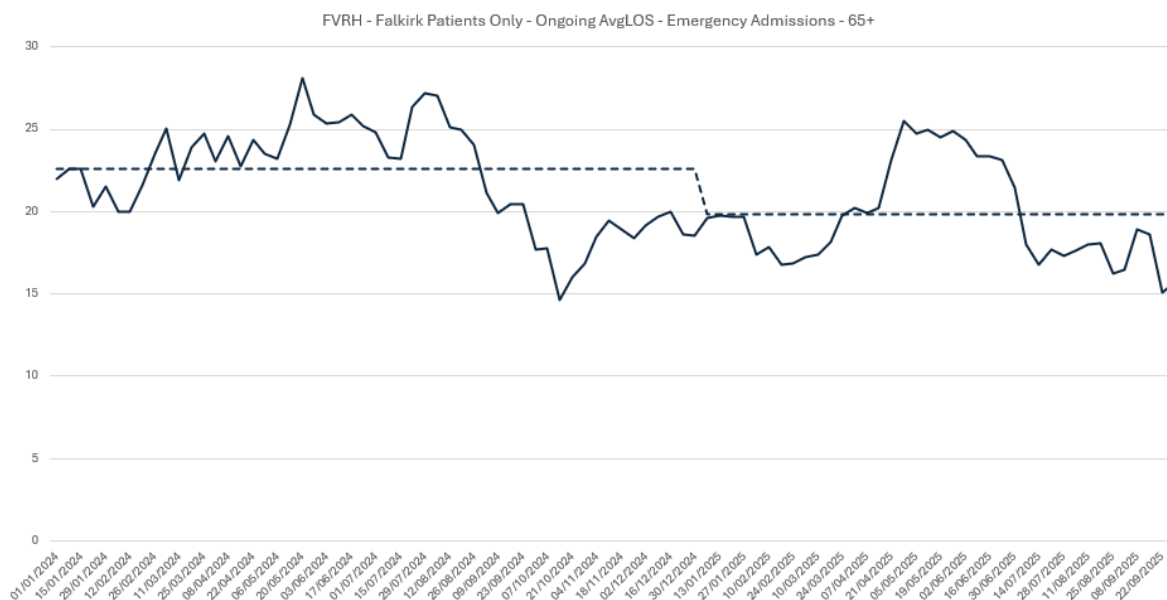


Figure 7: Average length of stay, ongoing stays, people aged 65+ admitted to the Emergency Department



What impact has discharge to assess had on readmission rates and care continuity?

Shifting the Balance of Care is designed to support each patient for 21 days post discharge on an interim care package while their long-term care needs are assessed. Some patients, however, have spent longer than 21 days with the interim care package. The average length of time per patient for this stage is 21.6 days (for patients that were discharged from the start of Shifting the Balance of Care to the end the August 2025). The maximum period that any individual was supported post-discharge was 55 days.

Table 1 shows how the support provided to patients via Shifting the Balance of Care has changed during the course of the initiative. The table includes data for all patients whose discharge has either been completed or has ended (due to, for example, being re-admitted to hospital) The data presented in Table 1 relates to patients discharged through via Shifting the Balance of Care during each respective month. While all figures are based on patients discharged in that month, some totals, such as hours of care, may have been accumulated over subsequent months as part of ongoing support.

Measures include:

- Number of patients joining SBoC: The total number of individuals discharged via the Shifting the Balance of Care approach during the month.
- Average hospital stay (days): The mean duration of hospitalisation prior to discharge.

- Average SBoC duration (days): The average length of time patients remained within the Shifting the Balance of Care pathway following discharge.
- Total actual hours of care provided: The cumulative hours of care invoiced by external providers for patients discharged that month, regardless of when the care was delivered.
- Average actual hours provided per client: The total hours of care divided by the number of patients discharged in the month.

Patients discharged in June received notably more care and remained engaged with the Shifting the Balance of Care initiative for a longer duration compared to those discharged in July and August. This disparity may be partially explained by a learning curve effect, as staff likely became more proficient in applying the Discharge to Assess model over time. Additionally, the average length of hospital stay prior to discharge was significantly longer in June, which may have contributed to greater deconditioning among patients. This is consistent with existing literature, which highlights the association between extended hospitalisation and functional decline, particularly among older adults. Consequently, those discharged in June may have required more intensive support post-discharge.

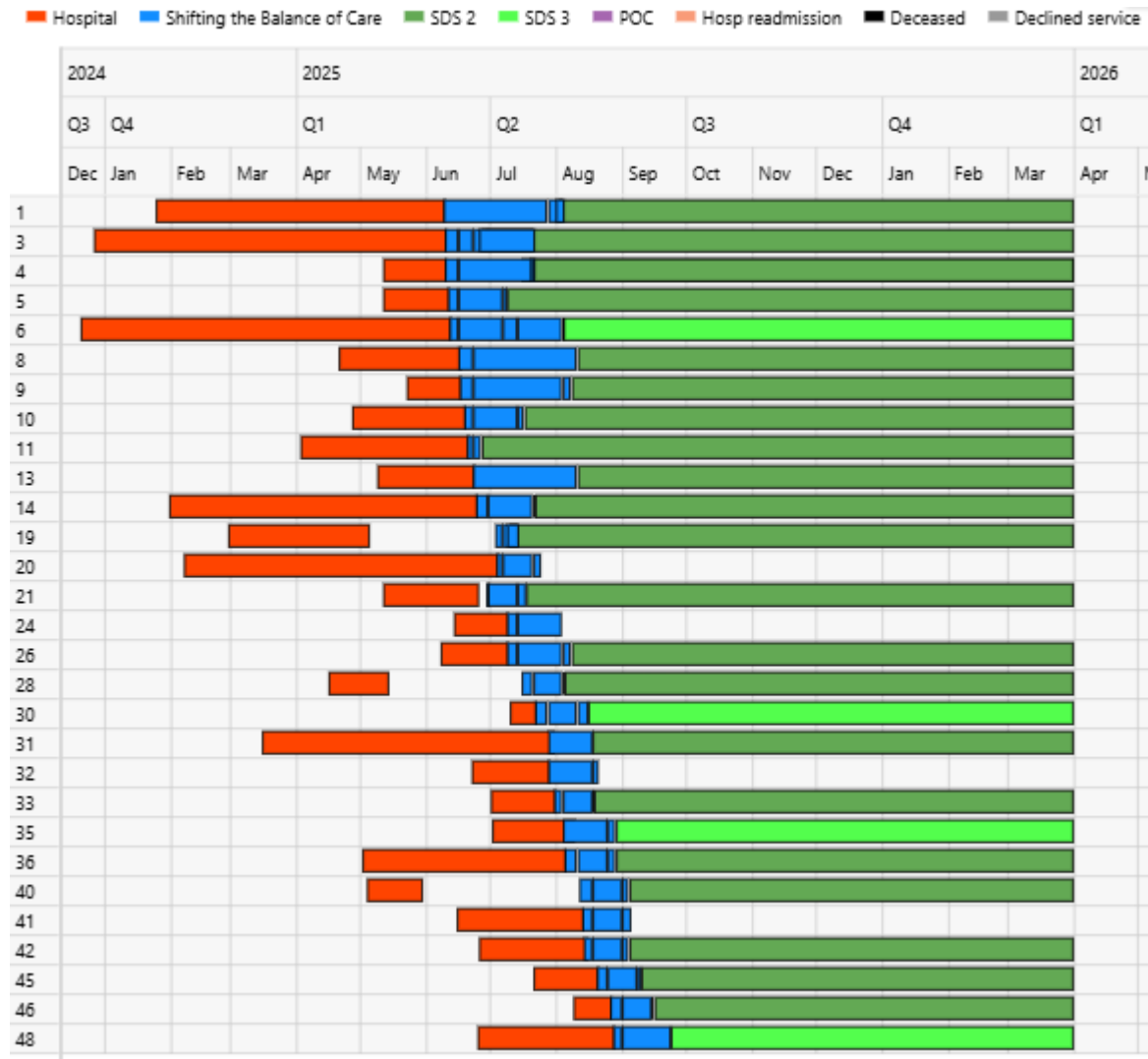
Table 1: Shifting the Balance of Care activity per month

| Year | No. of patients starting SBoC | Average Hospital Stay (Days) | Average SBoC Duration (Days) | Total actual hours of care provided | Av. actual hours provided per client |
|--------|-------------------------------|------------------------------|------------------------------|-------------------------------------|--------------------------------------|
| 2025 | 46 | 58 | 21.6 | 14895 | 324 |
| June | 16 | 79 | 30.7 | 7015 | 438 |
| July | 16 | 57 | 17.3 | 4082 | 255 |
| August | 14 | 36 | 16.1 | 3798 | 271 |

Service user outcomes

Figure 8 displays the chronology for each patient discharged through Shifting the Balance of Care that completed their discharge to assess period up to the end of August 2025. The visualisation displays the time spent in hospital, changes in the size of the care package during the 21-day discharge to assess period and the end outcome for each patient.

Figure 8: Chronology of patients that completed Shifting the Balance of Care, June to August 2025



Patients being discharged through Shifting the Balance of Care (until the end of August 2025) had, on average, spent 58 days in hospital before being discharged.

Hospital-associated deconditioning affects around 30% of older patients, often leading to a loss of functional independence, especially in those with frailty or cognitive impairments. These effects, largely preventable, can prolong hospital stays, increase care needs after discharge, and significantly impact both individual wellbeing and wider health and social care systems (Welch et al., 2024).

Table 2 summarises the outcomes for patients once they left Shifting the Balance of Care. The data relates to patients that completed the discharge to assess period or ended this period prematurely due to, for example, readmission to hospital. Based on the clinical judgement of those involved in discharge planning, patients discharged via Shifting the Balance of Care were deemed to be on a pathway toward long term care. Assuming that all patients would otherwise have entered long term care, the model has successfully allowed more people to return to their own homes and reduced care needs and associated costs.

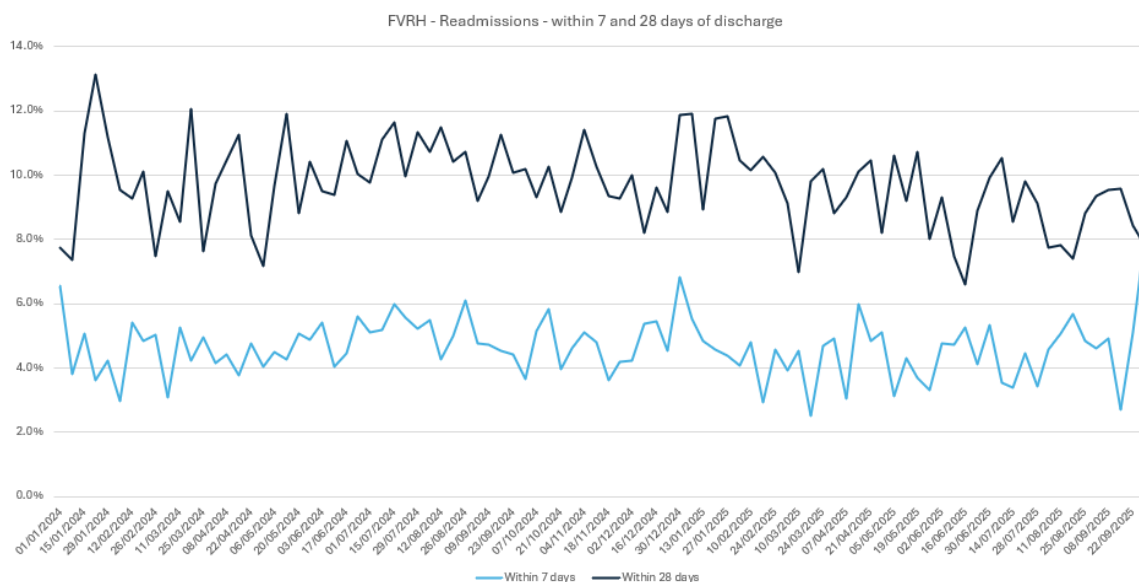
Table 2: Summary of outcomes, patients discharged via SBoC June to August 2025

| Outcome | Number of patients | % of patients |
|------------------------------|--------------------|---------------|
| SDS 1 | 1 | 2.2% |
| SDS 2 | 22 | 47.8% |
| SDS 3 | 6 | 13% |
| Package of Care total | 29 | 63% |
| Care Home | 7 | 15.2% |
| Hospital Readmission | 5 | 10.9% |
| Deceased | 4 | 8.7% |
| Declined service | 1 | 2.2% |

The readmission rate among the cohort during their time on Shifting the Balance of Care was 10.9%, which is broadly similar to the overall readmission rate within 28 days (see Figure 9), although the figures are not directly comparable.

Figure 9 illustrates hospital readmission rates within 7 and 28 days following discharge. Both measures show a reduction compared to the same period in the previous year. Notably, this downward trend began prior to the implementation of the Shifting the Balance of Care initiative, suggesting that other factors contributed to the improvement. Importantly, the introduction of the Discharge to Assess process has not led to an increase in readmission rates, addressing a concern that some stakeholders may have had about the potential risks of this approach.

Figure 9: Readmission rates to Forth Valley Royal Hospital within 7 days and 28 days following discharge



Has the model led to more efficient use of health and social care resources?

The Shifting the Balance of Care initiative appears to have supported more efficient use of health and social care resources, particularly through the reprovisioning of Ward A11 and a reduction in acute bed occupancy. However, the number of patients discharged via this pathway remains relatively small compared to overall hospital activity. While improvements in Emergency Department occupancy and OPEL scores were observed following implementation, these trends began prior to the initiative and may reflect wider operational changes, such as the opening of the Frailty Unit. As such, although the initiative may have contributed to efficiency gains, its impact should be interpreted cautiously and in the context of broader system developments.

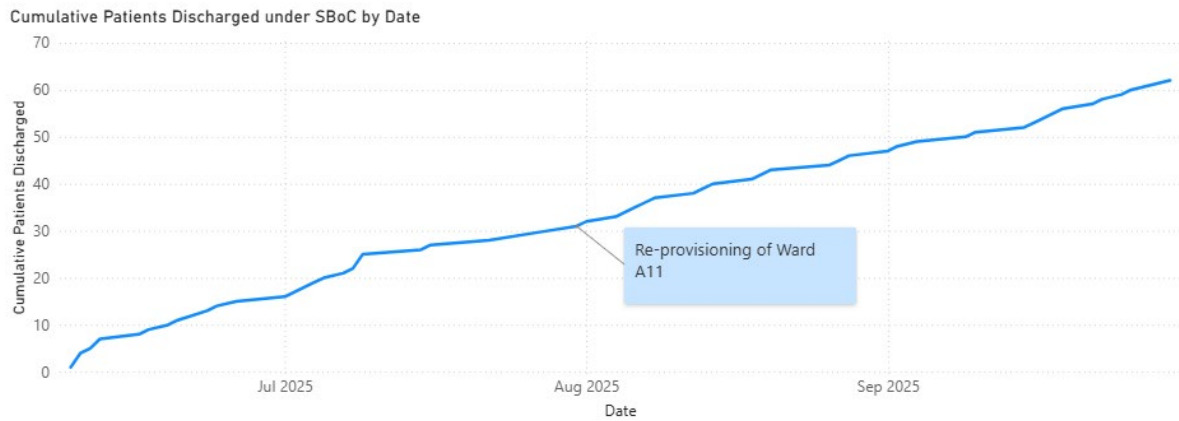
The Shifting the Balance of Care initiative has introduced a targeted discharge pathway, with patients being discharged via this route at a rate of just over four per week. Figure 10 shows that the weekly discharge rate fluctuated significantly during the early stages of implementation, reaching a peak of eight patients in the week beginning 3rd July 2025, with a minimum of two patients per week on occasions in August and September. These fluctuations were more pronounced during June and July, prior to the initiative becoming more embedded. The discharge rate subsequently stabilised, suggesting that operational processes may have matured over time. It should be noted that funding for the initiative was authorised in tranches, which may have influenced the pace and consistency of discharges during the initial phase.

Figure 10: Weekly discharge rate (rolling 7 day total)



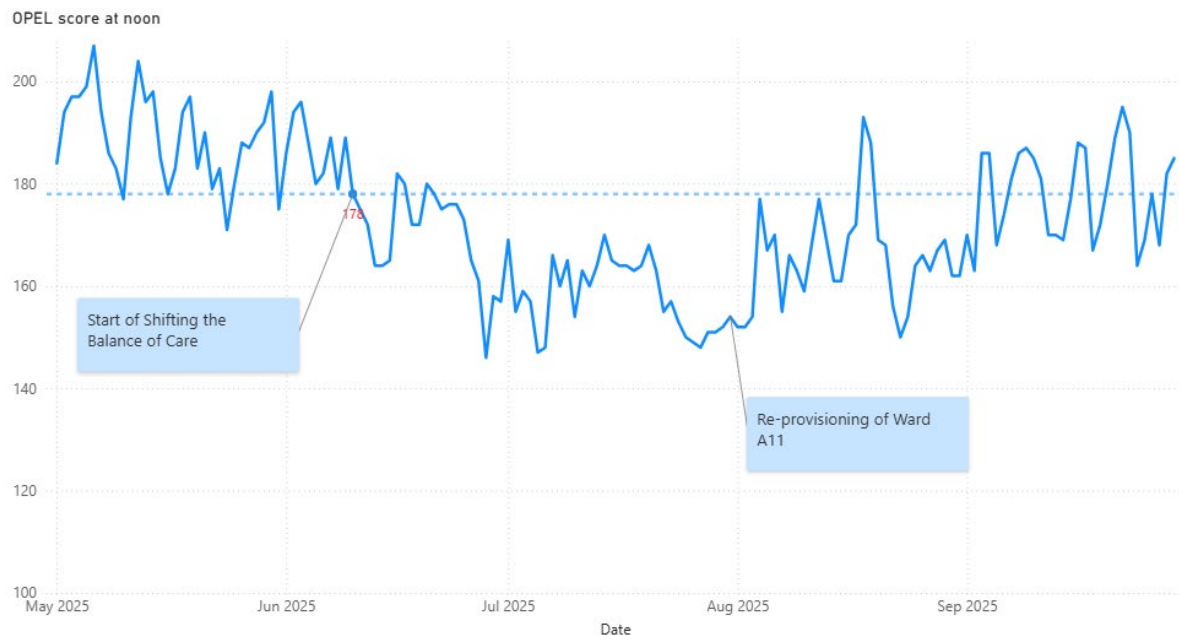
One of the primary aims of the initiative was to enable the reprovisioning of Ward A11 at Forth Valley Royal Hospital, which housed 32 beds. Figure 11 shows the cumulative number of patients discharged via Shifting the Balance of Care, demonstrating that sufficient discharges had occurred to allow the ward to be reprovisioned.

Figure 11: Cumulative total patients discharged via Shifting the Balance of Care



System-level impacts of the initiative can be observed through the NHS Forth Valley OPEL dashboard, which monitors key indicators of operational pressure, including emergency department activity, bed occupancy, staffing levels, and patient flow. Figure 12 shows the daily OPEL score recorded at noon. Following the commencement of Shifting the Balance of Care, the OPEL score showed a downward trend for several weeks, indicating a temporary reduction in system stress. However, the score began to rise again during August and September, suggesting that while the initiative may have contributed to short-term relief, other pressures within the system persisted or re-emerged.

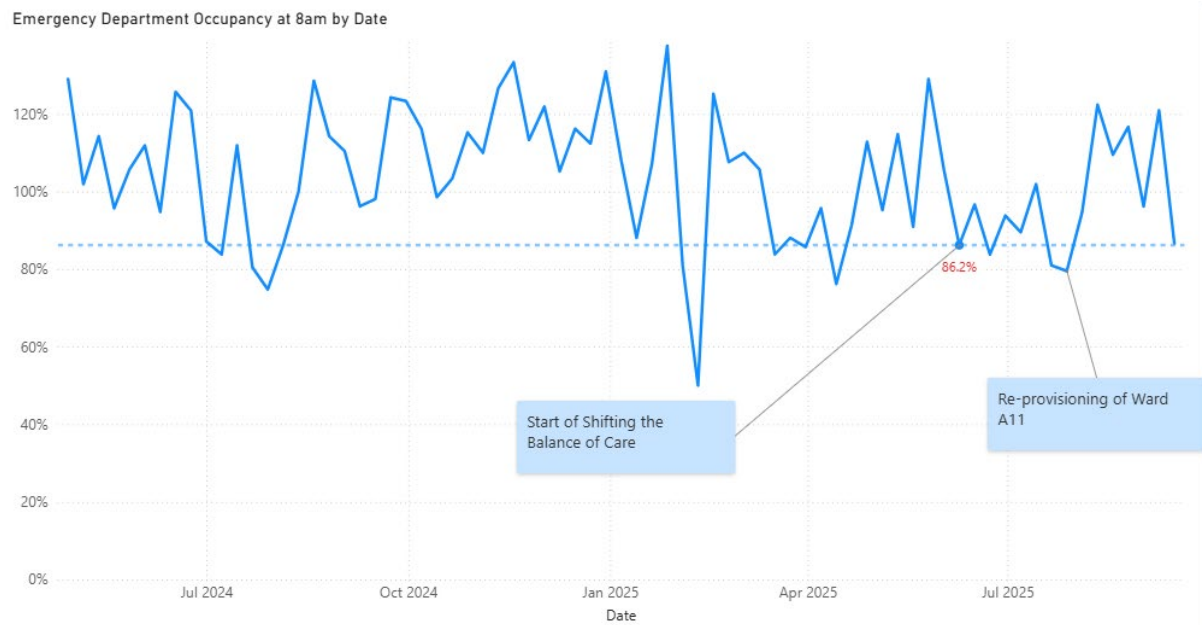
Figure 12: OPEL score at noon



Emergency Department (ED) occupancy has historically fluctuated, with a median occupancy rate of 105.7% over the past 18 months. Figure 13 shows that since the beginning of Shifting the Balance of Care, Emergency Department occupancy has generally been lower than this long-

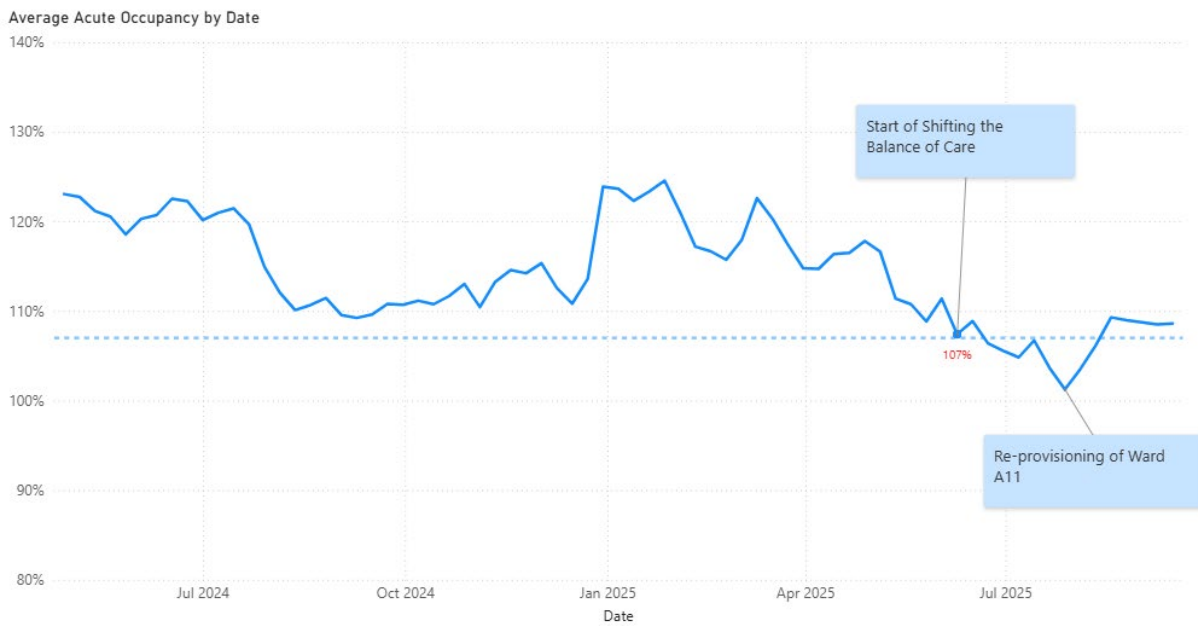
term median. However, this downward trend began prior to the initiative’s launch, with occupancy during 2025 consistently lower than corresponding periods in 2024. This suggests that while the initiative may have supported continued improvement, it was not the sole driver of reduced Emergency Department pressure.

Figure 13: Emergency Department occupancy at 8am



Average acute occupancy also declined following the establishment of Shifting the Balance of Care, continuing a trend that began in March 2025. Figure 14 shows that occupancy reached a low of 101% of capacity at the end of July, coinciding with the reprovisioning of Ward A11. Occupancy subsequently increased to 109%, though this remains below the long-term average. This pattern may reflect the system’s adjustment to the reduced bed base, with temporary increases in occupancy as patient flow stabilised.

Figure 14: Average Acute Occupancy



Further evidence of the initiative’s reach and potential impact on resource use can be seen in the discharge patterns of older adults. The number of people aged 65 and over being discharged from hospital following admission to the Emergency Department has increased since the beginning of Shifting the Balance of Care (Figure 15). This trend is accompanied by a reduction in the number of patients aged 65+ who were in hospital having been admitted as an emergency (Figure 16). These patterns suggest that the initiative may be contributing to more timely discharge and potentially preventing prolonged hospital stays among older adults, a group often associated with higher resource utilisation.

Figure 15: Discharges from Forth Valley Royal Hospital, patients aged 65+ admitted to the Emergency Department

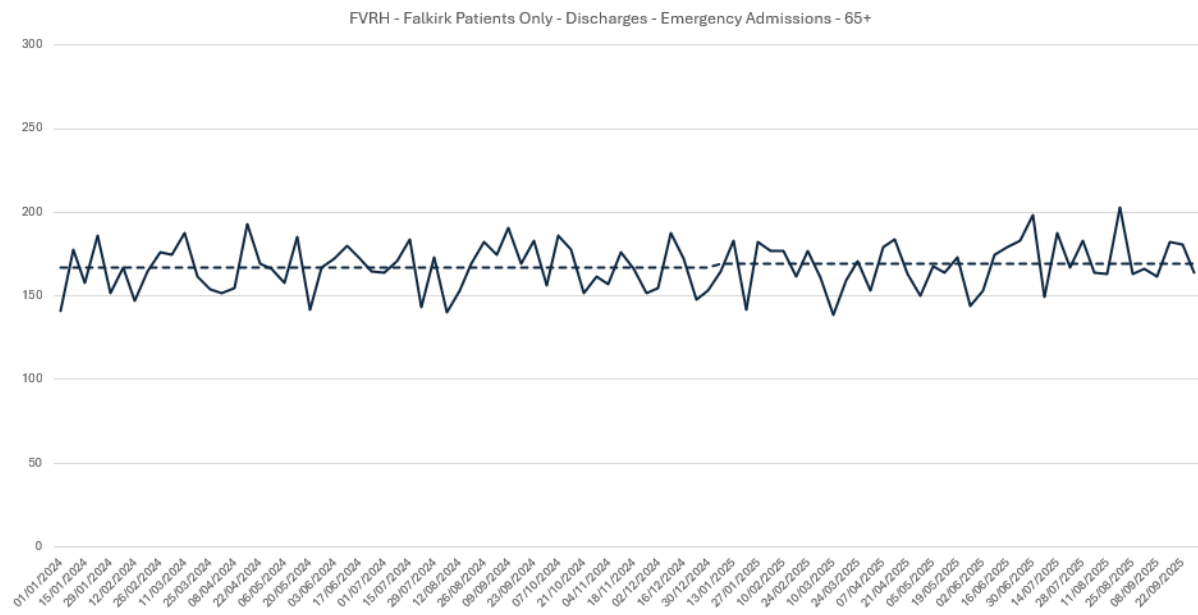
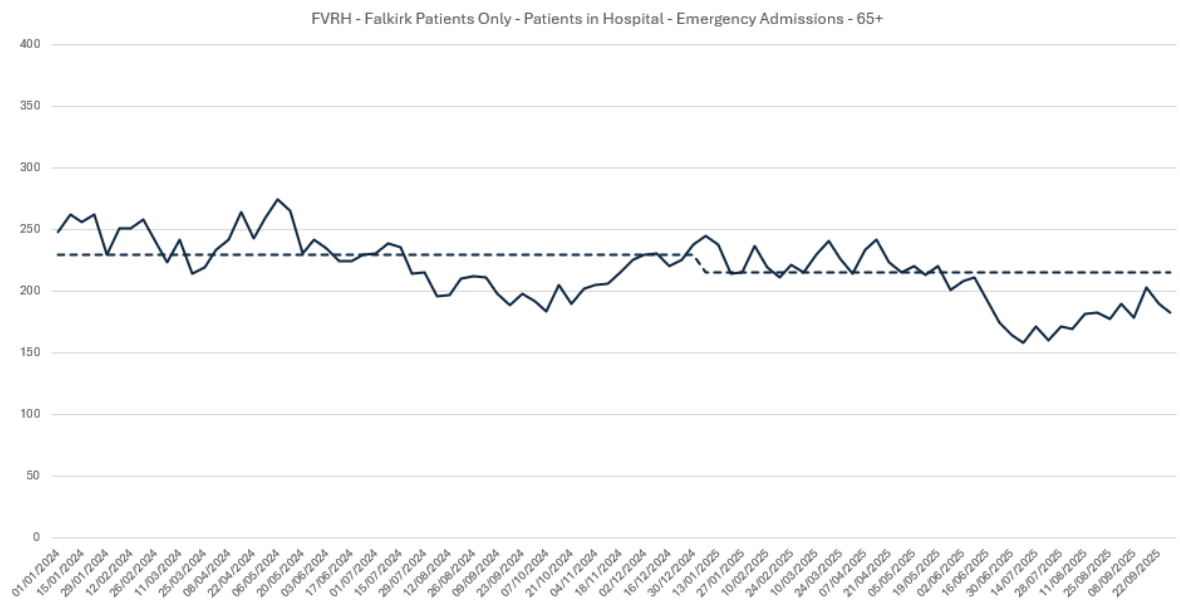


Figure 16: Number of patients in Forth Valley Royal Hospital, aged 65+ admitted to the Emergency Department



How do patients and carers perceive the quality and continuity of care under the discharge to assess model?

Feedback from patients (or their carers) discharged under Shifting the Balance or Care was captured by a survey. The survey was undertaken by telephone once the assessment period had finished. Seven survey responses were received, which are summarised below:

What went well?

Communication:

Most participants felt well-informed and involved in decisions about their care. Communication between hospital teams, care providers, and families was generally strong, with several respondents noting improvements compared to previous discharge experiences. The use of communication diaries and proactive updates helped build trust and clarity.

Discharge Process:

The discharge process was widely praised. Respondents described it as smooth, well-coordinated, and timely. Many appreciated that equipment and support were in place before discharge, and that assessments at home happened quickly. These factors contributed to a sense of readiness and confidence in returning home.

Support from paid carers:

External care providers were consistently commended for their punctuality, professionalism, and quality of care. Families felt that carers provided the support outlined in care plans, including personal care, medication, and meals. Night-time care was particularly valued, with some carers staying late to ensure patients were settled and safe.

Equipment and Telecare:

Telecare equipment such as MECS alarms and fall pendants were seen as reassuring and helpful. When equipment like hospital beds and commodes were in place from the start, it made a significant positive impact on the patient's comfort and safety.

Safety and Satisfaction:

Most respondents felt safe at home during the assessment period and expressed high levels of satisfaction with the overall service. Many described the experience as "brilliant," "excellent," or "great," and appreciated the holistic and responsive nature of the care provided. The service was seen as a valuable alternative to hospital stays, especially for those with complex needs.

Areas for improvement:

Communication:

While communication was generally strong, a few respondents reported confusion or lack of clarity, particularly around changes in care levels during the 21-day assessment. In some cases, families were not informed when care was reduced, leading to anxiety and the need for family members to step in. Additionally, communication appeared to drop off toward the end of the assessment period, with some carers or coordinators not following up as expected.

Discharge Planning:

Although many felt the discharge was smooth, some respondents highlighted gaps in planning. For example, equipment such as beds or stair lifts was not always in place at the time of discharge, which caused stress and logistical challenges. Some families had to chase updates or experienced delays in discharge timing, which could have been avoided with clearer coordination.

Support from paid carers:

While external care providers were generally praised, there were instances where patients declined personal care, especially in cases involving dementia or cognitive decline. This made it difficult for carers to deliver the planned support. Additionally, some families noted that care quality declined after the initial intensive support period ended, suggesting a need for better transition planning and continuity of care.

Safety:

One respondent expressed concern that safety decreased when care was reduced, particularly for a vulnerable patient who became anxious and unsettled.

Follow-Up and Continuity:

Some respondents mentioned unmet expectations around follow-up services (such as befriending support or respite care) which were discussed but not actioned. This suggests a need for clearer pathways and accountability for post-assessment referrals and ongoing support.

Conclusions

Overall, the findings suggest that the model has delivered several of its intended outcomes, particularly in relation to discharge efficiency, patient experience, and system-level resource use. However, the evaluation also highlights important limitations and contextual factors that shape the interpretation of these results.

Quantitative data shows a reduction in delayed discharges and hospital length of stay for older adults, particularly in the early weeks of implementation. These improvements align with the model's core objective of freeing up acute capacity and enabling more timely transitions to community-based care. The reprovisioning of Ward A11 and the observed decline in OPEL scores and Emergency Department occupancy further support the conclusion that the model contributed to short-term system relief.

Qualitative feedback from staff and patients reinforces the value of the model. Patients and carers reported high levels of satisfaction with the discharge process, care quality, and communication. Staff reflections highlighted improved collaboration across teams and a growing confidence in community-based assessment. However, challenges with information sharing, inconsistent documentation, and provider capacity were recurring themes, suggesting that operational systems have not yet fully adapted to support the model at scale.

Contextual Considerations:

Several contextual factors influenced the delivery and outcomes of the model. The rapid implementation timeline, staffing pressures, and limitations in digital infrastructure all shaped how the model was experienced. The test of change coincided with other system developments, such as the opening of the Frailty Unit, which may have confounded attribution of outcomes. Additionally, the relatively small number of patients discharged via the model limits the generalisability of findings, and the short evaluation period constrains assessment of longer-term sustainability.

Assessment against the rationale and theory of change:

The model's performance broadly aligns with the expectations set out in the rationale and theory of change. The reduction in delays and improved patient flow reflect the intended benefits of shifting assessment into the community. However, the evaluation also reveals areas where outcomes diverged from expectations. For example, while readmission rates did not increase, the downward trend began prior to implementation, indicating that other factors may have contributed. Similarly, the average duration of support exceeded the intended 21-day period for some patients, reflecting the need for greater flexibility in practice.

The evaluation broadly supports the assumptions underpinning the theory of change. Community-based assessment appears to improve person-centred care and discharge efficiency, and the model has demonstrated potential to reduce hospital-associated deconditioning. At the same time, the evaluation highlights the importance of ongoing investment, workforce planning, and system integration to sustain and scale the approach. While the model has shown promise, its long-term viability will depend on addressing

operational challenges and embedding the necessary infrastructure to support consistent delivery.

In relation to the evaluation questions, the findings indicate that the model was largely implemented as intended, with adaptations made in response to operational learning. Outcomes for patients and the system were generally positive, though variable across different groups. The experiences of patients and carers suggest that the model is valued and effective, but further work is needed to strengthen continuity of care and post-assessment support.

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Appendix A: Information sharing risks and requirements

Summary of key systems

| System | Primary Function | Used By | Key Features |
|------------------------|---|---|--|
| TrakCare | Electronic patient record and hospital management system | Hospital Ward, MDT, ReACH, Home First (limited) | Admission/discharge tracking, clinical notes, SSA storage, discharge letters |
| Liquid Logic | Social care case management system | MDT, Home First, Home Care, MECS | Care planning, assessments, finance tracking, provider commissioning |
| Live Dashboard | Localised discharge coordination and service capacity tracking | MDT, Home First, ReACH, Intermediate Care | Manual updates on discharge status, service availability, rehab progress |
| Clinical Portal | Read-only interface aggregating patient data across NHS systems | Hospital Ward | Access to discharge letters, medication summaries, vaccination records |
| OPEL Dashboard | Operational pressure escalation tool for acute NHS services | Hospital Ward | Real-time visibility of system pressure and bed capacity |
| eBrokerage | Online platform for commissioning and managing home care packages | Home Care Provider | Care package bidding, service start confirmation, provider capacity tracking |
| MECS Systems | Telecare monitoring and emergency response system | MECS, MDT, Home First | Alerts, equipment installation, patient safety monitoring |
| EMIS / Vision | GP clinical systems for patient records and prescribing | GP Practices | Medical summaries, prescriptions, referrals, discharge letter reception |

Summary of key documents

| Document | Purpose | Contents | Used By |
|---------------------------------------|---|---|---------------------------------------|
| SSA (Single Shared Assessment) | To assess an individual's health, care, and support needs across agencies | Personal details, health and social care needs, ADLs, risks, goals, carer input, IoRN score | Hospital Ward, MDT, Home First, ReACH |
| Discharge Letter | To inform primary care of hospital discharge and follow-up needs | Diagnosis, treatment summary, medication changes, follow-up plans | Hospital Ward → GP Practices |
| Discharge Plan | To coordinate safe discharge and post-discharge support | Planned discharge date, care arrangements, equipment needs, transport, contact details | MDT, Home First, Home Care |
| Handover Summary | To ensure continuity of care between hospital and community teams | Key clinical and functional information, risks, care instructions | MDT, Home First, ReACH, Home Care |
| Support Plan | To outline the care package commissioned for the individual | Tasks, timings, provider details, risk management, contingency plans | Home Care Provider, eBrokerage |
| Rehab Goals Summary | To track progress and guide therapy interventions | Functional baseline, rehab targets, progress notes | ReACH, Intermediate Care |
| MECS Referral Form | To request telecare equipment and monitoring | Risk profile, equipment needs, contact preferences | Home First, MECS |

Shifting the Balance of Care – Information Flow & Systems

| Stakeholder | Information received | Information shared | Information Systems Used |
|----------------------|---|--|---|
| Hospital Ward | <ul style="list-style-type: none"> • Communication from MDT regarding discharge planning • Feedback from Home First about any issues with discharge arrangements | <ul style="list-style-type: none"> • Patient’s medical status and discharge readiness • Functional assessments and rehab goals • Medication information • Planned and actual discharge dates • SSA • Barriers to discharge | TrakCare (primary system), Clinical Portal, E.D.D.S, OPEL (dashboard of acute capacity) |
| MDT | <ul style="list-style-type: none"> • Patient status (clinical status) • Planned and actual discharge dates • SSA results • Feedback from Home First, ReACH, MECS, and Home Care • Availability and capacity of community services (Home First, ReACH, etc.) • Home First capacity, feedback on patient / family preferences • ReACH functional assessments, rehab goals • Care provider availability, start date of care packages • MECS eligibility and feasibility of telecare equipment | <ul style="list-style-type: none"> • SSA outcomes • Discharge decision • Discharge plans • Identification of delayed discharges • Equipment needs • Risk assessments • Handover summary • Follow-up requirements • Weekly and daily MDT review outcomes | TrakCare, Liquid Logic, Live Dashboard, Teams |
| Home First | <ul style="list-style-type: none"> • SSA-referral • CRD status • Screening of information on SSA • Candidates shared by email for consideration • MDT agreement for SBOC • Seek consent from client • Home environment assessment required | <ul style="list-style-type: none"> • Discharge dates to be confirmed with wards and family • Requests for medication, transport and discharge actions progressed with ward & d/c hub • Discharge plans shared with homecare | Live Dashboard (primary), TrakCare (limited access), Liquid Logic . Ward notes, E.D.D.S |

- Equipment requirements and orders
- Risk assessments
- Home care availability
- LTC availability

- Care provider availability confirmed and shared with MDT and ward and family
- MECS telecare plans shared.
- LAS updated
- Assessment written and SDS options concluded

ReACH (AHP Team)

- SSA/MDT decisions
- Planned and actual discharge dates
- Discharge summary
- Discharge plan
- MECS equipment provision
- Medical background and medication info
- Patient / family preferences
- Any changes in patient condition or support needs
- Feedback from care providers on mobility issues and participation in exercises

- Rehab goals and functional baseline
- Equipment needs
- Progress toward rehab goals
- Suitability / safety of discharge
- Advice to patient / family on mobility exercises etc.
- Home visit findings
- Discharge from service
- Escalation in care needs

TrakCare, Live Dashboard (indirect)

Intermediate Care

- Referral information from MDT
- SSA
- Patient's rehab goals and care plan
- Updates on patient progress and discharge readiness

- Current functional status, medication and care needs (and changes in any of this)
- Equipment and adaptations needed at home
- Risk assessments
- Rehab outcomes and progress

Live Dashboard

Home Care Provider

- SSA/MDT decisions
- Planned and actual discharge dates
- Initial care package requirements (24–48 hrs)
- Handover notes
- Discharge plan
- Discharge summary, medication details
- MECS equipment and instructions

- Service start confirmation
- Daily updates on patient condition and care needs
- Info on adjusted care packages
- Support plan creation and submission to eBrokerage
- Risk identification and escalation
- Info on service availability / capacity

Liquid Logic, eBrokerage. Provider's own system, Teams

**MECS
(Telecare)**

- Advice from ReACH on mobility, exercises, equipment use
- Patient / family preferences
- Alerts from MECS about falls etc.
- SSA/MDT decisions
- Planned and actual discharge dates
- Telecare referral details
- Risk assessments
- ReACH assessment of needs and safety considerations
- Patient / family preferences

GP Practices

- Discharge summaries
- Care plans
- Risk assessments
- Progress updates or changes in care needs
- Alerts from community teams

- Alerts/incidents
- Feedback to MDT on patient safety and wellbeing
- Telecare equipment needs and installation
- Equipment malfunction reports
- Changes in equipment needs
- Availability of service
- Patient monitoring reports

- Medical summaries
- Prescription details and changes
- Follow-up care and appointments
- Referrals to other services
- Clinical advice
- Feedback on safety issues or concerns

**Internal MECS
systems, Liquid
Logic**

**EMIS (current),
Vision (future)**

Information flow risks

| Risk | Description | Impact | Stakeholders Affected |
|--|---|--|---|
| Delays in providing discharge letters | Discharge letters not prepared or shared in time | Missed medication changes, poor GP follow-up | Hospital Ward, GP Practices |
| Incomplete or delayed SSAs | SSAs vary in quality and timeliness | Delays in discharge planning and care coordination | MDT, Home First, ReACH |
| Limited system access | Non-NHS teams lack access to TrakCare and OPEL dashboard | Incomplete visibility of patient status and acute capacity | Home First, MECS, Intermediate Care |
| Manual data entry | Live Dashboard and Liquid Logic require manual updates | Increased admin burden, risk of errors | Home First, MDT, Intermediate Care |
| Fragmented communication channels | Reliance on Teams, email, calls, and face-to-face updates | Information loss, duplication, inconsistent updates | MDT, Home Care Providers, Hospital Ward |
| Unclear discharge pathways | Intermediate Care teams unsure if patients are on D2A pathway | Misaligned rehab planning and resource allocation | Intermediate Care |
| GP system transition uncertainty | EMIS to Vision migration paused | Risk to continuity of primary care data sharing | GP Practices |
| Lack of real-time updates | Systems do not sync in real time | Delays in decision-making and service mobilisation | MDT, Home First, ReACH |
| Inconsistent equipment planning | MECS and ReACH rely on manual referrals and updates | Delayed installations, safety risks at home | MECS, ReACH, Home Care |
| Over-reliance on individuals | Key liaison roles depend on face-to-face updates | Vulnerability to absence or workload pressures | Home First, MDT |

Interoperability and integration summary table

| System | Users | Interoperability Gaps | Opportunities for Automation / Integration |
|------------------------|---|---|--|
| TrakCare | Hospital Ward, MDT, ReACH, Home First (limited) | <ul style="list-style-type: none"> • Limited access for non-NHS teams (e.g. Home First) • SSAs not consistently uploaded • No direct link to Live Dashboard or Liquid Logic • IDLs (Immediate Discharge Letters) often delayed or unavailable | <ul style="list-style-type: none"> • Enable SSA auto-upload • Develop secure access for social care teams • Create alternative medication communication protocols when IDLs are delayed • API integration with Live Dashboard and Liquid Logic • The Integrated Discharge Tool improves access to TrakCare data for partners via a secure dashboard, reducing reliance on manual updates and email. However, full automation and real-time integration with TrakCare remain future opportunities. |
| Liquid Logic | MDT, Home First, Home Care, MECS | <ul style="list-style-type: none"> • Manual data entry required • No real-time sync with TrakCare or Live Dashboard | <ul style="list-style-type: none"> • Automate SSA import / export • Link with Live Dashboard for discharge tracking • Enable shared care plans across health and social care • The Integrated Discharge Tool brings together key social care data from Liquid Logic, supporting more consistent and timely information sharing. Manual input is still required, but centralisation reduces duplication. |
| Live Dashboard | MDT, Home First, ReACH, Intermediate Care | <ul style="list-style-type: none"> • Manual updates • Not accessible to all stakeholders • No real-time data feed | <ul style="list-style-type: none"> • Auto-populate from TrakCare and Liquid Logic • Expand access to all partners • Standardise update protocols to reduce reliance on individual liaison roles |
| Clinical Portal | Hospital Ward | <ul style="list-style-type: none"> • Read-only access • Limited contribution from social care | <ul style="list-style-type: none"> • Explore write-access for key roles • Integrate with TrakCare and Liquid Logic |

| | | | |
|-----------------------------------|--------------------------------|--|--|
| OPEL Dashboard | Hospital Ward | <ul style="list-style-type: none"> • Not shared with social care or third sector • Valuable tool for acute capacity but siloed within NHS systems | <ul style="list-style-type: none"> • Develop secure external access for key partners • Embed OPEL status into discharge planning tools used by MDT and Home First |
| eBrokerage | Home First, Home Care Provider | <ul style="list-style-type: none"> • Limited integration with Liquid Logic • Manual care package updates | <ul style="list-style-type: none"> • Link with Liquid Logic for auto-commissioning • Dashboard for real-time provider capacity |
| MECS Systems | MECS, MDT, Home First | <ul style="list-style-type: none"> • Limited integration with health/social care systems | <ul style="list-style-type: none"> • Connect alerts to Live Dashboard • Auto-update risk assessments |
| EMIS / Vision | GP Practices | <ul style="list-style-type: none"> • Poor integration with hospital and social care • Uncertainty due to system transition • Discharge letters are the main method of communication | <ul style="list-style-type: none"> • Standardise discharge summary format • Develop shared care record across primary and secondary care |
| Microsoft Teams (SBC Site) | MDT, Home First, Hospital Ward | <ul style="list-style-type: none"> • Technical issues sharing documents across organisational tenancies (e.g. Falkirk Council M365 vs NHS) • Reliance on email and chat for SSA sharing • Volume of chat messages difficult to manage | <ul style="list-style-type: none"> • Create shared document repository with cross-tenancy access • Integrate Teams with Live Dashboard for structured updates • Standardise communication protocols to reduce duplication and confusion • The Integrated Discharge Tool reduces reliance on Teams and email for sharing discharge information, providing a more structured and secure alternative. |

Appendix B: Summary of survey responses

Summary of Shifting the Balance of Care feedback survey responses (to 21/10/2025)

Total responses: 7

1. Were you involved in your care as much as you wanted to be?

- Most respondents felt involved and well-informed.
- A few noted improved communication compared to previous discharges.
- One respondent highlighted poor communication and confusion about care reduction during the 21-day assessment.

2. Did you feel that your discharge home went smoothly?

- Generally positive feedback: most felt the discharge was smooth.
- A few noted minor hiccups (e.g. miscommunication about discharge lounge).
- Equipment being in place before discharge was appreciated.

3. Did you feel that decisions about your care were communicated to you clearly?

- Most felt decisions were clearly communicated.
- One respondent experienced confusion due to conflicting hospital information.
- Another noted a lack of communication in the final week of the 21-day period.

4. Did you feel ready to be discharged on the day you went home?

Mixed responses:

- Several felt ready and eager to return home.
- Others felt unprepared due to missing equipment or unclear discharge planning.
- One respondent was apprehensive due to the patient's condition.

5. Did you feel you were discharged at an appropriate time of day?

- Most felt the timing was appropriate.
- One family had to chase up the discharge, which was delayed from morning to afternoon.

6. Did you feel that you were assessed in your home at an appropriate time following your discharge?

- Generally positive: assessments were timely and responsive.
- One respondent felt there wasn't enough on-site assessment.
- Another only learned about assessments through visiting, not direct communication.

7. Did you feel that your care team communicated well with each other?

- Most responses praised the care team's communication and coordination.
- One noted that external providers were better than hospital staff in this regard.

8. Did you get your discharge letter and medication for discharge upon leaving the hospital?

Mixed experiences:

- Some received everything as expected.
- Others faced challenges with medication collection and pharmacy coordination.
- One respondent did not see the discharge letter.

9. Are the carers arriving on time and staying for the full duration?

- Mostly positive: carers were punctual and stayed as required.
- Minor delays due to traffic were noted but not problematic.

10. Are the carers providing the support outlined in the care plan (e.g. personal care, medication, meals)?

- Strongly positive feedback: carers were praised for their support and dedication.
- A few noted challenges with personal care due to patient resistance.

11. Did you feel the night-time care support was adequate?

- Generally positive: night-time support was appreciated and reassuring.
- One respondent noted discomfort with lights being turned on but understood the necessity.
- Another mentioned reduced support later in the care period.

12. Did you feel having access to telecare equipment was reassuring?

- Most found telecare (e.g. MECS, alarms) reassuring and helpful.
- One noted that the patient removed the falls pendant, reducing its effectiveness.

13. Are there any issues or concerns with carers (e.g. communication, consistency, quality of care)?

- Largely no concerns: carers were praised.
- One respondent noted reduced care quality after initial support ended.

14. Did you feel safe at home while your care team were making assessments?

- Most felt safe and supported.
- One respondent noted that safety decreased when care was reduced.

15. Are you happy that your care and support needs are now being met at home following assessment?

- Majority expressed satisfaction with current care arrangements.
- A few noted concerns about future care or changes in provider.

16. Any other comments you want to share about your journey on StBoC?

Feedback was overwhelmingly positive:

- Many praised the service, staff, and communication.

- Some expressed sadness about losing current care providers.
- A few suggested improvements in communication and consideration of cognitive issues.

Equality & Poverty Impact Assessment 00997 (Version 1)

SECTION ONE: ESSENTIAL INFORMATION

| | | | |
|--------------------------------|---|----------------------|-------------|
| Service & Division: | Social Work Adult Services Community Care | | |
| | | Tel: | 07483913558 |
| Proposal: | <ul style="list-style-type: none"> • There have been discussions at executive level around “shifting the balance of care”. These discussions are based on the below challenges: • Continual investment into secondary care • Increasing demand • Challenges in delayed discharge performance • Empowering & enabling integration, innovation and transformation • A spend to save opportunity was identified to support the expansion and ongoing funding of the National Treatment Centre (NTC) which will require additional capacity within the hospital site for patient recovery. • A proposal has been made for a transfer of potential additional, recurring funding to be made to Falkirk HSCP to support the discharge of at least an additional 32 people from across the hospital sites, in May 2025. | Reference No: | |

| What is the Proposal? | Budget & Other Financial Decision | Policy (New or Change) | HR Policy & Practice | Change to Service Delivery / Service Design |
|-----------------------|-----------------------------------|------------------------|----------------------|---|
| | Yes | Yes | No | Yes |

| Who does the Proposal affect? | Service Users | Members of the Public | Employees | Job Applicants |
|-------------------------------|---------------------------|-----------------------|-----------|----------------|
| | Yes | No | Yes | No |
| | Children and young people | Significant impact? | | |
| | No | Yes / No | | |

Other, please specify:

| Identify the main aims and projected outcome of this proposal (please add date of each update): | |
|--|--|
| 31/03/2026 | Maintain, sustain or improve Falkirk HSCP standard delayed discharge profile staying in line with national rate per 100,000. |
| 31/03/2026 | Enable the development of community care at home pathways to provide health and social care closer to home, reduce pressure on hospitals (A11 reprovisioning to be sustained), motivate the workforce and leaders, and improve system efficiency. Indicators for this include bed days lost, length of stay reduction, outcomes of assessment at home. |
| 31/03/2026 | Enable whole system health and care costs to be utilised in the right place across the system to support good outcomes for people. Demonstrate affordability and whole system efficiencies of model and resource allocation (transfer of resource to IJB budget). |
| 31/03/2026 | People who do not require acute care will return home where possible, supporting our collective ambition of provision of the right care, at the right time and in the right place, and reducing the number of people experiencing harms as a result of longer hospital stays. Indicators for this include a reduction in length of stay for patients, patient outcomes, and impact and demands on primary care services) |
| 31/03/2026 | Stimulate development of further proposals and culture to shift health and social care closer to home in relation to reablement and discharge to assess. |
| | |

SECTION TWO: FINANCIAL INFORMATION

| For budget changes ONLY please include information below: | | | Benchmark, e.g. Scottish Average |
|---|-------------------------------|------------|---|
| Current spend on this service (£'0000s) | Total: | | |
| Reduction to this service budget (£'0000s) | Per Annum: | | |
| Increase to this service budget (£'000s) | Per Annum: | 2,027,180m | Transfer of funding totalling £2.027m from NHS Forth Valley to Falkirk Health and Social Care Partnership to cover the test of change period (June 2025 to March 2026) for "Shifting the balance of Care" to support a discharge to assess model. |
| If this is a change to a charge or concession please complete. | Current Annual Income Total: | | |
| | Expected Annual Income Total: | | |
| If this is a budget decision, when will the saving be achieved? | Start Date: | | |
| | End Date (if any): | | |

SECTION THREE: EVIDENCE

Please include any evidence or relevant information that has influenced the decisions contained in this EPIA. (This could include demographic profiles; audits; research; health needs assessments; national guidance or legislative requirements and how this relates to the protected characteristic groups.)

A - Quantitative Evidence

This is evidence which is numerical and should include the number people who use the service and the number of people from the protected characteristic groups who might be affected by changes to the service.

Shifting the Balance of Care (SBoC) describes a test of change which will see the discharge of at least an additional 32 people, maintained on a recurring basis, from across the hospital sites, from June 2025 through to the end of March 2026. This test of change will be supported through the transfer funding of £2.027m from NHS Forth Valley to Falkirk Health and Social Care Partnership to cover the test of change period. The objective of this is to free up one full 32 bedded ward: either Ward A11 (or an equivalent ward) to free up capacity for planned care and can quickly be repurposed to support increases in demand. The characteristics of the patients who may be involved in this project will be dependent on the patients within the acute hospital and relevant ward areas during the time of implementation. The project aims to reduce whole system costs as a result of supporting more people to be in a more appropriate place for their care needs. Protected characteristics will be monitored within the discharge data available to us. Key stake holders such as the carers centre will support formal and informal carers as part of discharge planning. Throughout the project, all patients/service users and families/carers/legal representatives will be provided with the opportunity to share feedback and participate in surveys, video feedback and questionnaires to inform and build the evidence base.

Qualitative evidence gathered through patient and carer surveys, staff feedback, and case studies indicates that the SBoC model was generally well received. Patients and carers reported high levels of satisfaction with the discharge process, the quality of care, and communication between teams. Many valued being assessed at home, felt safer, and appreciated the holistic and responsive nature of the support provided. Telecare equipment, such as alarms and fall pendants, was seen as particularly reassuring. However, some areas for improvement were identified, including occasional lapses in communication, delays in equipment provision, and challenges in delivering personal care to patients with dementia or cognitive decline. Some families also expressed concerns about safety when care was reduced and about the continuity of support after the initial assessment period.

Staff feedback highlighted improved collaboration and problem-solving across teams, but also pointed to ongoing challenges with information sharing, documentation, and provider capacity. There were concerns about the sustainability of the model, particularly in relation to staffing pressures and resource constraints. The evaluation also notes that the rapid implementation timeline and limitations in digital infrastructure influenced the delivery and outcomes of the model.

The SBoC approach aligns with national policy objectives and legislative requirements, including the Falkirk Health and Social Care Partnership's Strategic Plan and the Carers (Scotland) Act, by promoting integrated, person-centred care and supporting timely, appropriate discharge planning. The evaluation draws on national and international research, which emphasises the importance of adequate resourcing, effective communication, and person-centred approaches, especially for vulnerable groups.

In summary, the evidence suggests that the SBoC model has delivered positive outcomes for older adults and those with complex needs, supporting more timely and person-centred discharges from hospital. While the evaluation highlights some limitations, such as the lack of detailed demographic data and the short evaluation period, it provides a strong foundation for understanding the impact of the service and informing future planning, particularly in relation to equality and poverty considerations.

B - Qualitative Evidence

This is data which describes the effect or impact of a change on a group of people, e.g. some information provided as part of performance reporting.

Social - case studies; personal / group feedback / other

Current Position Total Falkirk delayed discharges across the last 52 weeks have been on average 76 delays from the weekly Thursday census point. There was a peak of 92 delays of 8 May 2025 and a low of 59 in October 24. Falkirk standard delayed discharges across the last 52 weeks have averaged 55 delays. There was a peak of 73 standard delays of 8 May 2025 and a low of 40 in October 2024. Opportunities to support more people to go home or to a homely location are currently limited for a number of reasons including financial grip and control measures which have been required as a result of Falkirk’s challenging financial position. As a result of this Falkirk HSCP could only provide support for an additional 32 people currently delayed in hospital to go home or to a homely environment if additional funding were available. Shifting the balance of care aligns with existing Strategic plan priorities, particularly "ensuring people can access the right care, at the right time, in the right place".

Quantitative evidence from the evaluation shows that, between June and August 2025, 46 patients were discharged via the SBoC pathway, with the majority being older adults aged 65 and over. The model was specifically designed to address the needs of this group, who are at greater risk of hospital-associated deconditioning and functional decline. The initiative enabled the reprovisioning of a 32-bed acute ward and contributed to a reduction in delayed discharges and hospital length of stay for older adults. For example, the number of delayed discharges fell from 80 to 63 during the initial implementation period, and the average hospital stay for patients discharged through SBoC was 58 days, with an average of 21.6 days spent in the community-based assessment pathway. The readmission rate for this cohort was 10.9%, which is broadly in line with the overall 28-day readmission rate for the hospital.

The evaluation also provides outcome data for patients discharged via SBoC: 63% returned home with a care package, 15% moved to a care home, 11% were readmitted to hospital, and 9% died during the assessment period.

| Best Judgement: | |
|---|---|
| Has best judgement been used in place of data/research/evidence? | No |
| Who provided the best judgement and what was this based on? | n/a |
| What gaps in data / information were identified? | n/a |
| Is further research necessary? | No |
| If NO, please state why. | <p>All data available around patients who are delayed in hospital. Data will be held by the project group around patients who were supported home, including protected characteristics, discharge destination and levels of care provided throughout the assessment period. The discharge without delay national collaborative programme provide key performance indicators to support this work.</p> <p>Information and benchmarking data was gathered from Tayside area, specifically Dundee Health and Social Care Partnership who have implemented a similar discharge to assess model. This showed positive outcomes for patients who were discharged timeously from hospital.</p> |

SECTION FOUR: ENGAGEMENT

Engagement with individuals or organisations affected by the policy or proposal must take place

| | | |
|---|--|--|
| Has the proposal / policy / project been subject to engagement or consultation with service users taking into account their protected characteristics and socio-economic status? | Yes | |
| If YES, please state who was engagement with. | <p>Prior to the start of the project, there was limited opportunity to engage with patients, service users/families/carers due to the short timescales to implement the discharge to assess model. The model is line with Scottish Government Home First policy and the National Discharge without Delay National Collaborative programme.</p> <p>Key stakeholders with this multidisciplinary team were involved in discussions Daily MDTs to support collaboration and daily review. Patient information sheet provided to acute colleagues by Home First to capture key information on the hospital ward. Patient leaflet to inform patients, carers and colleagues of the discharge to assess approach Patients and their family members/main carers Survey to be developed to support identification of protected characteristics and socio-economic status LAS to be cross referenced with data to support identification of service users</p> | |
| If NO engagement has been conducted, please state why. | | |
| How was the engagement carried out? | What were the results from the engagement? Please list... | |
| Focus Group | Yes | Key stakeholders attended a world cafe reflection, learning and development session. The feedback from this is being gathered around key themes and areas for development. Focus groups were also set up for clinical staff including acute staff (AHPs, nurses, clinicians) as well as community colleagues (such Primary Care, District nurses) |
| Survey | Yes | Patient surveys have been implemented after the end of every assessment period. Homecare manager offers to meet with service users and families/carers via telephone or in person to support with survey completion. |
| Display / Exhibitions | Yes | Patient and Family leaflets developed as part of this project - provided to all patients who were considering and being considered for assessment at home. |
| User Panels | Yes | Weekly Multidisciplinary meetings are held to ensure patients meet the criteria for discharge to assess supporting good conversations and discharge planning. |

| | | |
|--|---|--|
| Public Event | Yes | Daily record and Falkirk Herald have covered the impact of this approach due to a reduction in patient delays for service, as well as reprovisioning of a ward within the acute hospital site in Forth Valley. |
| Other: please specify | PDSA cycles for key stakeholders. Governance reports have been presented at Management Level/Boards within Falkirk HSCP and NHS Forth Valley. Regular provider forums to support delivery and implementation of this model. | |
| Has the proposal / policy/ project been reviewed / changed as a result of the engagement? | Yes | |
| Have the results of the engagement been fed back to the consultees? | Yes | |
| Is further engagement recommended? | Yes | |

SECTION FIVE: ASSESSING THE IMPACT

Equality Protected Characteristics: What will the impact of implementing this proposal be on people who share characteristics protected by the Equality Act 2010 or are likely to be affected by the proposal / policy / project? This section allows you to consider other impacts, e.g. poverty, health inequalities, community justice, carers etc.

| Protected Characteristic | Neutral Impact | Positive Impact | Negative Impact | Please provide evidence of the impact on this protected characteristic. |
|--------------------------|----------------|-----------------|-----------------|--|
| Age | | ✓ | | <p>Positive impact on older, frailer adults in the population who may experience recurring hospital presentations due to co-morbidities/health conditions and admissions due to their deteriorating health and changing circumstances at home. This project provides the opportunity for assessment to be complete at home, in a more homely environment. The risk of increased length of stay in hospital reduces for older adults in hospital, which in turn reduces the risk of deconditioning, falls and hospital acquired infections.</p> <p>The SBoC model is designed to benefit older adults, particularly those aged 65 and over, by supporting more timely discharges and promoting independence through community-based assessment. Many older people have experienced positive outcomes from this approach. There is, however, a risk that those with the greatest frailty or highest dependency may not always have all their needs met if community resources are stretched or if care packages break down. The effectiveness of the approach for this group depends on robust contingency planning and the availability of appropriate support.</p> |

Public Sector Equality Duty: Scottish Public Authorities must have 'due regard' to the need to eliminate unlawful discrimination, advance quality of opportunity and foster good relations. Scottish specific duties include:

| | | | | |
|---------------------------------------|---|--|--|---|
| | | | | <p>supporting the process and outcomes. Aim is also to reduce the percentage of people going directly from the acute hospital to long term care (currently there is a much higher percentage of people going direct from acute to long term care rather than returning home. These factors may impact people with comorbidities and disabilities within the population due to the likelihood that they may present more frequently to hospital due to changing health and care needs.</p> <p>For people with disabilities, the SBoC approach offers the potential for more person-centred, home-based care, which can support independence and wellbeing. Many patients have valued being assessed at home. The evaluation notes a risk that the pathway may not always be suitable for individuals with complex needs, including those with cognitive impairments or mental health conditions, particularly if their needs are not fully understood. The breakdown of care packages is often linked to mental health issues, which can make it difficult to maintain consistent support at home. Communication barriers, such as inconsistent information or lack of accessible formats, may also present a risk for people with sensory or cognitive impairments.</p> |
| Sex | ✓ | | | <p>There is commitment within the Partnership for people that require assessment at home, care and support, to access this free from barriers and discrimination. This service is provided using an outcome focused and person centred approach for all patients and Falkirk residents/carers.</p> |
| Ethnicity | ✓ | | | <p>Our data is limited, however there is commitment within the Partnership for people that require assessment at home, care and support, to access this free from barriers and discrimination. This service is provided using an outcome focused and person centred approach for all patients and Falkirk residents/carers.</p> |
| Religion / Belief / non-Belief | ✓ | | | <p>Our data is limited, however there is commitment within the Partnership for people that require assessment at home, care and support, to access this free from barriers and discrimination. This service is provided using an outcome focused and person centred approach for all patients and Falkirk residents/carers.</p> |

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|-------------------------------------|---|--|--|--|
| Sexual Orientation | ✓ | | | Our data is limited, however there is commitment within the Partnership for people that require assessment at home, care and support, to access this free from barriers and discrimination. This service is provided using an outcome focused and person centred approach for all patients and Falkirk residents/carers. |
| Transgender | ✓ | | | Our data is limited, however there is commitment within the Partnership for people that require assessment at home, care and support, to access this free from barriers and discrimination. This service is provided using an outcome focused and person centred approach for all patients and Falkirk residents/carers. |
| Pregnancy / Maternity | | | | |
| Marriage / Civil Partnership | ✓ | | | There is commitment within the Partnership for people that require assessment at home, care and support, to access this free from barriers and discrimination. This service is provided using an outcome focused and person centred approach for all patients and Falkirk residents/carers. |
| Poverty | ✓ | | | There is commitment within the Partnership for people that require assessment at home, care and support, to access this free from barriers and discrimination. This service is provided using an outcome focused and person centred approach for all patients and Falkirk residents/carers. There are links to 3rd sector organisations and support via the discharge to assessment process for those who may require additional support or access to benefit information. There are charges for services such as MECS following a 21 day assessment period. If this service is required long term, charges will be discussed. |
| Care Experienced | ✓ | | | Our data is limited, however there is commitment within the Partnership for people that require assessment at home, care and support, to access this free from barriers and discrimination. This service is provided using an outcome focused and person centred approach for all patients and Falkirk residents/carers. |

| | | | |
|---|--|--------------------------------------|--|
| <p>Other, health, community justice, carers etc.</p> | <p>✓</p> | | <p>Positive impact as the aim of the project is to reduce people's length of stay in hospital and provide the opportunity for assessment at home with key professionals supporting the process and outcomes.</p> <p>Being delayed in hospital when it is not clinically necessary increases risk of deconditioning, hospital acquired infections and falls.</p> <p>Aim is also to reduce the percentage of people going directly from the acute hospital to long term care (currently there is a much higher percentage of people going direct from acute to long term care rather than returning home).</p> <p>These factors may impact people with co-morbidities and significant health issues within the population due to the likelihood that they may present more frequently to hospital due to changing health and care needs. We are committed to working with the Carers Centre to support carers in their role.</p> <p>Key stakeholders shared feedback around the impact on carers in their role as this is a cultural change around assessing people back in their own homes. General population and patients/families are familiar with the current "norm" where assessments tend to take place within the acute hospital site. The assessor will work with closely with carers and the carers centre, monitoring the impact (positive or negative) as this will inform the assessment period, as well as adult carer support plans.</p> |
| <p>Risk (Identify other risks associated with this change)</p> | <p>People who may experience stress/distress or delirium due to dementia or a cognitive impairment may be at higher risk of hospital readmission if they are not familiar with their own home environment. This will be closely monitored within the multidisciplinary team and personal carers to support patient outcomes and reduce risk. The impact of a sustained delay in hospital and bed impact on skin integrity, mobility, dizziness and institutionalisation.</p> | | |
| | | <p>Evidence of Due Regard</p> | |
| <p>Eliminate Unlawful Discrimination (harassment, victimisation and other prohibited conduct):</p> | <p>Complies with National Scottish Government Policy and Home First ethos to support assessment at home. Discharge without Delay National Collaborative supports this approach. All patients who are delayed are reviewed at a multidisciplinary meeting against set criteria within the project.</p> | | |

| | |
|---|---|
| <p>Advance Equality of Opportunity:</p> | <p>Information on discharge to assess and expectations provided to patients and carers when identified by the Home First service. Based on knowledge of older people, their age and disability/frailty, each individual/their needs and outcomes, are reviewed by the multidisciplinary team. This is against the eligibility criteria agreed within Falkirk HSCP. This may restrict the persons wishes, versus their assessed needs and outcomes.</p> |
| <p>Foster Good Relations (promoting understanding and reducing prejudice):</p> | <p>Ongoing workshops and key stakeholder sessions supporting reflection, learning and future developments. The learning and reflections from these sessions have highlighted areas for improvement and to ensure feedback is in place to patients, families and colleagues. Eligibility criteria is under regular review to ensure robust oversight.</p> <p>At times, service user individual choice has impacted on care availability and delivery (such as declining International Carers). Self directed support options are discussed throughout the assessment period.</p> |

SECTION SIX: PARTNERS / OTHER STAKEHOLDERS

| Which sectors are likely to have an interest in or be affected by the proposal / policy / project? | | Describe the interest / affect. |
|--|-----|---|
| Business | Yes | The private sector care agencies have been utilised to provide the care and support required as part of this initial project stage. There are opportunities for further collaboration with the private sector within discharge to assess and wider service transformations. |
| Councils | Yes | <p>The Integrated Joint Board will be kept updated regarding the progress of this project and the impact on service user outcomes.</p> <p>Falkirk HSCP inhouse care services are undergoing a review and would have been the recommended provider of choice for this project. However due to project timescales and essential trade union consultation timescales, this was not possible.</p> <p>There is an outstanding regrading request with inhouse care at home services for a personal carer job description which limited the possibility of using inhouse services.</p> <p>MECS already delivered the service that was required, and additional funding for staffing was provided to support this growing model. MECS are able to support this model on an ongoing basis.</p> <p>The impact on JLES will also be measured throughout this project.</p> <p>Pharmacy technicians have supported a holistic view of a patient medication, supporting realistic medication reviews.</p> |
| Education Sector | Yes | Ongoing need for training for the discharge to assess service and self directed support legislation/process for Partnership staff. A training package for reablement was designed in preparation for the inhouse care at home services to be part of this project. |
| Fire | Yes | MECS have smoke alarms and carbon dioxide alarms connected to the fire service. |

| | | |
|--------------------------------|-----|--|
| NHS | Yes | <p>A shared expectation is required to support patients in their discharge journey. This shared understanding will support cultural change within services and general population around Home First and discharge to assess model and expectations.</p> <p>NHS colleagues wish to maintain and sustain the reprovisioning of a ward within the acute hospital site. Promoting whole system thinking around funding and community pathways.</p> <p>The model should promote whole system cultural change around discharge to assess and Home First. Work is required to embed this further.</p> <p>NHS services include primary care/community services, as well as acute hospital staff. We are committed to working with various different services such as Hospital at Home and Primary Care to ensure patient outcomes are met at home if necessary.</p> <p>Funding that was transferred was managed by the Partnership to support additional discharges, over and above the normal process</p> <p>The integrated mental health team (IMHT) were involved to support readmissions where risks were deemed as critical/high for patients. The development and integration of this team and the project needs to be strengthened.</p> <p>The REACH service in Falkirk has provided additional staffing and have been prominent in the assessment process for adults at home.</p> <p>This project will also support the development of the Integrated Discharge Service.</p> <p>District Nursing service have been vital and key to the safe discharge of patients in areas such as continence care and assessment, wounds and advice.</p> |
| Integration Joint Board | Yes | The Integrated Joint Board will be kept updated regarding the progress of this project and the impact on service user outcomes. |
| Police | Yes | Via the MECS process, there is connectivity to the Police Central Control Centre if required for any service user at home. |

| | | |
|--|-----|--|
| Third Sector | Yes | The carers centre are working closely with all key stakeholders to support patient and carer outcomes. The partnership are committed to working closely with all third sector colleagues around impact and risk. This can include the Food Train and transportation links. |
| Other(s): please list and describe the nature of the relationship / impact. | | |

SECTION SEVEN: ACTION PLANNING

Mitigating Actions: If you have identified impacts on protected characteristic groups in Section 5 please summarise these in the table below detailing the actions you are taking to mitigate or support this impact. If you are not taking any action to support or mitigate the impact you should complete the No Mitigating Actions section below instead.

| Identified Impact | To Who | Action(s) | Lead Officer | Evaluation and Review Date | Strategic Reference to Corporate Plan / Service Plan / Quality Outcomes |
|---|--|---|---|----------------------------|--|
| Increased demand on informal carers and increased risk in carer stress. Carers are crucial in informing the assessment process. Adult Carer support plans will identify any impact on carers as part of this process. | Formal and Informal carers identified as part of this process. | Impact will be monitored via Outcome focused assessments Regular multidisciplinary meetings Carer feedback Adult Carer Support Plans Carer Centre support Contingency planning Escalation process to support urgent resources if required. | Claire Chapman Natalie McLurg | 31/12/2025 | Falkirk HSCP 2023 - 2026 - creating a healthier Falkirk |
| Increase in assessment activity at home, reducing length of stay and hospital related harm. | All patients who may be delayed waiting for an assessment or service | Impact will be monitored via: Patient outcomes at home Delayed Discharge National Data Multidisciplinary meetings on a daily and weekly basis. Regular data discussions with performance and planning colleagues | Hazel Webb Homecare managers Natalie McLurg | 31/12/2025 | Falkirk HSCP 2023 - 2026 - creating a healthier Falkirk Home First Discharge without Delay National Collaborative programme |

| Identified Impact | To Who | Action(s) | Lead Officer | Evaluation and Review Date | Strategic Reference to Corporate Plan / Service Plan / Quality Outcomes |
|---|---|---|----------------|----------------------------|--|
| Risk of increased hospital readmissions | Patients who may be considered appropriate as part of the project | Collaborative working with key stakeholders, in particular: Primary Care Hospital at Home District Nursing MDT services Monitor readmission rate and primary care contacts as part of potential fluctuating health needs Evaluation activity against usual trends of readmission with performance and planning colleagues | Claire Chapman | 31/12/2025 | Falkirk HSCP 2023 - 2026 - creating a healthier Falkirk Home First Discharge without Delay National Collaborative programme |
| | | | | | |
| | | | | | |
| | | | | | |

No Mitigating Actions

Please explain why you do not need to take any action to mitigate or support the impact of your proposals.

| | |
|---|----|
| Are actions being reported to Members? | No |
| If yes when and how ? | |

SECTION EIGHT: ASSESSMENT OUTCOME

Only one of following statements best matches your assessment of this proposal / policy / project. Please select one and provide your reasons.

| | | |
|--|-----|---|
| No major change required | Yes | The project is intended to support a timely discharge from hospital with assessment / up to 24 hour care at home if required. As part of the assessment and multidisciplinary team process, there is a commitment to collaborate with all key stakeholders. |
| The proposal has to be adjusted to reduce impact on protected characteristic groups | No | |
| Continue with the proposal but it is not possible to remove all the risk to protected characteristic groups | No | |
| Stop the proposal as it is potentially in breach of equality legislation | No | |

SECTION NINE: EPIA TASK GROUP ONLY

| | |
|--|----|
| OVERALL ASSESSMENT OF EPIA: Has the EPIA demonstrated the use of data, appropriate engagement, identified mitigating actions as well as ownership and appropriate review of actions to confidently demonstrate compliance with the general and public sector equality duties? | No |
|--|----|

| | |
|--|---|
| ASSESSMENT FINDINGS If YES, use this box to highlight evidence in support of the assessment of the EPIA If NO, use this box to highlight actions needed to improve the EPIA | As of now, the test of change has been limited in terms of its duration and the number of people impact and engaged with. Further engagement is required as the project progresses. |
|--|---|

| | | |
|---|-----|--|
| Where adverse impact on diverse communities has been identified and it is intended to continue with the proposal / policy / project, has justification for continuing <u>without making changes been made?</u> | Yes | If YES, please describe: Mitigations have been identified where there are potentially negative impact, particularly for carers. It is important that these impacts are closely monitored. |
|---|-----|--|

LEVEL OF IMPACT: The EPIA Task Group has agreed the following level of impact on the protected characteristic groups highlighted within the EPIA

| LEVEL | | COMMENTS |
|--------|----------|---|
| HIGH | Yes | Although only a relatively low number of people have engaged with the discharge to assess model, the potential impact is significant. |
| MEDIUM | Yes / No | |
| LOW | Yes / No | |

SECTION TEN: CHIEF OFFICER SIGN OFF

| | | | |
|------------------------------------|----------------------|--------------|------------|
| Director / Head of Service: | | | |
| Signature: | <i>Gail Woodcock</i> | Date: | 17/11/2025 |

NHS Forth Valley

Forth Valley NHS Board



6(a) Clackmannanshire & Stirling IJB – Chair Appointment

Purpose: This report is for Ratification

Executive Sponsor: Kerry Mackenzie, Acting Director of Strategic Planning & Performance

Author: Jack Frawley, Board Secretary

Executive Summary

This report was circulated to Board Members on 3 March seeking electronic approval of Allan Rennie as Chair of the Clackmannanshire & Stirling Integration Joint Board. Electronic approval was confirmed by 10 March 2026. The Board is now asked to ratify this decision.

The Chair of Clackmannanshire & Stirling IJB moves to NHS Forth Valley Health Board from 1 April 2026. This report seeks appointment of Allan Rennie to the position of Chair of the Clackmannanshire & Stirling IJB from 1 April 2026.

Action Required

The Forth Valley NHS Board is asked to:

- (1) ratify the decision to appoint Allan Rennie as the Chair of the Clackmannanshire & Stirling Integration Joint Board from 1 April 2026, and
 - (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

This report builds on previous governance reporting to the Board most recently considering Non-Executive Director portfolios on 30 September 2025.

Risk Assessment and Mitigation

The proposals of this report contribute to a healthy governance ecosystem which leads to good management, good performance, good stewardship of public money, good public engagement and ultimately good outcomes. The proposed appointment is recommended having considered the Skills Matrix of Board Members and delivery of the Blueprint for Good Governance.

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, digital or infrastructure implications arising from this report.

Workforce Implications

There are no workforce implications arising from this report.

Quality / Patient Care Implications

A high functioning Integration Joint Board positively impacts on providing appropriate high-quality governance positively impacts on the quality of care and services. Effective integrated partnership working is crucial to delivery high quality care across the whole system.

Population Health & Care Strategy

There are no specific implications arising from this report.

Climate Change / Sustainability Implications

There are no climate change implications.

Engagement and Communications

Was statutory engagement with stakeholders required? Yes No

Engagement has taken place by the Board Chair with the Chief Executive, Interim Chief Officer and the current Chair and Vice Chair of the IJB.

Appendices

Appendix 1 – Considerations

Considerations

Clackmannanshire & Stirling Integration Joint Board

- 1.1 The Chairing arrangements relating to the C&S IJB are set out in the Integration Scheme. From 1 April 2026 it falls to NHS Forth Valley to appoint to the position of Chair. The appointing period set out in the Scheme which falls to each constituent authority is for two years. An appointing body may change its Chair or Vice-Chair during the appointing period.

NHS Forth Valley may only nominate as Chairperson or Vice Chairperson a voting member of the Integration Joint Board who is a Non-Executive Director.

- 1.2 The current NHS Forth Valley appointed Voting Members are:

- Allan Rennie (Vice Chair of the C&S IJB)
- Martin Fairbairn
- Stephen McAllister
- Clare McKenzie
- Finlay Scott
- John Stuart

- 1.3 Allan Rennie currently serves as Vice Chair of the IJB and will provide continuity and stability through a period of change within the IJB. It is recognised that a further review of the NHS Forth Valley Board appointment may be required to take account of Allan's completion of his term of office as a Non-Executive Director of the NHS Forth Valley Health Board before the 2-year tenure is complete.

2.1 **Recommendation:**

Following consideration by the NHS Board Chair and in discussion with the NHS Forth Valley Chief Executive, IJB Chair, Vice Chair and Interim Chief Officer, it is recommended that Allan Rennie is appointed Chair of the Clackmannanshire & Stirling IJB from 1 April 2026.

6(b) Appointments Report**Purpose:** This report is for Decision**Executive Sponsor:** Kerry Mackenzie, Acting Director of Strategic Planning & Performance**Author:** Jack Frawley, Board Secretary

Executive Summary

This report updates the Board and seeks decision on the following matters:

- (i) standing down of the Population Health & Care Task & Finish Group;
- (ii) changes in Committee membership arising from the appointments of Cllr Scott Farmer and Karren Morrison as Board Members, and
- (iii) appointment of a Counter Fraud Champion.

Action Required

The Forth Valley NHS Board is asked to:

- (1) note that the Population Health & Care Task & Finish Group has been stood down following publication of the Population Health & Care Strategy;
- (2) note that Cllr Scott Farmer was nominated by Stirling Council and subsequently appointed by the Cabinet Secretary as the Stirling Council representative on the Forth Valley NHS Board;
- (3) note that Robert Clark retired from the role of Employee Director on 27 February 2026 and that Karren Morrison was elected to the position of Employee Director. Her appointment as Employee Director and a Non-Executive Member was approved by the Cabinet Secretary from 2 March 2026;
- (4) agree to appoint Cllr Scott Farmer to the Audit & Risk Committee and note his appointment to the Strategic Planning, Performance & Resources Committee;
- (5) agree to appoint Karren Morrison to the Audit & Risk and Remuneration Committees and note her appointment to the Staff Governance and Strategic Planning, Performance & Resources Committee;
- (6) agree to appoint Karren Morrison as the Board's Counter Fraud Champion;
- (7) note that the Endowments Trustees agreed to appoint Finlay Scott to the Endowments Committee, and
- (8) 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 builds on previous governance reporting to the Board. The Committee Portfolios were most recently considered by the Board at its meeting of 30 September 2025.

Risk Assessment and Mitigation

The proposals of this report contribute to a healthy governance ecosystem which leads to good management, good performance, good stewardship of public money, good public engagement and ultimately good outcomes. The proposed appointments are recommended having considered the Skills Matrix of Board Members and delivery of the Blueprint for Good Governance.

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 no financial, digital or infrastructure implications arising from this report. Appointment of a Counter Fraud Champion is a key part of supporting oversight of processes to mitigate against fraud.

Workforce Implications

There are no workforce implications arising from this report.

Quality / Patient Care Implications

A high functioning Board and Governance Committees positively impact on providing appropriate scrutiny and assurance on the quality of care and services. They also enable assurance of staff and patient experience.

Population Health & Care Strategy

There are no specific implications arising from this report.

Climate Change / Sustainability Implications

There are no climate change implications.

Engagement and Communications

Was statutory engagement with stakeholders required? Yes No

Engagement has taken place between the Board Chair and Non-Executive Directors taking into account the balance of Board Member skillsets. There has also been engagement with Committee Chairs and Lead Executives regarding Committee appointments.

Appendices

Appendix 1 – Considerations

Appendix 2 – Non-Executive Member Portfolios at 1 April 2026

Considerations

Population Health & Care Task & Finish Group

The Population Health & Care Task & Finish Group was established by the Board at its meeting of 26 November 2024. The Group was chaired by Allan Rennie and through a series of meetings shaped the development of the Population Health & Care Strategy. The Strategy was approved by Board on 30 September 2025. The Group has been stood down and further arrangements for monitoring the implementation of the Strategy will be discussed at the Board Seminar on Governance on 21 April 2026.

Stirling Council Representative

Cllr Scott Farmer was nominated by Stirling Council as its member on the Forth Valley NHS Board at its Special Meeting of 10 November 2025. Cllr Farmer's nomination was confirmed by the Cabinet Secretary for Health & Social Care.

Following discussion between the Board Chair and Cllr Farmer, it is recommended that Cllr Farmer is appointed as a member of the Audit & Risk Committee. Cllr Farmer will also take up a place on the Strategic Planning, Performance & Resources Committee which comprises all Non-Executive Directors.

Employee Director

Robert Clark retired from the NHS, after 40 years of service, on 27 February 2026. Robert served as the Board's Employee Director from 2018. Following an election process, Karren Morrison was appointed as Employee Director from 2 March 2026. Karren Morrison's appointment was confirmed by the Cabinet Secretary for Health & Social Care.

Following discussion between the Board Chair and Karren Morrison, it is recommended that Karren Morrison is appointed as a member of the Audit & Risk, Remuneration and Staff Governance Committees. Karren Morrison will also take up a place on the Strategic Planning, Performance & Resources Committee which comprises all Non-Executive Directors. She will also Co-Chair the Area Partnership Forum in her role as Employee Director

Counter Fraud Champion

The Counter Fraud Champion is a position provided for in the Counter Fraud Services Partnership Agreement and CEL 11 (2013). The Partnership Agreement between Counter Fraud Services and NHS Forth Valley sets out that "The Scottish Government's Strategy asks the Board to appoint an Executive or Non-Executive Director to be the Counter Fraud Champion (CFC) to help with the process of promoting a counter fraud message within the organisation. This role is vital in representing counter fraud issues at Board level and communicating to staff to promote an anti-fraud culture.". Counter Fraud Services will provide support for the new Counter Fraud Champion.

Following consideration by the Board Chair and discussions with Non-Executive Directors it is recommended that Karren Morrison is appointed as the Board's Counter Fraud Champion.

Non-Executive Member Portfolios at 1 April 2026**Neena Mahal**

| Appointments |
|--|
| NHS Forth Valley Board Chair |
| Member of Remuneration Committee |
| Chair of Strategic Planning, Performance and Resources Committee |
| Ex-officio Member of Clinical Governance Committee |
| Ex-officio Member of Staff Governance Committee |
| In attendance at Audit and Risk Committee |
| Member of 3 Community Planning Partnerships across the 3 Local Authorities |

Allan Rennie

| Appointments |
|---|
| NHS Forth Valley Board Vice-Chair |
| Chair of the Remuneration Committee (including Chair of Discretionary Points Group) |
| Member of the Strategic Planning, Performance and Resources Committee |
| Member of the Endowments Sub Committee |
| Chair of the Organ Donation Committee |
| Chair of the Clackmannanshire & Stirling Integration Joint Board |

Kirstin Cassells

| Appointments |
|---|
| Chair of the Area Clinical Forum |
| Member of the Clinical Governance Committee |
| Member of the Strategic Planning, Performance and Resources Committee |
| Member of the Endowments Committee |

Karren Morrison

| Appointments |
|---|
| Co-Chair of the Area Partnership Forum |
| Member of the Audit and Risk Committee |
| Member of the Remuneration Committee |
| Member of the Staff Governance Committee |
| Member of the Strategic Planning, Performance and Resources Committee |
| Board Counter Fraud Champion |

Martin Fairbairn

| Appointments |
|--|
| Member of the Audit and Risk Committee |
| Member of the Remuneration Committee |
| Chair of the Staff Governance Committee |
| Member of the Strategic Planning, Performance and Resources Committee |
| Joint Chair of the Pharmacy Practices Committee/GP Practices Committee |
| Member of the Clackmannanshire & Stirling Integration Joint Board |

Alison Jaap

| Appointments |
|---|
| Member of the Remuneration Committee |
| Member of the Staff Governance Committee |
| Member of the Strategic Planning, Performance and Resources Committee |
| Member of the Falkirk Integration Joint Board |

Gordon Johnston

| Appointments |
|---|
| Member of the Clinical Governance Committee |
| Member of the Staff Governance Committee |
| Member of the Strategic Planning, Performance and Resources Committee |
| Board Whistleblowing Champion |
| Chair of the Falkirk Integration Joint Board |

Stephen McAllister

Appointments

Member of the Audit and Risk Committee

Member of the Clinical Governance Committee

Member of the Strategic Planning, Performance and Resources Committee

Member of the Clackmannanshire & Stirling IJB

Member of the Falkirk Integration Joint Board

Clare McKenzie

Appointments

Member of the Clinical Governance Committee

Member of the Strategic Planning, Performance and Resources Committee

Member of the Clackmannanshire & Stirling Integration Joint Board

Finlay Scott

Appointments

Member of the Audit & Risk Committee

Member of the Strategic Planning, Performance and Resources Committee

Member of the Clackmannanshire & Stirling Integration Joint Board

John Stuart

Appointments

Chair of the Clinical Governance Committee

Member of the Staff Governance Committee

Member of the Strategic Planning, Performance and Resources Committee

Joint Chair of the Pharmacy Practices Committee/GP Practices Committee

Member of the Endowments Committee

Member of the Clackmannanshire & Stirling Integration Joint Board

Councillor Fiona Collie

Appointments

Chair of the Audit and Risk Committee

Member of the Strategic Planning, Performance and Resources Committee

Chair of the Endowments Committee

Councillor Fiona Law

Appointments

Member of the Clinical Governance Committee

Member of the Strategic Planning, Performance and Resources Committee

Board Champion Climate Change and Sustainability

Councillor Scott Farmer

Appointments

Member of the Audit and Risk Committee

Member of the Strategic Planning, Performance and Resources Committee

COMMITTEE MEMBERSHIP APRIL 2026

| Audit & Risk Committee | Clinical Governance Committee | Staff Governance Committee | Strategic Planning, Performance & Resources Committee | Remuneration Committee |
|--|---|---|---|--|
| <p>Members Cllr Fiona Collie (Chair) Martin Fairbairn Cllr Scott Farmer Stephen McAllister Karren Morrison Finlay Scott</p> | <p>Members John Stuart (Chair) Kirstin Cassells Gordon Johnston Cllr Fiona Law Stephen McAllister Clare McKenzie Neena Mahal (Ex-officio member)</p> | <p>Members Martin Fairbairn (Chair) Alison Jaap Gordon Johnston Karren Morrison John Stuart Nicholas Hill (Staff Side) Janet Sneddon (Staff Side) Neena Mahal (Ex-officio member)</p> | <p>Members Neena Mahal (Chair) All Non-Executive Members</p> | <p>Members Allan Rennie (Chair) Martin Fairbairn Alison Jaap Neena Mahal Karren Morrison</p> |
| Q – 3 Non-Executive Directors | Q – 3 Non-Executive Directors | Q – 3 Non-Executive Directors | Q – 3 Non-Executive Directors | Q – 3 Non-Executive Directors |
| <p>Executive Lead Scott Urquhart</p> | <p>Executive Leads Andrew Murray Karen Goudie</p> | <p>Executive Lead Kevin Reith</p> | <p>Executive Lead Kerry Mackenzie (liaising with Scott Urquhart and Jennifer Champion)</p> | <p>Executive Lead Kevin Reith</p> |
| <p>Organ Donation Committee Member Allan Rennie (Chair)</p> | <p>Pharmacy Practices Committee & GP Practices Committee Members John Stuart (Joint Chair) Martin Fairbairn (Joint Chair)</p> | | | |

| Endowments Trustees | Endowments Committee |
|---|---|
| <p>Members Neena Mahal (Chair) All Board Members</p> | <p>Members Cllr Fiona Collie (Chair) Kirstin Cassells Andrew Murray (Executive Director) Allan Rennie Finlay Scott John Stuart Scott Urquhart (Executive Director)</p> |

| Falkirk Integration Joint Board | Clackmannanshire & Stirling Integration Joint Board | Falkirk Community Planning Partnership | Clackmannanshire Community Planning Partnership | Stirling Community Planning Partnership |
|---|---|---|---|---|
| <p>Voting Members Gordon Johnston (Chair) Alison Jaap Stephen McAllister</p> | <p>Voting Members Allan Rennie (Chair) Martin Fairbairn Stephen McAllister Clare McKenzie Finlay Scott John Stuart</p> | <p>Members Board Chair Board Chief Executive Director of Public Health</p> | <p>Members Board Chair Board Chief Executive Director of Public Health</p> | <p>Members Board Chair Board Chief Executive Director of Public Health</p> |

1 April 2026