FORTH VALLEY ANNUAL DELIVERY PLAN 2026/27

Contents

1. Introduction

The Forth Valley Annual Delivery Plan (ADP) for 2026/27 sets out how NHS Forth Valley will deliver national NHS Scotland priorities over the coming year, while responding to the needs of our population and the specific challenges facing our local system. It provides a clear, Board-level statement of what we are committed to deliver, why these actions matter, and how they will contribute to safer, more sustainable and more person-centred care.

The ADP is important because it brings together strategic priorities, operational actions and measurable deliverables in a single plan. It aligns local improvement work with national policy and is explicitly aligned to the Sub-National planning priorities, ensuring a coherent, system-wide approach to delivery across planned care, urgent care, diagnostics and regional collaboration. It is also aligned to the Forth Valley Workforce Plan and the Forth Valley three-year financial plan, ensuring that delivery priorities are supported by workforce planning, affordability and longer-term financial sustainability. It supports transparency and accountability, and ensures that quality, performance, workforce, finance and service reform are considered together. In doing so, it provides a practical framework for decision-making, prioritisation and delivery across the organisation and wider system.

The plan is structured around a set of key themes that are fully aligned to Scottish Government operational priorities for 2026/27, providing a clear and direct contribution to national improvement objectives:

- Reduce the longest waits for planned care
- Increase productivity across elective and diagnostic services
- Improve flow and performance in urgent and unscheduled care
- Expand Hospital at Home as a mainstream model of care
- Support safe, high-quality maternity and neonatal services
- Strengthen and improve access to services for Mental Health, Neurodiversity and Learning Disability
- Accelerate digital access and modernisation across care pathways
- Develop as a population health-focused organisation

Each section describes the future direction, operational priorities, and the key actions and deliverables that will be taken forward during the year, with clear linkage to OIP delivery programmes and Sub-National West trajectories and collaborative plans.

Progress will be monitored through a strengthened performance management approach, supported by clear governance and formal twice-yearly reporting. Delivery will be tracked against defined milestones, trajectories, performance measures and action plans, using Pentana/ Healthcare Guardian and routine reporting.

Performance will be reviewed at operational, executive and Board level, with exception reporting, escalation and targeted improvement where delivery is off track. Oversight will operate through established governance structures, including FV Programme Boards, which will play a key role in overseeing, directing and monitoring progress across these areas of activity, operational performance forums, the Senior Leadership Team, and reporting to SPPRC and the Board, aligned with Sub-National structures.

This approach supports routine review of progress, risks and dependencies, enables early corrective action, and ensures the ADP remains a live tool for improvement, performance management and accountability throughout 2026/27.

2. Reduce the longest waits in planned care

2.1 Future Direction

We must move beyond managing waiting lists to redesigning planned care systems that improve access, streamline pathways, and optimise patient flow, enabling sustainable reductions in the longest waits while reducing inequalities and maintaining robust clinical prioritisation across all services. This approach aligns with the national focus on reducing long waits, increasing capacity, and optimising regional and national elective working, ensuring that local delivery is fully integrated with wider system reform.

2.2 Operational Priorities for 2026/ 2027

- **Reduce waiting times and improve access to Planned Care services:** Maintain a clear and sustained focus on reducing backlogs, with targeted action for those waiting longest.
- **Maximise system-wide capacity:** Optimise elective capacity across all levels:
- National (e.g. National Treatment Centres)
- Regional / sub-national (through collaboration)
- Local services (including full utilisation of facilities and alternative care settings)
- **Improve productivity and efficiency:** Increasing throughput through better scheduling, enhanced theatre utilisation, and more effective pathway management, while improving equity and reducing unwarranted variation across Planned Care services.
- **Sustain and increase activity levels:** Maintain or improve delivery levels to continue progress on waiting times and support ongoing reductions in demand.
- **Protect clinical priorities (particularly cancer):** Ensure care is delivered based on clinical need, with a continued focus on improving cancer diagnostics and treatment performance, including the 62-day standard.

2.3 Key Actions and Deliverables for 2026/ 2027

NHS Forth Valley remains fully committed to reducing long waits; however, a number of significant challenges are emerging in 2026/27, including a reduction in National Treatment Centre allocation, reduced allocation from the Golden Jubilee National Hospital, and a pause on additional activity in Quarter 1. In recognition of these pressures, a proposal for additional funding has been submitted.
A detailed delivery plan has been developed in line with the operational priorities and themes set out above. However, implementation remains contingent on confirmation of the proposed funding.
Subject to approval, this investment will support delivery of the planned trajectories over the course of the year and strengthen the Board's ability to achieve the 52-week target. Local actions and deliverables relating to this priority are outlined in Table 1.

Table 1 Reduce the longest waits in planned care

Reduce waiting times and improve access to Planned Care services	
1	Continue targeted recovery action to reduce long waits and maintain progress in specialties with the highest backlog risk. Alongside maximising existing capacity, funding for the costed additionality proposals is essential. Without this investment, some services will be unable to reduce waiting times, impacting some specialties having patients waiting over 52 weeks.
Maximise system-wide capacity	
2	Maximise system-wide capacity by strengthening regional and sub-national collaboration to reduce long waits, particularly in orthopaedics, through optimising demand and capacity (including PMAT modelling), maximising use of local, regional and national assets (including NTC), and delivering productivity and efficiency improvements aligned to agreed recovery plans and the West orthopaedic blueprint.
3	Maximise utilisation of clinic and theatre facilities through stronger forward planning, adherence to 6-week annual leave notice to reduce avoidable cancellations. Full embedding of the Theatre INFIX scheduling system.

Improve productivity and efficiency	
4	Strengthen access and pathway management through rigorous application of the Access Policy, continued rollout of PFB to reduce DNAs, consistent adoption of CfSD productive opportunities (ACRT, PFB, PIR) across all services and ongoing recovery planning to support sustainable delivery.
5	Continue to embed digital and virtual approaches to improve waiting list management, clinic efficiency and patient access, including Bookwise to maximise clinic room capacity, Patient Hub for appointment letters, reminders and validation. Greater use of virtual appointments where appropriate.
Sustain and increase activity levels	
6	Support continued delivery through workforce development and service redesign that releases clinical capacity, including development of Advanced Practitioner roles and Surgical Care Practitioners, to safely undertake non-complex procedures and free consultant surgeons for more complex care.
Protect clinical priorities (particularly cancer)	
7	Ensure planned care recovery continues to support clinically urgent pathways, including cancer diagnostics and treatment standards.
8	The Acute Cancer Board will oversee delivery through its 2026/27 workplan by monitoring speciality-level performance and long-wait trajectories, embedding the ten principles of the National Framework, and strengthening governance through regular pathway reviews and targeted escalation. Delivery will be supported by implementing optimal pathways (Lung, Head & Neck, Colorectal) and progressing new pathways (Prostate, HPB).
9	Services will collaborate with regional partners to address capacity constraints and service dependencies, particularly in oncology and robotic surgery.

3. Increase productivity across elective and diagnostic services

3.1 Future Direction

NHS Forth Valley will transition towards a more integrated, digitally enabled whole-system approach to diagnostics and elective care, improving capacity utilisation, efficiency and workforce sustainability. This will support faster diagnosis and treatment through system redesign, optimising capacity across all levels, strengthening community access, and advancing digital infrastructure to improve patient flow. This aligns with the Operational Improvement Plan focus on backlog reduction, theatre productivity, increased NTC use, and digital scheduling tools.

3.2 Operational Priorities for 2026/ 2027

- **Capacity Optimisation and Throughput Improvement:** maximise utilisation of existing capacity to increase throughput and reduce delays, without reliance on new infrastructure investment.
- **Digital Enablement of Planned Care:** maximise digital solutions to modernise pathways, improve coordination, and enhance efficiency, access, and patient experience.
- **Pathway Redesign and Demand Management:** streamline patient pathways to reduce unwarranted variation and unnecessary activity, actively manage demand, and strengthen diagnostics and treatment to improve flow, outcomes and value across Planned Care services.
- **Workforce transformation and productivity**: optimise skill mix to release consultant capacity, strengthen multidisciplinary working, and deliver sustainable productivity through effective workforce planning and modern models of care.

3.3 Key Actions and Deliverables for 2026/ 2027

NHS Forth Valley is committed to delivering productivity gains and achieving national standards through capacity optimisation, pathway redesign, workforce transformation, digital enablement, and effective demand management to improve access and reduce waiting times. This includes delivery of the 6-week diagnostic standard across key endoscopy and radiology tests, supporting cancer waiting times Local actions and deliverables relating to this priority are outlined in Table 2.

Table 2 Increase productivity across elective and diagnostic services

Capacity Optimisation and Throughput Improvement	
10	Deliver the Endoscopy Plan by optimising capacity and reducing variation in workforce, utilisation, scheduling and booking, while expanding alternatives such as CT, cyto-sponge and trans-nasal endoscopy (TNE).
11	Provide additional capacity to reduce backlog to a sustainable waiting list size for new and surveillance patients.
12	Deliver 6-week diagnostic standard and support delivery of the cancer targets.
13	Implement an enhanced diagnostic imaging booking model to optimise appointment slot utilisation, aligning booking times to clinical need, and maximise CT and ultrasound capacity across all available sessions, including extended and weekend working, to improve throughput and reduce waiting times.
14	Increase productivity across elective and diagnostic cancer services by optimising capacity, strengthening community diagnostics and digital infrastructure, and enhancing cancer–diagnostics collaboration to support timely diagnosis and treatment.
Digital enablement of planned care	
15	Deliver and embed core diagnostic imaging digital systems (including RIS, PACS and Order Comms) to enable safe, secure, and efficient patient booking, improve workflow, and support service-specific needs across diagnostic pathways.
16	Introduce and embed a Clinical Decision Support system to ensure appropriate diagnostic imaging at each stage of the patient pathway, reducing unnecessary tests and improving the efficiency, quality, and focus of diagnosis, treatment, and surveillance.
17	Implement the clinical Endoscopy Reporting System to standardise reporting, streamline scheduling and improve booking efficiency.
Pathway Redesign and Demand and Demand Management	
18	Strengthen collaborative working with the Cancer Tracking Team to ensure all USoC patients receive diagnostic imaging within 7 days, with reporting completed within 14 days, supporting delivery of national cancer waiting time standards.
19	Implement and adhere to evidence-based clinical pathways and guidance (including BSG surveillance and existing pathways such as qFIT and IBD) to optimise diagnostic use, support demand management, and direct patients to the most appropriate care pathway.
Workforce transformation and productivity	
20	Continue to develop and expand Enhanced and Advanced practice roles, including within National Screening Programmes and extended scope areas, to maximise workforce capability and ensure all staff operate at the top of their skillset, improving efficiency and productivity across diagnostic services.
21	Expand the endoscopy workforce by continuing participation in national training programmes for Nurse Endoscopists and Endoscopy Assistant Practitioners, supported by workforce planning and multidisciplinary team model of care.

4. Improve Flow and performance in Unscheduled Care

4.1 Future Direction

Develop and implement a whole-system Urgent and Unscheduled Care model aligned to national priorities to improve access, flow and system resilience, by shifting from a reactive hospital-based approach to integrated care with strengthened community capacity, enhanced triage and navigation, early senior decision-making, admission avoidance, same-day care and timely discharge, supported by improved data use, clear accountability and strong clinical leadership, ensuring patients receive the right care, in the right place, first time.

This aligns with sub-national West priorities and commissioned workstreams, including navigation hubs, virtual capacity, escalation frameworks and future UEC model development, while supporting key national priorities on front door streaming, admission avoidance, discharge and hospital flow.

4.2 Operational Priorities for 2026/ 2027

- **Front door transformation & ED flow:** Strengthen senior clinical decision-making, streaming and rapid assessment to reduce crowding, improve timeliness and maximise same-day care.
- **Whole-system flow, discharge & delays:** Improve discharge reliability and reduce avoidable length of stay through consistent Discharge Without Delay, Criteria to Reside, Integrated Discharge and Discharge to Assess approaches.
- **Admission avoidance & community alternatives:** Expand sustainable alternatives to admission, including Hospital at Home, ambulatory care and community pathways, supporting care closer to home and reducing acute pressure.
- **Frailty & older people's pathways:** Embed early identification, comprehensive geriatric assessment and proactive same-day pathways to avoid unnecessary admission and improve outcomes.
- **Flow Navigation Centre & clinical coordination:** Establish a clinically led navigation function to strengthen real-time oversight, enable professional-to-professional decision-making and optimise pathway routing.
- **Governance, data & delivery grip:** Strengthen executive oversight, operational grip and use of real-time data to drive improvement, manage risk and support sustainable UEC delivery.

4.3 Key Actions and Deliverables for 2026/ 2027

In 2026/27, we will improve unscheduled care flow and performance through a whole-system model that strengthens front door streaming, senior clinical decision-making and rapid assessment; improves discharge and reduces delays; expands Hospital at Home and community alternatives; develops frailty pathways and seven-day support; establishes a Flow Navigation Centre; and strengthens governance, data and operational grip to reduce crowding and deliver the right care first time. Local actions and deliverables relating to this priority are outlined in Table 3.

Table 3 Improve Flow and performance in Unscheduled Care

Front door and ED flow	
22	Finalise and implement phase one of the ED workforce plan and phased front door improvement (triage, streaming, senior decision-making)
33	Complete breach analysis and structured process mapping to identify and implement priority changes
Flow Navigation Centre	
24	Progress transition from administrative to clinically led (SCDM) FNC model aligned to regional direction
25	Define and implement minimum dataset and electronic data capture for FNC activity and outcomes

Demand management	
26	Sustain and expand Hospital at Home capacity (core and pathway development), improving utilisation and referral processes
27	Strengthen professional-to-professional decision support (e.g. Consultant Connect) and community access pathways (MIU, RACU)
Whole-system flow and discharge	
28	Embed Criteria to Reside and strengthen discharge reliability through PDD, ward routines and escalation processes
29	Complete Integrated Discharge Service (IDS) review and implement pathway-based discharge coordination model
30	Define and test Discharge to Assess (D2A) model aligned to priority pathways and community capacity
Frailty pathways	
31	Implement consistent frailty screening and digital capture (Frailty RAG) in ED and Acute Frailty Unit
32	Develop and embed 7-day frailty MDT model with improved discharge conversion and flow from AFU
System integration and grip	
33	Develop and implement key dashboards (ED flow, FNC, H@H, discharge) to improve operational visibility and assurance
34	Strengthen whole-system governance through SLT and operational forums to drive alignment, pace and accountability

5. Expand Hospital at Home as a mainstream model of care

5.1 Future Direction

The NHS Forth Valley Population Health and Care Strategy sets a clear direction to deliver more care at home and in community settings, with Hospital at Home as a core model for delivering short-term, hospital-level care in people's own homes. This supports the national ambition to shift the balance of care away from acute hospitals, enabling earlier intervention, preventing deterioration and avoiding unnecessary admissions, particularly for people with frailty and other high-risk groups.

Expansion of Hospital at Home will reduce pressure on acute services by improving flow, minimising avoidable admissions and supporting timely discharge through safe alternatives to inpatient care. Delivery will be underpinned by stronger integration with primary care, community and urgent and unscheduled care pathways, alongside sub-national collaboration to promote consistency, share best practice and support sustainable delivery at scale, aligning with regional priorities for virtual capacity and national commitments to expand community-based alternatives to admission.

5.2 Operational Priorities for 2026/ 2027

- **Care Closer to Home / Shift to Community Care:** Expand Hospital at Home as a core alternative to admission, supporting admission avoidance, earlier intervention and anticipatory care for frailty and other high-risk groups.
- **Service Expansion & Pathway Development:** Embed Hospital at Home as a mainstream model, developing priority pathways (e.g. OPAT, heart failure, respiratory) and strengthening access to diagnostics and treatment in community settings.
- **Reducing Variation & Improving Consistency:** Minimise unwarranted variation by implementing consistent standards, supported by sub-national collaboration to scale delivery and spread best practice.

- **Integration & Whole-System Working:** Strengthen alignment across acute, primary, community and urgent and unscheduled care pathways, including integration with Flow Navigation Centres to support first-time-right care.
- **System Efficiency, Flow & Outcomes:** Reduce avoidable admissions, improve flow and minimise length of stay, alleviating pressure on acute services while delivering safe, high-value care closer to home.
- **Digital & Enabling Infrastructure:** Expand digital solutions and remote monitoring to enable safe, effective and scalable delivery of hospital-level care in patients' homes.

5.3 Key Actions and Deliverables for 2026/ 2027

In 2026/27, we will expand and mainstream Hospital at Home by developing priority pathways, strengthening referral routes and whole-system integration, improving digital visibility and reporting, and embedding it as a consistent alternative to admission that supports flow, reduces avoidable hospital use and delivers safe, high-value care closer to home. Local actions and deliverables relating to this priority are outlined in Table 4.

Table 4 Expand Hospital at Home as a mainstream model of care

Digital and Enabling Infrastructure	
35	Develop an electronic virtual ward model to improve real-time visibility of capacity, demand, utilisation and outcomes across Hospital at Home pathways
Service expansion and pathway development	
36	Deliver a Hospital at Home development session to align the future model, pathway priorities, workforce, governance and digital requirements.
37	Implement a paediatric Hospital at Home pathway, including defined scope, eligibility criteria, governance, operational processes and reporting arrangements.
Integration and whole-system working	
38	Develop and implement a communications plan for referrers covering Hospital at Home pathways, eligibility criteria, referral routes, response times and escalation processes.
Digital and enabling infrastructure	
39	Establish a Hospital at Home reporting framework and live dashboard to monitor capacity, utilisation, referral flow, acceptance/rejection patterns and outcomes.
System Efficiency, Flow and Outcomes	
40	Reduce avoidable attendances and admissions, improve flow and minimise length of stay by strengthening SCDM and Flow Navigation Centre arrangements to direct patients to the right service first time.

6. Support safe and high-quality maternity and neonatal services

6.1 Future Direction

Strengthen safe, high-quality maternity and neonatal services through full implementation of Healthcare Improvement Scotland (HIS) maternity inspection actions and delivery of the national networked neonatal intensive care model, ensuring mothers and babies receive care in the right place at the right time. This will be delivered through a focused programme of work prioritising population health and early years, women's health across the life course, maternity and neonatal quality improvement, and targeted action to reduce inequalities.

6.2 Operational Priorities for 2026/ 2027

- **Population Health & Early Years:** Delivering an integrated, prevention-focused early years model with universal pathways, enhanced parenting support, and strengthened partnerships to tackle child poverty and improve lifelong outcomes.

- **Maternity & Neonatal Quality:** Delivering safe, effective, and high-quality maternity and neonatal care.
- **Women's Health:** Supporting all women and girls to achieve the best possible health and wellbeing across the life course.
- **Equity & Inequalities Reduction:** Taking a whole-system, life course approach—targeting early years, women's health, poverty, and protected characteristics—to reduce health inequalities.

6.3 Key Actions and Deliverables for 2026/ 2027

During 2026/27, NHS Forth Valley will deliver the Children & Families Plan; embed continuity of care and health visiting pathways; strengthen screening and child health reviews; tackle child poverty; embed maternity, neonatal and miscarriage pathways; advance women's health services; implement pre-pregnancy care; and reduce inequalities through targeted, data-driven and anti-racism actions. Local actions and deliverables relating to this priority are outlined in Table 5.

Table 5 Support safe and high-quality maternity and neonatal services

Population Health & Early Years	
41	Finalise, publish and commence implementation of the Population Health & Care Plan for Children and Families, with defined outcomes, delivery programmes and performance measures.
42	Complete rollout and embed continuity of care models, as part of the Best Start programme, prioritising minority ethnic groups and those with additional needs, to deliver measurable improvements in experience and outcomes.
43	Sustain full delivery and improve coverage of the Universal Health Visiting Pathway, uptake and timeliness of reviews, with targeted outreach to families at risk of poorer outcomes.
44	Maintain universal developmental screening (ASQ) screening and deliver high-quality paediatric audiology, strengthening integration across newborn hearing screening, audiology and early years services to improve timeliness of referral, assessment and intervention.
45	Improve compliance and reduce variation in delivery of child health reviews, ensuring consistent use of ASQ and timely follow-up of identified needs.
46	Deliver Local Child Poverty Action Plans with partners, embedding whole-family support models and demonstrating measurable impact on access to financial support, employability and wider determinants.
Maternity & Neonatal Quality	
47	Complete implementation and embed maternity pathways aligned to national maternity standards, with assurance through audit, governance and patient experience measures.
48	Fully embed the neonatal intensive care model and expand outreach services, increasing earlier supported discharge and improving family-centred care and outcomes.
49	Implement miscarriage care pathways in line with the national framework for miscarriage care, improving access to specialist support, ensuring consistent standards and strengthening data reporting.
50	Embed Women's Health Plan (phase 2) priorities into business-as-usual delivery, reducing inequalities and strengthening integration across maternity, primary care and mental health.
Women's Health	
51	Implement and evaluate the adolescent gynaecology pathway, improving access, information and experience for young women.

52	Sustain established, equitable access to specialist menopause services, with continued development of workforce capability and expansion of community-based models of care.
Equity & Inequalities Reduction	
53	Implement integrated pre-pregnancy pathways, improving early risk identification and care planning for women with complex needs, including cardiac conditions.
54	Deliver and evidence impact of Anti-Racism Plan actions in maternity services, improving access, experience and outcomes for minority ethnic women.
55	Strengthen use of data, EQIA and targeted interventions across all programmes, demonstrating measurable reductions in variation in access and outcomes.

7. Improve and support services around Mental Health, Neurodiversity and Learning Disability

7.1 Future Direction

Improve support and delivery of services for Mental Health, Neurodiversity and Learning Disability by stabilising and progressively improving timely access for all age groups through locally agreed improvement plans. This will include strengthening neurodevelopmental assessment pathways and enhancing access to evidence-based interventions. In parallel, we will further develop integrated, community-based pathways across the wider mental health system, working in partnership with local and national stakeholders to ensure equitable, sustainable and person-centred care. This work aligns with national priorities to reduce CAMHS waiting times, sustain delivery of the 18-week standard, and improve access to psychological therapies.

7.2 Operational Priorities for 2026/ 2027

- **Strategic Planning and Governance:** Implementation of the Mental Health & Wellbeing Strategic Commissioning Plan; progression of action plans aligned to national specifications (e.g. Psychological Therapies); alignment with national frameworks and standards (e.g. PEP, DBI).
- **Access and Waiting Times Improvement:** Continued focus on reducing Psychological Therapies waiting times, including expansion of group and brief interventions and “Waiting Well” approaches, supporting the overall ambition to improve access, stability and quality across mental health, neurodiversity and learning disability services.
- **Quality, Outcomes and Value-Based Care:** Maintenance of CAMHS performance using a Value Based Health & Care approach, with a focus on improving outcomes, service quality, and consistent, evidence-based practice.
- **Service Transformation and Pathway Development:** Expansion and diversification of therapeutic models (group work, brief interventions), strengthening community-based pathways, and refresh of the Psychiatric Emergency Plan including the DBI model for unscheduled care.
- **Data, Reporting and Continuous Improvement:** Improvement of reporting through CAMHS and Psychological Therapies datasets (CAPTND), using data to drive performance, planning, and continuous improvement.
- **Workforce Sustainability and Delivery:** Ongoing delivery of the workforce action plan across MHLD inpatient and community settings, ensuring workforce capacity and sustainability to support service delivery.
- **Integration and System-Wide Delivery:** Strengthening community-based and integrated care pathways, aligning programmes to improve access, flow, and outcomes across the system.

7.3 Key Actions and Deliverables for 2026/ 2027

In 2026/27 we will deliver the Forth Valley Mental Health Strategy, aligned to national standards and regional collaboration; improve access through neurodivergence and psychological therapies pathways; redesign urgent and learning disability services; strengthen quality, safety and outcomes; implement a sustainable workforce model; and embed robust data, governance and integrated system delivery. Local actions and deliverables relating to this priority are outlined in Table 6.

Table 6 Improve and support services around Mental Health, Neurodiversity and Learning Disability

Strategic Planning & Governance	
56	Deliver FV Mental Health Strategy - with clear milestones and reporting
57	Align delivery with national specifications (e.g. Psychological Therapies, DBI)
58	Progress regional collaboration initiatives (e.g. Barron Report, Coming Home)
Access & Waiting Times	
59	Develop and implement neurodivergence support pathway plan
60	Progress the implementation of the Psychological Therapies improvement plan
61	Implement pathway redesign linked to access policy and booking processes
Quality, Outcomes & Value-Based Care	
62	Deliver HIS/SDC action plan and complete all requirements
63	Embed sexual safety policy and improved adverse event analysis
64	Align risk reporting with the new framework
65	Strengthen outcome and safety monitoring using Safeguard and adverse event data
Service Transformation & Pathway Delivery	
66	Implement refreshed Psychiatric Emergency Plan (including DBI integration)
67	Improve urgent care pathways, including pre-hospital triage with SAS
68	Complete review and redesign of Learning Disability Services
Data, Reporting & Continuous Improvement	
69	Establish accessible, usable performance data and live dashboards covering waiting times (Psychological Therapies, LD, CAMHS) and workforce/absence, aligned to agreed reporting standards.
70	Ensure full HIS/ SDC evidence tracking and delivery of routine audit cycles (falls, safety, estates, infection control) to meet agreed compliance standards
Workforce Sustainability	
71	Implement workforce action plan to deliver a sustainable workforce model by reducing key vacancies, optimising non-core staffing levels, bed configuration, over-recruitment and implementing reduced working week arrangements against agreed staffing and cost benchmarks.

Integration & System Delivery	
72	Deliver integrated system improvement by implementing joint inspection actions with partners and strengthening pathway flow across discharge, access, and crisis services to agreed performance standards.

8. Accelerate digital access and modernisation

8.1 Future Direction

Digital access, integration and modernisation will be accelerated across all care settings, improving patient access and experience through a consistent digital front door and expanded remote care. Care coordination will be strengthened through better information sharing and EPR expansion, supported by modern, reliable systems across hospital, community and primary care. Delivery will align with national programmes and Local priorities and the maintenance and refresh of local systems and infrastructure.

8.2 Operational Priorities for 2026/ 2027

- **Accelerate Digital Access, Patient Experience and Engagement:** Improve access through a consistent digital front door and expanded remote care.
- **Integrated Records and Care Coordination:** Enable safe, joined-up care through better information sharing and EPR expansion.
- **Modernisation of Systems Across Care Settings:** Modernise systems to support reliable, efficient services across hospital and community care.
- **National Alignment, Infrastructure and Connectivity:** Align with national programmes and strengthen secure, resilient digital infrastructure. This must be balanced with local priorities and local refresh of infrastructure and technologies.
- **Innovation and Future Capability:** Scale innovation and build workforce capability to support future digital services.

8.3 Key Actions and Deliverables for 2026/ 2027

In 2026/27, we will accelerate digital access and modernisation by expanding digital access and remote care, improving care coordination through better information sharing and EPR development, modernising core systems and infrastructure, delivering national digital programmes, strengthening cyber resilience, and building workforce capability to support safer, more efficient and connected services. Local actions and deliverables relating to this priority are outlined in Table 7.

Table 7 Accelerate digital access and modernisation

National Alignment, Infrastructure and Connectivity	
73	Continue delivery of national digital programmes and key system implementations, including GP IT and Child Health system replacements, DOCMAN upgrade, LIMS, PACS, M365/SharePoint deployments, and Scan for Safety.
74	Maintain and strengthen cyber resilience by delivering the improvement plan, embedding secure-by-design in all new systems, and preparing for CAF implementation.
75	Refresh Cyber-vault technology to provide business continuity capability
Digital Access, Patient Experience and Engagement	
76	Continue to build workforce digital capability at scale through the formalisation of the Digital Champions network and core digital services workforce requirements.
77	Expand the use of ‘Near Me’ home teleconference service as business-as-usual across priority pathways

78	Roll out MyCare.scot and equivalent platforms across services Improve communication, booking and patient interaction.
79	Pilot PROMS & PREMS solutions using existing systems capability
Innovation and Future Capability	
80	Work collaboratively with other organisations to scale and adopt innovation (e.g. via ANIA pathways) and support innovations to move from “project” to BAU at scale to maximise benefits.
81	Enhance Research, Development and Innovation delivery through working with academia and industry, to develop a cost recovery model for projects.
Accelerate digital access and modernisation of systems	
82	Complete the Digital Maturity Assessment to identify gaps and drive prioritisation and investment decisions.
83	Build a business case to deliver an EPR for ICU
84	Digitise Corporate Processes using existing M365 and supporting systems
85	Continue the rollout of OPEN Eyes and support move to EPR
86	Continue the move to an Acute EPR through development of TRAK Capability
87	Continue to refresh and modernise the Core Infrastructure for FV.
88	Continue to upgrade systems to ensure appropriate support.
89	Produce a business case to Digitalise Health Records (Burnbank).

9. Develop as a population health organisation

9.1 Future Direction

In response to rising demand, financial constraints and workforce pressures, our ambition is to become a population health organisation, as set out in the Forth Valley Population Health and Care Strategy (2025–2035). This will be achieved by improving and protecting population health and wellbeing through prevention and earlier intervention, tackling health inequalities by targeting those with the greatest need, redesigning services around population need to reduce avoidable demand, and delivering high-value, sustainable care.

9.2 Operational Priorities for 2026/ 2027:

Becoming a population health organisation, through:

- Improving and protecting population health and wellbeing: by focusing on prevention and early intervention
- Tackling health inequalities: by targeting those with the greatest need and reducing avoidable differences in outcomes
- Improving how services are developed and delivered: by redesigning services around population need and reducing avoidable demand
- Delivering high-value, sustainable care: by working with partners and making best use of resources to address wider determinants of health

9.3 Key Actions and Deliverables for 2026/ 2027

We will deliver integrated prevention; strengthen vaccination and HCID preparedness; advance sexual health and lifestyle prevention; expand LARC access; implement inequalities, screening, anti-racism and inclusion strategies; reduce drug deaths through MAT and recovery systems; embed person-centred redesign; work with communities on wellbeing and employability; grow community

wealth; assess population health maturity and deliver improvement actions. Local actions and deliverables relating to this priority are outlined in Table 8.

Table 8 Develop as a population health organisation

Improving and protecting population health and wellbeing	
90	Develop an integrated prevention plan across primary, secondary and tertiary prevention
91	Strengthen governance and the public health focus in vaccination programmes; continue alignment with the Scottish Vaccination and Immunisation Programme (SVIP) 5-year framework
92	Enhance High Consequence Infectious Disease (HCID) pathways, preparedness and training
93	Deliver the Sexual Health and BBV Action Plan focused on HIV elimination and STI prevention
94	Prioritise smoking cessation, healthy weight management and diabetes prevention
95	Increase LARC training for healthcare professionals to improve patient access
Tackling health inequalities	
96	Develop and implement a Healthcare Inequalities Action Plan
97	Target underserved populations to reduce health inequalities
98	Implement the Screening Inequalities Plan aligned with the Scottish Equity in Screening Strategy (2023–2026)
99	Align Anti-Racism Plan with Ethnic Diversity Network activity and improve maternity care to address racialised healthcare inequalities
100	Launch the new Equality and Inclusion Strategy 2025–2029
101	Strengthen drug death prevention through monitoring, multi-agency reviews and strengthen support systems and commissioned services for addiction recovery, including continued implementation of Medication Assisted Treatment (MAT) standards.
Improving how services are developed and delivered	
102	Embed person-centred care into all service redesign
103	Collaborate with community partners on health and wellbeing initiatives (e.g., employability, addiction recovery)
Delivering high-value, sustainable care	
104	Expand employability and community wealth-building programmes
Become a population health organisation	
105	Assess population health maturity and deliver a resulting improvement action plan

10. Performance Management and Risk Management

Performance management will be central to delivery of the 2026/27 Annual Delivery Plan. It will provide a structured approach to monitoring whether priorities are being delivered as planned, whether expected improvements are being achieved, and where additional action is required. Each section of the plan will be supported by clear actions, milestones, trajectories and outcome measures, enabling progress to be tracked consistently across operational, tactical and strategic levels. This will ensure that delivery is not only described, but actively managed through regular review, challenge and follow-up.

Delivery will be monitored through a combination of routine reporting, dashboard review, milestone tracking and exception management. Pentana/ Healthcare Guardian will be used to record actions, evidence and status updates, while operational dashboards and service-level reporting will provide more frequent visibility of performance trends, risks and emerging issues. This will allow teams and leaders to identify early where delivery is slipping, understand the causes of variation, and take timely

corrective action. Where appropriate, performance information will also be aligned to Sub-National reporting requirements to support collaboration and shared oversight.

This performance management approach will be linked to NHS Forth Valley's wider risk management arrangements. Risks to delivery, including delays, capacity constraints, workforce pressures, financial dependencies or system barriers, will be identified through routine monitoring and escalated through established management and governance routes where they threaten delivery of ADP commitments. Where appropriate, these will be reflected within directorate and corporate risk registers, enabling alignment between performance oversight, risk mitigation and executive assurance. This will support a more joined-up approach to identifying where delivery challenges require formal mitigation, additional support or Board-level attention.